

The Relation between Subjective well - being, Resilience, and Hope among Psychiatric Patients

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Abstract

Background: Hope has a significant direct effect on greater subjective well-being, consequently, allow individuals to manage with a stressful environment, such as assisting patients with major mental health issues in their recovery. **Aim:** The current study emerged aiming to assess the relation between subjective well-being, resilience, and hope among psychiatric patients. **Design:** Descriptive correlational research design was used to achieve the aim of this study. **Sample:** A convenience sample of established diagnosed two hundreds hospitalized psychiatric patients admitted to inpatient units of Minia Hospital for Mental Health and Addiction Treatment in Minia governorate. **Tools:** Four tools were utilized in this study included. A structured interview questionnaire, Subjective Well-being Scale, Connor-Davidson Resilience scale, and Dispositional Hope Scale. **Results:** The study result reveals that (79%) of the studied patients are male, (51%) are single and not working. While (68%) of them have schizophrenic disorders. Moreover (52.50%) of the studied patients have moderate level of total subjective well-being. **Conclusion:** More than half of the studied patients have moderate level of total subjective well-being and resilience; while nearly half of them have moderate hope level. In addition, there is a statistically significant positive correlation between total subjective well-being score with resilience, and dispositional hope. Moreover, there is a statistically significant positive correlation between Connor –Davidson resilience and dispositional hope. **Recommendations:** Targeting psychotherapeutic programs that aim to improve resilience, hope and well-being may help in decrease the rate of relapse among psychiatric patients

Keywords: Subjective well – being, Resilience, Hope, Psychiatric patients.

Introduction

Well-being is separated into two categories in positive psychology: eudaimonic well-being (EWB) and subjective well-being (SWB) (SWB). EWB, also known as psychological well-being, is linked to the realisation of intimate potential and includes factors like pleasant relationships and self-acceptance. SWB, also known as hedonic well-being, is linked to a sense of fulfilment and includes both a cognitive (content with

life) and an affective (good emotions) component. (Henna, et al., 2016; Machado, et al., 2015).

The widest and most inclusive word is psychological well-being. It includes subjective well-being, which is how people assess or rate their own lives and current circumstances as good or desirable vs bad or negative. These assessments might be in the form of cognitive reflections, which represent reflective appraisals of life and domains such

as work, or they can be in the form of affect. **(Diener, et al., 2017)**. Subjective well-being/life satisfaction can also be defined as cognitive and affective evaluation of an individual's life. This is a subjective feeling of contentment with one's life, associated with a sense of happiness and self-fulfillment, making it possible to adapt in an optimum way to changing life conditions and is strongly related to personality traits **(Ryff, 2014)**.

Recent research studying subjective well-being also investigate loads of evidence SWB predicts a wide range of positive outcomes, including long healthy life and psychological functioning **(Arslan, et al., 2020; Belen & Yildirim, 2020)**.

Positive change in psychological health and subjective well-being is an important treatment goal for both inpatients and outpatients diagnosed with serious mental illness **(Bechdolf et al., 2014)**. Determining a patient's level of subjective well-being early in treatment may aid person-specific interventions that focus on improving self-appraisal and optimism, while also reducing emotional distress **(Blais et al., 2013)**.

In addition, advantage of inducing positive change in well-being and decreasing emotional distress in patients with serious mental illness help in gaining a greater understanding of the factors that influence the well-being of this population is important as it may lead to improved resilience to stress, self-efficacy and social support **(Bechdolf et al., 2014)**.

One persistent problem in the resilience literature understands its meaning. Specifically, resilience tends to have two somewhat distinct meanings. The first, resilience can mean the ability to resist being damaged or deformed by traumas, or destructive forces. On the other hand, resilience can also be viewed as one's ability to bounce back or recovery from those

traumas or destructive forces. The first definition perceives resilience as a trait an individual needs to survive, while the second concept instead emphasizes resilience as a means of thriving. This distinction is important, as an individual facing adversity can go further than merely coping by finding meaning in the trauma-inducing events and utilizing this meaning to enhance their well-being. **(Feeney & Collins, 2014; Jayawickreme & Blackie, 2014)**.

Resilience is one of important stress resistant factors as The American Psychological Association defined it as "The ability to adjust well when faced with trauma, adversity, threats, tragedy, or severe stress such as serious health issues, family and relationship issues, or employment and financial difficulties." It means, bouncing back from difficult experiences. **(The American Psychological Association Road to Resilience, 2019)**. In addition, resilience is described as a dynamic developmental process that encompasses an individual's capacity to adapt positively following significant adversity **VanMeter & Cichetti (2020)**. Resilience is referred to the ability to turn a potentially disruptive and important incident into a personal search that allows a person to reorganise his life in a favorable way **(La Marca, Festeggiante, & Schiavone, 2014)**.

Despite the fact that resilience is a widely used concept across disciplines, there is no consensus among researchers on the underlying theoretical construct due to differences in definition and assessment. Resilience has been shown to have a favourable impact on a variety of mental health and well-being outcomes in previous study **(Arslan, 2019; Yildirim & Belen, 2019; McDonnell & Semkovska, 2020)**. A research study was performed to study resilience in some mental disorders as mood disorder and schizophrenia. Most of these studies revealed that resilience in patients with mental disorders is generally less than resilience in healthy patients **(Bozikas, et al., 2016)**.

In this respect **Sharma, et al., (2014)** reported that effective resilience and stress management reduces depression and anxiety, and lead to improved well-being of the individual. Evidence indicated that resilience is a strong determinant of subjective well-being and negatively linked with neuroticism (**Migliorini, et al., 2013**). Moreover, resilience and hope are sources of inner strength that contribute to human development and well-being throughout one's life; they can also defend against the effects of traumatic events and psychopathology (**Rutter 2013**).

