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"The Impact of Family Support on Recovery of Depressed Patients in Gaza Governorates"

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Abstract

Topic: "the impact of family support on recovery of depressed patients in Gaza governorates".

Background: Family support among depressed patients is an important factor in recovery from many mental illnesses. **Objectives:** the overall objective of this study was to assess the impact of family support in recovery of depressed patients in Gaza governorates. Specific objectives were to assess the effect of family emotional, instrumental, informational status on recovery of depressed patients, and to identify the effects of group with common interest on recovery of depressed patients, and the last objective was to assess the relationship between demographical variables of family and recovery of depressed patients. **Study design:** Cross sectional design was used. **Methods:** one hundred and seventy two depressed patients and those families received questionnaires (family support scale and recovery from depression scale) in six community mental health clinics in Gaza governorates, the participants from major depression disorders diagnosed in 2009-2010 years, to fill questionnaires including the demographic data.

Collected data was entered and analyzed using statistical package for social sciences (SPSS). **Results:** Prevalence rate of recovery from depression that received family support was 68.46%, and family support rate was 69.65% . The results revealed that there is a significant relationship between family support and level of recovery of depressed patients. The rate of recovery of depression is negatively affected by the duration of the illness and positively affected by the educational level of family.

Conclusion: It is concluded from this study that family support has positive effect and increases the recovery prevalence among depressed patients. Integrating patients with social and family network are important in increasing the recovery process.

Key words: Family Support, Recovery from Depression.

ملخص الدراسة

عنوان الدراسة:"أثر الدعم الأسرى على تعافى مرضى الاكتئاب في محافظات غزة"

خلفية الدراسة: الدعم الأسرى لمرضى الإكتئاب له تأثير إيجابى فى التعافى من تلك الاضطرابات النفسية.

أهداف الدراسة: الهدف العام لهذه الأطروحة هو وصف معدل الدعم الأسرى فى عملية التعافى من مرض الإكتئاب فى محافظات غزه, أما الأهداف الفرعية,يهدف البحث لوصف وتقييم تأثير الدعم العاطفى,الأدائى والمعلوماتى للأسرة فى التعافى من الإكتئاب,كما يهدف لوصف ومعرفة تأثير المجموعات ذو الإهتمامات الواحدة مثل المؤسسات المجتمعية الداعمة وتأثيرها على عملية التعافى من الإكتئاب,أخر هدف هو تقييم ووصف العلاقة بين العوامل الديمغرافية للأسرة ونسبة التعافى من الاكتئاب ,**تصميم الدراسة و أسلوبها:** أجريت هذه الدراسة بالطريقة التحليلية التقاطعية على عينة مكونة من مائة واثنان وسبعون مريض اكتئاب مشخصين فى العامين 2009-2010م

وهم يتابعوا حالاتهم فى عيادات الصحة النفسية المجتمعية الست المنتشرة فى محافظات غزة.

بعد الموافقة بالمشاركة فى الدراسة,تم تعبئه الإستبانات لكلا من مرضى الإكتئاب (استبانه التعافى من الإكتئاب)وأسرهم (استبانة الدعم الأسرى).

تم ادخال وتحليل البيانات المجمعة باستخدام الحزمة الإحصائية للعلوم الإجتماعية (SPSS).

النتائج: معدل انتشار نسبة التعافي من الاكتئاب الذين يتلقون الدعم الأسرى كان 68.46% ,ونسبة الدعم الأسرى لهؤلاء المرضى هو 69.65% وهذا يعنى أن هناك علاقة مهمة بين الدعم العائلى ومستوى التعافي من الاكتئاب.

وختاما: الدعم العائلي له تأثير إيجابي ويزيد من مستوى التعافي لمرضى الاكتئاب,بالمقارنة مع عدة دراسات سابقة,لهذا أنصح بعمل دراسات وأبحاث أكثر على اضطرابات نفسية أخرى,ووضع أولوية في علاج وإدارة مرضى الاكتئاب وإشراك العائلة وأعضائها في خطة العلاج ,كما أوضحت النتائج الإيجابية للدراسة.

الكلمات الدالة: الدعم الأسرى,التعافى من الاكتئاب.

Dedication

I dedicated this work to

My parents,

My wife and my kids (Yosef & Aboud),

And my brothers

Who has shown unconditional love and support from beginning to end.

Acknowledgements

This thesis would not have come to fruition without the help of our god "Allah" firstly and mainly after that some key individuals.

I am truly grateful for Dr Ashraf Eljedi,and Dr Mohamomed ElHeluo who has provided guidance and support throughout this process, and serving as my mentor, and Dr.abd ftah Hams and Dr.Jehad Hammad about there guidance and monitoring.

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My thanks are extended to all those not mentioned in person and who contributed in any way during this research. I wish all of them along and prosperous life.

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List of abbreviations:

- **DALY:** Age-standard Disability Adjusted Life Year.
- **DSMIV:** Diagnostic and Statistical Manual of Mental Disorders.
- **ECT:** Electroconvulsive Therapy.
- **MOH:** Ministry Of Health.
- **GG:** Gaza Governorates.
- **MDD**: Major Depressive Disorders.
- **MD:** Major Depression.
- **UNRWA:** United Nation Relief and Work Agency.
- **SSRIs:** Selective Serotonine Reuptake Inhibitors.

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Chapter I

Introduction

Chapter one: Introduction

1.1 Overview

Family is considered a cornerstone in surrounding environment of any person with mental disorders.

According to mental health worker's observing and experiences in working with mental ill patients, there is burden on families of mental ill patients in provision of support to patients from those disorders, especially depression, and that in light of definition of family support" the provision of information that leads subjects to believe their basic social needs are gratified through interaction with their family"(Thoits, 1982).

In reviewing several studies concerning with the relationship between special support and depression," study suggest that intervention to alleviate depressive symptoms in patients by social support " (Elsevier, 2000), and another study said "family interventions reflect as lift from viewing families as the cure of illness to a source of support for the ill relatives"(Stuart, 1990).

In the same time, families are the largest group of the mentally ill. In another hand, recovery process consider from updates concepts and procedures in management of mentally ill specifically in Arab countries, in time of "the concept of recovery began to obtain legitimacy" (Sullivan, 1997).

So when we identify the definition of recovery as" away of living, a satisfying, hopeful and contributing life, even within the limitations caused by the illness"(Anthony, 1993), and compare it with symptoms of depression as, a painful experiences, hopelessness as diagnostic and statistical manual of mental disorders (DSMIV) criteria of depression, so the need is important to recover from those symptoms by recovery process steps, and so the study will try to explore the role of family support in promoting the recovery among depressed patients, to improve their integration in the community.

1.2 Context of Thesis

1.2.1 Geography and Demography of Palestine

Palestine has an important geographic and strategic location; it is situated on the Eastern coast of the Mediterranean Sea, in the Middle East.

Gaza Strip is a narrow piece of land lying on the coast of Mediterranean sea. Its position on the crossroads from Africa to Asia made it a target for occupiers and conquerors over the countries. The last of these was Israel who occupied the Gaza Strip from Egyptians in 1967 (Annual Report, 2005).

Gaza strip is very crowded place with an area of 365 sq. Km and constitute 6.1% of total area of Palestinian territory land. In mid year of 2005 the population number was to be 1,389,789 mainly concentrated in cities and small villages, and eight refugee's camps that represent two thirds of the population in Gaza strip. In Gaza strip, the population density is 3,808 inhabitants per km2 that comprises the following main five governorates: North of Gaza, Gaza City, Mid-Zone, Khan-younis, and Rafah (MOH, 2005).

The Palestinian population living in Palestine territories (Gaza Strip, West Bank and East Jerusalem) was estimated for the year 2004 at 3.6 millions; about 2.3 millions live in West Bank (63.2%), and 1.3 million in Gaza Strip (36.8%) (Annual Report, 2005).

More than (70%) of the population lives in rural areas (Barghouti, 2001). According to the United Nations Relief and Works Agency (UNRWA) statistics in2005, (43.8%) of the total number of population in Palestinian territories are refugees (MOH, 2005). Seventy five percent of Gaza Strip populations are refugees and 40% of them live in the camps. In Gaza Strip the population density in the refugees' camps is one of the highest in the world (Keng, 2006).

Palestinian population is considered to be mostly young .The percentage of population under 15years in Gaza strip is (49.1%), (2.5%)above 65 years and the median age is 15 years (Annual Report, 2005).

Gaza Strip is considered one of the lowest incomes in the Middle East area. The most of the income comes from salary of the employees and security persons, while the agriculture products share by reasonable portion in the economy. The economy nowadays mainly depends on international donors that are suspended. International aids were

funding some projects and paid the salaries. The economic situation is bad especially after Al-Aqsa Intifada because of frequent closure and restriction of trade.

The deteriorating economic situation, limited income and lack of work opportunities lead to low standard of living and inadequate health facilities (Annual Report, 2004).

Despite poverty the Palestinians are eager to learn, adult literacy ratio among those aged 15 years and more is 91% which is considered among the high percentage literacy rates of Arab countries (Annual Report, 2004).

The following map in figure (1) shows Gaza Governorates and in ever governorate have community mental health clinic,(Gaza, Rafah, Khan Younes, Nussirate, and North Gaza).

Figure (1) Gaza governorates

1.2.2 Health care system in Palestine

Health care system is defined as" The complete network of agencies, facilities, and all providers of health care in a specified geographic area"(Elsevier, 2009)

Based on decision maker's opinion in Ministry of Health, there is no clear health care system in Palestine, mental health services are classified as a part of the Health care system.

1.2.2.1 Mental health services

The Ministry Of Health (MOH) of the Palestinian National Authority is the main statutory health provider responsible for supervision, regulation, licensing and control of all health services, other health providers including the United Nations Relief and Work Agency for Palestinian Refugees in the Near East (UNRWA),Military Medical Services, health services belonging to national and international non- governmental organization (NGOs) including the Palestinian Red Crescent Society and some private health sector (for profit) organization.

Overall, service provision is fragmented. The territory has neither a mental health policy nor a comprehensive plan that addresses both ongoing cares for the severe mentally ill and services for those affected by the traumas and losses of the conflicts. There is no mental health legislation , and no separate budget line for mental health in Ministry of Health's budget. (Thabet, 2002)

Recently, there are six community mental health clinics in Gaza Strip beside psychiatric hospital established in Gaza separated from primary health care in MOH, as follows:

- North Gaza (Abu shiback clinic). - Gaza (Suranni and west Gaza clinics).
- Mid zone (Shuhada'aa Nussirate clinic). - Khan Younes (Jasser El Agha clinic). - Rafah Clinic (Tal El Sultan clinic).

And about the prevalence of affective disorders in Gaza Strip in 2009 was 162 cases, in comparison with total prevalence of it in 2005 to 2009 are 974 cases. (Annual Report, 2011).

1.3 Overall aim of the study

"The purpose of this study is to assess the impact of family support in recovery of depressed patients in Gaza governorates, to explore the role of family support in promoting the recovery among depressed patients and to improve their integration in the community."

1.3.1 Specific objectives

1- To assess the effect of family emotional status on recovery of depressed patients.

2- To identify the family instrumental support and its effect on recovery of depressed patients.

3- To describe the family informational support and its effect on recovery of depressed patients.

4- To identify the effects of group with common interests on recovery of depressed patients.

5- To describe the family spiritual support and its effect on recovery of depressed patients

6- To assess the relationship between demographic variables of family and recovery of depressed patients.

1.4 Problem statement

From increasing number of depressed patients ,and in light of continuous threatening events and crisis in Gaza Strip, and with a big burden and responsibility on mental health workers and mental health administration and provision of care for those patients . On the other hand, the shortage of care provided for depressed patients and recovery and engagement in community to become empowered and have significance in their community.

1.5 Research questions

1- What is the effect of family emotional status on recovery of depressed patients?

2- Does the family's instrumental support affect recovery of depressed patients?

3- Does the family's informational support affect recovery of depressed patients?

4- What are the effects of group with common interests and relation with family on recovery of depressed patients?

5- Does the family's spiritual support affect recovery of depressed patients?

6-What is the relationship between demographic variables of family and recovery of depressed patients?

1.6 Significance of the study

Family is primary care agent and enormous source of social support and strong contributing factor to recovery, moreover, there is no previous recovery process implementation in mental health centers in Gaza strip, but in some centers implementing partially or some stages of it, in time of Gaza's society and most of population have Islamic religion and culture that care in human being and contributing in recovery of mental illness without scientific base.

On the other hand, the researcher predicts – through the result of the study - to add new approach in dealing with therapy of depression and decrease of its burden, beside all this consideration, the prevalence of depression increasing with years.

1.7 Definitions of operational terms:

1.7.1 Family support

- *Theoretically:* According to (Joanne K, Scheider et al, 2009)."The provision of information that leads subjects to believe their basic social needs are gratified through interaction with their family" The family and friends of persons depressed now have their own support group much like family and friends of those suffering from other problems. We all know that a family member with a serious problem affects the entire family or system and throws it out of balance.

- *Operationally:* "Provision of information to subjects to achieve life goals that made dysfunction in life activities and its achieved by many aspects of support as emotionally, structurally, and informational." *Adopted and modified from* (scheider et al, 2009)

1.7.2 Recovery process

- *Theoretically:* according to (karyen baker & wayne skinner, 2005) "Recovery relatives and families can move beyond maintenance of symptoms to worthwhile or enjoyable life – there is now a greater appreciation for a potential of those with mental health /disorders and their families. Through the process of recovery, relatives /families are able to manage their difficulties and achieve meaningful goals.

- *Operationally:* " The way of living with satisfying life according to surrounding environment of patients and its circumstances as economic status, unique culture and religion and specific support to the patients. *Adopted and modified from* (Anthony, 2003)

1.7.3 Depression

- *Theoretically:* (Suzana & Jack ,2007) mentioned, Depression is more than just the sad mood that most people might experience when they have had a bad day. Major depression is a medical disorder that lasts at least two weeks and that produces a combination of physical and emotional symptoms that makes it very difficult to function in life. At the heart of clinical depression is a loss of pleasure in activities that used to be fun or exciting.

- *Operationally:* The researcher adopted definition of (Newell & Gonrnay, 2000*),*Major depressive disorder (MDD) (also known as recurrent depressive disorder, clinical depression, major depression, unipolar depression, or unipolar disorder) " Is a mental disorder characterized by an all-encompassing low mood accompanied by low self-esteem, and by loss of interest or pleasure in normally enjoyable activities ."

And the researcher will include all depressed patients registered in six governmental clinics in Gaza strip in 2009&2010.

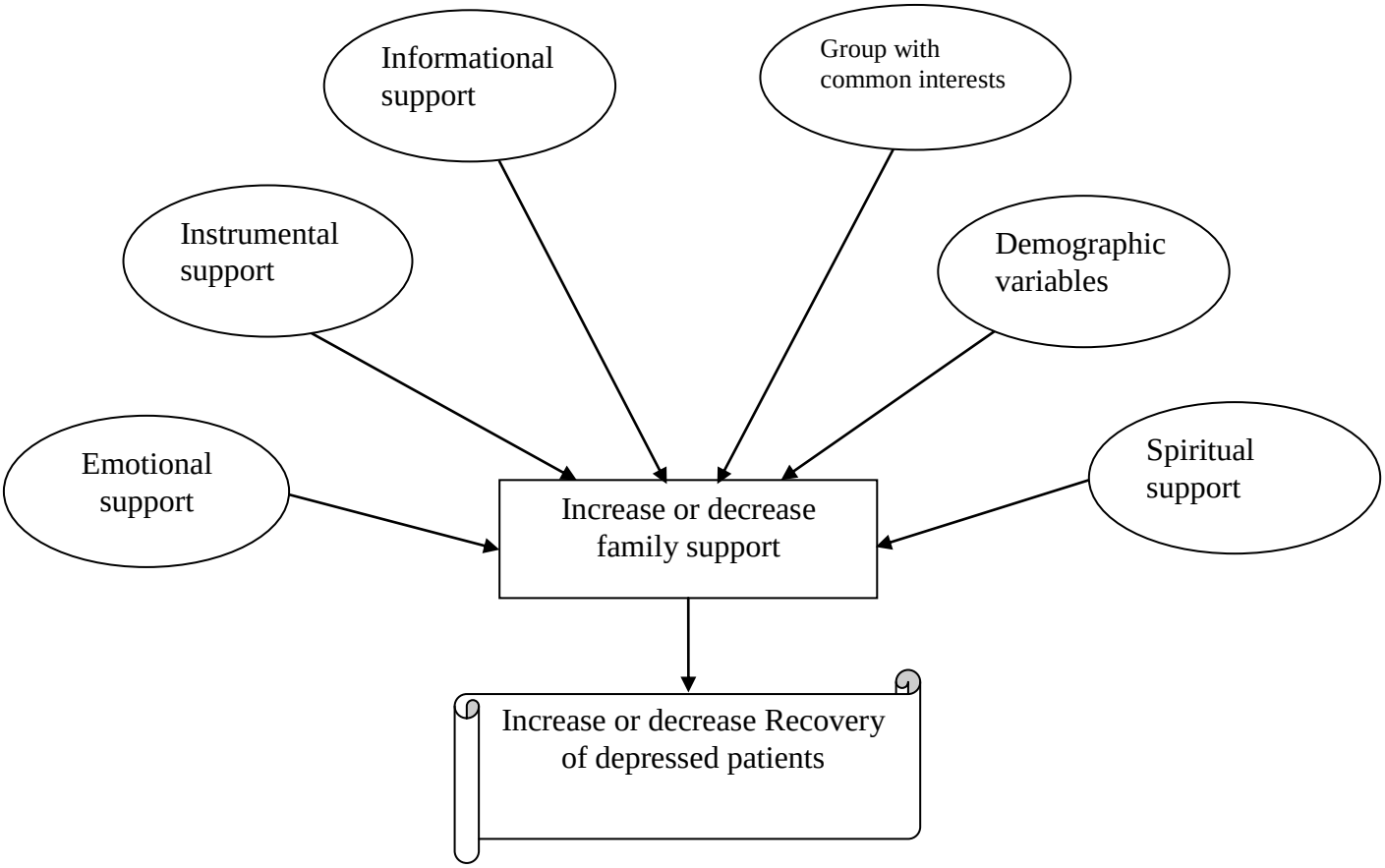
Chapter II

Conceptual Framework

Chapter II: Conceptual Framework

2.1 Conceptual framework:

Figure (2):



The researcher developed his model about the conceptual basis of his research, this diagram clarifies the study about the impact or effect of family support with its domains, contents and effect at each domain on recovery of depressed patients and its relation with positive or negative progress on recovery among depressed patient, and this model claries the independent variable are family support the cause of recovery of depressed patients as dependent variables. In addition the researcher will clarify and measure the family support with its domain as informational, instrumental, emotional, spiritual and group with common interests support, and will study the effect of demographical data of family as gender, address, relation to the patient, economic status and educational level of member of family who provide support to the patient, and all of those domains will affect positive or negative on recovery of depressed patients in six community mental health clinics distributed in Gaza governorates.

Chapter III

Literature Review

Chapter III: Literature Review(Theoretical framework)

For most people sustained mental illness, major depression (target population in this thesis) faces a lot of difficulties in management of them illness, and recovery process have many steps and criteria to implement and help in fasting of adaptation and management of it on scientific base method. Social supports for depressed patients have effective significance in management process, and from big group of social support is family.

This chapter discusses the theoretical framework to major depression, family support, and recovery process of it and another part is previous studies about it.

3.1 Part One: Theoretical framework

3.1.1 Depression (Major Depression)

Definition: Depression is a mental condition that affects the body mentally, emotionally and physically. The most common types of depression include major depression and chronic depression. Major depression is more severe in comparison to chronic depression. Both types require special treatment to help to alleviate the symptoms that may occur. (Romi, 2009)

According to *DSMIV* definition of depression "Is one type of mood disorders (depression and mania), and classify into three types as follows:

- Major depressive (unipolar) disorder.
- Bipolar disorder (sometimes called manic depressive disorder).
- Dysthymias including cyclothymia.

