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Psychosocial Supports Offered to People with Psychotic Disorders by Community Members in Temeke District, Tanzania

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Abstract

This study was about psychosocial support offered to people with psychotic disorders by community members in Temeke district, Tanzania. The findings answered two questions which are: what is the quality of psychological support offered by community members to people suffering from psychotic disorders? To what extent do the people with the psychotic disorder have been socially supported and included in the social network within their communities? Both qualitative and quantitative methods of data collection were used and a descriptive design was adopted. Participants were People with Psychotic Disorders (PPDs) who had received treatment at the psychiatric unit of Temeke district hospital in 2020. A total of 80 PPDs were randomly sampled, of which 57answered study questions by themselves, and 23 were presented by their caregivers. The study noted that both psychological and social supports were rarely given to people with psychotic disorders by community members. It was further revealed that there was a strong and significant association between psychosocial supports and hospitalisation or prognosis of PPDs (p-value < 0.0001). In which one unit increase in psychological supports could significantly reduce hospitalisation of PPDs by 0.365 units (p-value 0.025). Meanwhile, one unit increase in social supports could significantly reduce hospitalisation by 0.22 units (p-value 0.038). Hence, psychosocial supports from community members were significantly important in reducing hospitalisation and improving the prognosis of PPDs. It was recommended that the community should be educated on the causes, treatment, and importance of 'psychosocial support' in the comprehensive treatment of psychotic disease.

Keywords: psychotic disorders, psychology, social, psychosocial support

1. Introduction

Psychotic disorders or illness include a wide range of mental health problems. It is the disease of the mind; the pain is felt in the mind rather than in any physical part of the body in (Lee, Feng, & Smoller, 2021; Low, Bentley, & Ghosh, 2020; Vigo et al., 2016). The causes of psychotic disorders have been explained by different theories. These are hereditary or genetic causes, brain degeneration causes, chronic physical diseases, substance abuse, cultural beliefs and psychosocial stress or life-threatening causes (i.e. broken relations, death of a loved one, war and displacement, political disappointment, poverty, accidents and other social sufferings(Freudenreich, 2020; O'Donoghue et al., 2021).

Worldwide, psychotic disorders account for 13 percent of all diseases, or 25.3 percent of all non-infectious diseases in the world. The annual increase rate of new psychotic disorders is 7.4 percent (Sfetcu, et al, 2017; Anderson & Edwards, 2020; Nourredine et al., 2021). For instance, the Middle Eastern people have the highest level of mental health service needs followed by Sub-Saharan people across their life span(Hollander et al., 2020; Terhune et al., 2022). This is based on the argument that there is a high rate of psychotic disorders and a low habit of mental health service seeking within these regions. At least one-quarter of people in Sub-Saharan Africa have experienced a psychotic disorders at some point in their lives (Galvin & Byansi, 2020; Roberts, Smith, Cluver, Toska, & Sherr, 2021).

The WHO's slogan of 2004, which stated that "no health without mental health," wants mental health to be viewed in biological, psychological, and sociological domains through a model known as the biopsychosocial approach (Vigo, et al., 2016; Ng et al., 2021; Peña-Vargas, Armaiz-Peña, & Castro-Figueroa, 2021; Steele, Berry, & Brown, 2022). The slogan also insists on the involvement of the entire community in the improvement of the mental wellbeing of those suffering from mental illnesses. It refutes the medical and social distinction between diseases of the mind and diseases of the body in terms of caring and support resources (Mathew, *et al.*, 2018; Beckers, Jaeqx-van Tienen, Willems, Koopmans, &

Corstens, 2020; Oldfield, Stevenson, & Ortiz, 2020).

Numerous studies have found a lack of psychosocial support for people with psychotic disorders (PPDs) from relatives, partners, friends, and the community at large (Masambia, 2014; Vigo, et al., 2016; Van-Weeghel, et al., 2019; Brouwers, 2020; Chevance et al., 2020). Restricted or small psychosocial support results in the isolation of the patient, intimidation of psychological or emotional well-being, threatening the quality of life of the patient, minimising utilisation of available mental health services, and increasing the possibility of psychiatric re-hospitalization (Kpanake, 2018; Llewellyn-Beardsley, *et al.,* 2019(Brouwers, 2020; Stuijfzand et al., 2020). This has overwhelming effects on the patients and even their families when seeking effective treatment, so they rely on self-help.

