Relation between Perceived Social Support and psychological Stress among patients with Depressive disorder

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Abstract: Persons with depression live under the dark shadow of sustained stress of mental illness. Perceived social support significantly predicts the patient's ability to cope with stress and support network has been found to reduce the negative effects of stress. **Aim of this study:** It was conducted to determine the relation between perceived social support and psychological stress among patients with depressive disorders. **Design:** This study followed a descriptive research design. **Setting:** The study was conducted at Neuro psychiatry inpatient departments of Tanta University Hospital. **Subject:** A convenience sample of 150 patients was diagnosed with depressive disorder in the above previously mentioned setting was selected. **Tools:** Two tools of were used to carry out this study **Tool (1)** Multidimensional Scale of Perceived Social Support **Tool (2)** Perceived Stress Scale (PSS). **Results:** Majority of the studied subjects had poor level of perceived social support and moderate level of perceived stress and there was a non- significant relation between perceived stress level and perceived social support level. **Conclusion:** The study concluded that, social support has important in reducing stress among patients with depression. In other words patient who has social support are more likely to experience stress. **Recommendation:** Developing of social skill training program for patients with depressive disorders. Develop training program for nurses about the importance of social support to patients and their families during difficult times.

Keywords: Depressive disorders, Psychological stress, Social support.

Introduction

Depression is the most common mental health condition in the general population. It is characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness, and poor concentration. Severe form, depression can lead to suicide and increased risk of mortality. (1) The global prevalence of depression has been increasing in recent decades and the estimated lifetime prevalence of depression is 10% of general population and in clinical setting; its prevalence may reach as high as 20%. Depression is a significant determinant of quality of life and survival, accounting for approximately 75% Diagnosed depression and 12% of all mental hospital admissions. Indeed, depression is the leading cause of disability and is a major contributor to the disease burden worldwide. (2)

Persons with depression live under the dark shadow of sustained stress of mental illness. Because of significant and remarkable stressors that persons with depression experience such as chronicity and illness management, unemployment, ,loss of productivity, rejection from society, isolation, homelessness and stigma , the risk of patient's' vulnerability to experience stress is becoming high . Stress has been defined as an unpleasant state of emotional and physiological arousal that people experience in situations that they perceive as dangerous or threatening to their well-being.(4)

After summarizing the results obtained from nearly twenty years of research about the relationship between stress and depression, **Kessler (2010)** indicated that stress is closely related with depression and stress intensity and degree of depression have a closed relationship. (5) Stress has a vital role in exacerbated depression symptoms, relapse rates, decreased self-esteem, and non-adherence to prescribed medication resulting in reducing the like hood of patient's recovery and patient's' integration into community .Consequently stress is a considerable great problem among individuals with depression and has a stamped negative impact on the wellbeing of them. Therefore, imperious attention for stress issues among patients with depression is emerged. (3, 6)

Social support generally refers to the various types of support that people receive from others, which lead them to believe that they are cared for, are esteemed and valued, and are part of a network of communication and mutual obligations. Social support can be divided into four categories: informative

support (the provision of information, suggestions, and guidance), instrumental support (the provision of financial assistance or material aid), emotional support (the provision of empathy, affection, trust, acceptance, and care), and companionship support (the provision of a sense of social belonging). Social support is provided by networks consisting of family, relatives, friends, neighbors, and coworkers, especially when the interaction is positive. (7)

A good social support can provide protection for an individual under stress and it has been demonstrated to lower the risk of depression by assisting individuals in coping with everyday hardships and has common gaining function on maintaining an individual's good emotional experience. Perceived social support significantly predicts the patient's ability to cope with stress and support network has been found to reduce the negative effects of stress. Person's knowing that they are valued, cared and esteemed by others are an important psychological factor in helping them to forget the negative aspects of their lives and thinking more positively about their environment. (8)