Hope is defined as a cognitive, goal-oriented pattern of thought in which people come up with several paths to reach their goals, remain motivated to continue these paths, and actively seek out alternate paths when necessary (**Snyder, 2002**). Hope allows a person to cope with a stressful situation by anticipating a favourable outcome. The individual is motivated to act in the face of uncertainty because a favourable consequence is expected. As a result of this perspective, people who are high in hope perceive stresses as more challenging (rather than more frightening), and hence have the ability and incentive to discover solutions to alleviate unpleasant feelings and resolve the stressor (**Snyder, et al., 2006**).

Positive psychology researchers have been attempting to focus on and examine positive psychological states such as hope, well-being, resilience, hardiness, feeling of coherence, and other related notions that operate as stress mediating and moderating factors, hence increasing satisfaction. Researchers and clinicians in psychology, medicine, and nursing have established a theoretical and scientific interest in the concept of hope in the late twentieth century (**Mittal & Mathur 2011**).

Hope can be viewed as a starting point for the recovery process, as well as the foundation for determination, which is essential for achieving any goal (**Adams &**

Hope, 2018). Patients' drive to participate in the recovery process can be boosted by a greater sense of hope. Courage, faith, projects, expectation, and the future are all crucial parts of hope (**Park, 2016**).

Hope has been linked to improved health, quality of life, and day-to-day functioning. There is a lot of evidence that shows a detrimental correlation between hope and mental health challenges. Higher levels of hope are linked to reduced levels of stress and depressive symptoms (**Waynor, et al., 2012**), better quality of life (**Hawro et al., 2014**), and improvements in the daily functioning (**Gelkopf, et al., 2013**). Hope has been found to have a direct impact on life satisfaction, positive affect, and negative affect (**Muyan-Yılık, & Demir, 2019**). The same author added that hopeful people are those who are persistent and creative in pursuing their goals; patients who report higher levels of hope and resilience are less likely to show mood disturbances.

Muyan-Yılık, & Demir, (2019) added that hope and resilience may play an important role in the out-come of depressive disease and in suicidality, as mentioned above. Moreover, A better knowledge of the function of resilience and subjective well-being in people with psychological disorders could lead to the development of new interventions aimed at promoting it, potentially resulting in better treatment options for them. These therapies have the potential to improve personal and clinical recovery rates (**Johnson et al., 2010**). As regard to hope, evidence suggests that hope has a significant direct effect on greater SWB, consequently, individuals will be able to cope with a stressful scenario, such as enhancing the recovery of persons with major mental health problems (**Werner, 2012**).

Significance of the study

An interesting evidence conducted by **Yıldırım, & Arslan, (2020)** showed that resilience and hope had significant direct

effects on subjective wellbeing and psychological health. The results also indicated that resilience mediated the relationship between hope, psychological health and subjective wellbeing.

In the field of mental health, hope, resilience and subjective well-being have long been considered relevant variables in medical disciplines, but little attention has been paid to these concepts, its clinical and research implications, in psychiatry. So, it's important to open the door for more empirical research on these topics which are not well established in psychiatric patients. Therefore, the current study emerged aiming to assess the relation between subjective well-being, resilience, and hope among psychiatric patients.

Aim of the study:

The current study emerged aiming to assess the relation between subjective well-being, resilience, and hope among psychiatric patients.

Research questions

- 1- What are the levels of subjective well-being among psychiatric patients?
- 2- What are the levels of resilience among psychiatric patients?
- 3- What are the levels of hope among psychiatric patients?
- 4- Is there a relation between subjective well-being, resilience, and hope among psychiatric patients?

Subjects and Methods:

Research design:

Descriptive correlational research design was used to achieve the aim of this study. A correlational research design investigates relationships between two

variables or more, without the researcher controlling or manipulating any of them. It's a non-experimental type of quantitative research and is very important to note that correlation doesn't imply causation. In a correlational design, the variables have been measured without manipulating any of them (**Rahi, 2017**).

Research Setting:

The study conducted at inpatient units of Minia Hospital for Mental Health and Addiction Treatment that is affiliated to the ministry of health located in New Minia city. It is divided into two levels, with the first floor housing outpatient clinics, a pharmacy, and a female inpatient unit. The second floor includes administrations, inpatient unit for males, addiction treatment department, and nursing office, the hospital capacity is 53 beds for both sexes. This hospital serves Minia governorate with its all nine districts.

Subjects:

A purposive sample of established diagnosed two hundred hospitalized psychiatric patients admitted to the previously mentioned setting get involved in the study. This sample size calculated according to the following statistical equation:
$$n = \frac{N}{(N-1)B^2+1}$$
 .n= sample size, N= total population number at previous year, B= proportion of error (0.05), this sample size formula was developed by **Thompson, (2012)**. Patients were chosen based on the following criteria for inclusion and exclusion:

Inclusion Criteria:

- The patients' age were 18 years and more
- The patients' cognitive capacity is sufficient to complete the study tools.

Exclusion criteria:

- Mental retardation
- Comorbid diagnosis of substance abuse.

- Organic brain diseases.

Tools of data collection:

Data collected through the utilization of the following tools:

Tool (1): A structured interview questionnaire:

A structured interview questionnaire was developed by the researcher to cover socio-demographic and medical data of the studied patients; which includes: age, sex, marital status, educational level, job, residence, diagnosis, duration of hospitalization, frequency of hospitalization.

Tool (2): Subjective Well-being Scale (SWB):

SWB scale was adopted from **Kinderman, Schwannauer, Pontin & Tai (2011)**. SWB was designed to assess people's subjective experiences across the wide breadth of domains commonly included in definitions of well-being; it comprised 24 items hypothesized to reflect three underlying subscales: the first subscale is assessing psychological well-being (12 items). The second subscale was evaluating the physical health and well-being (7 items). The last subscale is estimating relationships (5 items). These included the three subscales.