* The researcher will study the major depressive disorder, it's defined as:

"Require five or six of symptoms to be presented to diagnose major depressive disorder from ten symptoms as listed in DSMIV:

1- Depressed mood most of day, nearly every day.

2- Markedly diminished interest or pleasure in all or most activities most of day, nearly every day.

3- Loss of energy or fatigue nearly every day.

4- Loss of confidence or loss of self esteem.

5- Unreasonable feelings of self-reproach or excessive or inappropriate guilt, nearly every day.

6- Re-current thoughts of death or suicide or any suicidal behavioral.

7- Diminished ability to think or concentrate or inclusiveness, nearly every day.

8- Psychomotor gestational retardation- nearly every day.

9- Insomnia or hypersomnia nearly every day.

10- Change in appetite (decrease or increase with corresponding weight change).

Signs and symptoms: according to (Newell &Gonrnay, 2000),Major depressive disorder (MDD) (also known as recurrent depressive disorder, clinical depression, major depression, unipolar depression, or unipolar disorder) "is a mental disorder characterized by an all-encompassing low mood accompanied by low self-esteem, and by loss of interest or pleasure in normally enjoyable activities. This cluster of symptoms (syndrome) was named, described and classified as one of the mood disorders in the 1980 edition of the American Psychiatric Association's diagnostic manual. The term "depression" is ambiguous. It is often used to denote this syndrome but may refer to other mood disorders or to lower mood states lacking clinical significance. Major depressive disorder is a disabling condition which adversely affects a person's family, work or school life, sleeping and eating habits, and general health.

Also as mentioned DSMIV and (Newell and Gonrnay, 2000), the diagnosis of major depressive disorder is based on the patient's self-reported experiences, behavior reported by relatives or friends, and a mental status examination. There is no laboratory test for major depression, although physicians generally request tests for physical conditions that may cause similar symptoms. If depressive disorder is not detected in the early stages it may result in a slow recovery and affect or worsen the person's physical health. Standardized screening tools such as Major Depression Inventory can be used to detect major depressive disorder. The most common time of onset is between the ages of 20 and 30 years, with a later peak between 30 and 40 years.

Also, people often have feelings of sadness, hopelessness, and pessimism. These symptoms are accompanied by a wide variety of physical symptoms, such as difficulties sleeping, poor concentration and memory, low energy, and changes in appetite. (Anna, 2009)

Prevalence : (David et al ,2005) said," It is thought that clinical depression will affect up to 1 in 4 of us at some point in our lives. Depression is more than just sadness or feeling "a bit down in the dumps". It can be a long term condition with no obvious cause and with debilitating symptoms including extremely low mood, low self-esteem, being unable to take pleasure in things, poor concentration, insomnia, anxiety and feelings of worthlessness or hopelessness."(Furukawa TA,et al ,2008)

According to (Emy &et al ,2009), Major depression; is one of the effective disorders , is a mood disorders characterized by a sense of inadequacy ,dependency , decreased activity, pessimism, anhedonia and sadness where these symptoms severely disrupt and adversely affect on the person's life ,sometimes to such on extent that suicide is attempted or results."(George & Karen L, 2009)

World health organization (WHO, 2002), identifies major depression as the fourth leading cause of disease burden in the world.

The disease burden consists of two elements, mortality and disability, with regard to mortality; it is sobering to note that 15% of patients hospitalized for depression will eventually commit suicide (Hawton & van Heeringen, 2000).

And according to (Hawton & van Heeringen, 2000), Symptoms and signs of Major depression significantly affects a person's family and personal relationships, work or school life, sleeping and eating habits, and general health. Its impact on functioning and well-being has been equated to that of chronic medical conditions such as diabetes.

The etiology: it can be abbreviate the etiology of MD according to (Benjamin & Virgina,2002) to biological factors such as, biogenic amines – nor epinephrine or dopamine- . And Genetic factors such as family, adoption, twin and linkage studies. And psychosocial factors such as life events and environmental stress, personality factors , psychodynamic in depression.

Theories of depression: And (Kaplan &Sadock's, 2002) continued and mentioned many psychotherapeutic approaches to depression as:

- Psychodynamic approach by Frued, Abraham, Jacobson, Kohut Ego regression; damaged self-esteem and resolved conflict due to childhood object loss and disappointment.

- Cognitive approach by Plato, Alder, Beck, Rush, Distorted thinking; dysphoria due to learned negative views of self, others, and the world.

- Interpersonal approach by Meyer, Sullivan, Klerman, Weissman; impaired interpersnal relations, absent or unsatisfactory significant social bonds.

Also, there is pharmacotherapy method in treating depression, one group of antidepressant such as tricyclic drugs, and another group of SSRIs.

Moreover, from important approach and alternative to drugs treatment, two organic therapies that are ECT and photo therapy. (Benjamin and Virgina, M.D, 2002)

The prognosis of MD according to (Kaplan &Sandock's, 2002), MD is not a benign disorder, it tends to be chronic, and patients tend to relapse. The percentage of patients recovering after repeated hospitalization decreases with passing time. About 25 percent of patients experience a recurrence in the first 6 months, and about 30-50 percent in the first 2year, and 50 to 75 percent in 5years.

Management: It is difficult to deal with depression, because the condition can drain a person of the energy he or she needs to combat the feelings associated with depression. A chronically depressed individual needs to get plenty of sleep at night, but taking frequent naps during the daytime is not good for depression. A person who is depressed needs to go outside and mingle with people, because living the life of a hermit often causes a person to plunge into a deeper state of depression.(Mayer,2011)

Otherwise, according to (Benjamin & Virgina, M.D, 2002) the management of MD directed toward several goals; first, the patient's safety must be guaranteed, second, a complete diagnostic evaluation of patient must be carried out. Third, a treatment plan that addresses not only the immediate symptoms but also the patient's prospective well-being must be initiated. In another hand, and in the same concern, psychosocial therapy

includes cognitive therapy, interpersonal therapy, psychoanalytically oriented therapy and family therapy

3.1.2 Family support

Definition: According to (Thompson & Uyeda ,2004), Families are big, small, extended, nuclear, or multi-generational, with one or two parents and /or grandparents, they live under one roof or many and can be as temporary as a few weeks or as permanent as forever. Individuals become part of a family by birth, adoption, marriage, or from a desire for mutual support. A family is a culture unto itself, with different values and unique ways of realizing dreams. Together, families become the source of rich cultural heritage and diversity and are what create neighborhoods, communities, states, and nations.

Origin of Family Support: Family support movement has existed in some form throughout history, the modern concepts and strategies arose in the late 1970s as a grass-roots movement organized around a common set of principles to serve entire families in a non-judgmental and highly inclusive way.

Private support for needy families has its origins in many religious traditions, and the public form of family support that developed in the US evolved from the English Poor Laws that codified how needy families would receive community support.

It was not until the 1970's when changing family demographics and the full impact of women entering the workforce was appreciated that family support policy began to change.

And according to Lisa Thompson &kemperly Uyeda, 2004, the development of a family support movement nationally and internationally, a more integrated and comprehensive set of services are being offered both to targeted populations and universally to all parents. These services may be delivered through "one-stop" service and referral centers organized around collaborative of federal, state, county, regional, city, and community entities.

The idea of having a special group just for family members is to help each other understand the nature of depression and learn how in the meantime to take care of their own needs. The group helps the focus stay on their own issues and not that of the depressed." (Johns, 2009).

Moreover, according to (Patcharee Komjakraphan& Sang-arun Isalamalai,2009), "Understanding the multidimensionality of the family support construct is useful when identifying specific kinds of family support that may be beneficial for depressed patients. Family support was defined as the provision of information that leads subjects to believe their basic social needs are gratified through interaction with their family support can be categorized into structural and functional aspects. Structural aspects of support are concerned with integration of the person within the support network, while functional aspects of support are concerned with the function or role served (i.e. what actually is gained or believed to be gained). Functional aspects of family support refer to the type or nature of family support and can be classified into 4 domains: Instrumental support, emotional support, informational support and social integration. Instrumental support refers to tangible assistance that others may provide, such as helping with housekeeping and the provision of transportation or money, but emotional support refers to the experience of feeling liked, admired, respected or loved, while informational support involves the provision of information during the time of stress. Belonging to a group whose members share a common interest and activity describes social integration."

Likely , as mentioned by Best Practices Project (Beebe,1996), the philosophy of family support is based on nine principles for practice. These principles describe good family support practice

• Staff and families work together in relationships based on equality and strength.

• Staff enhance families' capacity to support the growth and development of all family members—adults, youth, and children.

• Families are resources to their own members, to other families, to programs, and to communities.

• Programs affirm and strengthen families' cultural, racial, and linguistic identities and enhance their ability to function in a multicultural society.

• Programs are embedded in their communities and contribute to the community-building process.

• With families, programs advocate for services and systems that are fair, responsive, and accountable to the families served.

• Practitioners work with families to mobilize formal and informal resources to support family development.

• Programs are flexible and continually responsive to emerging family and community issues.

• Principles of family support are modeled in all program activities, including planning, governance, and administration.

3.1.2.1 Family Support and Mental Illness

Having a family member with a mental illness can be very stressful. Whether the ill person is a son, daughter, husband, wife, brother or sister, you will be affected by their illness too.

A person with psychiatric disorder often needs much love, help and support. At the same time, the problems, fear and behavior of your ill relative may strain your patience and your ability to cope. (Halows.2010)

(Jem, 2012) "Prevention, treatment, and recovery in behavioral health require a multifaceted approach in which individuals, families, schools, and communities all play a vital role. This show will focus on one of these critical success factors – families. Whenever a family member is experiencing the mental or substance use health problem-parent or child – the response should involve the entire family. A strong family support environment is a proven protective factor in the prevention of mental or substance use disorders just as strong family support is critical in treatment and recovery"

3.1.3 Recovery Process

(Anthony, 1993) defined recovery process as. "A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and /roles. It's the way of living satisfying, hopeful, and contributing life even with limitations caused by the illness"

History: In general medicine and psychiatry, recovery has long been used to refer to the end of a particular experience or episode of illness. The broader concept of "recovery" as a general philosophy and model was first popularized in regard to recovery from substance abuse/drug addiction, for example within twelve-step programs.**(**Fisher D, 2005)

(Anthony, 2003), was categorized recovery into Five Stages; it can be helpful to view recovery as a process with five stages. People go through these stages at different

speeds. Recovery from an illness like depression or bipolar disorder, like the illness itself, has ups and downs. Friends and family who are supportive and dependable can make a big difference in a person's ability to cope within each of these stages.

1. Handling the Impact of the Illness.

2. Feeling like Life is Limited.

3. Realizing and Believing Change is Possible.

4. Commitment to Change. 5. Actions for Change.

"Recovery-oriented systems support person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities to take responsibility for their sustained health, wellness and recovery from major depression.

A **recovery approach** to mental disorder or substance dependence (and/or from being labeled in those terms) emphasizes and supports a person's potential for recovery. Recovery is generally seen in this approach as a personal journey rather than a set outcome, and one that may involve developing hope, a secure base and sense of self, supportive relationships, empowerment, social inclusion, coping skills, and meaning. Other names for the concept are recovery model or recovery-oriented practice.

Moreover, according to (Mars & Lina ,2005)**,** there are many pathways to recovery*;* Individuals are unique with specific needs, strengths, goals, health attitudes, behaviors and expectations for recovery. Pathways to recovery are highly personal, and generally involve a redefinition of identity in the face of crisis or a process of progressive change. Furthermore, pathways are often social, grounded in cultural beliefs or traditions and involve informal community resources, which provide support for sobriety. The pathway to recovery may include one or more episodes of psychosocial and/or pharmacological treatment. For some, recovery involves neither treatment nor involvement with mutual aid groups.

Also (Mars & Lina ,2005) continue, Recovery is self-directed and empowering, While the pathway to recovery may involve one or more periods of time when activities are directed or guided to a substantial degree by others, recovery is fundamentally a self-directed process, and recovery involves a personal recognition of the need for change and

transformation, Individuals must accept that a problem exists and be willing to take steps to address it; these steps usually involve seeking help for a substance use disorder. The process of change can involve physical, emotional, intellectual and spiritual aspects of the person's life, recovery is holistic and has cultural dimensions also exists on a continuum of improved health and wellness and recovery supported by peers and allies and finally recovery is a reality.

At conclusion, (Mars & Lina ,2005), abbreviate systems of care elements in steps: Person-centered, Family and other ally involvement, Individualized and comprehensive services across the lifespan, Systems anchored in the community, Continuity of care, Partnership-consultant relationships, Strength-based, Culturally responsive, Responsiveness to personal belief systems, Commitment to peer recovery support services, Inclusion of the voices and experiences of recovering individuals and their families, Integrated services, System-wide education and training, Ongoing monitoring and outreach, Research-based, Outcomes-driven, Adequately and flexibly financed. . **(**Fisher D, 2005)

Elements of recovery It has been emphasized that each individual's journey to recovery is a deeply personal process, as well as being related to an individual's community and society. A number of features or signs of recovery have been proposed as often core elements, (Hope, secure base, self, supportive relationships, empowerment and Inclusion, Coping strategies and Meaning). (Repper J &Perkins R,2006)

Recovery process:

- provides a holistic view of mental illness that focuses on the person, not just their symptoms
- believes recovery from severe mental illness is possible
- is a journey rather than a destination
- does not necessarily mean getting back to where you were before
- happens in 'fits and starts' and, like life, has many ups and downs
- calls for optimism and commitment from all concerned
- is profoundly influenced by people's expectations and attitudes
- requires a well organized system of support from family, friends or professionals
- Requires services to embrace new and innovative ways of working. (MHF,2009)

Also (Maloos, 2009) continued and abbreviate the elements about, **what support recovery?**

Research has found that important factors on the road to recovery include:

- good relationships
- financial security
- satisfying work
- personal growth
- the right living environment
- developing one's own cultural or spiritual perspectives
- Developing resilience to possible adversity or stress in the future.

Further factors highlighted by people as supporting them on their recovery journey include:

- being believed in
- being listened to and understood
- getting explanations for problems or experiences
- Having the opportunity to temporarily resign responsibility during periods of crisis.

In addition, it is important that anyone who is supporting someone during the recovery process encourages them to develop their skills and supports them to achieve their goals.

Assessment A number of standardized questionnaires and assessments have been developed to try to assess aspects of an individual's recovery journey. These include the Milestones of Recovery (MOR) Scale, Recovery Enhancing Environment (REE) measure, Recovery Measurement Tool (RMT), Recovery Oriented System Indicators (ROSI) Measure Stages of Recovery Instrument (STORI), and numerous related instruments.

What are the links between recovery and social inclusion?

"Too many services fail to empower their users to 'get their life back on track' and get back into the community."

There is a strong link between the recovery process and social inclusion. A key role for services is to support people to regain their place in the communities where they live and take part in mainstream activities and opportunities along with everyone else. There is a growing body of evidence that demonstrates that taking part in social, educational, training, volunteering and employment opportunities can support the process of individual recovery.

So, according to (Natalie Jeanne, 2011) Recovering from mental illness is terrifying and exhausting, both for the person diagnosed and those who stand beside them throughout the recovery process. Sometimes, particularly when the diagnosis is new, the person suffering feels as if they will not ever become well again. Family and friends might be unsure if recovery is possible. They question how they can help. Mental illness creates a feeling of helplessness for everyone involved. My and my family's experience with chronic mental illness has allowed me to understand how important it is to have a support group. It can define the journey taken to recover from mental illness.

3.2 Part two: Previous Studies

There are lack of studies done in Palestine about family support and recovery of mental illness, but few studies done in other countries about depression, and other studies done concern of recovery process and family support will present separately, studies about depression, family support, and recovery of mental illness, will present as follows:

3.2.1 Studies about Depression

There is a study done in Palestine about depression by (Melissa Tracy et al, 2008), the purposes assess the predictors of depressive symptoms in a population–based cohort exposed to ongoing and widespread terrorism, with method of Interviews of a representative sample of adults living in Israel, including both Jews and Arabs, were conducted between August and September 2004, with follow-up interviews taking place between February and April 2005. Censoring weights were estimated to account for differential loss to follow-up. Zero-inflated negative binomial models with bootstrapped confidence intervals were fit to assess predictors of severity of depressive symptoms, assessed using items from the Patient Health Questionnaire.

Results : total of (1613) Israeli residents participated in the baseline interview (80.8% Jewish, 49.4% male, mean age 43 years); 840 residents also participated in the follow-up interview. In multivariable models, Israeli Arab ethnicity, lower household income, lower social support, experiencing economic loss from terrorism, experiencing higher levels of psychosocial resource loss, and meeting criteria for post-traumatic stress disorder were significantly associated with increased severity of depressive symptoms.

In addition, there is study done by (Thabet et al, 2004) concern of to investigate the nature of depression among end stage renal disease patients, in comparison with a group of chronic patients at Shifa Hospital, and to make a focus on depression as a serious reaction to End stage renal disease.

In this study used method, the level of depression was assessed in a sample of 80 adult end stage renal disease cases, and 80 control group of chronic medically ill adult patients aged from 18-75 years. Beck Depression Inventory was used, non probability purposive sampling design was used for a selected sample of end stage renal

disease cases hospitalized in the haemodialysis unit, then one control was selected for each case from the chronic patients hospitalized in the medical department, this study conducted in El-Shifa hospital in Gaza-Palestine.

The study's findings revealed high levels of depression in ESRD patient treated with haemodialysis where as 52% reported severe depression compared to 45% of the chronic patients admitted to other department.

The third study done by (Abu Hein F, 2005) concern of Children and adolescents of the Gaza Strip have been subjected to continuous violence since the eruption of the second Intifada (Uprising). Little is known, however, about the psychological effects of this violence on children and adolescents of Gaza. Thus, the purpose of the present investigation was to evaluate and describe the psychological effects of exposure of war-like circumstances on this population. Participants for this study were 229 Palestinian adolescents living in the Gaza Strip who was administered measures of post-traumatic stress disorder (PTSD), depression, anxiety, and coping. The results were 229 participants, 68.9% were classified as having developed PTSD, 40.0% reported moderate or severe levels of depression, 94.9% were classified as having severe anxiety levels, and 69.9% demonstrated undesirable coping responses. A canonical discriminant analysis

revealed that adolescents diagnosed with PTSD tended to be those who reported the highest levels of depression, anxiety, and positive reappraisal coping, and the lowest levels of seeking guidance and support coping.

Moreover , there is another study conducted by, (Cole Martin,2010), risk factors for Major Depression in Older Medical Inpatients: A Prospective Study: the Objective are to determine risk factors for major depression in older medical inpatients. Method: In a prospective cohort study, 86 older medical inpatients without depression or antidepressant medication were assessed 3, 6, and 12 months after enrollment. Incident major depression was diagnosed using the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition,* criteria. Potential predictive variables included sociodemographic variables, physical state, cognition, depressive symptoms, medication use, prior depressive episode, social network, support, and bereavement. Results: Twenty-six patients (30.2%) met criteria for incident major depression. Predictors of major depression included the following: prior depressive episode, birth outside Canada, low co morbidity, inadequate emotional support, fewer children seen, depressed mood, and diurnal variation.

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3.2.2 Family Support's Studies

A study conducted by *Joanne K.Scheider et al (2009):* Study about family support in Thailand; the purpose of this study was to develop an instrument for assessing family support for elderly Thai parents, the researcher use method, both quantitative and qualitative approach were employed in development and testing the Thai family support scale for elderly parents (TFSS-TP),and with sample 35 elderly parents, addressing perceptions about types of family support provided by adult children, and the most important result was TFSS-EP appears to be a reliable and valid instrument for measuring family support for elderly Thai parents.