Social support may play a role at two different points in the causal chain linking stress to illness. First, perceived support may intervene between the stressful event (and expectation of that event) and stress reaction by attenuating or preventing a stress appraisal response. That is, the perception that others can and will provide necessary resources may redefine the potential for harm posed by a situation and/or bolster one's perceived ability to cope with imposed demands, and hence prevent a particular situation from being appraised as highly stressful. (9)Second, adequate support may intervene between the experience of stress and the onset of the pathological outcome by reducing or eliminating the stress reaction by directly influencing physiological processes. Support may alleviate the impact of stress appraisal by providing a solution to the problem, by reducing the perceived importance of the problem. (10)

Significant of the study

Person with depression encounters by many stressors and perceived highly stress and finds difficulty in social support. Social support has been shown to promote mental health and acts as a buffer against stressful life events. Social support is derived from a network of people drawn from family, friends and community. A lack of social support is a determinant of mental health problems including depressive symptoms

and has a negative impact on quality of life for patients. Social support helps people to cope with stress. Being surrounded by people who are caring and supportive helps people to see themselves as better capable of dealing with the stresses that life brings, so that, one of the main psychiatric nursing objectives is to reducing patients' stress through enhancing social support provided to the patient. In order to do this the nurse should first assess patients' stress and social support and identify the problems within social support. [11, 12]

Subjects and Method

Aim of the Study

Was to determine the relation between perceived social support and psychological stress among patients with depressive disorders.

Research question

What is the relation between perceived social support and psychological stress among patients with depressive disorders?

Study Design: A descriptive design was utilized in the study.

Research setting: This study was conducted at Neuro psychiatry inpatient departments of Tanta University Hospital which affiliated to the Ministry of Higher Education. It has a capacity of (32) beds divided into two wards for male (17beds) and two wards for female (15 beds). It provides health care services to three governorates, namely Gharbya, El-Menofeya, and Kafr- El-sheikh.

Subjects:

A convenience of 150 patients was diagnosed with depressive disorder in the above previously mentioned setting selected according to Epi- Info software statistical package created by World Health Organization and Center for Disease Control and Prevention, Atlanta, Georgia, USA version 2002.The criteria used for sample size calculation were as follows:

-Total number of admission in one year is 250 diagnosed by depression.
-95% confidence limit. The sample size based on the previously mentioned criteria was found at n=150 for the study.

Inclusion Criteria of the Study

-Adult patient

- Patient diagnosed with major depressive disorder or depressive episode of bipolar disorder

- Patient who able to communicate and participate in the study

Exclusion Criteria of the Study

- Patient diagnosed with mentally retarded or other psychiatric disorder.

- Patient in a cute phase of depression.

- Chronic medical illness that may affect psychological state of the patient such as

(kidney diseases, liver diseases, chronic heart disease and cancer).

- Patient with neurological illness and head trauma.

Tools of the study

Two tools were used to collect data for this study.

Tool I: Multidimensional perceived social support scale (MSPSS)

It was developed by (Zimet et al 1988) [13]. It is a brief research tool designed to measure perception of social support from 3 sources: Family, Friends, and Significant other. The scale is comprised of a total of 12 items, the response rated with 7 point likert scale for each subscale from very strongly disagree=1 to very strongly agree=7. The scale is divided into three subscales, they named: 1-Significant other subscale: It contained 4 items 1, 2, 5, & 10. For example (There is a special person who is around when I am in need).

2-Family subscale: It contained 4 items 3, 4, 8, & 11. Like statement (My family really tries to help me).

3-Friends subscale: It contained 4 items 6, 7, 9, & 12. Like statement (My friends really try to help me).

Scoring system: - The minimum and maximum score that can be acquired from each total score is 12 and 84 respectively, and 4 and 28 respectively for each subscale.

- 12–48 as low perceived social support.
- 49–68 as moderate perceived social support.
- 69–84 as high perceived social support.

Tool (II):- Perceived Stress Scale (PSS) 10 items. It was developed by **Cohen et al, 1983**[14]**.** It is a self-report measure designed to assess patient's perception about the degree of a given support in daily life is considered stressful. It consists of 10 Items are rated on a 5-point Likert scale of occurrence. (0 = never, to 4 = very often). There was reverse scores for questions 4, 5, 7, and 8. The minimum and maximum score that can be acquired from each total score is 0 to 40 with higher scores indicating higher perceived stress is taken as 0-13 as low level of stress,14-26 as moderate level of stress and 27-40 as considered high level of stress.