Participants responding to the scale questions were instructed that the questionnaire 'attempts to assess how happy you feel generally in most facets of your life'. Respondents were asked to choose their answer from one of five responses that best describes their status. The responses were: 'not at all' (1); 'a little' (2); 'moderately' (3); 'very much' (4); and 'extremely' (5). All items except one were scored positively from one to five, with five reflecting greater well-being. One item (4), asking about anxiety and depression, was reversed scored. The level of subjective well-being shown as follows: 24-55: low subjective well-being; 56-87:

moderate subjective well-being; 88-120: high subjective well-being.

Tool (3): Connor-Davidson Resilience scale (CD-RISC)

Connor-Davidson Resilience Scale (**Connor & Davidson, 2003**) was administered to measure the overall score of individuals' sense of resilience and capacity to change and cope with adversity. It is a self-report scale that widely considered the "gold standard" of resilience measures and encompasses 25 statements with each rated on a five-point Likert scale as: 0 = not at all true, 1 = rarely true, 2 = sometimes true, 3 = often true, and 4 = true nearly all of the time. That modified from 7- point Likert type, because the difference between adjacent categories is minor. So, when the modification done, the scale is easier to be respond by patients. CD-RISC yields a total resilience score from 0–100, with higher scores reflecting higher resilience. The level of resilience shown on the CD-RISC is as follows: 0-32: low resilience, 33-65: moderate resilience; finally, high resilience decided when the score was 66 to 100.

Tool (4): Dispositional Hope Scale (DHS)

This tool adopted from **Snyder, Harris, Anderson, Holleran, Irving, Sigmon, et al. (1991)**. It is one of the most often used hope scales for mental health patients. It is a self-report scale consisted of 12 items namely, (Agency: add Scores on 4 items: 2, 9, 10 and 12; Pathways: add scores on 4 items: 1, 4, 6 and 8; and the remaining 4 items are fillers). Each item was rated on four points Likert-type scale starting from definitely false that scored as (0); to definitely true that scored as (3). The total score was summed, with a higher score indicating a greater level of optimism. A score of less than 12 suggests a low degree of hope, a score of 12-24 shows a moderate level of hope, and a score of more than 24 indicates a high level of hope.

The three scales were translated into Arabic language by an accredited professional translator and back-translated by an independent bilingual professional from the population group.

Validity and reliability of tools:

Content validity measured for the study tools by a panel of five professors in the domain of Psychiatric and Mental Health Nursing, all jury members agree that the current study tools had a valid content and relevant to the aim of the study. Reliability of the study tools has done by the researcher using the test re-test method of measuring internal consistency. Repetitive test responses have been contrasted using Cronbach's alpha-coefficient test. The Cronbach's α for subjective well-being scale in testing reliability in the current study was 0.85. Connor-Davidson Resilience scale revealed a high internal consistency as its Cronbach's α test equal 0.918, according to **Richard, Kaarin & Timothy (2011)**. The Cronbach's α in testing reliability in the current study was 0.91. Finally, Cronbach's alpha test for dispositional hope scale showed high internal consistency when measured in the present study; it equalized 0.90 for overall, 0.87 for pathways, and 0.85 for agency.

Procedure:

Formal permission granted from the executive manager of mental health and addiction treatment hospital in Minia governorate after the explanation of the purpose and nature of the current study. The researcher explained the aim of the study through a direct personal interview with the patients for getting their approval, cooperation and voluntary participation in the study. Confidentiality also was assured. The data collected between the periods of April 2021 to September 2021. The researcher collected data through interviewing patients for two days/ week from 10 AM to 2 PM. The time spent to fill the study tools ranged

from 25 to 35 minutes according to the needed explanation with each patient.

Pilot study:

A sample of 20 patients (representing 10% of the total sample) recruited for pilot testing of the study tools. The tool tested for clarity, comprehensiveness, applicability, and time consumed in filling the study tools, also, for testing the feasibility of the study process. No changes have done in the assessment, so the sample selected for the pilot study was included in the primary study sample.

Ethical consideration:

A written official approval obtained from the ethical research committee of the Faculty of Nursing, Minia University, and from the patient right committee in the study setting. Written informed consent obtained from patients and patient's right committee in the hospital after the researcher introduced herself to the patients and explained the aim and nature of the study. The patient has the right to agree or refuse to participate in the study without any rationale. The patients assured with confidentiality of their personal information that it will be used only for a research purpose, and there is no risk for their participation. Code numbers were created and kept by the researcher for each patient.

Limitation of the study

The sample of the present study was conducted on an extended period because the study setting was the only psychiatric hospital with small capacity that services Minia governorate with its' all nine districts. Absence of special or quiet place to interview patients, so, the researcher faced many interruptions by other patients, and sometimes this leads to repeat the interview.

Statistical analysis:

A Statistical Package for Social Sciences (SPSS) version 21 used to analyze

the data of the current study. The reliability analysis was used to determine reliability of the tools for present sample. Qualitative data used to describe the frequency distribution of the study sample. Quantitative data presented as mean & SD. Chi square and Spearman correlation test were used to identify differences in the prevalence of subjective well-being, resilience and hope among psychiatric patients. Statistical significance was considered at P . value ≤ 0.05 .

Results

Table (1) shows that the studied patients' socio-demographic data. It reveals that (37%) of the studied patient is in the age group ranged between $28 < 38$ yrs with mean age is (31.02 ± 7.54) . In addition, (79%) of them are male, more than half of them (51%) are single and not working. Moreover, about one third of the patients (33%) have secondary education and more than two thirds (68%) residing urban area.