There is another study mentioned by *Tsouna-Hadjis et al,2002*: aimed "To determine the role of family social support in three stroke rehabilitation variables (functional status, depression, social status) during a 6-month recovery period.", and use design of assessment of first-stroke patients 'functional status, depression, and social status before discharge and at 1, 3, and 6 months after stroke onset, in comparison with

the amount of family social support received, with use instrument of the family social support scale compliance, instrumental, and emotional support was employed in the first month, this study setting in a university hospital and patients 'residences, the important result is high levels of family support –instrumental and emotional –are associated with progressive improvement of functional status, mainly in severely impaired patients, while the psychosocial status is also affected .

Another study done in Ireland by *Board, 2009* , to study of experiences, needs and support requirements of families with enduring mental illness, The study involved semi-structured interviews with 38 participants from Dublin city who were closely related to people with enduring mental illness, the result identified basic supports required for corers and families at varies stages of mental illness.

Prospective Relations between Social Support and Depression Differential Direction of Effects for Parent and Peer Support, this study done by (Eric Stice &et al, 2000) The authors tested whether deficits in perceived social support predicted subsequent increases in depression and whether depression predicted subsequent decreases in social support with longitudinal data from adolescent girls (*N* _ 496). Deficits in parental support but not peer support predicted future increases in depressive symptoms and onset of major depression. In contrast, initial depressive symptoms and major depression predicted future decreases in peer support but not parental support. Results are consistent with the theory that support decreases the risk for depressions but suggest that this effect may be specific to parental support during early adolescence. Results are also consonant with the claim that depression promotes support erosion but imply that this effect may only occur with peer support during this period.

Attrition analyses verified that girls who dropped from the study did not differ from the remaining girls on age, ethnicity, parental education, parental support, peer support, or depressive symptoms at T1. As latent growth curve (LGC) models can accommodate cases with only two out of three waves of data, the effective attrition rate was 1%.

The study examined change in family support and depressive symptoms over the course of 23 years and included the potential moderators of gender and participation in treatment. A sample of 373 depressed individuals provided data in five waves, with

baseline, 1-year, 4-year, 10-year, and 23-year follow-ups. Multilevel modeling was used to evaluate longitudinal relationships between variables. Higher family support was associated with less depression at baseline and predicted a steeper trajectory of recovery from depression over 23 years. This relationship was moderated by gender, such that women with supportive families reported the most rapid recovery from depression. Evaluating family context may be clinically relevant when beginning treatment with a depressed patient, particularly for female patients. (Charles Kamen & et al, 2011)

3.2.3 Recovery process's studies

A study done by (Nasser & J.C.Overholser, 2004) "Recovery from major depression: the role of support from family, friends, and spiritual beliefs "Many of the risk factors for major depression are not amenable to change. The present study was designed to identify factors associated with recovery from depression that could be targets for clinical intervention. Sixty-two psychiatric in-patients who met diagnostic criteria for major depression were interviewed while hospitalized and re-interviewed 3 months after discharge. Analyses examined the relationship between depression and three sources of emotional support: family, friends, and spiritual beliefs. Results were Depression severity at baseline was the most consistent predictor of depression severity and diagnosis at follow-up. Patients who had recovered from depression by the time of the follow-up assessment reported higher perceived emotional support from family and friends at baseline. Support from friends, support from family and a composite of emotional support were significant predictors of depression beyond the effects of initial depression severity.

There is a study done by (Bakto et al, 2000)," the purpose of the study is to explore the gender differences in depression and recovery process." The Sample is three male and female with major depression disorder were invented to participate in this study. The result showed, there is differences in gender & lack of support from family and friends affect positively in same times and negativity in another time the objective of this study was to explore the meaning of recovery from the perspective of consumers receiving mental health services in Canada.

In addition, there is a study conducted by (John Curry&Susan Silva, 2011),are: "Recovery and Recurrence Following Treatment for Adolescent Major Depression" the

Objectives are to determine whether adolescents who responded to short-term treatments or who received the most efficacious short-term treatment would have lower recurrence rates, and to identify predictors of recovery and recurrence. In twelve academic sites in the United States. The participants are One hundred ninety-six adolescents (86males and 110 females) randomized to 1 of 4 short-term interventions (fluoxetine hydrochloride treatment, cognitive behavioral therapy, their combination, or placebo)in the Treatment for Adolescents With Depression Study were followed up for 5 years after study entry(44.6% of the original Treatment for adolescents With Depression Study sample).

Moreover, according to, (Jutta Joormann & Ian H. Gotlib,2007), the study was designed to examine intentional biases in the processing of emotional faces in currently and formerly depressed participants and healthy controls. Using a dot-probe task, the authors' presented faces expressing happy or sad emotions paired with emotionally neutral faces.

Whereas both currently and formerly depressed participants selectively attended to the sad faces, the control participants selectively avoided the sad faces and oriented toward the happy faces, a positive bias that was not observed for either of the depressed groups. These results indicate that attention biases in the processing of emotional faces are evident even after individuals have recovered from a depressive episode.

Otherwise, according to (Gainotti, et al, 2001) study was "Relation between depression after stroke, antidepressant therapy, and functional recovery "The aim was to evaluate the effects of post stroke depression and antidepressant therapy on the improvement of motor scores and disability, to verify if the negative effects of post stroke depression on functional recovery could be counterbalanced by taking antidepressant drugs. Results obtained before, during, and after rehabilitation on the Barthel index, Canadian neurological scale, and River mead mobility index—by 49 depressed patients with stroke, who had been treated (n=25) or not treated (n=24) according to the different therapeutic approaches of their physicians, were compared with results similarly obtained by 15 non-depressed patients with stroke. There was a non-significant difference between the groups in their motor and functional scores, and a significant improvement on time. Furthermore, recovery from depression was significantly greater in treated than in non-treated depressed patients with stroke.

Chapter IV
Methodology

Chapter IV: Methodology

4.1 Introduction

This chapter describes the methodology that was used in this research. The adopted methodology to accomplish this study uses the following techniques: information about the research design, research population, questionnaire design, statistical data analysis, content validity and pilot study.

4.2 Research design

The first phase of the research thesis proposal included identifying and defining the problems and establishing an objective of the study and development research plan.

The second phase of the research included a summary of the comprehensive literature review. Literatures on claim management were reviewed.

The third phase of the research included a field survey conducted with **the impact of family support on recovery of depressed patients in Gaza governorates.**

The fourth phase of the research focused on the modification of the questionnaire design, through distributing the questionnaire to pilot study, the purpose of the pilot study was to test and prove if the questionnaire was clear to be answered in a way that helps to achieve the target of the study. The questionnaire was modified based on the results of the pilot study.

The fifth phase of the research focused on distributing questionnaire. This questionnaire was used to collect the required data in order to achieve the research objective.

The sixth phase of the research was data analysis and discussion. Statistical Package for the Social Sciences, (SPSS) was used to perform the required analysis. The last phase includes the conclusions and recommendations. **One hundred ninety five** questionnaires were distributed to the research population and **one hundred seventy two questionnaires** were received.

4.3 Study design

Cross-sectional, analytic, descriptive study design was used.

4.4 Population study sample

- Largest population: All depressed patients in the Gaza strip.

"Unfortunately, there is no formal statistics about accurate number of depressed patients of mental health clinics in Gaza governorates .Hence the researcher performed this task (collect the number of depressed –major depression- in every clinics in Gaza governorates)

Accessible population: All depressed patients registered in Gaza community mental health (CMH) clinics, which are 383 depressed patients.

4.4.1. Sample study: One hundred and ninety five 195 patients, selected purposively from the population (383), and 195questionnaires were distributed to the patients and 172 received, and the rest of depressed patients were received incomplete and not prepared to analyze that,7 did not respond and 16 were excluded from the study because they did not meet the criteria of inclusion. The number of Questionnaires was selected according to the low (Yemen, 1967).

$$N = \frac{NP}{1 + (NP \times e^2)} = \frac{383}{1 + 383 * 0.05^2} = 195$$

Where:
N: Sample size
NP: population size
E: the errors term = 0.05

4.5 Eligibility of the sample

4.5.1 Inclusion criteria

The researcher includes all depressed patients who registered in his study community mental health clinics with confirmed diagnosis of major depressive disorders and not co morbid with other diseases. The depressed patients from the year 2009 to 2010 who follow up in community mental health clinic.

4.5.2 Exclusion criteria

The researcher excludes all depressed patients who were not diagnosed with major depressive disorders and depression co morbid with other diseases. And all depressed patients diagnosed before the year 2009 and 2010 year will be excluded in the study.

4.6 Data Collection Methodology

In order to collect the needed data for this research, the researcher used the secondary resources in collecting data such as books, journals, statistics and web pages, in addition to preliminary resources that were not available in secondary resources through distributing questionnaires of study population in order to measure the effect of family support and another questioner to measure recovery of depressed patients. Research methodology depended on analysis of data through the use of descriptive analysis, which depends on the poll and use the main program (SPSS).

4.7 Questionnaire design and content

After reviewing the literature and after interviewing experts who were dealing with similar subject at different levels, all the information that could help in achieving the study objectives were collected, reviewed and formalized to be suitable for the study survey. After many stages of brain storming, consulting, amending, and reviewing executed by the researcher with the supervisor, a questionnaire was designed into closed ended questions.

The questionnaire was translated into Arabic language (Annex 2) by the researcher, and then sent to a specialist in English translation and after that the Arabic version sent to a specialist in Arabic for accreditation, and finally back translation to English was done. An English version is attached in (Annex 4).

Two questionnaires were provided with a covering letter explaining the purpose of the study, the way of responding, the aim of the research and the security of the information in order to encourage a high response. The questionnaire included multiple choice questions: which was used widely in the questionnaire, the variety in these questions aims first to meet the research objectives, and collect all the necessary data that can support the discussion, results and recommendations in the research.

The sections in the questionnaires verify the objectives in this research that are related to measure the effect of family support and another questioner to measure recovery from depression as the following:

Unnecessary personal data, complex and duplicated questions were avoided. The questionnaire was provided with a covering letter which explained the purpose of the study, the way of responding, the aim of the research and the security of the information in order to encourage high response.

There are six axes for **family support scale** and every axis contains elements to measure every axis effect only:

Axis I: Effect of structural aspect of family (integration of the person with the support network)

Axis II: Effect of instrumental support of family.

Axis III: Effect of emotional support of family.

Axis IV: Effect of informational support of family.

Axis V: Effect of belonging of a group with common interests to family.

Axis VI: Effect of spiritual support of family.

The second scale measure the **recovery of depression**, the scale contains six factors as the following:

Factor 1: personal confidence and hope.

Factor 2: willingness to ask for help.

Factor 3: goal and success orientation.

Factor 4: reliance on others.

Factor 5: no domination by symptoms.

Factor 6: compliance with psychotherapy

And all questions follow Lekart scale as the following:

Strongly disagree	**disagree**	**Don't know**	**agree**	**Strongly agree**	Level
1	2	3	4	5	Scale

4.8 Pilot Study

Pilot study for the questionnaire was conducted before collecting the results of the sample. It provides a trial run for the questionnaire, which involves testing the wordings of question, identifying ambiguous questions, testing the techniques that were used to collect data, and measuring the effectiveness of standard invitation to respondents. The researcher selected 25 participants from sample participants, to measure the validity and reliability of two scale of study (family support and recovery process), and the two scale are valid and reliable so it included with total sample for analysis.

4.8.1 Validity of the instrument

The researcher defines the validity of an instrument as a determination of the extent to which the instrument actually reflects the abstract construct being examined. Validity refers to the degree in which an instrument measures what is supposed to be measured (Pilot & Hungler, 1999) High validity is the absence of systematic errors in the measuring instrument. When an instrument is valid; it truly reflects the concept that is supposed to be measured.

Achieving good validity requires a care in the research design and sample selection. The amended questionnaire was by the supervisor and six experts in tendering and bidding environments to evaluate the procedure of questions and the method of analyzing the results. The experts expertees agreed that the questionnaire was valid and suitable enough to measure the purpose that the questionnaire was designed for.

The six experts were as following:

- Dr.Derdah Sha'er (assistant professor in psychology).
- Dr. Ashraf Jedie (assistant professor in public health).
- Dr. Ayesh Samour(Genereal administrator of mental health).
- Dr. Habeeb Hawajry(Clinical psychologist).
- Dr.Nafez Barakat (assistant professor in statistics).
- Mr.Ayman Emad (Master degree in Arabic).

4.8.2 Content Validity of the instrument

Content validity test was conducted by consulting two groups of experts. The first was requested to evaluate and identify whether the questions agreed with the scope of the items and the extent in which these items reflect the concept of the research problem. The other was requested to evaluate that the instrument which was used is valid statistically and that the questionnaire was designed well enough to provide relations and tests between variables. The two groups of experts agreed that the questionnaire was valid and suitable enough to measure the concept of interest with some amendments.

4.8.3 Statistical Validity of the instrument

To insure the validity of the questionnaire, two statistical tests were applied. The first test is Criterion-related validity test (Pearson test) which measures the correlation coefficient between each item in the field and the whole field. The second test is structure validity test (Pearson test) that was used to test the validity of the questionnaire structure by testing the validity of each field and the validity of the whole questionnaire. It measures the correlation coefficient between one filed and all the fields of the questionnaire that have the same level of similar scale.

4.8.4 Criterion Related Validity

1) Internal consistency

Internal consistency of the questionnaire is measured by a scouting sample, which consisted of **twenty five** questionnaires, through measuring the correlation coefficients between each paragraph in one field and the whole filed. Tables No.'s (1-2) below shows the correlation coefficient and p-value of each field items. As shown in the table the p- Values are less than 0.05 or 0.01,so the correlation coefficients of this field are significant at $\alpha = 0.01$ or $\alpha = 0.05$, so it can be said that the paragraphs of this field are consistent and valid to what was set for.

Table (1)
The correlation coefficient between each paragraph in the field and the whole field (Recovery from depression)

p-value	Pearson coefficient	Statement	No.
		Factor I: Self confidence and hope in life:	
0.002	0.594	I depend on myself to manage and run my life	1
0.000	0.651	Fear is not an obstacle to achieve my goals	2
0.038	0.418	I feel that life is a beautiful trip	3
0.007	0.533	I believe in myself and my abilities when I do any work	4
0.001	0.629	I have a clear plan for my future	5
0.002	0.589	I feel optimistic towards my future	6
0.012	0.494	I am satisfied about myself and my work	7
0.001	0.610	I enjoy life of work and completion	8
0.044	0.406	My illness doesn't stop me from reaching my ambitions	9
		Factor II: Ability to seek help:	
0.007	0.528	I don't hesitate to ask for help when I need it	10
0.007	0.526	Asking for help increases my insistence to overcome my problem	11
0.003	0.570	I know when I ask for help	12
0.003	0.569	When I need help I ask specialized people	13
0.000	0.646	Following up with specialists helps me to overcome my problem	14
		Factor III: Awareness about goals and successes:	
0.001	0.613	I plan for my life realistically	15
0.001	0.625	I put clear goals for myself	16
0.004	0.550	I always plan for my life	17
0.028	0.439	I always plan to be successful in my life	18
0.005	0.540	I put reachable goals for myself	19
0.019	0.466	I achieve my goals quickly and perfectly	20
0.005	0.539	I divide my goals into partial objectives	21
0.005	0.540	I feel satisfied when I reach my goals	22
0.005	0.548	I feel my life is valuable because I have clear goals	23
0.003	0.573	My success makes me feel happy and satisfied	24
		Factor IV: Dependence on others:	
0.006	0.535	I depend a lot on my family to meet my needs	25
0.034	0.425	I believe in my family's abilities to overcome my problem	26
0.000	0.774	It's hard for me to run my life without my family	27
0.002	0.586	My family helps me to overcome my problem	28
0.000	0.771	My family provides me with what I needs	29
0.001	0.605	My family helps me in treat my illness	30
0.024	0.451	I adjust with the depression symptoms as any other disease	31
		Factor V: Dominant on symptoms:	

0.000	0.735	I see that the depression symptoms are temporary	32
0.005	0.546	I can cope to live with depression symptoms without problems	33
0.033	0.428	I feel that depression symptoms are decreasing by the time	34
0.003	0.567	The depression symptoms don't stop me from reaching my goals	35
0.008	0.520	I have the ability to overcome the depression symptoms	36
0.015	0.482	I seek to challenge depression symptoms	37
		Factor VI: Compliance on psychotherapy:	
0.029	0.438	I 'm sure about having the antidepressant regularly.	38
0.026	0.455	I take my medications according to my prescription	39
0.001	0.640	I visit mental health clinic periodically to follow up my case with the psychologists.	40
0.000	0.761	I feel that compliance with the treatment has positive effects on my case	41
0.001	0.642	I go directly to the psychologist to treat my illness and relapses.	42

Table(2)
The correlation coefficient between each paragraph in the field and the whole field (Family support)

p-value	Pearson coefficient	Statement	No.
		Factor I: Integration person within the support network:	
0.000	0.789	We help patient to be close to his/ her friends	1
0.000	0.702	We provide patient with advice to overcome illness	2
0.003	0.564	We seek to provide the patient with his / her needs	3
0.000	0.660	We follow the patient health and psychological conditions continuously	4
0.003	0.565	We offer social network for the patient that keeps him / her happy	5
0.012	0.494	The patient feels happy for being with his /her family	6
0.005	0.545	We let the patient participate in social occasions	7
		Factor II: Instrumental support:	
0.008	0.519	We provide the patient with of treatment he/she needs	8
0.040	0.422	We spend much money for relief of the patient's mental situation	9
0.005	0.541	We take the patient to the mental health clinic for therapy	10
0.000	0.746	When the patient gets money he becomes capable to overcome his/her problem .	11
0.002	0.589	We give the patient the opportunity to find a job	12
0.018	0.469	We pay the patient's dept (which make him / her	13

		worried)	
0.009	0.509	We offer gifts for the patient in different occasions	14
0.002	0.592	We help the patient to find institutions that provide assistance for him / her	15
0.030	0.443	We accept the patient with his / her illness as he/she is	16
		Factor III: Emotional support:	
0.017	0.491	We include the patient with love , kindness and compassion	17
0.002	0.592	The patient feels satisfied when he stays with his family	18
0.001	0.642	The family is main source of happiness for the patient	19
0.008	0.519	We always comfort the patient about his/her illness	20
0.002	0.594	We the patient include with harmony and happiness	21
0.001	0.602	We alleviate	22
0.012	0.496	We always invite and host the patient's friends at home	23
		Factor IV: Informational support:	
0.000	0.682	We give the patient accurate information about his/her illness	24
0.022	0.457	We give the patient the information that makes him aware with his problem.	25
0.000	0.735	We provide the patient with information that helps him / her to overcome his/her problem.	26
0.016	0.477	We always listen to the patient's thoughts	27
0.000	0.680	We provide the patient with the basics of psychosocial support and guidance.	28
		Factor V: Spiritual support:	
0.007	0.526	We encourage the patient to keep his/her prayers	29
0.003	0.575	We provide the patient with Qur'an taps and encourage him/her to listen to them.	30
0.006	0.531	We encourage the patient to participate in many worksheps.	31
0.000	0.646	We decrease the tension feels of the patient by reading Qur'an	32
0.010	0.507	We take the patient to warship houses	33
0.029	0.438	We encourage patients to be patient while doing the warships	34
0.041	0.411	We provide the patient with religious books in order to relief his/her problem	35
0.003	0.570	The patient feels that we help him to overcome distress and tension	36
		Factor VI: Belonging with a group with common interest:	
0.005	0.543	We get the patient closer to people he/she can benefit from them	37
0.001	0.604	We encourage the patient to build up relations with religious people	38

0.006	0.533	We assist the patient to meet new groups in order to alleviate his /her illness	39
0.008	0.516	We help the patient to be integrated in the society	40
0.002	0.584	The patient feels happy when we listen to his / her stressor	41
0.001	0.603	The patient feels pleasure when he / she is taken to the social occasions.	42

4.8.5 Structure Validity of the Questionnaire

Structure validity is the second statistical test that was used to test the validity of the questionnaire structure by testing the validity of each field and the validity of the whole questionnaire. It measures the correlation coefficient between one filed and all the fields of the questionnaire that have the same level of Likert scale.