-The tools of the study was supported by covering sheet about socio- demographic and clinical characteristic of the patient: - It was developed by the researcher to elicit socio demographic data about the patient it contained 9questions (sex, age, marital status, level of education and occupation as well as clinical data which includes, history of disease, frequency of follow up, duration

of illness, previous history of admission, medication and other medical illness).

Method

The study was accomplished according to the following steps

-An official letter was obtained to conduct the study from the responsible authorities after clarifying the purpose of the study to gain permission and cooperation and it approved from ethical committee.

-Ethical considerations throughout the study process were be considered:

-This study was approved by the research and ethical committee at Faculty of Nursing Tanta University.

-Informed consent to participate in the study was obtained from the patient.

- Assure the participants about their privacy and confidentiality of the obtained data.

-Emphasizing the right to withdraw from the study at any time.

-Nature of the study didn't cause any harm or pain to subjects of the study.

-Anonymity of the subjects was assured.

-Tools of the study were translated into Arabic language by the researcher and were tested for content validity by a jury of five experts in Psychiatric and Mental Health Nursing Field.

- A pilot study was conducted on (10%) of subjects after taking their oral approval and explanation the purpose of the study to check and ensure the clarity of the tools, identify obstacles and problems that may be encountered during actual data collection. Subject of pilot study were selected randomly and were excluded later from the study sample.

-Reliability was tested for both tools of the study by using Cronbach's Alpha (0.832**,** 0.901) respectively.

Actual data collection procedure

-After obtaining the permission to conduct the research from the required authorities, the patients who met the inclusion criteria were invited to participate in the study after being informed of the nature of the study.

-The actual data collection was carried out by interviewing the study subjects on an individual basis and each interview was range about 30-45 minutes. The duration of data collection taken seven months, starting from November 2019 to April 2020.

Statistical analysis

The collected data were organized, tabulated and statistically analyzed using SPSS software statistical computer package version 26. For quantitative data, the range, mean and standard deviation were calculated. For qualitative data, comparison was done using Chi-square test ($\chi 2$).

Correlation between variables was evaluated using Pearson and Spearman's correlation coefficient r. A significance was adopted at P<0.05 for interpretation of results of tests of significance (*). Also, a highly significance was adopted at P<0.01 for interpretation of results of tests of significance (**).

Results

Table (1) represents distribution of the studied patients according to their socio-demographic characteristics. It was noted that 28.0% of the studied patients were in the age group between 35 to 45 years old with a Mean± SD = 39.16±12.841. Most of the studied patients were male 82.0%. As Regards marital status 32.0% of the studied patients were married while 8.7% of them were divorced. Concerning the educational level 38.0% of the studied patients were read and write and 13.3% of them had university education. Regarding the occupation 78.7% of the studied subjects were not worked and lived in rural area. Regarding the co-habitation 52.7% of the studied patients were live with family. Concerning having children 51.3% of them hadn't children. As regards the income, the majority (80.7%) of the studied patients reported that their income was not enough.

Table (2) shows clinical characteristics of studied patients, It was clarified majority of studied subject (60.7 %) suffered from depression less than 5 years. As regard having previous hospital admissions79.3% of the studied patients had previous hospital admissions. 77.3% of them having (1-3) times of admission, while 4.2% of the studied patients having (5-7) times of admission.

Regarding last hospitalization most of the studied patients (79.8%) had last hospitalization less than 6 months and the majority (70.7%) of the studied patients had involuntary admission. According to family history of depression, it was founded that 6.7% of the studied patients had family history of depression.

Figure (1) illustrates total mean scores of perceived social support subscales of studied patients. It showed that total mean± SD score was (42.89 ±10.38) in which Mean± SD score (14.09±5.89) was for significant other subscale. Mean± SD score for family and friends social support subscale were (15.37±4.70 and 13.43±5.09) respectively.

Figure (2) illustrates of the studied patients according to their level of perceived social

support. It showed that majority of the studied subjects (74%) had poor level of perceived social support, while (25.3%) of them had moderate level of perceived social support and only 0.7% had high level of perceived social support.