Table (2) illustrates frequency distribution of the studied patients according to their medical data. It is observed that more than two thirds (68%) of the studied patients have schizophrenic disorders. While (39%) of them suffered from the illness ≥ 3 years ago. As regards to frequency of hospital admission (44%) of the studied patients are admitted one time to the hospital. Furthermore, most of them (85%) and (90%) are stay from $1 < 2$ month in the hospital with involuntary admission respectively.

Figure (1): demonstrates that more than half (52.5%) of the studied patients have moderate level of total subjective well-being, and (43.5%) of them have low level of total subjective well-being. However (4%) only have high level of total subjective well-being

Figure (2): illustrates that (53.5%) of the studied patients have moderate resilience level; while (12.5%) of them have high levels of resilience.

Figure (3): reveals that (48%) and (45.5%) of the studied patients have moderate and low level of total dispositional hope respectively; while (6.5%) only of them have high level of total dispositional hope.

Table (3): Shows that there is a significant relation between dispositional hope with (age, educational level, and job) at P value = (.006, .020, & 0.001) respectively. While there is no significant relation between subjective wellbeing with socio-demographic data except for age at p value = (.010). As well as there is no significant relation between resilience with socio-demographic data except for marital status at p value = (.050).

Table (4): reveals a significant relation between subjective wellbeing with frequency of hospital admission, and duration of hospitalization at P value = (.027*, .008*) respectively. As regard Connor- Davidson resilience there is a significant relation with duration of illness, and duration of hospitalization at P value = (.023*, .059*) respectively. In addition there is a significant relation between dispositional hope and frequency of hospitalization at P value = (.027*). **Table (5):** summarizes that, there is a statistically significant positive correlation between total subjective well-being score with Connor –Davidson resilience, and dispositional hope at $r = (.698)$ P -value= (.001), $r = (.776)$ P -value= (.001) respectively. Moreover, there is a statistically significant positive correlation between Connor –Davidson resilience and dispositional hope at $r = (.678)$ P - value = (.001).

Table (1): Frequency and percentage distribution of the studied patients according to their socio-demographic data (N =200).

Socio-demographic data		No	%
Age			
	18 < 28 years	70	35
	28 < 38 years	74	37
	+ 38 years	56	28
	Mean \pm SD =		31.02 \pm 7.54
Sex			
	Male	158	79
	Female	42	21
Marital statuses			
	Single	102	51
	Married	84	42
	Divorce	12	6
	Widow	2	1
Education level			
	Not read or write	56	28
	Primary education	52	26
	Secondary education	66	33
	High education	26	13
Job			
	Not work	102	51
	Work	96	48
	Other	2	1
Residence			
	Urban	136	68
	Rural	64	32

Table (2): Frequency and percentage distribution of the studied patients according to their medical data (N =200)

Medical data	NO	%
Diagnosis		
	Schizophrenia	136
	Mood disorder (Depression)	40
	Mood disorder (Mania)	24
Duration of illness		
	<1	70
	1-<2	30
	2<3	22
	\geq 3	78
Frequency of hospitalization		
	1 time	88
	2 times	36
	3 times	42
	More than 3 times	34
Duration of hospitalization		
	1-< 2month	170
	2-3 months	28
	>3 months	2
Type of admission		
	Voluntary	20
	Involuntary	180

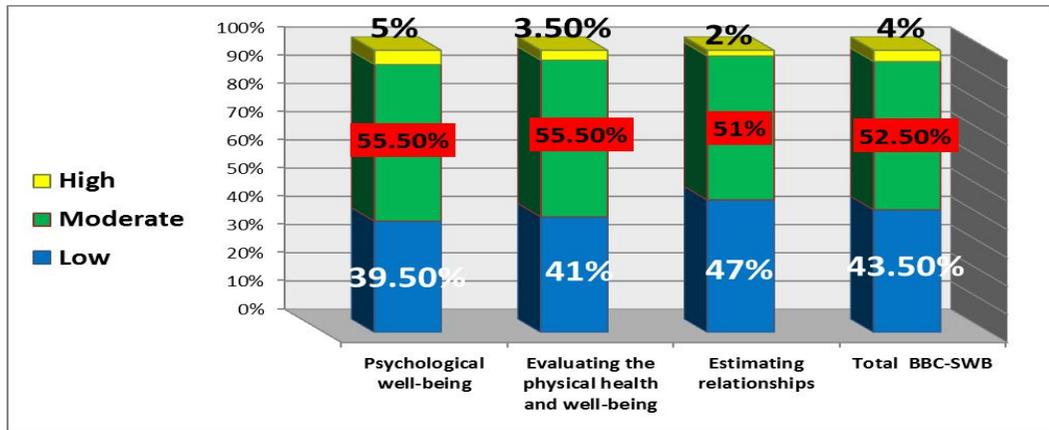


Figure (1): Subjective Well-being levels among the studied patients (N= 200)

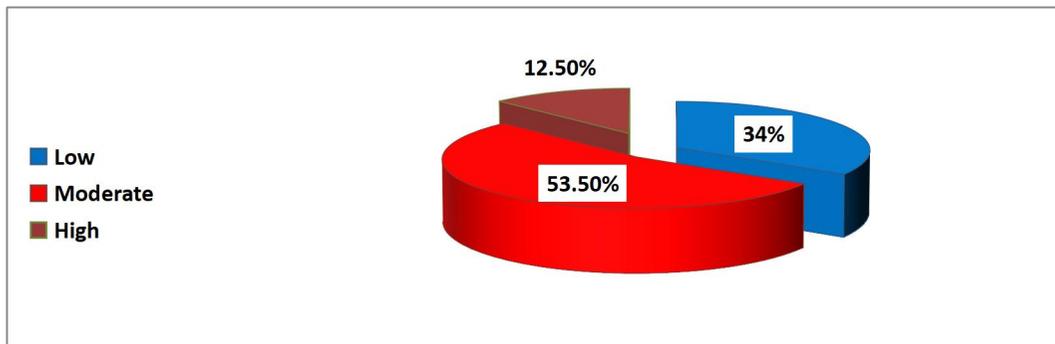


Figure (2): Resilience levels among the studied patients (N= 200):