As shown in table(3), the significance values are less than 0.05 or 0.01, so the correlation coefficients of all the fields are significant at $\alpha = 0.01$ or $\alpha = 0.05$, so it could be said that the fields are valid to be measured for they were set for to achieve the main aim of the study

Table (3)
Structure Validity of the Questionnaire

p-value	Pearson **correlation coefficient**	Factor	**Number**
0.000	0.752	Factor 1: personal confidence and hope.	**Recovery process**
0.004	0.558	Factor 2: willingness to ask for help.	
0.047	0.401	Factor 3: goal and success orientation.	
0.003	0.573	Factor 4: reliance on others.	
0.022	0.457	Factor 5: no domination by symptoms.	
0.000	0.788	Factor 6: compliance with psychotherapy	
0.000	0.861	Axis I: Effect of structural aspect of family (integration of the person with the support network)	**Family support**
0.000	0.808	Axis II: Effect of instrumental support of family.	
0.000	0.810	Axis III: Effect of emotional support of family.	
0.000	0.753	Axis IV: Effect of informational support of family.	
0.000	0.807	Axis V: Effect of belonging of a group with common interests to family.	
0.000	0.726	Axis VI: Effect of spiritual support of family	

4.9 Reliability of the questions

The reliability of an instrument is the degree of consistency which measures the attribute; that is supposed to be measured (Pilot & Hungler, 1999). The test is repeated to the same sample of people on two occasions and then compares the scores obtained by computing a reliability coefficient. For the most purposes reliability coefficient above 0.7 are considered satisfactory. A Period of two week up to a month is recommended between two tests. Due to complicated conditions that the contractors is facing at the time being, it was too difficult to ask them to responds to our questionnaire twice within short period. The statistician's explained that, overcoming the distribution of the questionnaire twice to measure the reliability can be achieved by using Cronpakh Alpha coefficient and Half Split Method through the SPSS software.

4.9.1 Half Split Method

This method depends on finding Pearson correlation coefficient between the means of odd rank questions and even rank questions of each field of the questionnaire. Then, correcting the Pearson correlation coefficients can be done by using Spearman Brown correlation coefficient of correction. The corrected correlation coefficient (consistency coefficient) is computed according to the following equation:

Consistency coefficient = 2r/(r+1), where r is the Pearson correlation coefficient. The normal range of corrected correlation coefficient 2r/(r+1) is between 0.0 and + 1.0 As shown in Table(4), and the general reliability for all items equal 0.8436, and the significant (α) is less than 0.05 so all the corrected correlation coefficients are significance at α = 0.05. It can be said that according to the Half Split method, the dispute causes of group are reliable.

Table (4)
Split-Half Coefficient method

Sig. (2-Tailed (	Spearman-Brown Coefficient	person-correlation	Factor	Number
0.000	0.8083	0.6782	Factor 1: personal confidence and hope.	recovery process
0.000	0.8514	0.7412	Factor 2: willingness to ask for help.	
0.000	0.8416	0.7265	Factor 3: goal and success orientation.	
0.000	0.8631	0.7592	Factor 4: reliance on others.	
0.000	0.8193	0.6939	Factor 5: no domination by symptoms.	
0.000	0.8109	0.6819	Factor 6: compliance with psychotherapy	
0.000	0.8558	0.7479	**Total factors**	

0.000	0.8436	0.7296	Factor 1: Effect of structural aspect of family (integration of the person with the support network)	**Family support**
0.000	0.8588	0.7525	Factor 2: Effect of instrumental support of family.	
0.000	0.8182	0.6924	Factor 3: Effect of emotional support of family.	
0.000	0.8824	0.7895	Factor 4: Effect of informational support of family.	
0.000	0.8737	0.7758	Factor 5: Effect of belonging of a group with common interests to family.	
0.000	0.8152	0.6881	Axis VI: Effect of spiritual support of family	
0.000	0.8870	0.7960	**Total factors**	

4.9.2 Cronbach's Coefficient Alpha

This method is used to measure the reliability of the questionnaire between each field and the mean of the whole fields of the questionnaire. The normal range of Cronbach's coefficient alpha value between 0.0 and + 1.0, and the higher values reflects a higher degree of internal consistency. As shown in Table(5)the Cronbach's coefficient alpha was calculated for the first field of the causes of claims, the second field of common procedures and the third field of the Particular claims. the general reliability for all items equal .0.8821 This range is considered high; the result ensures the reliability of the questionnaire .

Table (5)
For Reliability Cronbach's Alpha

Cronbach's Alpha	Factor	Q.
0.8396	Factor 1: personal confidence and hope.	**recovery p**
0.8895	Factor 2: willingness to ask for help.	
0.8795	Factor 3: goal and success orientation.	
0.8870	Factor 4: reliance on others.	
0.8496	Factor 5: no domination by symptoms.	
0.8625	Factor 6: compliance with psychotherapy	
0.8729	**Total factors**	

		rocessFamily support
0.8678	Factor 1: Effect of structural aspect of family (integration of the person with the support network)	
0.8896	Factor 2: Effect of instrumental support of family.	
0.8391	Factor 3: Effect of emotional support of family.	
0.9157	Factor 4: Effect of informational support of family.	
0.9057	Factor 5: Effect of belonging of a group with common interests to family.	
0.8425	Axis VI: Effect of spiritual support of family	
0.8924	**Total factors**	

4.10 Statistical Manipulation

To achieve the research goal, the researcher used the statistical package for Social Science (SPSS) for Manipulating and analyzing the data.

4.10.1 Statistical methods are as follows

1- Frequencies and Percentile.

2- Alpha- Cronbach Test for measuring reliability of the items of the questionnaires.

3- Person correlation coefficients for measuring validity of the items of the questionnaires.

4- Spearman –Brown Coefficient.

5- One sample T test.

6- Independent sample t test.

7- One way ANOVA.

4.11 Research setting and period

The study was conducted in Gaza community mental health clinics, (from 1st, September to 15th, November 2011).The clinics are quasi-naturalistic setting that allow the researcher to examine the natured responses of participants & his/her families.

4.12 Ethical consideration

A letter of permission for the study from the general administration of mental health was obtained. Also a written consent form the participant was obtained.

4.13 Limitation of the study

- It is difficult to follow all patients after discharge or revision at community mental health clinics.

- There is difficult in sharing all sample participates in the study, especially mental ill patients(MD) and lack of awareness level about their cases and sharing in researches and studies ,also their caregivers and families.

- There is no previous statistics in mental health administration, so the researcher found difficulty in collecting the number of depressed patients in community mental health clinics.

- Lack of logistic support such as electricity, internet to complete the study faster than the time consumed to end this study.

Chapter V
Results Of Data

Chapter V: Data Analysis and result

In this chapter, the researcher presents the result of the study and interpretation, to be sure about the study's questions within the most important result of the study.

5.1 Demographical data:

5.1.1 Recovery from depression

1. Gender:

Figure (4) shows that 62.8% from the sample were "Males", and 37.2% from the sample were "Females"

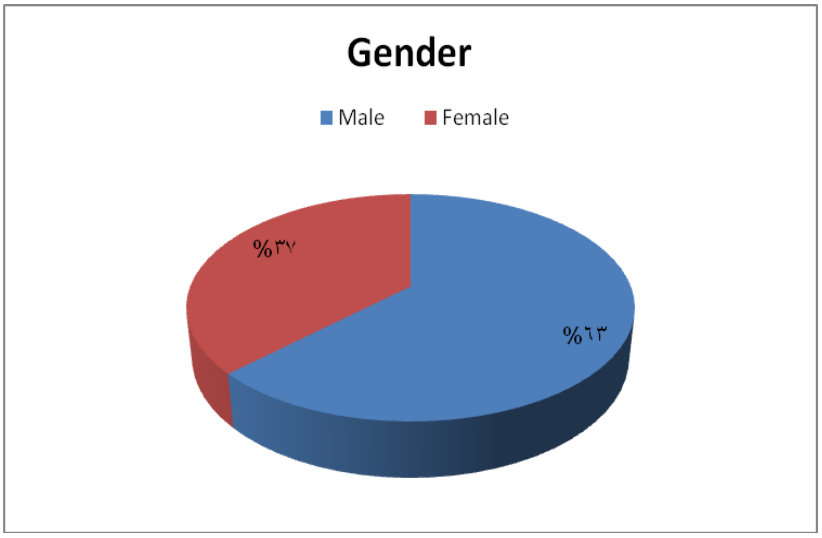

Figure (4)

2. Marital status:

Figure (5) shows that 22.1 % from the sample were " Single " , and 46.5% from the sample are " Married " , and 12.2 % from the sample were " widows " , and 19.2 % from the sample were " Divorced "

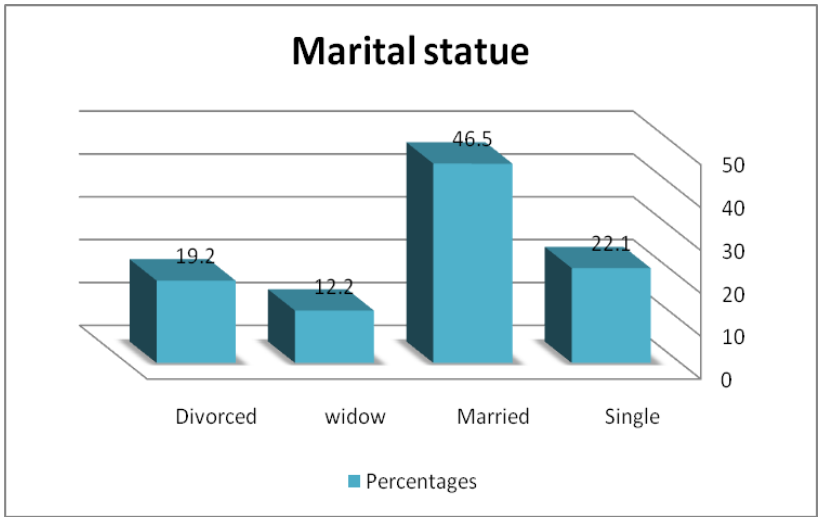

Figure (5)

3. Address:

Figure (6) shows that 9.9% from the sample are from " Gaza Governorate " , and 15.7% from the sample are from " North Governorate " , and 36.0% from the sample are from " Middle Governorate " , and 8.7% from the sample are from " Khanyounis Governorate " , and 29.7% from the sample are from " Rafah Governorate ".

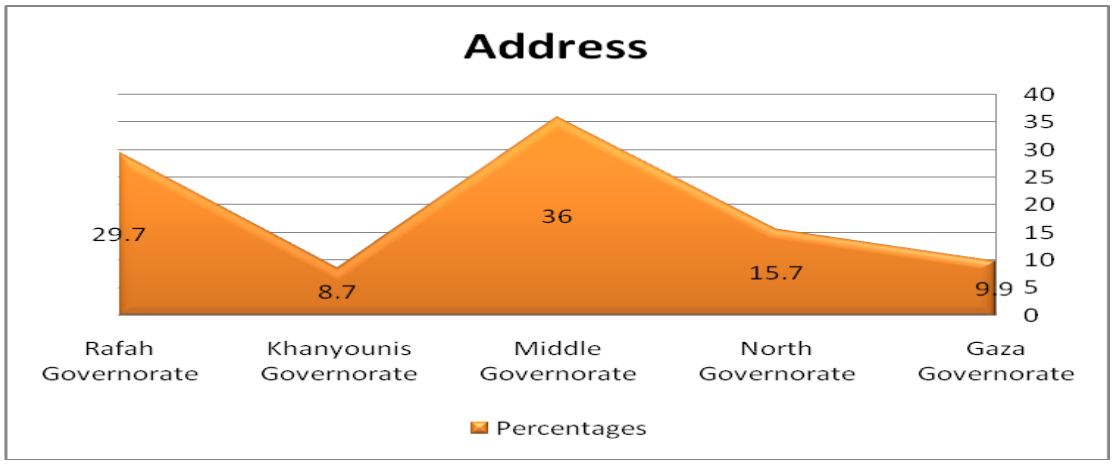

Figure (6)

4. Age:

Figure (7) shows that 7.0 % from the sample ages "Less than 20 years ", and 45.3% from the sample ages from "From 20 – 30 years ", and 47.7 % from the sample ages "More than 30 years ".

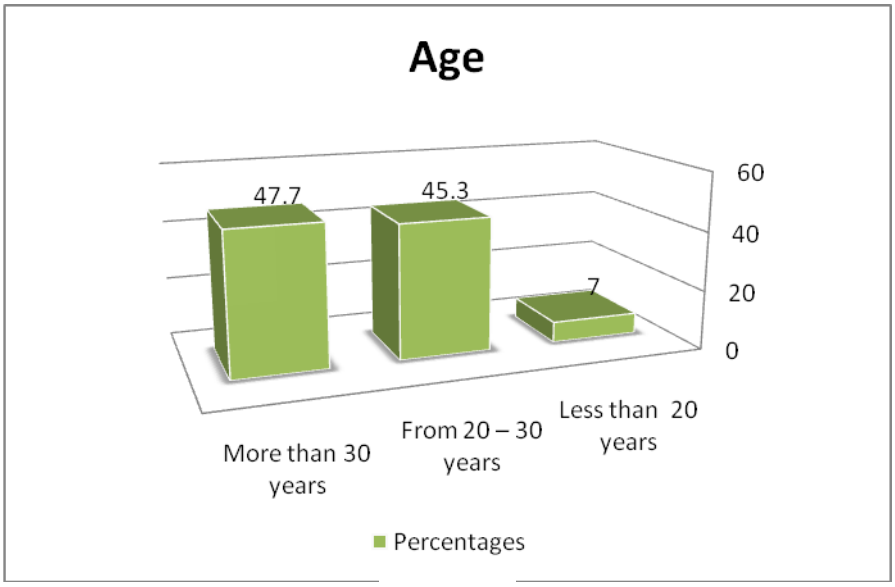

Figure (7)

5. Years of disorder / illness:

Figure (8) shows that 100.0 % from the sample the Years of disorder / illness "are less than 2years, and 0 % from the sample are the other choices.

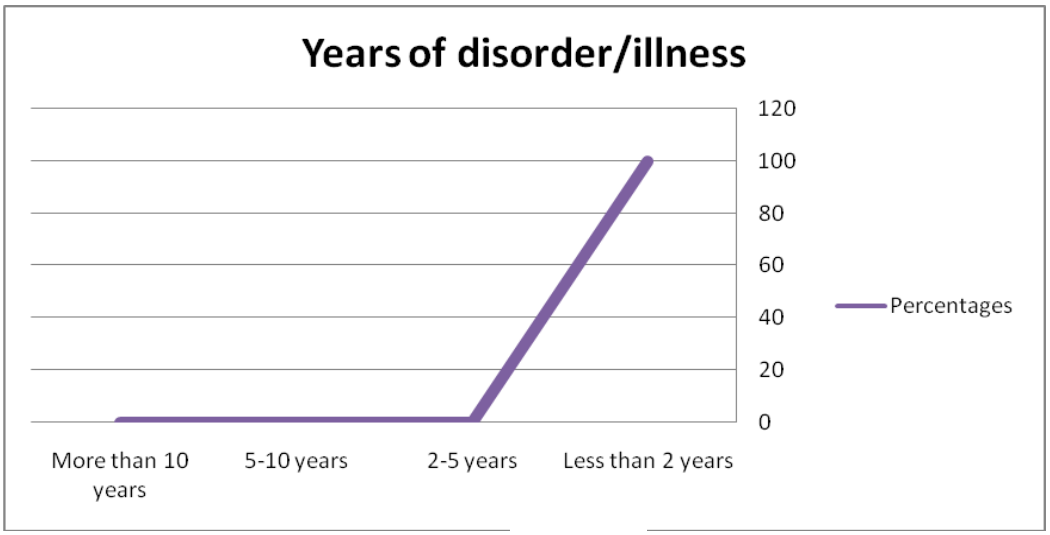

Figure (8)

6. Economic status:

Figure (9) shows that 52.9% from the sample the economic status between "500-1000 NIS " , and 41.9% from the sample the economic status between " 1000 – 2000 NIS " , and 5.2% from the sample the economic status between " More than 2000 NIS ".

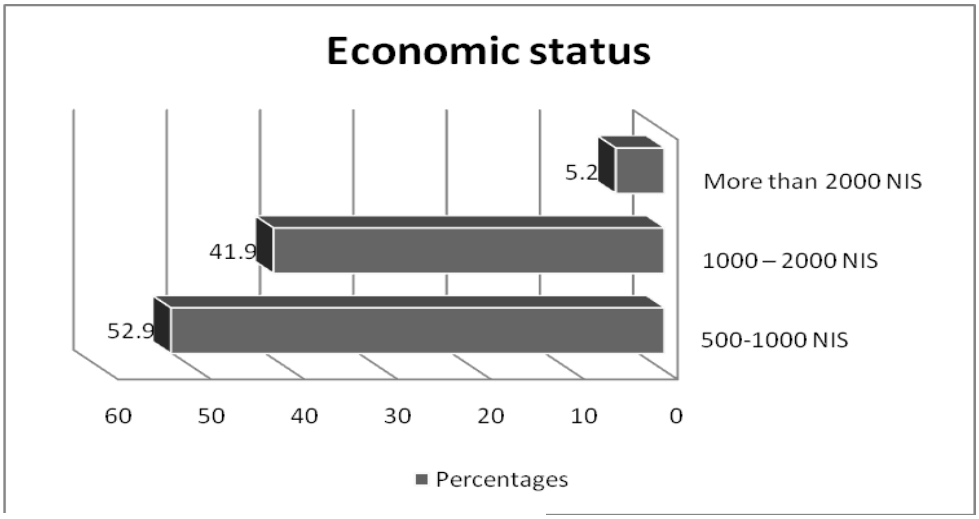
Economic status
5.2
More than 2000 NIS
41.9
1000 – 2000 NIS
52.9
500-1000 NIS
60
50
40
30
20
10
0
Percentages

Figure (9)

7. Educational level:

Figure (10) shows that 19.8% from the sample the educational level are " Elementary " , and 36.6% from the sample the educational level are " Preparatory " , and 29.7% from the sample the educational level are " Secondary " , and 14.0% from the sample the educational level are " University " .