Figure (3) illustrates distribution of the studied patients according to level of stress. It showed that majority of the studied subjects (70%) had moderate level of perceived stress, while (28%) of them had high level of perceived stress and (2%) had low level of perceived stress.

Table (3) illustrates correlation between perceived social support and perceived stress score among studied subjects. The statistical table showed that there was a non-significant relation between perceived stress level and perceived social support level and its domains with (p = 0.587, p=0.548 and p=0.963) respectively.

Tables (4) Clarifies relationship between perceived social support and socio-demographic characteristics among studied patients. It was noticed that, there was significant relationship between perceived social support and items of socio-demographic characteristics except gender, occupation, place of residence and income (P= 0.072, P= 0.393, P= 0.571 and P= 0.436) respectively.

Tables (5) Clarifies relationship between perceived stress and socio-demographic characteristics among studied subjects. It was noticed that, there was non-significant relationship between perceived stress and items of socio-demographic characteristics except gender and educational level (P= 3.206, 0.025* and P= 6.275, 0.013*) respectively.

Table (1): Distribution of The Studied Patients Regarding Sociodemographic Characteristics.

Socio demographic Characteristics	The studied patients (n=150)	
	N	%
Age (in years)		
▪ (< 25)	18	12.0
▪ (25-< 35)	38	25.3
▪ (35-< 45)	42	28.0
▪ (45-< 55)	29	19.3
▪ (55-< 65)	15	10.0
▪ (≥ 65)	8	5.3
Range **Mean ± SD**	**(18-70)** **39.16±12.841**	
Sex		
▪ Male	123	82.0
▪ Female	27	18.0
Marital status		
▪ Single	61	40.7
▪ Married	48	32.0
▪ Widow	17	11.3
▪ Divorced	13	8.7
▪ Separated	11	7.3
Educational level		
▪ Illiterate	29	19.3
▪ Read and write	57	38.0
▪ Secondary school	44	29.3
▪ University	20	13.3
Occupation		
▪ Not work	118	78.7
▪ Work	32	21.3
Place of residence		
▪ Urban	32	21.3
▪ Rural	118	78.7
Co-habitation		
▪ Alone	14	9.3
▪ Father/Mother/brothers	79	52.7
▪ Wife/Husband/Boys	57	38.0
Having children		
▪ No	77	51.3
▪ Yes	73	48.7
Income		
▪ Not enough	121	80.7
▪ Enough	29	19.3

Table (2): Distribution of The Studied Patients According to Clinical Characteristics.

Clinical characteristics	The studied patients (n=150)	
	N	%
Duration of the disease (in years)		
▪ (< 5) year	91	60.7
▪ (5–<10) year	37	24.7
▪ 10 year or more	22	14.7
Having previous hospital admissions	119	79.3
▪ Yes	31	20.6
▪ No		
In case of yes.		
Number of previous hospital admissions	92	77.3
▪ (1-3) times	30	25.2
▪ 4 times	5	4.2
▪ (5-7) times	23	19.3
▪ more than 7 times		
Last hospitalization		
▪ <6 months	95	79.8
▪ (6-12) months	29	24.3
▪ >12 months	26	21.8
Mode of admission		
▪ Voluntary	44	29.3
▪ Involuntary	106	70.7
Family history of depression		
▪ Yes	10	6.7
▪ No	140	93.3