Tanzania, like other developing countries, has a shortage of mental health services and psychosocial support programmes for people with mental illness. Every year, approximately 20–30% of Tanzania's population requires mental health services. Unfortunately, only one third of them have access to a professional mental health service. Untreated mentally ill patients may suffer from a variety of health consequences that affect both the patients and their families (Mbatia and Jenkins, 2010(Lasater et al., 2021; Mboya et al., 2020; Moran et al., 2020).The existing treatment gap has been said to be widening due to the lack of effective psychosocial assistance that improves mental health seeking behaviour and enhances treatment success (Tumbwene, *et al.,* 2015; Essien & Asamoah, 2020; Mutahi et al., 2022; Papola et al., 2020). It is in this context that there is increasing re-hospitalization in the psychotic wards.

After learning that, this study was intended to investigate the quality of psychosocial support that has been given to Patients with Psychotic Disorders (PPDs) by their community members. In other words, the study assessed how the community, especially the neighbours of the families with patients suffering from psychotic disorders, had fulfilled the major psychosocial support tasks. It should be noted, however, that better community assistance has an impact on the effective adaptation that is associated with a better healing process.

The researcher was stimulated by the philosophical suggestion that states that people are social by nature and interdependent for survival. Hence, social supports are very important to the wellbeing of psychotic patients so that they can enjoy a better life. Similarly, psychological supports are meaningful because it is necessary to enhance the restoration of the emotional and personality wellbeing of psychotic patients. This is to say that psychosocial supports for PPDs were the main explored subject in this study. The study was guided by the following two objectives: (i) to assess the level of psychological support provided by community members to people suffering from psychotic disorders, and (ii) to analyse the extent to which people with psychotic disorders have been socially supported and included in the social network within their communities.

The psychosocial support provided by individual neighbourhood residents who live near the homes of PPDs was the focus of the study rather than supports from community organisations. This is due to the fact that developing nations like Tanzania have a very low number of formal community organisations. It is possible to find a community without an established community organisation in the developing nations. Therefore, the most important psychosocial supports for the patients come from their family members and individuals within their communities (residents of the community).

2. Literature Review

2.1 Psychotic Disorders

Psychotic disorders are mental disorders (diseases of the mind) that are characterised by behavioural changes (Barke, et al., 2011). Psychotic disorders affect an individual's ability to perform work independently, to be involved in social functioning, to study, and to take care of themselves (Lysaker, et al., 2018; Daniel, et al., 2019). The disease is also simply known as psychosis which is considered when a person has at least three of the following characteristics: delusion (bizarre or non-bizarre), hallucination, thought disorder, and agitation (Lysaker, *et al.,* 2018).

People with psychotic disorders need support from a multidisciplinary team to overcome the challenges associated with these disorders. A comprehensive team provides psychological support, social support, and medical support to the patient. The golden approach to treating psychotic disorders is the psychosocial approach, which involves the provision of optimum psychotherapy and social support to the patients. Based on knowledge published in the literature and the experience of experts in the field of mental illnesses, there is a significant interconnection between psychotic disorders and psychosocial problems (Lysaker, *et al.,* 2018; Van-Weeghel, *et al.,* 2019; Freudenreich, 2020).

2.2 Psychological Supports

Psychological consultations help psychotic patients to understand and accept their mental illness or disorders, and develop or adopt coping strategies that promote improvement in mental well-being (Leonhard, *et al.,* 2017). Improvement in mental well-being impacts on the well-being of physical and social functions. Psychological support can be offered by both professional and unprofessional individuals. Family or community members who are not trained in the psychological field (unprofessional people) are the primary sources of consultative services to the patient. They can advise patients to avoid situations that cause stress, teach them how to control anger and deal with unhealthy thoughts and behaviors, and provide emotional support. Supportive family and community members are involved in soliciting professional psychologists who intensify treatment procedures by using clinical psychological techniques to trim down the symptoms of psychotic disorders (Bal et al., 2021; Fang et al., 2021).

Clinical psychology is a clinical discipline that involves the use of psychological knowledge and skills to improve the mental health of mentally ill patients (Read and Doku, 2012). It has also been defined as the use of psychological principles to assess/diagnose, to treat, and rehabilitate a person with psychological distress as well as to prevent the development of a mental illness in the person. Obvious, it focuses on the psychological, emotional, biological, intellectual, and behavioral aspects of human function in relation to the culture, social status, and economic level of the patient and his or her society (Hynie, *et al.,* 2015; Leonhard, *et al.,* 2017; Fiest et al., 2021).