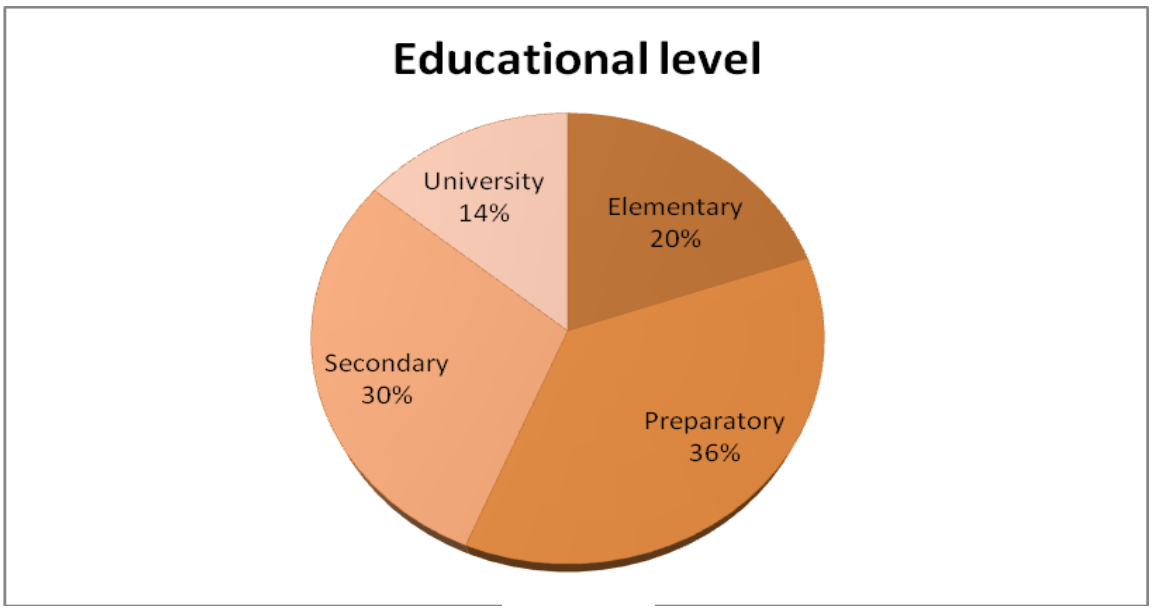

Figure (10)

5.1.2 Family support

1. Gender:

Figure (11) shows that 48.8% from the sample are "Males", and 51.2% from the sample are "Females"

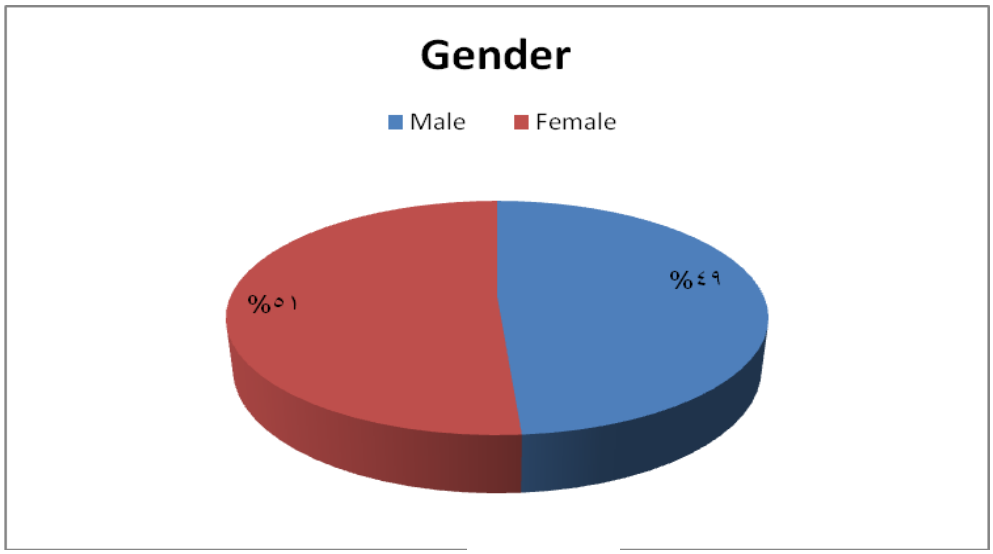

Figure (11)

2. Address:

Figure (12) shows that 10.5% from the sample are from " Gaza Governorate " , and 14.0% from the sample are from " North Governorate " , and 36.6% from the sample are from " Middle Governorate " , and 8.1% from the sample are from " Khanyounis Governorate " , and 30.8% from the sample are from " Rafah Governorate "

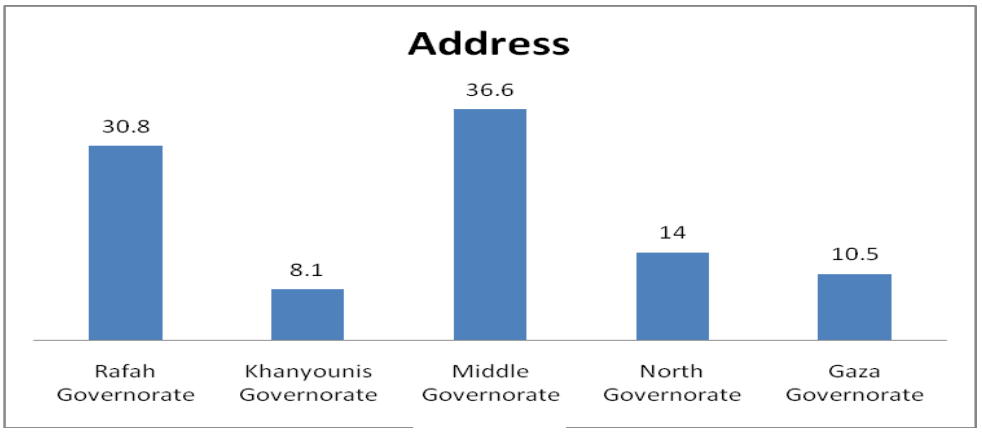

Figure (12)

3. Age:

Figure (13) shows that 3.5 % from the sample ages "Less than 20 years ", and 52.9% from the sample ages from "From 20 – 30 years ", and 43.6 % from the sample ages "More than 30 years ".

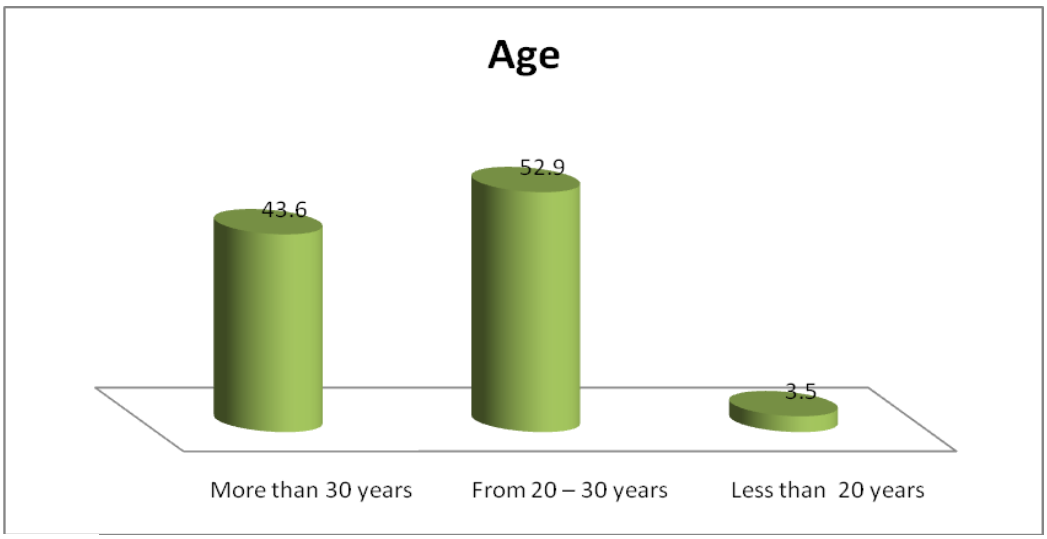

Figure (13)

4. Relation to the patient:

Figure (14) shows that 20.3% there is relationship between the patients and parents “Father /Mother “, and 35.5% between “Brothers / Sisters “, and 18.0% between “Son / Daughter “, and 26.2% between patients and “Husbands / Wives “.

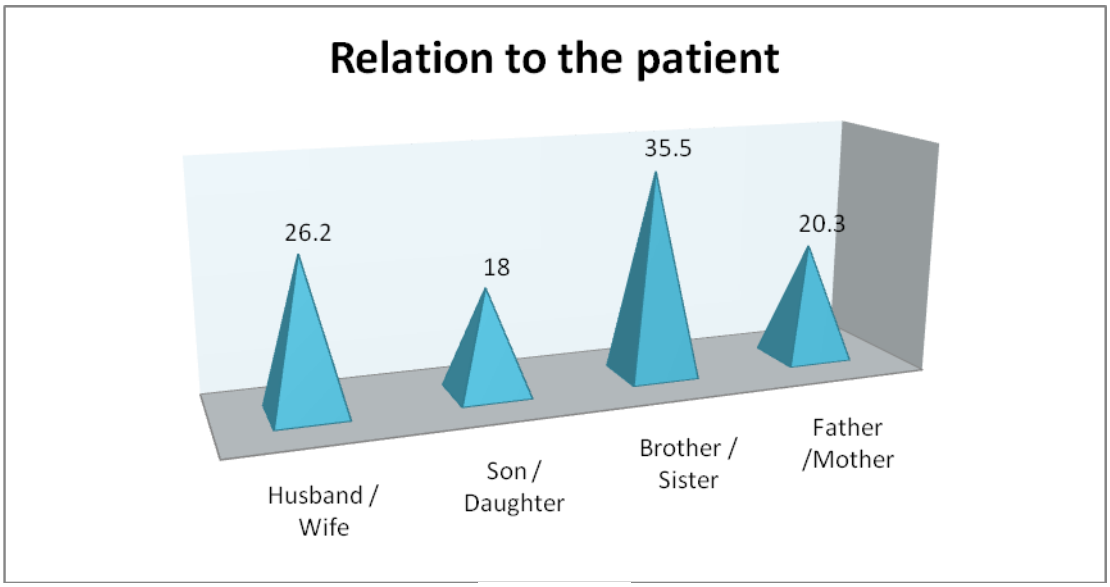

Figure (14)

5. Economic status:

Figure (14) shows that 55.2% from the sample the economic status of the family is between "500-1000 NIS " , and 33.7% from the sample the economic status between " 1000 – 2000 NIS " , and 11.0% from the sample the economic status between " More than 2000 NIS " .

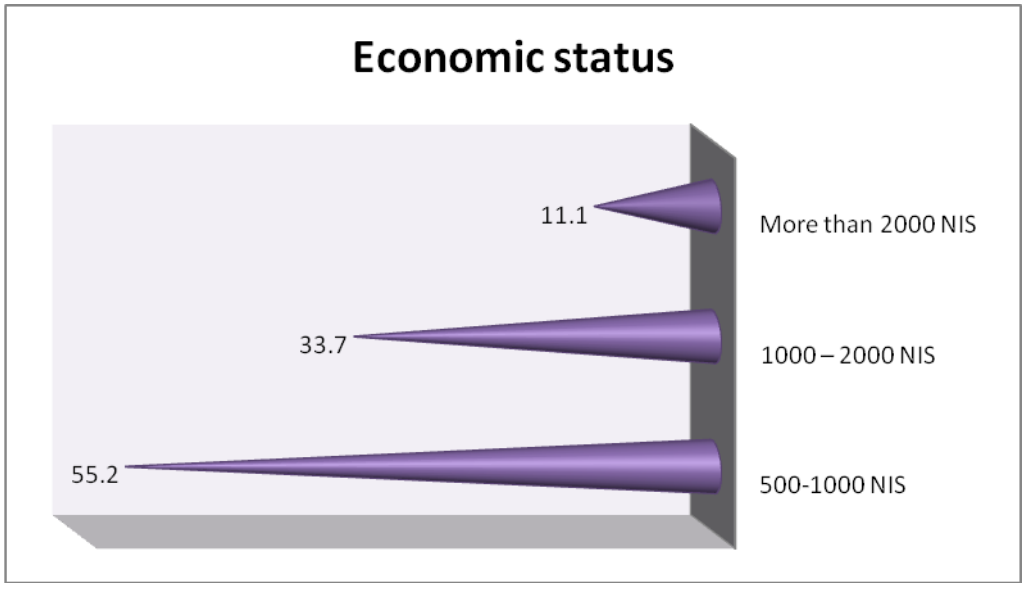

Figure (15)

6. Educational level:

Figure (16) shows that 11.6% from the sample the educational level of the family is " Elementary " , and 46.5% from the sample the educational level is " Preparatory " , and 15.1% from the sample the educational level is " Secondary " , and 26.7% from the sample the educational level is " University" .

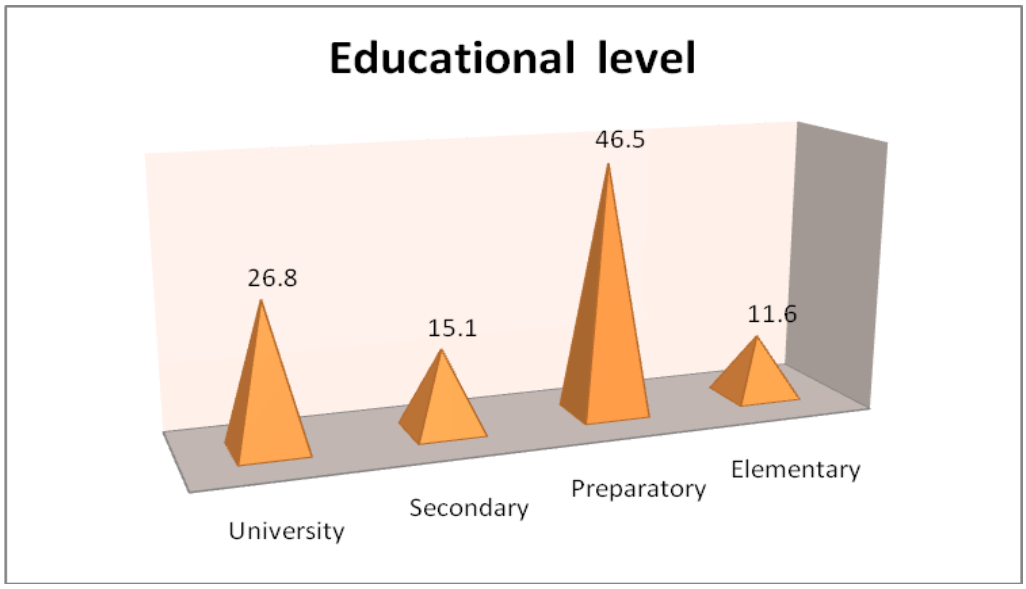

Figure (16)

5.2 One Sample K-S Test

One Sample K-S test the researcher used to identify if the data follow normal distribution or not, this test is considered necessary in case testing questions as most parametric Test stipulate data to be normality distributed and this test used when the size of the sample are greater than 50.

Results test as shown in table (6), clarifies that the calculated p-value is greater than the significant level which is equal 0.05 (p-value. > 0.05), this in turn denotes that data follows normal distribution, and so parametric Tests must be used.

Table (6)
One Sample K-S

Number	Factor	Statistic	P-value
recovery process	Factor 1: personal confidence and hope.	0.928	0.355
	Factor 2: willingness to ask for help.	0.514	0.954
	Factor 3: goal and success orientation.	1.192	0.116
	Factor 4: reliance on others.	0.761	0.609
	Factor 5: no domination by symptoms.	0.767	0.599
	Factor 6: compliance with psychotherapy	0.924	0.361
	Total factors	0.625	0.83
Family support	Factor 1: Effect of structural aspect of family (integration of the person with the support network)	0.726	0.667
	Factor 2: Effect of instrumental support of family.	1.056	0.214
	Factor 3: Effect of emotional support of family.	0.98	0.292
	Factor 4: Effect of informational support of family.	1.243	0.091
	Factor 5: Effect of belonging of a group with common interests to family.	0.849	0.467
	Axis VI: Effect of spiritual support of family	1.307	0.066
	Total factors	1.232	0.096

5.3 Interpretation of questions

In the following tables the researcher used a one sample t test to test if the opinion of the respondent in the content of the sentences are positive (weight mean greater than "60%" and the p-value less than 0.05) or the opinion of the respondent in the content of the sentences are neutral (p- value is greater than 0.05) or the opinion of the respondent in the content of the sentences are negative (weight mean less than "60%" and the p-value less than 0.05)

5.3.1 First: Recovery from depression

Factor I: Self confidence and hope in life

The researcher used a one sample t test to test if the opinion of the respondent about the **Self confidence and hope in life** and the results shown in Table No. (7) which show that the average mean for all items equal 3.24 and the weight mean equal 64.78 % which is greater than " 60%" and the value of t test equal 5.020 which is greater than the critical value which is equal 1.97 and the p- value equal 0.000 which is less than 0.05 except item number 1&3 the p-value more than 0.05 and that not affect on whole factor, that means my illness doesn't stop me from reaching my ambitions.

Table (7)
Self confidence and hope in life

No.	Factor	Mean	standard deviation	Weight mean	t-value	P-value
1	I depend on myself to manage and run my life	3.13	1.379	62.56	1.216	0.225
2	Fear is not an obstacle to achieve my goals	3.25	1.219	65.00	2.689	0.008
3	I feel that life is a beautiful trip	2.86	1.067	57.21	-1.715	0.088
4	I believe in myself and my abilities when I do any work	3.39	0.975	67.88	5.271	0.000
5	I have a clear plan for my future	3.20	1.069	63.95	2.426	0.016
6	I feel optimistic towards my future	3.44	0.992	68.84	5.839	0.000
7	I am satisfied about myself and my work	3.37	1.070	67.33	4.488	0.000
8	I enjoy life of work and completion	3.23	1.011	64.65	3.018	0.003
9	My illness doesn't stop me from reaching my ambitions	3.28	1.166	65.58	3.138	0.002
	All factors	3.24	0.624	64.78	5.020	0.000

Critical value of **t** at df "171" and significance level 0.05 equal 1.97

Factor II: Ability to seek help

The researcher used a one sample t test to test if the opinion of the respondent about the Ability to seek help and the results shown in Table No. (8) which show that the average mean for all items equal 3.48and the weight mean equal 69.53% which is less than " 60%" and the value of t test equal 9.996which is greater than the critical value which is equal 1.97 and the p- value equal 0.000which is less than 0.05, that means asking for help increase my insistence to overcome my problem

Table (8)
Ability to seek help

No.	Factor	Mean	standard deviation	Weight mean	t-value	P-value
10	I don't hesitate to ask for help when I need it	3.30	1.140	66.05	3.478	0.001
11	Asking for help increase my insistence to overcome my problem	3.30	1.155	66.05	3.432	0.001
12	I know when to ask for help	3.37	1.135	67.44	4.300	0.000
13	When I need help I ask specialized people	3.72	0.894	74.42	10.578	0.000
14	Following up with specialists help me to overcome my problem	3.69	0.902	73.72	9.978	0.000
	All factors	3.48	0.626	69.53	9.996	0.000

Critical value of **t** at df "171" and significance level 0.05 equal 1.97

Factor III: Awareness about goals and successes

The researcher used a one sample t test to test if the opinion of the respondent about the Awareness about goals and successes and the results shown in Table No. (9) which show that the average mean for all items equal 3.39and the weight mean equal 67.88% which is greater than " 60%" and the value of t test equal 9.354which is greater than the critical value which is equal 1.97 and the p- value equal 0.000 which is less than 0.05 except item number 18&20 the p-value more than 0.05 and that not affect on whole factor, that means my success makes me feel happy and satisfied.