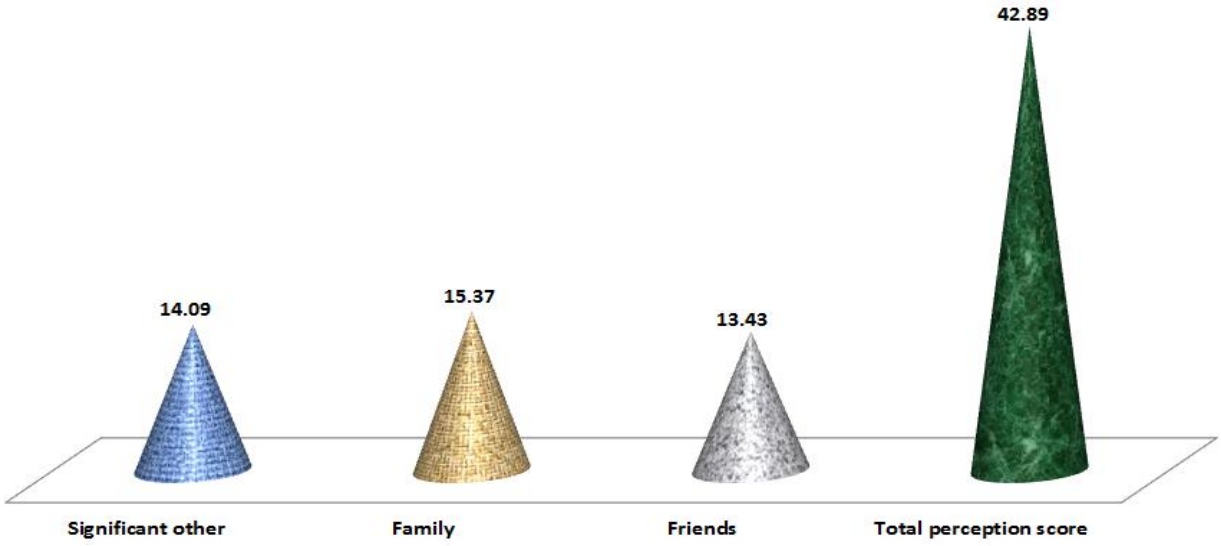

Figure 1: Total mean scores of perceived social support subscales of studied patients.

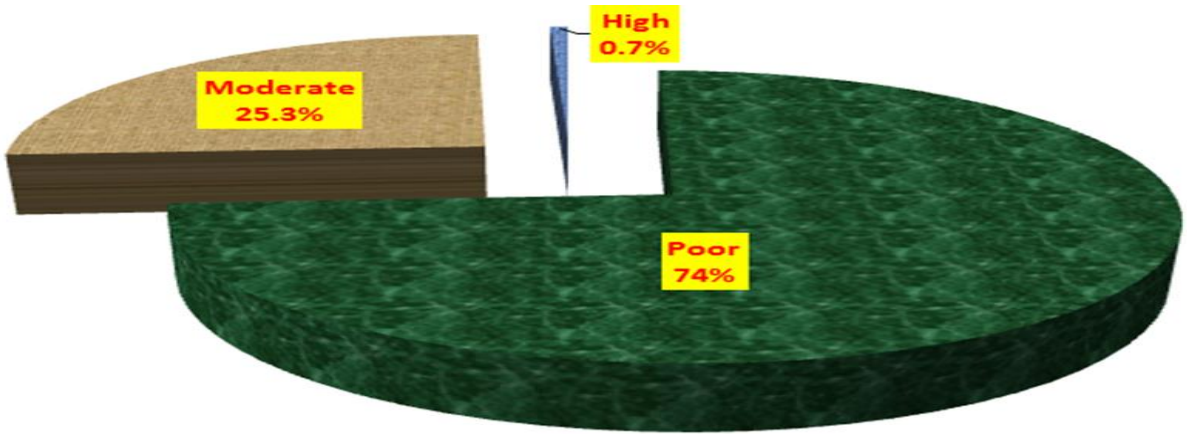

Figure2: Distribution of level of perceived social support scale among studied patients.

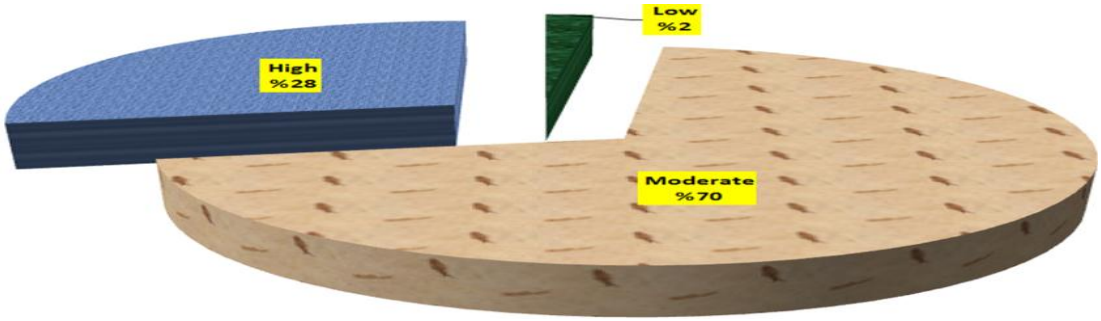

Figure 3: Distribution of the studied patients according to level of perceived stress.