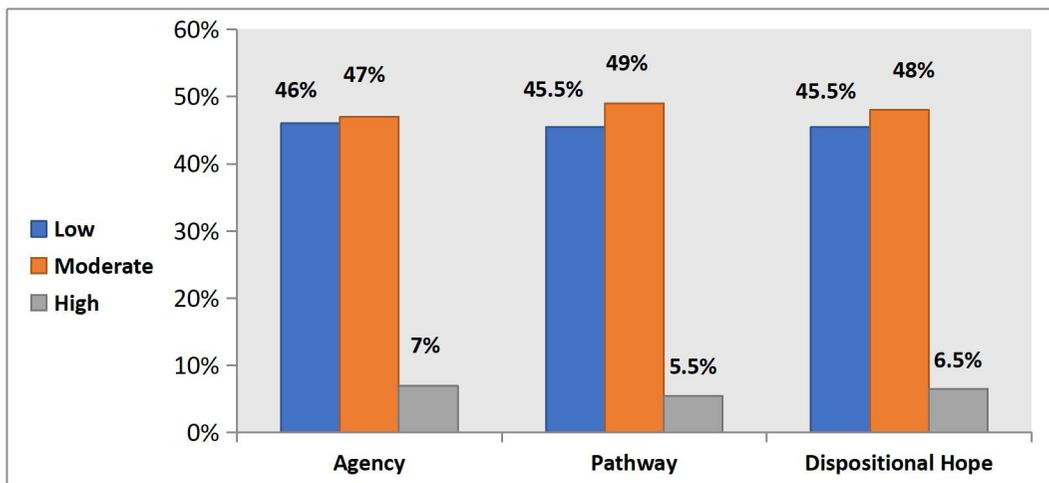


Figure (3): Dispositional Hope levels among the studied patients (N= 200)

Table (3): Relation between the studied patient's subjective well-being, Connor-Davidson resilience, dispositional hope and their socio-demographic data (N=200):

Socio-demographic data	Subjective well-being						X2 (p-value)	Connor-Davidson Resilience						X2 (p-value)	Dispositional Hope						X2 (p-value)
	Low (no.=87)		Moderate (no.=105)		High (no.=8)			Low (no.=68)		Moderate (no.=107)		High (no.=25)			Low (no.=91)		Moderate (no.=96)		High (no.=13)		
	no.	%	n	%	n	%		n	%	n	%	n	%		n	%	n	%	n	%	
Age																					
18 < 28 years	31	44.3	3	47	6	8.6	12.40	2	31	3	54	1	14	2.120	3	47	2	40	9	12.9	13.895
			3	.1	6		2	2	.4	8	.3	0	.3	(.722)	3	.1	8				(.006*)
28 < 38 years	26	35.1	4	64	0	0	(.010)	2	31	4	55	1	13	NS	2	35	4	62.2	2	2.7	
			8	.9			3	.1	1	.4	0	.5		6	.1	6					
+38 years	30	53.6	2	42	2	3.5		2	41	2	50	5	8.9	3	57	2	39.3	2	3.6		
			4	.9	5			3	.1	8				2	.1	2					
Sex																					
Male	70	44.3	8	51	6	3.8	.442	5	31	8	55	2	12	1.926	7	44	7	47.5	1	8.2	3.907
			2	.9	8		(.826)	0	.6	8	.7	0	.7	(.364)	0	.3	5		3		(0.144)
Female	17	40.4	2	54	2	4.8	NS	1	42	1	45	5	11	NS	2	50	2	50	0	0	NS
			3	.8	8			8	.9	9	.2		.9		1		1				
Marital status																					
Single	42	41.1	5	56	2	2	7.959	3	32	5	57	1	9	11.21	4	43	5	50	7	6.9	3.830
			8	.9			(.218)	3	.4	9	.8	0	8	7	4	.1	1				(.719)
Married	41	48.8	3	44	6	7.2	NS	3	38	4	51	9	10	(.050)	4	50	3	42.9	6	7.1	NS
			7		2		2	.1	3	.2		.7		2		6					
Divorcee	4	33.3	8	66	0	0		3	25	4	33	5	41		5	41	7	58.3	0	0	
			.7							.3		.7			.7						
Widow	0	0	2	10	0	0		0	0	1	50	1	50		0	0	2	100	0	0	
			0																		
Educational level:																					
Not read or write	26	46.4	3	53	0	0		2	48	2	42	5	8.9	8.694	3	55	2	41.1	2	3.6	14.296
			0	.6			6.388	7	.2	4	.9		9	(.185)	1	.3	3				(.020*)
Primary education	21	40.4	2	51	4	7.7	NS	1	23	3	59	9	17	NS	2	40	3	59.6	0	0	
			7	.9	7		2	.1	1	.6		.3		1	.4	1					
Secondary education	31	47	3	50	2	3		2	33	3	54	8	12		3	45	2	40.9	9	13.6	
			3		2		2	.4	6	.5		.1		0	.5	7					
High education	9	34.6	1	57	2	7.7		7	26	1	61	3	11		9	34	1	57.7	2	7.7	
			5	.7	7			.9	6	.6		.5			.6	5					
Job																					
Not work	49	48	5	50	2	2	5.363	4	41	5	49	1	9	6.061	5	52	4	47.1	0	0	25.548
			1				(.250)	2	.5	0		0	5	(.144)	4	.9	8				(.001**)
Work	38	39.6	5	54	6	6.2	NS	2	27	5	57	1	15	NS	3	38	4	50	1	11.5	
			2	.2	2		6	.1	5	.3	5	.6		7	.5	8			1		
Other	0	0	2	10	0	0		0	0	2	10	0	0		0	0	0	0	2	100	
			0							0											
Residence																					
Urban	61	44.9	6	50	6	4.4	.566	4	32	7	55	1	12	.598	6	47	6	46.3	8	5.9	1.096
			9	.7	4		(.741)	4	.4	5	.1	7	.5	(.750)	5	.8	3				(.597)N
Rural	26	40.6	3	56	2	3.2	NS	2	37	3	50	8	12	NS	2	40	3	51.6	5	7.8	S
			6	.2	2			4	.5	2		.5			6	.6	3				