Table (9)
Awareness about goals and successes

No.	Factor	Mean	standard deviation	Weight mean	t-value	P-value
15	I plan for my life realistically	3.76	0.923	75.12	10.737	0.000
16	I put clear goals for myself	3.69	0.902	73.72	9.978	0.000
17	I always plan for my life	3.44	0.992	68.84	5.839	0.000
18	I always plan to be successful in my life	3.02	1.054	60.47	0.289	0.773
19	I put reachable goals for myself	3.58	1.008	71.63	7.562	0.000
20	I achieve my goals quickly and perfectly	3.03	1.045	60.58	0.365	0.716
21	I divide my goals into partial objectives	3.41	1.107	68.14	4.822	0.000
22	I feel satisfied when I reach my goals	3.28	1.040	65.70	3.592	0.000
23	I feel my life is valuable because I have clear goals	3.35	1.069	67.09	4.351	0.000
24	My success makes me feel happy and satisfied	3.38	1.109	67.56	4.468	0.000
	All factors	3.39	0.553	67.88	9.354	0.000

Critical value of **t** at df "171" and significance level 0.05 equal 1.97

Factor IV: Dependence on others:

The researcher used a one sample t test to test if the opinion of the respondent about the Dependence on others and the results shown in Table No. (10) which show that the average mean for all items equal 3.56and the weight mean equal 71.13% which is greater than " 60%" and the value of t test equal 11.219which is greater than the critical value which is equal 1.97 and the p- value equal 0.000which is less than 0.05, that means we depend a lot on my family to meet my needs

Table (10)
Dependence on others

No.	Factor	Mean	standard deviation	Weight mean	t-value	P-value
25	I depend a lot on my family to meet my needs	3.51	1.157	70.23	5.799	0.000
26	I believe in my family's abilities to overcome my problem	3.47	0.988	69.47	6.226	0.000
27	It's hard for me to run my life without my family	3.55	1.126	70.93	6.368	0.000
28	My family help me to overcome my problem	3.29	1.080	65.81	3.530	0.001
29	My family provide me with what I needs	4.02	0.761	80.35	17.542	0.000

30	My family help me in treat my illness	3.80	0.869	76.05	12.102	0.000
31	I adjust with the depression symptoms as any other disease	3.27	1.179	65.35	2.975	0.003
	All factors	3.56	0.650	71.13	11.219	0.000

Critical value of **t** at df "171" and significance level 0.05 equal 1.97

Factor V: Dominant by symptoms:

The researcher used a one sample t test to test if the opinion of the respondent about the Dominant on symptoms and the results shown in Table No. (11) which show that the average mean for all items equal 3.38 and the weight mean equal 67.62% which is greater than " 60%" and the value of t test equal 6.667which is greater than the critical value which is equal 1.97 and the p- value equal 0.000 which is less than 0.05, that means.

Table (11)
Dominant by symptoms

No.	Factor	Mean	standard deviation	Weight mean	t-value	P-value
32	I see that the depression symptoms are temporary	3.19	1.067	63.84	2.358	0.019
33	I can cope to live with depression symptoms without problems	3.40	1.024	68.02	5.138	0.000
34	I feel that depression symptoms are decreasing by the time	3.35	1.018	67.09	4.567	0.000
35	The depression symptoms doesn't stop me from reaching my goals	3.49	1.157	69.88	5.601	0.000
36	I have the ability to overcome the depression symptoms	3.56	1.243	71.28	5.949	0.000
37	I seek to challenge the depression symptoms	3.28	1.253	65.58	2.920	0.004
	All factors	3.38	0.749	67.62	6.667	0.000

Critical value of **t** at df "171" and significance level 0.05 equal 1.97

Factor VI: Compliance on psychotherapy

The researcher used one sample t test to test if the opinion of the respondent about the Compliance on psychotherapy and the results shown in Table No. (12) which show that the average mean for all items equal 3.62 and the weight mean equal 72.44% which is less than " 60%" and the value of t test equal 12.146 which is greater than the critical value which is equal 1.97 and the p- value equal 0.000 which is less than 0.05, that means we feel the compliance with the treatment has positive effects on my case.

Table (12)
Compliance on psychotherapy

No.	Factor	Mean	standard deviation	Weight mean	t-value	P-value
38	I make sure to have the antidepressant in regular time	3.65	1.035	73.02	8.254	0.000
39	I take my medications according to my prescription	3.69	0.952	73.73	9.369	0.000
40	I visit the mental health clinic periodically to follow up my case with the psychologists.	3.60	1.041	71.98	7.544	0.000
41	I feel the compliance with the treatment has positive effects on my case	3.63	1.149	72.67	7.231	0.000
42	I go directly to the psychologist to treat my illness and relapses.	3.55	1.171	70.93	6.119	0.000
	All factors	3.62	0.671	72.44	12.146	0.000

Critical value of **t** at df "171" and significance level 0.05 equal 1.97

5.3.2 Second: Family support

Factor I: Integration person within the support network:

The researcher used a one sample t test to test if the opinion of the respondent about the Integration person within the support network and the results shown in Table No. (13) which show that the average mean for all items equal 3.53 and the weight mean equal 70.63% which is greater than " 60%" and the value of t test equal 10.700 which is greater than the critical value which is equal 1.97 and the p- value equal 0.000which is less than 0.05 except item number 5 the p-value more than 0.05 and that not affect on whole factor,, that means the patient feels happy for being with his /her family.

Table (13)
Integration person within the support network

No.	Factor	Mean	standard deviation	Weight mean	t-value	P-value
1	We help patient to be close to his/ her friends	4.05	0.846	81.05	16.304	0.000
2	We provide patient with advices to overcome illness	3.83	0.939	76.51	11.531	0.000
3	We seek to provide the patient with his / her needs	3.62	1.225	72.33	6.597	0.000

4	We follow the patient health and psychological conditions continuously	3.39	1.073	67.79	4.761	0.000
5	We offer social network for the patient that keeps him / her happy	3.03	0.994	60.58	0.384	0.702
6	The patient feels happy for being with his /her family	3.56	1.140	71.28	6.487	0.000
7	We let the patient participate in the social occasions	3.24	1.159	64.88	2.763	0.006
	All factors	3.53	0.652	70.63	10.700	0.000

Critical value of **t** at df "171" and significance level 0.05 equal 1.97

Factor II: Instrumental support:

The researcher used a one sample t test to test if the opinion of the respondent about the Instrumental support and the results shown in Table No. (14) which show that the average mean for all items equal 3.50 and the weight mean equal 70.05% which is greater than " 60%" and the value of t test equal 12.161 which is greater than the critical value which is equal 1.97 and the p- value equal 0.000 which is less than 0.05, that means when the patient gets money he becomes capable to overcome his/her problem.

Table (14)
Instrumental support

No.	Factor	Mean	standard deviation	Weight mean	t-value	P-value
8	We provide the patient with the treatment he/she needs	3.46	0.975	69.19	6.175	0.000
9	We spend much money to relief the patient mental situation	3.33	1.010	66.63	4.264	0.000
10	We take the patient to the mental health clinic for therapy	3.46	1.186	69.19	5.077	0.000
11	When the patient gets money he becomes capable to overcome his/her problem .	3.41	1.208	68.28	4.459	0.000

12	We give the patient the opportunity to find a job	3.36	1.107	67.21	4.269	0.000
13	We pay the patient's dept (which make him / her worried)	3.55	1.186	70.93	6.042	0.000
14	We offer gifts for the patient in different occasions	3.29	1.217	65.81	3.131	0.002
15	We help the patient to find institutions that provide assistance for him / her	4.09	0.635	81.78	22.302	0.000
16	We accept the patient with his / her illness as he/she is	3.59	0.862	71.83	8.924	0.000
	All factors	3.50	0.542	70.05	12.161	0.000

Critical value of **t** at df "171" and significance level 0.05 equal 1.97

Factor III: Emotional support:

The researcher used a one sample t test to test if the opinions of the respondent about the Emotional support and the results shown in Table No. (15) which show that the average mean for all items equal 3.36 and the weight mean equal 67.26% which is greater than " 60%" and the value of t test equal 8.571 which is greater than the critical value which is equal 1.97 and the p- value equal 0.000 which is less than 0.05, that means the patient feels satisfied when he stays with his family.

Table (15)
Emotional support

No.	Factor	Mean	standard deviation	Weight mean	t-value	P-value
17	We include the patient with love , kindness and compassion	3.59	1.019	71.86	7.519	0.000
18	The patient feels satisfied when he stays with his family	3.24	0.936	64.85	3.371	0.001
19	The family is a main source of happiness for the patient	3.32	1.037	66.39	4.005	0.000
20	We always comfort the patient about his/her illness	3.35	1.133	67.09	4.107	0.000
21	We the patient include	3.18	1.013	63.60	2.334	0.021

	with harmony and happiness					
22	We alleviate	3.51	0.882	70.23	7.609	0.000
23	We always invite and host the patient's friends at home	3.31	1.046	66.28	3.937	0.000
	All factors	3.36	0.555	67.26	8.571	0.000

Critical value of **t** at df "171" and significance level 0.05 equal 1.97

Factor IV: Informational support:

The researcher used a one sample t test to test if the opinions of the respondent about the Informational support and the results shown in Table No. (16) which show that the average mean for all items equal 3.55 and the weight mean equal 71.08% which is greater than " 60%" and the value of t test equal 11.083 which is greater than the critical value which is equal 1.97 and the p- value equal 0.000 which is less than 0.05, that means we provide the patient with information that helps him / her to overcome his/her problem.

Table (16)
Informational support

No.	Factor	Mean	standard deviation	Weight mean	t-value	P-value
24	We give the patient accurate information about his/her illness	3.64	0.980	72.77	8.399	0.000
25	We give the patient the information that makes him aware with his problem.	3.41	1.042	68.14	5.124	0.000
26	We provide the patient with information that helps him / her to overcome his/her problem.	3.52	1.011	70.47	6.785	0.000
27	We always lesson to the patient's thoughts	3.67	0.962	73.37	9.119	0.000
28	We provide the patient with the basics of psychosocial support and guidance.	3.56	1.010	71.28	7.326	0.000
	All factors	3.55	0.656	71.08	11.083	0.000

Critical value of **t** at df "171" and significance level 0.05 equal 1.97

Factor V: Spiritual support:

The researcher used a one sample t test to test if the opinion of the respondent about the Spiritual support and the results shown in Table No. (17) which show that the average mean for all items equal 3.40and the weight mean equal 68.09% which is greater than " 60%" and the value of t test equal 10.625 which is greater than the critical value which is equal 1.97 and the p- value equal 0.000 which is less than 0.05 except item number 32 the p-value more than 0.05 and that not affect on whole factor, the researcher opinion ,the depressed patients not understood well, that means the patient feels that we help him to overcome distress and tension.

Table (17)
Spiritual support

No.	Factor	Mean	standard deviation	Weight mean	t-value	P-value
29	We encourage the patient to keep his/her prayers	4.02	0.688	80.35	19.394	0.000
30	We provide the patient with Quran taps and encourage him/her to listen to them.	3.58	1.026	71.63	7.435	0.000
31	We encourage the patient to participate in all of the warships	3.44	1.186	68.84	4.887	0.000
32	We decrease the tension feels of the patient by reading Quran	3.04	1.141	60.81	0.468	0.641
33	We take the patient to warship houses	3.24	0.929	64.85	3.394	0.001
34	We encourage patients to be patient while doing the warships	3.24	1.117	64.77	2.800	0.006
35	We provide the patient with religious books in order to relief his/her problem	3.37	0.986	67.44	4.950	0.000
36	The patient feels that we help him to overcome distress and tension	3.30	1.109	66.05	3.576	0.000
	All factors	3.40	0.499	68.09	10.625	0.000

Critical value of **t** at df "171" and significance level 0.05 equal 1.97

Factor VI: Belonging with a group with common interest:

The researcher used a one sample t test to test if the opinion of the respondent about the Belonging with a group with common interest and the results shown in Table No. (18) which show that the average mean for all items equal 3.58 and the weight mean equal 71.55% which is greater than " 60%" and the value of t test equal 12.139 which is greater than the critical value which is equal 1.97 and the p- value equal 0.000 which is less than 0.05, that means the patient feels pleasure when he / she is taken to the social occasions.

Table (18)
Belonging with a group with common interest

No.	Factor	Mean	standard deviation	Weight mean	t-value	P-value
37	We get the patient closer to people he/she can benefit from them	3.55	1.115	71.05	6.498	0.000
38	We encourage them patient to build relations with religious people	3.41	1.169	68.14	4.567	0.000
39	We assist the patient to meet new groups in order to alleviate his /her illness	3.55	0.993	70.93	7.218	0.000
40	We help the patient to be integrated in the society	3.58	1.026	71.63	7.435	0.000
41	The patient feels happy when we listen to his / her stressor	3.66	0.963	73.26	9.030	0.000
42	The patient feels pleasure when he / she is taken to the social occasions.	3.72	1.040	74.30	9.016	0.000
	All factors	3.58	0.624	71.55	12.139	0.000

Critical value of **t** at df "171" and significance level 0.05 equal 1.97

5.4 Research questions analysis

In the following tables the researcher used a one sample t test to test if the opinion of the respondent in the content of the sentences are positive (weight mean greater than "60%" and the p-value less than 0.05) or the opinion of the respondent in the content of the sentences are neutral (p- value is greater than 0.05) or the opinion of the respondent in the content of the sentences are negative (weight mean less than "60%" and the p-value less than 0.05).

5.4.1 Recovery from depression

The researcher used a one sample t test to test if the opinion of the respondent about the recovery from depression and the results shown in Table No. (19) which show that the average mean for all items equal 3.42 and the weight mean equal 68.46% which is greater than " 60%" and the value of t test equal 13.098 which is greater than the critical value which is equal 1.97 and the p- value equal 0.000 which is less than 0.05, that means recovery from depression is good.

Table (19)
Recovery from depression

No.	Factor	Mean	standard deviation	Weight mean	t-value	P-value
1	personal confidence and hope.	3.24	0.624	64.78	5.020	0.000
2	willingness to ask for help.	3.48	0.626	69.53	9.996	0.000
3	goal and success orientation.	3.39	0.553	67.88	9.354	0.000
4	reliance on others.	3.56	0.650	71.13	11.219	0.000
5	no domination by symptoms.	3.38	0.749	67.62	6.667	0.000
6	compliance on psychotherapy	3.62	0.671	72.44	12.146	0.000
	All factors	3.42	0.424	68.46	13.098	0.000

Critical value of **t** at df "171" and significance level 0.05 equal 1.97

5.4.2 Family support

The researcher used a one sample t test to test if the opinion of the respondent about the **Family support** and the results shown in Table No. (20) which show that the average mean for all items equal 3.48and the weight mean equal 69.65% which is greater than " 60%" and the value of t test equal 13.797which is greater than the

critical value which is equal 1.97 and the p- value equal 0.000 which is less than 0.05, that means **the family support is enough**

Table (20)
Family support

No.	Factor	Mean	standard deviation	Weight mean	t-value	P-value
1	Effect of structural aspect of family (integration of the person with the support network)	3.53	0.652	70.63	10.700	0.000
2	Effect of instrumental support of family.	3.50	0.542	70.05	12.161	0.000
3	Effect of emotional support of family.	3.36	0.555	67.26	8.571	0.000
4	Effect of informational support of family.	3.55	0.656	71.08	11.083	0.000
5	Effect of belonging of a group with common interests to family.	3.40	0.499	68.09	10.625	0.000
6	Effect of spiritual support of family	3.58	0.624	71.55	12.139	0.000
	All factors	3.48	0.459	69.65	13.797	0.000

Critical value of **t** at df "171" and significance level 0.05 equal 1.97

1- Is there a significant relation at level α =0.05 between **Recovery from depression and Family support**?

To test the questions the researcher used the Pearson correlation between **Recovery from depression and Family support**, and the results shown in table No. (21) which illustrate that the p-value equal 0.001 which is less than 0.05, and the value of Pearson correlation is equal 0.262 which is greater than the critical value which is equal 0.145 that means there is a significant relationship at significant level α =0.5 between **Recovery from depression and Family support .**

Table No. (21)
Correlation between Recovery from depression and Family support

section	Statistic	Family support
Recovery from depression	Pearson coloration	0.262
	p-value	0.001
	N	172

Critical value of r at significance level 0.05 and df equal 170 equal 0.145

2- Is there a significant relation at level α =0.05 between **Recovery from depression** and the factors of **Recovery**?

To test the question the researcher used the Pearson correlation between **Recovery from depression** and the factors of **Recovery**, and the results shown in table No. (22) which illustrate that the p-value for each factor are less than 0.05, and the value of Pearson correlation for each factor are greater than the critical value which is equal 0.145 that means There is a significant relationship at significant level α =0.5 between **Recovery from depression** and the factors of **Recovery**.

Table No. (35) Annex (7)
Correlation between Recovery from depression and the factors of Recovery

3- Is there a significant relation at level α =0.05 between **Family support** and the factors of **Family support?**

To test the question the researcher used the Pearson correlation between **Family support** and the factors of **Family support,** and the results shown in table No. (23) which illustrate that the p-value for each factor are less than 0.05, and the value of Pearson correlation for each factor are greater than the critical value which is equal 0.145 that means There is a significant relationship at significant level α =0.5 between **Family support** and the factors of **Family support .**

Table No. (23) Annex (8)
Correlation between Family support and the factors of Family support

Is there a significant difference at α ≤ 0.05 among Recovery from depression due to demographic variables?
And this question divided into sub questions as follows:

1. Is there a significant difference at α ≤ 0.05 among Recovery from depression due to Gender?

To test the question the researcher used the Independent Samples Test and the result illustrated in table no. (24) which show that the p-value equal 0.320 which is greater than 0.05 and the absolute value of T test equal 0.997 which is less than the value of critical value which is equal 1.97, that's means There is no significant difference at α ≤ 0.05 among **Recovery from depression due to Gender.**

Table No. (24)
Independent Samples Test for difference among recovery from depression due to gender

Field	Gender	N	Mean	Std. Deviation	T	P-value
Recovery from depression	male	108	3.398	0.426	-0.997	0.320
	female	64	3.465	0.419		

Critical value of r at significance level 0.05 and df equal 170 equal 0.145

2. Is there a significant difference at $\alpha \leq 0.05$ among Recovery from depression due to marital status?

To test the question the researcher used the one way ANOVA and the result illustrated in table no. (25) which show that the p-value equal 0.560 which is greater than 0.05 and the value of F test equal 0.689 which is less than the value of critical value which is equal 2.66, that's mean There is no significant difference at $\alpha \leq 0.05$ **among Recovery from depression due to Marital status.**

Table No. (25)
One way ANOVA test for difference among Recovery from depression due to marital status

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
Recovery from depression	Between Groups	0.373	3	0.124	0.689	0.560
	Within Groups	30.301	168	0.180		
	Total	30.674	171			

Critical value of F at df "3,168" and significance level 0.05 equal 2.66

3. Is there a significant difference at $\alpha \leq 0.05$ among Recovery from depression due to Address?

To test the question the researcher used the one way ANOVA and the result illustrated in table no. (26) which show that the p-value equal 0.144 which is greater than 0.05 and the value of F test equal 1.736 which is less than the value of critical value which is equal 2.43 , that's mean There is no significant difference at $\alpha \leq 0.05$ **among Recovery from depression due to Address.**

Table No. (26)
One way ANOVA test for difference among Recovery from depression due to Address

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
Recovery from depression	Between Groups	1.225	4	0.306	1.736	0.144
	Within Groups	29.449	167	0.176		
	Total	30.674	171			

Critical value of F at df "3,168" and significance level 0.05 equal 2.43

4. Is there a significant difference at $\alpha \leq 0.05$ among Recovery from depression due to Age?

To test the question the researcher used the one way ANOVA and the result illustrated in table no. (27) which show that the p-value equal 0.473 which is greater than 0.05 and the value of F test equal 0.752 which is less than the value of critical value which is equal 3.05, that's mean There is no significant difference at $\alpha \leq 0.05$ **among Recovery from depression due to Age**.

Table No. (27)
One way ANOVA test for difference among Recovery from depression due to Age

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
Recovery from depression	Between Groups	0.271	2	0.135	0.752	0.473
	Within Groups	30.403	169	0.180		
	Total	30.674	171			

Critical value of F at df "2,169" and significance level 0.05 equal 3.05

5. Is there a significant difference at $\alpha \leq 0.05$ among Recovery from depression due to Years of disorder / illness?