Table (3): Correlation between Perceived Social Support and perceived stress among studied subjects.

Perceived Social Support domains	Total Perceived Stress level	
	R	P
1. Significant other 2. Family 3. Friends	-0.045 0.049 -0.002	0.587 0.548 0.985
Total	-0.004	0.963

Table (4): Relationship between Perceived Social Support and Socio-demographic characteristics of the studied patients.

socio-demographic Characteristics	The studied patients (n=150) Perceived Social Support		
	Mean	SD	T P
Age (in years)			
▪ (< 25)	44.17	9.076	
▪ (25-< 35)	**46.37**	**9.936**	
▪ (35-< 45)	44.21	10.747	**3.880**
▪ (45-< 55)	40.97	10.514	**0.003***
▪ (55-< 65)	38.20	7.457	
▪ (≥ 65)	32.25	8.328	
Sex			
▪ Male	**43.60**	**10.750**	3.292
▪ Female	39.63	7.855	0.072
Marital status			
▪ Single	**48.00**	**11.131**	
▪ Married	40.00	7.374	**8.748**
▪ Widow	35.18	8.361	**0.000***
▪ Divorced	39.92	9.004	
▪ Separated	42.55	9.223	
Educational level			
▪ Illiterate	37.28	7.545	
▪ Read and write	42.95	11.366	**4.467**
▪ Secondary school	**45.91**	**10.048**	**0.005***
▪ University	44.20	8.983	
Occupation			
▪ Not work	42.51	10.677	0.733
▪ Work	**44.28**	**9.222**	0.393
Place of residence			
▪ Urban	43.81	10.142	0.322
▪ Rural	**42.64**	**10.472**	0.571
Co-habitation			
▪ Alone	37.64	8.581	
▪ Father/Mother/brothers	**46.54**	**11.344**	**12.024**
▪ Wife/Husband/Boys	39.11	7.073	**0.000***
Having children			
▪ No	**46.48**	**10.889**	**21.588**
▪ Yes	39.10	8.332	**0.000***
Income			
▪ Not enough	42.56	10.695	0.611
▪ Enough	**44.24**	**8.987**	0.436

Table (5): Relationship between Perceived stress and socio-demographic characteristics of the studied subjects.

socio-demographic Characteristics	The studied patients (n=150) Perceived stress		
	Mean	**SD**	**T P**
Age (in years)			
▪ (< 25)	24.67	6.660	
▪ (25-< 35)	**25.03**	**4.693**	
▪ (35-< 45)	21.88	5.553	1.992
▪ (45-< 55)	23.79	5.341	0.083
▪ (55-< 65)	21.20	4.799	
▪ (≥ 65)	22.63	8.417	
Gender			
▪ Male	22.82	5.712	**6.275**
▪ Female	**25.78**	**4.742**	**0.013***
Marital status			
▪ Single	23.61	5.649	
▪ Married	23.40	5.156	0.383
▪ Widow	21.82	8.210	0.820
▪ Divorced	23.38	4.682	
▪ Separated	**24.09**	**4.505**	
Educational level			
▪ Illiterate	21.45	6.237	
▪ Read and write	22.58	5.161	**3.206**
▪ Secondary school	**24.95**	**6.134**	**0.025***
▪ University	24.80	3.736	
Occupation			
▪ Not work	23.17	5.600	0.584
▪ Work	**24.03**	**5.878**	0.446
Place of residence			
▪ Urban	**24.34**	**4.823**	1.252
▪ Rural	23.08	5.845	0.265
Co-habitation			
▪ Alone	**24.29**	**6.568**	0.372
▪ Father/Mother/brothers	23.49	5.749	0.690
▪ Wife/Husband/Boys	22.93	5.338	
Having children			
▪ No	23.00	5.719	0.617
▪ Yes	**23.73**	**5.593**	0.433
Income			
▪ Not enough	23.21	5.466	0.420
▪ Enough	**23.97**	**6.434**	0.518

Discussion

Social support may alleviate the impact of stress appraisal by providing a solution to the problem and by reducing the perceived importance of the problem. It provides faith to the individual and leads people to cope with the stress-filled events more effectively [15].