A report of the Rwanda Ministry of Health (2016) noted that about nineteen percent of Rwandans had some sort of mental illness. Hence, society should take mental illness very seriously and support those suffering from mental illnesses. A study conducted by Hynie, *et al.* (2015) in Rwanda reported that almost three quarters of Rwandese have little insight about psychotic illness. Society does not consider that people with psychosis and their care givers need psychological and social assistance to help them cope with the challenges of this disorder. Therefore, people who had experienced psychotic illness in their families were facing ostracism, stigmatism, and alienation.

Patel, et al (1997) expertly linked psychological services with biomedical services on the basis of biopsychosocial approach. The study reviewed different published reports by previous researchers and came up with substantial evidence that psychological support creates an environment in which biomedical treatment provides better outcomes in the treatment of mental illness. Therefore, when dealing with health problems of the mind, physicians have to consider the kind of psychological services offered to patients together with the presence or absence of behavioural health discipline. The study concluded that psychology is the key to diagnosing and treating mental health since it helps to improve healthy behavioural functions. The study added that caregivers of people with mental illnesses should receive basic psychological counselling in order to promote healthy behaviour suitable for helping their sick relatives.

2.3 Social Supports

The World Health Organization recognises that mental illnesses (i.e. psychosis, depression, anxiety, bipolar) do not only have psychological and/or biological characteristics, but they also have concurrent social characteristics (Van-Weeghel, et al., 2019). The mental well-being of an individual is influenced by a mixture of social factors such as adequate availability and accessibility of basic needs like enough meals, better clothes, and shelter. Also, social support includes participation in social gatherings, education service, access to information, job or employment opportunities, financial advice, and protection from criticism (Katherine, et al., 2020). Daniel, *et* al (2019) found that social factors play a crucial role in creating, promoting, and maintaining the mental and physical wellness of individuals. In epidemiology, disease prevalence and persistence have been monitored through different factors, including social factors (Vigo, *et al.,* 2016; Hou et al., 2020; Kirsch, 2022).

Social support provides psychological, biological, and physical advantages for people suffering from any form of illness (Leonhard, *et al.,* 2017). Social support has an important role in the treatment outcomes of psychotic disorders since it reduces psychological stress and improves the quality of life of patients (Ventevogel, *et al.,* 2013; Jingyi,*et al.,* 2018(Hou et al., 2020; Kirsch, 2022). Studies conducted by Daniel, *et al*., (2019) and Westerinen (2018) are among numerous studies which have reported a strong correlation between social support and treatment outcomes for mental disorders. Both relatives and community members of psychotic patients should pay attention to the quality and quantity of social support offered to the patients in their homes or areas. Adequate social support assists psychotic patients to explore social networks and social services available within society. Sociologists need to work closely with relatives and community members of psychotic patients to ensure available social-supportive interventions influence or promote the well-being of the psychotic patients (Hou et al., 2020; Kirsch, 2022).

According to some studies conducted in Malawi about the experiences and effects of caregivers of patients with severe mental illness in the rural areas and the study performed day long observations and ethnographic observations with six families, they depicted that this vulnerable individuals were relegated(Jumbe et al., 2022; Kola et al., 2021). The caregiver's experience of living with a mentally ill person was marked by neglect, isolation, and impoverishment. The study reported limited social networks for the caregivers and their patients; this left caregivers and patients hopeless and uncertain about the future. The study concluded that caregivers and mentally ill patients in rural areas of Malawi were abandoned and living marginalised lives(Chikasema, Hunt, Sorsdahl, & Tomlinson, 2021).

Daniel, et al., (2019) looked at perceptions of mental disorders and help seeking behaviour among the Maasai community of northern Tanzania. The study reported that there were many negative consequences associated with stigma that worsen the quality of life of psychotic patients. These were restricted opportunities for education and employment, unsatisfactory housing, and social exclusion. The stigma could also lower the ability of the patients to cope with their biological, psychological, and cognitive problems(Ho, Chee, & Ho, 2020; Lai et al., 2021).

2.4 Conceptual Model and Hypotheses

Conceptual framework for this study had two sets of variables, which were: independent variables (psychological and social supports) and dependent variable (disease prognosis). The conceptual framework/model of the study assumes that family members (relatives of the psychotic patient) and community members (i.e., neighbours) have to provide or ensure there is provision of proper psychosocial supports/services to the patient suffering from psychotic disorders. Appropriate psychosocial supports influence a good prognosis of psychotic disease, which is characterised by a continuous process of decreasing re-hospitalizations that can be achieved by access to appropriate medical treatment as well as adherence to medication.