To test the question the researcher used the one way ANOVA and the result illustrated in table no. (28) which show that the p-value equal 0.013 which is less than 0.05 and the value of F test equal 3.709 which is greater than the value of critical value which is equal 2.66 , that's mean There is a significant difference at $\alpha \leq 0.05$ **among Recovery from depression due to Years of disorder / illness**

Table No. (28)
One way ANOVA test for difference among Recovery from depression due to Years of disorder / illness

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
Recovery from depression	Between Groups	1.906	3	0.635	3.709	0.013
	Within Groups	28.768	168	0.171		
	Total	30.674	171			

Critical value of F at df "3,168" and significance level 0.05 equal 2.66

6. Is there a significant difference at $\alpha \leq 0.05$ among Recovery from depression due to Economic status?

To test the question the researcher used the one way ANOVA and the result illustrated in table no. (29) which show that the p-value equal 0.858 which is greater than 0.05 and the value of F test equal 0.153 which is less than the value of critical value which is equal 3.05, that's mean There is no significant difference at $\alpha \leq 0.05$ **among Recovery from depression due to Economic status.**

Table No. (29)
One way ANOVA test for difference among Recovery from depression due to Economic status

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
Recovery from depression	Between Groups	0.055	2	0.028	0.153	0.858
	Within Groups	30.618	169	0.181		
	Total	30.674	171			

Critical value of F at df "2,169" and significance level 0.05 equal 3.05

7. Is there a significant difference at $\alpha \leq 0.05$ among Recovery from depression due to Educational level?

To test the question the researcher used the one way ANOVA and the result illustrated in table no. (30) which show that the p-value equal 0.339 which is greater than 0.05 and the value of F test equal 1.128 which is less than the value of critical value which is equal 2.66, that's mean There is no significant difference at $\alpha \leq 0.05$ **among Recovery from depression due to Educational level**.

Table No. (30)
One way ANOVA test for difference among Recovery from depression due to Educational level

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
Recovery from depression	Between Groups	0.609	3	0.203	1.128	0.339
	Within Groups	30.060	167	0.180		
	Total	30.669	170			

Critical value of F at df "3,168" and significance level 0.05 equal 2.66

Is there a significant difference at $\alpha \leq 0.05$ among family support due to demographic variables?

And this question divided into sub questions as follows:

1. Is there a significant difference at $\alpha \leq 0.05$ among family support due to Gender?

To test the question the researcher used the Independent Samples Test and the result illustrated in table no. (31) which show that the p-value equal 0.503 which is greater than 0.05 and the absolute value of T test equal 0.671 which is less than the value of critical value which is equal 1.97, that's means There is no significant difference at $\alpha \leq 0.05$ among **family support due to Gender.**

Table No. (31)
Independent Samples Test for difference among family support due to Gender.

Field	Gender	N	Mean	Std. Deviation	T	P-value
family support	male	84	3.459	0.482	-0.671	0.503
	Female	88	3.506	0.437		

Critical value of **t** at df "170" and significance level 0.05 equal 1.97

2. Is there a significant difference at $\alpha \leq 0.05$ among family support due to Address?

To test the question the researcher used the one way ANOVA and the result illustrated in table no. (32) which show that the p-value equal 0.316 which is greater than 0.05 and the value of F test equal 1.192 which is less than the value of critical value which is equal 2.43, that's mean There is no significant difference at $\alpha \leq 0.05$ **among family support due to Address.**

Table No. (32)
One way ANOVA test for difference among family support due to Address

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
family support	Between Groups	0.998	4	0.250	1.192	0.316
	Within Groups	34.982	167	0.209		
	Total	35.980	171			

Critical value of F at df "4,167" and significance level 0.05 equal 2.43

3. Is there a significant difference at $\alpha \leq 0.05$ among family support due to Age?

To test the question the researcher used the one way ANOVA and the result illustrated in table no. (33) which show that the p-value equal 0.577 which is greater than 0.05 and the value of F test equal 0.552 which is less than the value of critical value which is equal 3.05 , that's mean There is no significant difference at $\alpha \leq 0.05$ **among family support due to Age.**

Table No. (33)
One way ANOVA test for difference among family support due to Age

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
family support	Between Groups	0.234	2	0.117	0.552	0.577
	Within Groups	35.747	169	0.212		
	Total	35.980	171			

Critical value of F at df "2,169" and significance level 0.05 equal 3.05

4. Is there a significant difference at $\alpha \leq 0.05$ among family support due to Relation to the patient?

To test the question the researcher used the one way ANOVA and the result illustrated in table no. (34) which show that the p-value equal 0.954 which is greater than 0.05 and the value of F test equal 0.111 which is less than the value of critical value which is equal 2.66, that's mean There is no significant difference at $\alpha \leq 0.05$ **among family support due to Relation to the patient**.

Table No. (34)
One way ANOVA test for difference among family support due to Relation to the patient

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
family support	Between Groups	0.071	3	0.024	0.111	0.954
	Within Groups	35.909	168	0.214		
	Total	35.980	171			

Critical value of F at df "3,168" and significance level 0.05 equal 2.66

5. Is there a significant difference at $\alpha \leq 0.05$ among family support due to Economic status?

To test the question the researcher used the one way ANOVA and the result illustrated in table no. (35) which show that the p-value equal 0.664 which is greater than 0.05 and the value of F test equal 0.410 which is less than the value of critical value which is equal 3.05, that's mean There is no significant difference at $\alpha \leq 0.05$ **among family support due to Economic status**

Table No. (35)
One way ANOVA test for difference among family support due to Economic status

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
family support	Between Groups	0.174	2	0.087	0.410	0.664
	Within Groups	35.807	169	0.212		
	Total	35.980	171			

Critical value of F at df "2,169" and significance level 0.05 equal 3.05

7. Is there a significant difference at $\alpha \leq 0.05$ among family support due to Educational level?

To test the question the researcher used the one way ANOVA and the result illustrated in table no. (36) which show that the p-value equal 0.148 which is greater than 0.05 and the value of F test equal 1.805 which is less than the value of critical value which is equal 2.66, that's mean There is no significant difference at $\alpha \leq 0.05$ **among family support due to Educational level.**

Table No. (36)
One way ANOVA test for difference among family support due to Educational level

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
family support	Between Groups	1.123	3	0.374	1.805	0.148
	Within Groups	34.857	168	0.207		
	Total	35.980	171			

Critical value of F at df "3,168" and significance level 0.05 equal 2.66

Chapter VI
Discussion, conclusion, and Recommendations

Chapter vi: Discussion, Conclusion and Recommendations

6.1 Overview

As shown in chapter two ,social supports have many forms, the most important types of them are family support for mentally ill patients.

As discussed in chapter three, literature confirms that, family support with many depressed patients is a part of recovery process, it's considered

as effective factors in recovery from major depression.

In this cross-sectional study, the researcher used two scales to ask about some subjects (major depressed patients) answer and describe the role of family support in recovery from major depression disorder.

6.2 Population characteristics

The respondents for the study are representative of major depressed patients in community mental health clinics) ,six clinics) distributed in Gaza governorates.

The study used two scales (family support scale and scale of recovery from depression).

First, the researcher discusses the demographical data for each scale as follows:

6.2.1 Recovery from depression's scale

1- Gender :as mentioned in chapter five in Figure (4) the frequency of male 108 with percentages 62.8 , but the frequency of females 64 with percentages 37.3

The researcher's opinion is, that Gaza community described in male and youth community, and female patients rarely go and follow up their cases in governmental organization such as ministry of health or its clinics, and that’s up to different studies shown in literature ,the rate of males and females are slightly equal in frequency and percentages and females feel stigmatized more than males especially in Arab country.

2- Marital status: as mentioned in Figure (5), the frequency of single patients is 38 with percentages 22.1, but married patients is 80 with percentages 46.5, also widow patients 21 with percentages 12.2, and divorced patients is 33 with percentages 19.2

The researcher sees, the biggest rate is married patients ,because of the nature of people of Gaza people are patients have different types of facing of problems ,and the problem is not (mental illness) an obstacle to stop his/her life, and culture and religion of most people is stronger than facing their problems .

In another hand, nature of depression is commonly resulted from divorce or single especially in female patients.

3- Address: as shown in Figure (6), the frequency of patients in middle governorate 62 with percentage of 36.0 , this is considered the biggest rate with comparison with other governorates. Rafah governorate has 51 frequency with percentage 29.7 , then north governorate , frequency of 27 with percentage 15.7 ,then Gaza governorate with frequency 17 with percentage of 9.9 , and Khan Yuones governorate with frequency of 15 with percentage 8.7 .

The researcher finds that, the distribution of depressed patients according to governorates , when he made sample comparing with an account of study sample according to governorates and its clinics ,also factor of nature of mentality level of people between villages ,cities , education and culture level.

4- Age: as shown in Figure (7) age less than 20years the frequency was 12 with percentage 7.0, then from 20-30 years the frequency 78 with percentage 45.3, and age more than 30years the frequency 82 with percentage 47.7

The researcher found that Gaza community discriminate in youth rate was more than that of other ages, so most of problems and responsibilities of life focuses in youth stage, therefore, mental illness was clear especially in that age.

5- Years of disorders : as shown in Figure (8) all the sample received from data collection of 172 depressed patients with percentage 100.0 ,that was normal result ,because the researcher limited the included criteria of disorders is major depressed patients less than two years 2009-2010 years.

6- Economic status: as shown in Figure (9), most of sample was with low level of income, 52.9 (500-1000NIS), then 41.9 (1000-2000NIS) ,and the least one 5.2 percentage the level of income more than (2000NIS).

The researcher found that, most of sample from poor people, and that was related to many factors founded in Gaza community as (unemployment 67.5%, recurrences of crises and siege lasted for 5years ...)

7- Educational level: as shown in Figure (10), most of percentages of educational level (preparatory level 36.7, then secondary level 29.7, then elementary 19.8 and university 14.0

The researcher's rationale was that, although the people of Gaza community are educated, mental illness has been founded, the right of education lost, especially in females and future impious and hope gone and stigma level increased.

6.2.2 Family support's scale

1- Gender: as shown in Figure (11), the percentage of male was 48.8 and females 51.2.

The researcher found that, there was slightly difference in this percentage between males and females, and that was related to factors of family support introduced to patient by member of supporting by family to the patient.

2- Address: as shown in Figure (12), 9.9 percentage from sample living in Gaza governorate, and 15.7 live in North Gaza, and 36.0 are lives in Middle governorate, and 8.7 are living in Khan Younes governorate, and 29.7 from sample lives in Rafah governorate.

The researcher found that, the same percentage of place of address with address of patients, and its already normal, because it should be the source of family support to depressed patients in same time and place to the patient.

3- Age: as shown in Figure (13), the percentage of age less than 20years was 3.5, and the percentage from 20-30years was 52.9 and percentage of age more than 30years was 43.6.

The researcher found out that , source of family support to patient was better than when people get close to the patient age ,also getting close from cognitive level and type of thinking and level of needs of patient.

4- Relation to the patient: as shown in Figure (14) most of relation with the patient was with brothers and sisters 35.5 percentage , then husband and wife 26.2 percentage , then father and mother 20.3 percentage , then the last one son and daughter 18.0 percentage .

The researcher found that, the level of family support with brothers and sisters are the most one and that related to closest level of thinking and culture to the patient in comparison with fathers and mothers.

5- Economic status: as shown in Figure (15) level of monthly income (500-1000NIS) is 55.2 percentage, then (1000-2000NIS) 33.7 percentages, then more than (2000NIS) 11.0 percentage.

The researchers found that, low economic status plays strong role in support level with the patient, because most causes of mental illness (depression) were with low economic status.

6- Educational level: as shown in Figure (16) the preparatory educational level the researcher found that high educational level of member of supported family helped in understanding and awareness about the nature of mental illness and models of management and care should be introduced to patients.

As shown in table (32), there is weight mean 68.46%, and p. value 0.000 that means that recovery from depression was good.

The researcher's opinion; despite of lack of implementation of recovery process on theoretical based in community mental health clinics, there was good recovery from depression, and that was related to Arab and Islamic culture in Gaza Strip, culture has a unique nature about social support in different types.

On the other hand, as shown in table (33), the weights mean of instrument was 69.65% and p .value 0.000, that's means the family support is enough.

The researcher's opinion; building on good recovery from depression, that's an indicator about family support and that's differs with most of previous studies in chapter three , and that's related to culture and religion's differences from country to country.

As shown in table (34), there is a significant relationship at level **α =0.05** between recovery from depression and family support.

And as shown in table (35), there is a significant relationship at level **α =0.05** between recovery from depression and factors of recovery.

Also, as shown in table (36), there is a significant relationship at level **α =0.05** between family support and factors of family support.

And that guide to many indicators such as: there is a positive relationship between recovery from depression and family support ,family support is important part of social support consider a helping factors and essential in recovery process and step of it ,and its agree with many previous studies ,as study done by Tsonna-Hadjis et al,2002 that clarify a high level of family support –instrumental and emotional are associated with progressive improvement of functional status, mainly in severity impaired patients (depression),and agree with another study done by Furukana TA,et al in Japan that expect further amelioration in social adjustment after symptomatic remission and recovery of major depressive episodes.

On the other hand, recovery process as a journey consists of many steps and every step is built on the former, and family support is considered as supportive column, and that was clear in this study and agreed with other studies as that done by Bakto et al, 2000 in Canada, the result showed, that was difference in gender and lack of support from family and friends affect positively in same times and negativity in another time. Also agrees with study done by John curry and Susan Silva, 2011 in United States shows recovery that recurrence following treatment for adolescent major depression was positive.

The thesis has proved some facts as shown below :

- Family support has a positive and effective role at the recovery from mental disorder specially depression , this thesis agreed with (AlAqra'a , 2004) which shown the positive effect of the social support on the schizophrenic patients The study was conducted on the major depression patients whose cases were chronic and were following up in the clinic , of course we can't deny the great , long and hard role of the patient's families who didn't give up supporting their patients through their treatment journey and still supporting them , that made us optimistic about the family support and its positive effect on the major depression patients . All of that partially concurred with the study of (Michel G,2000) , which proved the positive effect of the post-traumatic disorder with major depression episode

despite that in the study it was only episodes and not full disorder as the cases in my study .

- Despite that the recovery process is an integrated process based on scientific basis as it has many fixed steps , measuring tools and assessments (as in many published international studies) , this study revealed the amount of awareness that Gaza people have – even if it was natural – in dealing with the psychiatric patients, as the families of the patients proved the worthiness of their social support for their patients even if it was natural and not based on scientific basis . That disagreed with the international studies that ensured the fact the recovery process has to be done with scientific basis through fixed steps , measuring tools and assessments in specialized institutions .

- The study ,along with other studies, proved the huge burden caused by the continues spread of the depression disease , as it considered the third global burden diseases, the need of care and rehabilitation . However, the Gaza people has religious faith and social support appropriate for psychiatric patients , the researcher has noticed that most of the families are extended families , and that played a positive role in supporting the depressed patients as it helped them to stay away from isolation and in touch with others most of the time . And if we gave a closer look to the symptoms of depression , we will find that depressed patients have no feels of fun and enjoyment in general even in social relations with others , from this point we can see that the family support can bring the fun and energy back gradually to the life of depressed patients and that what was proved by the study . Moreover when making a literature review we will notice (Okasha,2004) observes & describes the prevalence of depression in Palestine with 62% , which is a huge proportion and for that reason there is an urgent need to focus on this category and develop new methods for their treatment and rehabilitating them , here the study has proved the effect of the family support on the recovery from depression .
- In addition the study has proved that the demographic factors for the patients and their families have no effect on the recovery process ,which emphasize that the

family support is one of the basic needs in our society, besides being a right of the patients .

- The study has proved that the factors of the tool (recovery from depression) have a positive effect , and if we linked those factors - such as self confidence and hope in life, ability to seek help, dominance by symptoms, with the factors of the family support tool such as integrated patient with social network, informational support, instrumental support and emotional support, we found a strong relation in integrating the patient in the surrounding social network , specially family . This support comes only if the patient had the needed self confidence to ask for help , and this happens when he/she trust and depend on his family .

- On the other hand, the study has proved that the family support tool ,which contain the emotional, informational and instrumental support , only occurs when there is a social network especially a strong supporting family that has a great role in helping the depressed patient in his recovery .

- Another important point is that the study has proved that when the family provides spiritual support and has a strong religious faith , the patient recovery process becomes faster and stronger , if we make a simple comparison between a family had the spiritual support , a strong religious faith and social correlation , this will prevent conflicts between what he thinks and does and between what the family do .

- Second, discussing every factor in every scale, the researcher arranged that as follows:

6.2.3 *Recovery from depression's scale (factors discussion)*

Self confidence and hope in life: in a study showed in table (15), the average mean of all items was equal 3.24 and weight mean equal 64.78% and p .value equal 0.000 which was less than 0.05% and that indicate to positive direction, and that is considered normal result, because self confidence has an effect on response and cooperation with disorders and helps in recovery of depressed patient.

Ability to seek help: in table (16), the average mean of all items equals 3.48 and the weight mean equals 69.53% and p .value equal 0.000 which was less than 0.05% and that indicates to positive direction, the researcher disagrees with this result, because through signs of depression, represented in disability to seek or cooperate and general fatigue and lack of energy to seek help from others, although cultural differences between foreign and Arab countries.

Awareness about goals and successes: in table (17), the average mean of all items equals 3.39 and the weight mean equals 67.88% and p .value equal 0.000 which was less than 0.05% and that indicates to positive direction, the researcher comment, from the effect of depression there are loss of achievement of goals and that need to community and family support and awareness about disorders and how to recover from it.

Dependence on others: in table (18), the average mean of all items equal 3.56 and the weight mean equal 71.13% and p .value 0.000 which was less than 0.05% and that indicate to positive direction, most important causes of this study depend on sharing others, especially family in recovery process, because the surroundings and living with the patient should be in suitable social context to rehabilitate and recover as fast as possible.

Dominant by symptoms: in table (19), the average mean of all items equaled 3.38 and the weight mean equaled 67.62% and p .value 0.000 which was less than 0.05% and that indicates to positive direction, through the management plan of depression, treatment plan (antidepressant drugs) and psychotherapy, to accomplish the recovery from depression as showed in theoretical framework in chapter two, and this finding agree with this result.

Compliance of psychotherapy: in table (20), the average mean of all items equaled 3.62 and the weight mean equaled 72.44% and p .value 0.000 which was less than 0.05% and that indicates to positive direction, that reflects work of community mental health services in GG on clients and mental health team , despite lack of manpower ,trained professionals, and logistic support.

6.2.4 *Family support's scale (factor's discussion)*

Integration person within the support network: in table (21), the average mean of all items equaled 3.53 and the weight mean equaled 70.63% and the p .value 0.000 which was less than 0.05% and that indicates to positive direction, social support for those patients are have network classify to many parts sum with together to become network, family support consider from essential parts, so integration patients with social and family network are important in recovery process.

Instrumental support: in table (22), the average mean of all items equaled 3.50 and the weight mean equaled 70.5% and the p .value 0.000 which was less than 0.05% and that indicates to positive direction, the researcher's comment about this result by, the integration of parts of family support and one of that is instrumental to accomplish the whole image of family support.

Emotional support: in table (23), the average mean of all items equaled 3.36 and the weight mean equaled 67.26 % and the p .value 0.000 which was less than 0.05% and that indicates to positive direction, this result agreed with study done by Jutta Joormann mentioned in chapter four, and the researcher's sees, should be family have basic features in method of deal and treatment by together, as emotion, warmth, and respect.

Informational support: in table (24), the average mean of all items equaled 3.55 and the weight mean equaled 71.8. % and the p .value 0.000 which was less than 0.05% and that indicates to positive direction, the researcher's rationale is ,awareness the patient and them family about them disorders increase the level of insight and cooperation in sharing recovery process and fast the remission.

Spiritual support: in table (25), the average mean of all items equaled 3.40 and the weight mean equaled 68.09 % and the p .value 0.000 which was less than 0.05% and that indicates to positive direction, from the main obstacle in family support is the conflict between what is patient believed, and what is implemented in their life, in another side, spiritual support are positive when it increase the patience and positivistic in recovery process.