Table (4): Relation between the studied patient's subjective well-being, Connor-Davidson resilience, dispositional hope and their medical data (N=200):

Medical data	Subjective well-being					X2 (p value)	Connor-Davidson Resilience					X2 (p value)	Dispositional Hope					X2 (p value)					
	Low (no.=87)		Moderate (no.=105)		High (no.=8)		Low (no.=68)		Moderate (no.=107)		High (no.=25)		Low (no.=91)		Moderate (no.=96)		High (no.=13)						
	n	%	n	%	n		%	n	%	n	%		n	%	n	%	n		%	n	%		
Diagnosis																							
Schizophrenia	6	44	7	52	4	2.9	4	34	7	54	1	11	6	47	6	46	8	5.9					
Mood disorder (Depression)	1	.9	1	.2			7	.6	4	.4	5		5	.8	3	.3							
Mood disorder (Mania)	8	45	2	52	1	2.5	4.614 (.297) NS	1	37	2	52	4	10	3.851 (.423) NS	1	42	2	55	1	2.5	5.095 (.254) NS		
Duration of illness																							
<1	3	42	3	51	4	5.7	5.640 (.427) NS	2	35	3	48	1	15	14.5 (.023)	3	44	3	44	8	11.4	6.359 (.363) NS		
1-<2	0	.9	6	.4	7			5	.7	4	.6	1	.7		1	.3	1	.3					
2<3	1	50	1	50	0	0		1	40	1	53	2	6.7		1	50	1	50	0	0			
≥3	5	5						2	6	.3				5	5								
Frequency of hospitalization																							
1 time	6	27	1	63	2	9.1	12.97 (.027)	4	18	1	81	0	0	5.353 (.500) NS	8	36	1	54	2	9.1	13.46 (.027)		
2 times	3	48	4	46	4	4.5		2	36	4	51	1	12		4	50	3	43	6	6.8			
3 times	0	.8	2	.1	.1			1	27	1	52	7	19		1	30	1	52	6	16.7			
More than 3 times	1	35	2	64	0	0		0	.8	9	.8	.4			1	.5	9	.8					
Duration of hospitalization																							
1-<2 month	5	7	7	.3			12.38 (.008)	1	26	2	64	4	9.5	7.834 (.059)	1	38	2	59	1	2.4	4.427		
2-3 months	1	55	1	44	0	0		1	2	7	.3	5			6	.1	5	.5					
>3 months	3	9	.9	.1				1	44	1	47	3	8.8		2	58	1	41	0	0			
Type of Admission																							
Voluntary	8	40	1	60	0	0	.538 (.704) NS	5	.1	6	.1	8		.388 (.797) NS	0	.8	4	.2			2.670 (.235) NS		
Involuntary	7	43	9	51	8	4.4		6	33	9	53	2	12.8		8	46	8	48	1	5.3			

Table (5): Correlation between subjective well-being, Connor-Davidson resilience and dispositional hope among the studied patients (No=200):

Variable		Subjective Well-being	Connor-Davidson Resilience	Dispositional Hope
Subjective Well-being	r	1	.698**	.776**
	P		.001	.001
Connor-Davidson Resilience	r	-	1	.678**
	P			.001
Dispositional Hope	r	-	-	1
	P			

Discussion:

Individuals with high resilience possess high ability to recover from stressful situations which in turn allow them to have greater hope and subjective well-being. The current study emerged aiming to assess the relation between subjective well-being, resilience, and hope among psychiatric patients. Concerning socio-demographic characteristics of the studied patients the current results revealed that the mean age of the studied patients is 31.02 years old. This finding is concordant with the literatures which indicate that the psychiatric disorders in adults appear in the young/or adulthood and interfere with their social and occupational functioning which need hospitalization. These findings agree to somewhat with (McDonald, 2020) who reported that the inpatients respondents were with a mean age of 39.5 years. Also a study done by (Cetin & Aylaz, 2020) who found that, more than one third of the studied patients their age between 30 to 40 years. However this result was contradicted with a study done by (Barranha, et al., 2020) who found that the majority of studied patients aged between 40 to 50 years. As regards to sex, the current study revealed that more than three quarters of studied patients were males. This may be explained by that the number of females rooms and beds were less than those for males, where there were three rooms with two beds only for each one of females' section from the total capacity of the hospital as well as the underlying protective effect of women estrogen. This result was similar to (Kaşlı & Badeli, 2020) who found that more than half of the studied psychiatric patients were males. Moreover this result was in the same line with a study done by (Awaad, et al., 2020 & Philip et al., 2020) who mentioned that more than three quarters of the studied patients were male.