One of the most devastating penalties of severe mental illnesses is the interruption of interpersonal relationships. This can be speculated by the finding of the current study which stated that majority percent of the studied patients had poor social support. Along with the same line Egyptian study conducted by **Harfush& Gemeay (2017)** [16] in the same setting of the current study and by using the same tool to assess level of social support among psychiatric patients, they concluded that seventy four percent of their respondents had poor social support. Additionally this finding is also consistent with results of another Egyptian study by **Sabra& Mohamed (2019)** [17] they concluded that more than one third of studied subjects had poor social support. Along with the same line a study conducted by **Munikanana et al (2017)** [18] **stated** that about 72% of the respondents had poor perceived social support. Unfortunately, these studies denote that people with mental illness have low social support at nationally and internationally levels.

This may be attributed to more than one explanation. First, patients become generally apathetic, inactive; having poverty of speech, socially withdrawn and showed disinhibited behaviors which typically are stable features of patients with depression. Second, People are often hesitant to frequent contact with those patients under such conditions because they find such distortions in normal behaviors which lead to stigma against mental illness more upsetting and impose considerable pressure to deal with. Third, patients may also refuse assistance as they are not adversely affected by social isolation.

Family members are considered the most important part of social support for individuals with a psychiatric disorder. This goes with the results of the current study, where the highest sense of social support was found in the family. This may be because most of the patients in this study live with their families, which explain the higher level of social support received from family. Moreover, it is not surprising considering it in Egyptian culture, responsibilities towards the immediate family members have the highest priority, and precede loyalty toward other parties such as friends.

Furthermore, more than half of studied subjects live in rural area which characterized by empathetic & own individualities in terms

of belief systems. It is a stigma for rural family to leave their patient cared by another person except in emergency and hospitalization. Furthermore, the majority of the patients in the present study live with their family and about more than half of them were not worked so family is considered the main source of support by giving practical assistance such financial support, reminding taking prescribed medication and accessing to professional seeking help. This finding is consistent with prior qualitative findings that described "helping with medication" to be an important type of instrumental support for persons with mental illness as mentioned by **Chronister،elal.,(2015)** [19] .

On the other side, a very small percent of the studied subjects perceive friends as social support and reported friends as the latest source of social support .Again as mentioned previously stigma and discrimination and multiple and long hospitalization may b have a great part for this result. In the same stream **Harfush& Gemeay (2017)** [16] found that the highest sense of social support among their respondents was found in family subscale and lowest scale for friends. In the same stream, **McGuire (2018)** [20] found that the majority of patients received social support from their families. This result contradicted with **Ota (2017)** [21] reported that the majority of patients received social support from their friends.

Regarding the factors affecting social support, the present study showed that social support was significantly higher with employed, single, having enough of income, and living with their family. This may be explained by the employment enriched social network and social support. These results are in accordance with **Harfush& Gemeay (2017) [16]** explained it by the fact that employed attained a better social relationship, had aspirations to live like normal people, financially satisfied, and had better global functioning . This result contradicted with **Adams R (2015) [22], Naseri N (2018)** [24] and **Hou, F (2019)** [23] found that married patients in the sample group were received better social support from their husbands and sons.

Level of education is considered among factors affecting level of social support. Patients who are highly educated are significantly more social than illiterate patients. This may due to education level be able to affect one's perceptions of others and person can find help by sharing experiences with other and people who have a higher educational level may have better communication ability and interpersonal skills so that they can utilize support resources actively. This study supported by **Duman M (2016**) [25] found that the higher perceived

social support mean scores were obtained by patients who were graduates of middle/high school or higher level of education. This result contradicted with **Costa-Requena (2016)** [26] showed that education level has no effect on the level of social support received.