Belonging with a group with common interest: : in table (26), the average mean of all items equaled 3.58and the weight mean equaled 71.55 % and the p .value 0.000 which was less than 0.05% and that indicates to positive direction, the researcher agreed and supported this result ,because family, peers ,community association are integrates in supporting the patient and add scientific based theories and formal studies in implementation of recovery process and create a good surrounding environment to complete recovery process and keep about continuity of it .

6.3 Conclusion

- The study revealed that the major of depressed patients mainly male (62.8%), and approximately (46.5%) are married.
- About the biggest rate of patients from middle governorate, in comparison with other governorates, the Rafah governorate.
- Most of sample (depressed patients) from youth ages in comparison with other age stages.
- 52.9% from sample are from low economic status, and most of participants from low educational level (preparatory level).
- There is slightly good recovery from depression rate 68.46% and 69.65% rate family support for depressed patients.
- There is a significant relationship between recovery from depression and family support.
- There is no significant difference between recovery from depression due to (sex, marital status, address, age, and years of disorders, economic status and educational level).
- There is no significant difference between family support due to (gender, address, age, relation to the patient, economic status and educational level).
- Depression is a major cause of morbidity worldwide. Lifetime prevalence varies widely, from 3% in Japan to 17% in the US.
- Population studies have consistently shown major depression to be about twice as common in women as in men, although it is unclear why this is so, and whether factors unaccounted for are contributing to that.

- People are most likely to suffer their first depressive episode between the ages of 30 and 40, and there is a second smaller peak of incidence between ages 50 and 60.
- Depressive disorders are most common to observe in urban than in rural population and the prevalence is in groups with higher socioeconomic factors i.e. homeless people.
- Family support as apart from social context ,consider from essential source of support and contributive factor in recovery from mental disorders as showed in thesis (depression disorders)

6.4 Recommendations

6.4.1 Practical recommendations

- Advocates for the rights of mental ill patients especially depressed patients for specialized process for rehabilitation, recovery and engagement.
- The researcher recommends the ministry of health and decisions makers to put enough budgets for mental health rehabilitation and recovery programs and statistics of mental disorders in Palestine.
- Facilitate methods of life activities by more social support, recreations programs to increase rate of recovery process implementation.

6.4.2 Recommendations for further studies

- Further researches about family support among schizophrenic patients and post partum psychosis.
- Increasing the study level and qualified mental health team to implement recovery process on scientific based.
- Increasing number of community mental health clinics to include more number of patients and mental health team.

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Annex (1)

نموذج الموافقة على المشاركة بالدراسة

استبانـــــــــــــــــــــــة

تهدف هذه الإستبانة إلى جمع البيانات اللازمة حول:

"مدى تأثير الدعم الأسرى على التعافى من مرض الإكتئاب فى محافظات غزه."

أرجو من حضرتكم التعاون فى تعبئة هذه الإستبانة والتى هى جزء من دراستى لتكملة رسالة الماجستير فى الصحة النفسية المجتمعية / الجامعة الإسلامية ـ كلية التربية.

الإستبانة تحتوى على خمسة خيارات للإجابة فأرجو اختيار مدى الرضا الذى يصف شعورك حول حالتك.

فى حال موافقتك المشاركة فى البحث فأرجو التوقيع بالموافقة على ذلك وسيكون لك الحق فى الإنسحاب متى شئت,علما بأن إجاباتك ستعامل بكامل السرية وستستخدم فى أغراض البحث العلمى فقط,ولاداعى لذكر اسم المشترك على الإستبانة.

- إذا وافقت على المشاركة فى البحث ,نرجو وضع علامة (X) .....

شكرا لتعاونكم

الباحث: أحمد الخالدي

Annex (2)

استبانة (1)
مقياس الدعم الأسري

التاريخ: / / 2011 الرقم----------
(خاص بالباحث)

سيدى/تى الفاضل/ة نرجو عليك الإجابة على العبارات الأتية بوضع إشارة (X) أمام كل عبارة حسب رأيك ومشاعرك نحو حالتك/ى :

البيانات الشخصية :

الجنس	ذكـــــــــــر	أنـــــثى

المهنـــــــــــــــة	

العنوان	محافظة غزه	محافظة الشمال	محافظة الوسطى	محافظة خان يونس	محافظة رفح

العمر	أقل من 20	من 20 إلى 30	30 فأكثر

علاقتك بالمريض	والد/والدة	أخ/أخت	ابن /ابنة	زوج/زوجة

المستوى الاقتصادى	من500-1000شيقل	من1000-2000شيقل	من 2000 شيقل فأكثر

المستوى التعليمي	ابتدائي	إعدادي	ثانوي	جامعي

الرقم	العبارة	أوافق بشدة	أوافق	لا أعلم	لا أوافق بشدة	لا أوافق
1	نقرب مريضنا من أصدقائه .					
2	نقدم الكثير من النصائح المفيدة فى التغلب على المرض.					
3	نسعى دائما لتوفير إحتياجات المريض .					
4	نتابع الوضع الصحى النفسى بشكل مستمر .					
5	نوفر للمريض شبكة علاقات اجتماعية تشعره /ها بالسعادة .					
6	يشعر بالسعادة لمجرد وجوده بين أفراد أسرته .					
7	نشرك المريض فى كل المناسبات الإجتماعية.					
8	نوفر للمريض مايحتاجه من علاج .					
9	ننفق الكثير من المال للتخفيف من حالة المريض النفسية .					
10	نصطحب المريض للعيادات النفسية للعلاج .					
11	حصول المريض على المال يزيد من قدرته على تخطى محنته .					
12	نوفر للمريض خدمات البحث عن عمل نافع له/ها.					
13	نسدد ديون المريض التى تقلقه وتزيد من مشكلته/ها.					

14	نقدم للمريض الهدايا فى المناسات المختلفة .					

الرقم	العبارة	أوافق بشدة	أوافق	لا أعلم	لا أوافق بشدة	لا اوافق
15	نساعد المريض فى إيجاد مؤسسات تقدم له/ها يد المساعدة.					
16	نتقبل المريض بمرضه/ها.					
17	نوفر للمريض مشاعر الحب والعطف والحنان .					
18	يشعر المريض بالرضا عندما يجلس بين أفراد أسرته/ها.					
19	الأسرة مصدر سعادة المريض.					
20	دائما نواسي المريض فى مرضه/ها .					
21	نوفر للمريض مشاعر الألفة والسعادة .					
22	نرفع عن المريض كل مشاعر الضيق والتوتر .					
23	دائما ما تستضيف أصدقاء المريض.					
24	نوفرللمريض معلومات صحيحة عن مشكلته/ها.					
25	نعطي المريض المعلومات التى تجلعه/ها على بصيرة بمشكلته/ها .					
26	نقدم للمريض معلومات تساعده/ها على التغلب على مشكلته/ها.					
27	نصغى دائما لأفكار المريض .					

28	نوفر للمريض أساسيات الدعم والإرشاد النفسي.					

الرقم	العبارة	أوافق بشدة	أوافق	لا أعلم	لاأوافق بشدة	لا اوافق
29	ندفع المريض إلى الإكثار من الصلاة .					
30	نوفر للمريض أشرطة تلاوة للإستماع إليها .					
31	نشارك المريض معظم العبادات .					
32	نقلل حالات الضيق لدى المريض بقراءة القران .					
33	نصطحب المريض إلى دور العبادة .					
34	نعود المريض الصبر على العبادة.					
35	نقدم للمريض الكتب الدينية التى تخفف من مشكلته/ها.					
36	يشعر المريض بأننا نرفع عنه كل مشاعر الضيق والتوتر.					
37	نقرب المريض من أشخاص يستفيد منهم.					
38	نزيد من علاقات المريض مع أشخاص متدينين .					
39	نساعد المريض فى التعرف على جماعات تخفف من مرضه/ها.					
40	نساعد المريض الإندماج فى المجتمع .					
41	يشعر المريض بالسعادة عندما نستمع لهمومىه/ها .					
42	يجد المريض متعة فى إصطحابه فى المناسبات الإجتماعية.					

Annex (3)

استبانة (2)
التعافى من الإكتئاب

التاريخ: / / 2011 الرقم----------
(خاص بالباحث)

سيدى/تى الفاضل/ة نرجو عليك الإجابة على العبارات الأتية بوضع إشارة (X) أمام كل عبارة حسب رأيك ومشاعرك نحو حالتك/ى :

البيانات الشخصية:

الجنس	ذكر	أنثى

الحالة الاجتماعية	أعزب/أنسة	متزوج/ة	أرمل/ة	مطلق/ة

العنوان	محافظة غزه	محافظه الشمال	محافظه الوسطى	محافظه خان يونس	محافظه رفح

العمر	أقل من 20	من 20 إلى 30	30 فأكثر

عدد سنوات المرض	أقل من سنتين	2-5 سنوات	من 5-10 سنوات	أكثر من 10

المستوى الاقتصادى	من 500-1000شيقل	من 1000-2000شيقل	من 2000 فأكثر

المستوى التعليمى	ابتدائي	إعدادي	ثانوي	جامعي

الرقم	العبارة	أوافق بشدة	أوافق	لا أعلم	لا أوافق بشدة	لا أوافق
1	أعتمد على نفسي فى إدارة شئون حياتى .					
2	الخوف ليس عائقا لي من بلوغ أهدافى.					
3	أشعر بأن الحياة رحلة جميلة					
4	أثق بنفسي وبقدراتى عند قيامى بأي عمل .					
5	لدى خطة واضحة لمستقبلى .					
6	أشعر بالتفاؤل لمستقبل حياتى .					
7	أرضى عن نفسي وعملى .					
8	أستمتع بحياة العمل والإنجاز.					
9	مشكلتى لا تعيقنى عن تحقيق طموحاتى.					
10	لا أتردد في طلب المساعدة إذا احتجت إليها.					
11	طلب المساعدة يزيدني إصرارا على حل مشكلتي.					
12	أعرف متى أطلب المساعدة.					
13	أختار أهل الاختصاص لطلب مساعدتي.					
14	متابعة أهل الاختصاص تساعدني فى حل مشكلتى.					

الرقم	العبارة	أوافق بشدة	أوافق	لا أعلم	لا أوافق بشدة	لا أوافق
15	أخطط لحياتى بواقعية.					
16	أضع لنفسي أهدافا واضحة.					
17	دائما ما أخطط لحياتى.					
18	أخطط دائما لكى أكون ناجحا فى حياتى .					
19	أضع لنفسي أهدافا تمكنني من الوصول إليها .					
20	أحقق أهدافى بسرعة وإتقان .					
21	أقسم أهدافى لأهداف جزئية.					
22	أشعر بالرضى عند بلوغ أهدافى.					
23	أشعر بقيمة حياتى, لأن لى أهدافا واضحة.					
24	نجاحي يشعرنى بالسعادة والرضى.					
25	أعتمد كثيرا على أسرتى فى إشباع حاجاتى.					
26	أثق بقدرة أسرتى لحل مشكلتى.					
27	يصعب على إدارة شئون حياتى بدون أسرتى.					
28	أسرتي تعيننى فى التغلب على مشكلتي.					

الرقم	العبارة	أوافق بشدة	أوافق	لا أعلم	لا أوافق بشدة	لا أوافق
29	أسرتي توفر لى متطلبات حياتي .					
30	أسرتي تساعدنى فى علاج مشكلتي .					
31	أتوافق مع أعراض الاكتئاب كأى مرض أخر.					
32	أرى بأن أعراض الاكتئاب مؤقتة.					
33	أستطيع العيش مع أعراض الاكتئاب بدون أعراض.					
34	أشعر بأن أعراض الإكتئاب تقل مع مرور الزمن.					
35	أعراض الاكتئاب لاتعيقنى عن بلوغ أهدافي .					
36	لدي القدرة على التغلب على أعراض الاكتئاب.					
37	أسعى لتحدى أعراض الاكتئاب.					
38	أحرص على تناول مضادات الاكتئاب بأوقات منتظمة.					
39	أتناول علاجي حسب الوصفة الطبية.					
40	أذهب إلى عيادة الصحة النفسية بشكل دوري لمتابعة حالتى وزيارة الأخصائيين النفسيين .					
41	أشعر بأن الالتزام بالعلاج له أثارا إيجابية على حالتى.					
42	أسارع إلى الطبيب النفسي لعلاج مرضي وسوء حالتى.					

Annex (4)
Questionnaire (1)
Family support

Date: / /2011 **serial number…….**

Dear Sir/ Madam

Please read the following statements and choose the best sentence that suits your feeling towards yourself, put (^{x}) in front of your choice.

Personal information:

Sex	Male	Female

Profession	

Address	Gaza Governorate	North Governorate	Middle Governorate	Khanyounis Governorate	Rafah Governorate

Age	Less than 20 years	From 20 – 30 years	More than 30 years

Relation to the patient	Father /Mother	Brother / Sister	Son / Daughter	Husband / Wife

Economic status	500-1000 NIS	1000 – 2000 NIS	More than 2000

Educational level	Elementary	Preparatory	Secondary	University

s	*Statement*	*Strongly agree*	*agree*	*Don't know*	*Disagree*	*Strongly disagree*
	Factor I: Integration person within the support network:					
1	We help patient to be close to his/ her friends					
2	We provide patient with advices to overcome illness					
3	We seek to provide the patient with his / her needs					
4	We follow the patient health and psychological conditions continuously					
5	We offer social network for the patient that keeps him / her happy					
6	The patient feels happy for being with his /her family					
7	We let the patient participate in the social occasions					
8	***Factor II: Instrumental support:*** We provide the patient with the treatment he/she needs					
9	We spend much money to relief the patient mental situation					
10	We take the patient to the mental health clinic for therapy					
11	When the patient gets money he becomes capable to overcome his/her problem .					
12	We give the patient the opportunity to find a job					
13	We pay the patient's dept (which make him / her worried)					
14	We offer gifts for the patient in different occasions					
15	We help the patient to find institutions that provide assistance for him / her					
16	We accept the patient with his / her illness as he/she is					
17	***Factor III: Emotional support:*** We include the patient with love , kindness and compassion					
18	The patient feels satisfied when he stays with his family					
19	The family is a main source of happiness for the patient					
20	We always comfort the patient					

s	*Statement*	*Strongly agree*	*agree*	*Don't know*	*Disagree*	*Strongly disagree*
	about his/her illness					
21	We the patient include with harmony and happiness					
22	We alleviate					
23	We always invite and host the patient's friends at home					
24	***Factor IV: Informational support:*** We give the patient accurate information about his/her illness					
25	We give the patient the information that makes him aware with his problem.					
26	We provide the patient with information that helps him / her to overcome his/her problem.					
27	We always lesson to the patient's thoughts					
28	We provide the patient with the basics of psychosocial support and guidance.					
29	***Factor V: Spiritual support:*** We encourage the patient to keep his/her prayers					
30	We provide the patient with Quran taps and encourage him/her to listen to them.					
31	We encourage the patient to participate in all of the warships					
32	We decrease the tension feels of the patient by reading Quran					
33	We take the patient to warship houses					
34	We encourage patients to be patient while doing the warships					
35	We provide the patient with religious books in order to relief his/her problem					
36	The patient feels that we help him to overcome distress and tension					
37	***Factor VI: Belonging with a group with common interest:*** We get the patient closer to people he/she can benefit from them					
38	We encourage them patient to build relations with religious people					

s	*Statement*	*Strongly agree*	*agree*	*Don't know*	*Disagree*	*Strongly disagree*
39	We assist the patient to meet new groups in order to alleviate his /her illness					
40	We help the patient to be integrated in the society					
41	The patient feels happy when we listen to his / her stressor					
42	The patient feels pleasure when he / she is taken to the social occasions.					

Annex (5)
Questionnaire (2)
Recovery from depression

Date: / / 2011 **serial number……**

Dear Sir/ Madam
Please read the following statements and choose the best sentence that suits your feeling towards yourself, put (^{x}) in front of your choice.

Personal information:

Sex	**Male**	**Female**

Profession	

Marital statue	**Single**	**Married**	**widow**	**Divorced**

Address	**Gaza Governorate**	**North Governorate**	**Middle Governorate**	**Khanyounis Governorate**	**Rafah Governorate**

Age	**Less than 20 years**	**From 20 – 30 years**	**More than 30 years**

Years of disorder / illness	**Less than 2 years**	**2-5 years**	**5-10 years**	**More than 10 years**

Economic status	**500-1000 NIS**	**1000 – 2000 NIS**	**More than 2000**

Educational level	**Elementary**	**Preparatory**	**Secondary**	**University**

s	*Statement*	*Strongly agree*	*agree*	*Don't know*	*Disagree*	*Strongly Disagree*
1	***Factor I: Self confidence and hope in life:*** I depend on myself to manage and run my life					
2	Fear is not an obstacle to achieve my goals					
3	I feel that life is a beautiful trip					
4	I believe in myself and my abilities when I do any work					
5	I have a clear plan for my future					
6	I feel optimistic towards my future					
7	I am satisfied about myself and my work					
8	I enjoy life of work and completion					
9	My illness doesn't stop me from reaching my ambitions					
10	***Factor II: Ability to seek help:*** I don't hesitate to ask for help when I need it					
11	Asking for help increase my insistence to overcome my problem					
12	I know when to ask for help					
13	When I need help I ask specialized people					
14	Following up with specialists help me to overcome my problem					
15	***Factor III: Awareness about goals and successes:*** I plan for my life realistically					
16	I put clear goals for myself					
17	I always plan for my life					
18	I always plan to be successful in my life					
19	I put reachable goals for myself					
20	I achieve my goals quickly and perfectly					
21	I divide my goals into partial objectives					
22	I feel satisfied when I reach my goals					
23	I feel my life is valuable because I have clear goals					
24	My success makes me feel happy and satisfied					
	Factor IV: Dependence on					

s	*Statement*	*Strongly agree*	*agree*	*Don't know*	*Disagree*	*Strongly Disagree*
25	***others:*** I depend a lot on my family to meet my needs					
26	I believe in my family's abilities to overcome my problem					
27	It's hard for me to run my life without my family					
28	My family help me to overcome my problem					
29	My family provide me with what I needs					
30	My family help me in treat my illness					
31	I adjust with the depression symptoms as any other disease					
32	***Factor V: Dominant on symptoms:*** I see that the depression symptoms are temporary					
33	I can cope to live with depression symptoms without problems					
34	I feel that depression symptoms are decreasing by the time					
35	The depression symptoms doesn't stop me from reaching my goals					
36	I have the ability to overcome the depression symptoms					
37	I seek to challenge the depression symptoms					
38	***Factor VI: Compliance on psychotherapy:*** I make sure to have the antidepressant in regular time					
39	I take my medications according to my prescription					
40	I visit the mental health clinic periodically to follow up my case with the psychologists.					
41	I feel the compliance with the treatment has positive effects on my case					
42	I go directly to the psychologist to treat my illness and relapses.					

Annex (6) table
Correlation between Recovery from depression and the factors of Recovery

section	statistic	personal confidence and hope	willingness to ask for help	goal and success orientation	reliance on others	no domination by symptoms	Compliance with psychotherapy
Recovery from depression	Pearson coloration	0.533	0.669	0.691	0.636	0.690	0.744
	p-value	0.000	0.000	0.000	0.000	0.000	0.000
	N	172	172	172	172	172	172

Critical value of r at significance level 0.05 and df equal 170 equal 0.145

Annex (7) table
Correlation between Family support and the factors of Family support

section	statistic	Effect of structural aspect of family	Effect of instrumental support of family	Effect of emotional support of family	Effect of informational support of family	Effect of belonging of a group with common interests to family	Effect of spiritual support of family
Family support	Pearson coloration	0.755	0.772	0.721	0.795	0.853	0.822
	p-value	0.000	0.000	0.000	0.000	0.000	0.000
	N	172	172	172	172	172	172

Critical value of r at significance level 0.05 and df equal 170 equal 0.145