Regarding to marital status the present study postulated that more than half of the studied patients were single. This may be due to the concept that having a psychiatric

disorder is a social stigma which interfere with marriage as well as the debilitating nature or impact of the illness on the overall functioning of the individual which make patients face difficulties to keep up marital relations or may be a reason for divorce or separation as majority of them were single. This is consistent with (Picco, et al, 2016) who mentioned that, more than half of the psychiatric outpatients had never been married yet. On the other hand this study was contradicted with a study done by (Jaberi, et al, 2020) who found that three quarter of the studied sample was married. This may be due to cultural differences

According to clinical data of the studied patients the current study results reported that, more than two thirds of the studied patients have schizophrenic disorders and more than one third had the disease for ≥ 3 years. This could be related to that schizophrenia is the most prevalent chronic psychiatric disorder (WHO, 2019) reported that schizophrenia affecting 21 million people worldwide. While in Egypt by the end of 2019 the number of schizophrenic patients is estimated to be about (1 million) people (Ramy, 2019). This finding is supported by (Hassan & Zaki, 2018) they postulated that more than half of the studied sample was diagnosed with schizophrenia. Also this finding is supported by the study conducted by (Mahmoud & Zaki, 2015) who reported that more than half of the patients in thier study had schizophrenia with the mean duration of the disease 5.2 + 4.8 years.

The present study demonstrates that, more than half of the studied patients have moderate level of total subjective well-being, while less than half of them have low level of total subjective well-being. This result might be due to that; remission or control of psychotic symptoms among those patients as a result of medication adherence during period of hospitalization. In addition subjective well-being in patients with psychiatric disorders is important because it is recognized as an important shift in the evaluation of treatment goals.

This finding is in agreement with **(Lambert, et al., 2017)** who stated that subjective well-being of patients with psychiatric disorders improved during treatment. Several studies mentioned that; high symptom severity was correlated with negative subjective well-being. In addition subjective well-being was influenced by anxiety, depression, negative and positive symptoms **(Karow, et al., 2017, Clouth, et al., 2018)**. The study result is contradict with, **(Naber, et al., 2015)** who found that a relatively weak association between symptom severity and subjective well-being.

As regard Connor-Davidson resilience levels among the studied patients, the present study showed that, more than half of the studied patients have moderate resilience level; while less than quarter of them have high level of resilience. This result might be due to that, stability of patient condition, and increase of the patient ability to deal with symptoms of mental disorders. Beside; more resilience level is, less of the relapse frequency will be. This revealed that resilience is a very important factor that can maintain remission and decrease of relapse in psychiatric patients. This finding is in contrast with **(Bozikas, et al., 2016)** who stated that; in all study participants, there was 40% of patients had low resilience, 28.75% had moderate resilience and 37.5% had high resilience.

While **(Abdel-Rahman, et al., 2020)** reported that, more than three quarters of the studied patients (76%) had low level of total resilience. The same author added that; this result due to neurocognitive dysfunction decreasing the patient's response to psychosocial stress and adverse events and stress among such patients arises from many factors such as hospitalization, lack of behavioral and social skills, lack of empathy and support from surroundings, impaired interpersonal relationships, poor role functioning and stigma. On the other hand; the study result is congruent with **(Porcelli, et al., 2016)** who reported that resilience is one of important protective factors that if it

got strengthen in schizophrenic patients , may decrease the severity of symptoms and frequency of relapse.

Concerning dispositional hope levels among the studied patients, the results of the present study revealed that, less than half of the studied patients have moderate and low level of total dispositional hope; while the rest of them have high level of total dispositional hope. This result could be attributed to, there are many factors negatively or positively influence the level of hope in psychiatric patients, such as age, severity of symptoms, number of psychiatric hospitalizations, family support, patient insight, self-esteem and stigma of psychiatric disorders.

The finding of the present study supported by several previous studies **(Schrank, et al., 2014, Wartelsteiner, et al., 2016 , Hasson-Ohayon, et al., 2018)** who stated that ; although hope is a form of spirituality, it can be undermined by life experiences. (i.e., numbers of psychiatric hospitalizations). The outcomes indicate that the level of the self-stigma was significantly inversly correlated with levels of hope. In the same line **(Yen, et al., 2019)** added that patients' drive to participate in the recovery process can be boosted by a greater sense of hope. Hope and resilience may be crucial factors in the treatment of depression and suicidality. Beside that **(Park, 2016)** reported that patients with a diagnosis of major depression have lesser hope and resilience than patients with a diagnostic of bipolar disorder in the depressed phase.

As regard the relation between studied patients subjective well-being, Connor-Davidson resilience, dispositional hope and their socio-demographic data. The results of the study revealed that there is a significant relation between dispositional hope with (age, educational level, and job). While there is no significant relation between subjective wellbeing with socio-demographic data except for age .As well as there is no

significant relation between resilience with socio-demographic data except for marital status.

Concerning significant relation between dispositional hope with (age, educational level, and job). This finding could be attributed to; level of hope among patients that suffered from psychiatric disorders affected with their age group, level of education and job; with regard to being employed as a factor that improves level of hope among patients with psychiatric disorders. This result disagrees with (Hayes, et al., 2017) who reported that was no significant difference in hope, recovery, and depression according to participants' sex, marital status, and occupational status. On the other hand the current result is supported by (Young-Chul Shin, et al., 2019) who concludes that; the outcome of disease in patients affected by depressive episode depends on objective factors such as socio-demographic characteristics (age, gender, occupation) and on subjective factors such as psychosocial characteristics of resilience and hope.

The current result also shows that; there is no significant relation between subjective wellbeing with socio-demographic data except for age. The previous finding is supported by (Naber, et al., 2011) There was no significant difference of the subjective wellbeing score according to the gender and educational level. Also, score did not significantly difference between the groups according to the job status or marital status.