Regarding level of perceived stress of study patients, the present study showed that seventy percent of the studied patients had moderate level of perceived stress; while more than one quarter of them had high level of perceived stress, this result may be due to psychiatric patients had feeling of harassment, overload, irritability, lack of joy, fatigue, worries and tension, fear from stigma of their disease could lead to mood disorders, undesirable living situations and lose of job. This result was in accordance with **Zhang (2015)** [27] conducted study on people with depression had high level of perceived stress. This result contradicted with **Rankin (2017)** [28] found that majority of the patients had poor level of perceived stress.

The present study showed about third of studied patients are younger 25-45 years which the age of productivity and self-achievement and majority of them female, have children, low level educated and don't have partner (most of patients are(separated),so all of these factors increase patients' vulnerability to have moderate level of perceived stress. These results come in congruent with **Nikolich-Zugich (2020**) [29] found that older adults (55-65) years reported a lower level of perceived stress**.** In the same stream **Shanahant (2020)** **[30]** found that people aged between 18 and 25 or 21–38years old would demonstrate higher rates of stress.

The current study revealed that there was a negative non- significant relation between perceived stress level and perceived social support. This may be due to social support being able to reduce the negative effects of stressful life events via the supportive actions of others that enhance coping performance. Social support plays vital role in providing information, sympathy, and assurance, financial and practical assistance for patients during times of stress, or through the belief that support is available, which leads to the appraisal of potentially threatening situations as less stressful and increase life enjoyment. This explanation is supported by **Mobasherietal., (2014)** **[31]** stated hat for people with mental illness social support serves a protective role during times of stress by enhancing adaptive coping behaviors. This result was in accordance with **Berrios (2016)** **[32], Gonzalez (2017)** **[33]** and **Akbari (2018)** **[34]** found that there was a negative non-significant relation between perceived stress level and social support domains of significant other.

The present study showed that people who live in an urban had high level of perceived stress. This result may be due to that the urban environment had the lack of connection with others, a lack of means to keep in contact with loved ones increase the perception of vulnerability and isolation, affecting the perception of stress. This result was agreement with **Recchi (2020)** [35] found that there is evidence that spending confinement in a densely populated city is a risk factor, affecting people's stress. Conversely, this result was disagreement with **Rodríguez-Rey (2020)** [36] found that people who live in rural or urban environments, those who spent confinement in residential/suburban environments had lower levels of stress.

The current study revealed that there was statistically significant relationship between perceived stress and income. This result may be due to depressive disorders caused an acute financial strain, taking into account that some people may have lost their jobs, seen their income plummet or been furloughed this may lead to difficulties in obtaining basic supplies and protective equipment and may increase stress levels. This result was supported by **Mazza, C (2020)** [37] found that both income and work conditions may be risk factors for stress.

The present study showed that patient who was separated had high level of perceived stress. This may be due to separated person loosed source of social support because stigma from psychiatric disorders and also loosed income source and patient was worried more about their daily life. This result agreed with **Vicario-Merino(2020)** [38] found that people who were separated or divorced demonstrated similar levels of control of stress during confinement to those who were married, living with a partner, or single.

The current study revealed that patients who were secondary school and higher education level had high level of perceived stress. This result may be based on greater awareness and understanding of the risks of the illness and have coping skill and more experience in dealing with stressor events in daily life .this result supported with by **Wei W (2020)** [39] found that people with higher levels of education had greater levels of depression and stress. Conversely, this result was disagreed with **Brooks (2020)** [40] suggested that educational levels do not have significant associations with indices of population stress.

Conclusion and recommendation

The current study concluded that social support has important in reducing stress among patients with depression. In other words patient

who has social support are more likely to experience stress.

Based on the results of this study the following recommendations are suggested:

-Development of social skills training program for patients with patients with depressive disorders.

-Develop training program for nurses about the importance of social support to patients and their families during difficult times.

-Training of psychiatric hospital staff to increase their understanding about the importance of their supportive role to provide appropriate nursing intervention for patients with psychiatric disorders

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