In the same respect (De Haan et al., 2012) reported that; no significant correlation between the subjective wellbeing score and sociodemographic factors such as age, , and disease duration of schizophrenia. In contrast, (Lambert, et al., 2019) mentioned that there was a significant positive correlation between the subjective wellbeing score and patients' education years, suggesting that patients with more education years showed a higher level of subjective well-being.

As well as there is no significant relation between resilience with socio-demographic data except for marital status. This result can be described in terms of the importance of social support from family and spouses, which has a good impact on the patient's resilience and ability to remain calm in all situations and deal with any negative feelings that may develop. In the same line a study done by (Wei, et al., 2020) reported that there are a significant relation between resilience level and age at the onset of the disease. This finding was in contrast with, (Deng, et al., 2018) who stated that no significant relation between resilience and age at onset of disease.

This finding is in contrast with (Benestad, 2020) who reported that; there are statistically significant relation between total resilience of the studied patients with number of previous hospitalizations and duration of hospitalization at p-value < 0.01, This was due to hospitalization, which increased feelings of isolation. On the other hand, patients were forced to be admitted, resulting in increased stress and decrease resilience.

In the same respect (Senormanci, et al., 2020) reported that there are a significant relation between duration of hospitalization and resilience level. Hospitalization may cause the resilience of patients with psychiatric disorders to be weaker, which is not conducive to recovery. Similarly, there is a statistically significant relation between total resilience of the studied patients and their age at the onset of the disease at p-value < 0.05. This related to that, less than one thirds their ages at onset of disease ranged from 20-< 25 years thus reflecting less certainty about the nature of schizophrenia-like symptoms but, still have cognitive impairments that cause low resilience.

The current study showed significant relations between subjective wellbeing with frequency of hospital admission, and duration

of hospitalization. As regard to resilience there was significant relationship with duration of illness, and duration of hospitalization. In addition there was significant relationship between dispositional hope and frequency of hospital admission. This could be explained by the subjective wellbeing, resilience and hope are interrelated variable that affect each other when one of these variables are decreased the other two variables are negatively affected. Many factors affect resilience as perceived social support from family, friends and community which the patient may be lost by hospital admission, duration of hospitalization, and duration of illness that in turn affects subjective wellbeing and hope.

This result came in agreement with a study done by (Mokhtar, et al., 2021) who founded that highly statistically significant relation between total resilience of the studied patients and their number of previous hospitalizations and duration of hospitalization at p -value < 0.01 , this related to, hospitalization which cause exacerbated feelings of isolation. On the other hand patients were involuntary admitted and so on stress increased which result in decreasing resilience. Furthermore this result came in line with a study done by (Senormanci, et al., 2020) who reported a significant relation between duration of hospitalization and resilience level and hospitalization may cause the resilience of patients with psychiatric disorders to be weaker, which is not conducive to recovery.

The findings of the present study illustrated that, there were a significant positive correlation between total subjective well-being score with resilience, and dispositional hope. This means that hope increases, resiliency and subjective well-being in patients also increases. This might be explained by that resilience means bouncing back from adversities. It means that persons who possess this trait will make every effort to meet obstacles in a productive and constructive manner. This, in turn, may make such people happier and more content

with their lives, so improving their subjective well-being. The current findings are consistent with the study findings of (Mahmood & Ghaffar, 2014) who reported that significant positive correlations between resilience and subjective well-being and psychological distress.

This was also supported by the study of (Yıldırım & Arslan, 2020) who indicated that hope was found to have a strong and favourable predictive effect on resilience and subjective well-being in adults, as well as a negative predictive effect on psychological health. These findings imply that adults who have a high level of hope are more likely to recover from stressful situations, have higher subjective well-being, and have better psychological health. In addition (Satici, 2016) demonstrated the mediating role of hope in the relationship between resilience, mental vulnerability and well-being in Turkish college students. A similar result regarding the moderating effect of resilience on the relationship between perceived hope and depression was obtained in one of the Czech Hope Barometer sub studies (Panek, 2017).

Moreover, the current study revealed that there were a significant positive correlation between resilience and dispositional hope. This may be explained by that hope enables an individual to cope with a stressful situation by expecting a positive outcome. Individuals high in hope often appraise stressors as more challenging (as opposed to more threatening), and thus have the ability and motivation to find solutions to ameliorate the stressful feelings and resolve the stressor so they have strong resilience. This result is in the agreement with the study of (Arslan, 2016) who reported that Individuals with a greater dispositional hope are more likely to be motivated to achieve their goals and to establish paths to achieve them. This psychological energy can assist such people in dealing with difficult situations, making them more resilient and promoting their overall well-being and psychological health. Furthermore in a study

conducted by (Arampatzi, et al. ,2019) who founded that positive emotion would enable people to adapt more resiliently in bad situations, resulting in less negative outcomes from setbacks. This result agreed with a study done by (Pleeging, et al. ,2019) who showed that, lower levels of hope are linked to lower levels of happiness on average.

Conclusion

The current study revealed that more than half of the studied patients have moderate level of total subjective well-being and resilience and nearly half of them have moderate hope level. In addition, there is a statistically significant positive correlation between total subjective well-being score with resilience, and dispositional hope. Moreover, there is a statistically significant positive correlation between Connor – Davidson resilience and dispositional hope.

Recommendations:

- Further studies regarding psychoeducational intervention to enhance patient's subjective well-being, resilience, and hope through positive behavior skills and training strategies. This will also improve patient social, occupational and other areas of functioning.

- Targeting psychotherapeutic programs that aim to improve resilience, hope and well-being may help in decrease the rate of relapse among psychiatric patients.

- Enhancing resilience through mindfulness program, identifying strengths, and self-efficacy, sense of coherence, resourcefulness and building a positive identity to improve resilience, subjective wellbeing and hope of psychiatric patients.

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