A patient with a good prognosis has a high likelihood of completely recovering from this illness. Compared to other diseases, Mathew, *et al*., (2018) reported that the healing process of psychotic disease takes a long period of time and, therefore, the support network of family, friends, community members, health professionals, and psychological professionals should be available. The network of support helps to improve the treatment outcome for the patient. Mathew, et al., (ibid) showed that patients with a satisfactory large network size of supports were likely to report a better prognosis. Potential psychological supports that community members can solicit and ensure their availability to psychotic patients and their caregivers were presented in the upper left box. These were the provision of interpersonal therapy, cognitive therapy, occupation therapy, social interaction therapy, financial management therapy, conflict management therapy, stress management therapy, and motivation to deal with the challenges of life.

The lower left box represented social support necessary for the good treatment and recovery progress of the psychotic patients. These supports were mentioned as education and training support, employment support, which could be obtained by providing job opportunities or job information to PPDs and their caregivers. Others are faith support, basic needs (meals, clothes and shelter). Encourage and involve the patients in the social conferences; encourage patients to participate in the peer groups' discussions, and support the medical costs/bills incurred by the patients and their caregivers. The model shows that there is interlink between psychological and social support, meaning that improvement in psychological support can bring improvement in social support and vice versa.

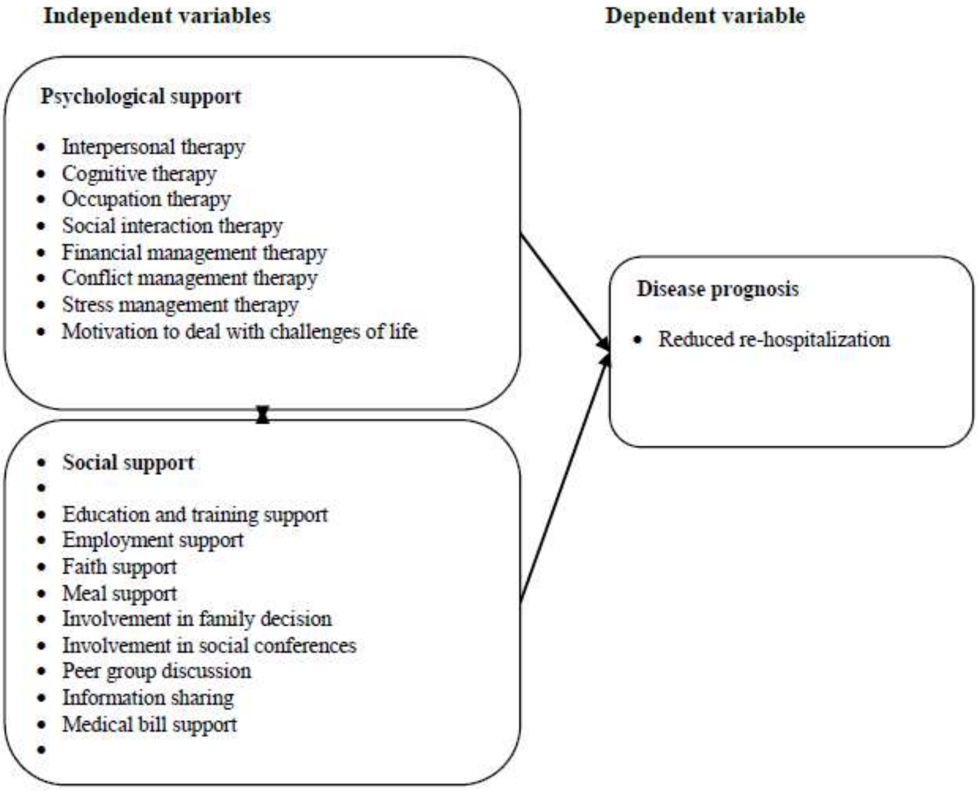


Figure 1. Conceptual Framework of the Study

3. Methodology

3.1 Research Approach

This study used both quantitative and qualitative approaches. The quantitative wing of the study was used to collect and analyse numerical data that showed statistically how psychosocial supports were offered to PPDs. The qualitative component allowed direct collection of subjective opinions of people about psychotic disorders and individuals with these disorders. Qualitative views were used to support numerical results of the study variables and their relationships for an in-depth understanding of the study. Data was collected via questionnaires and interviews.

3.2 Research Design

This was a descriptive study which focuses on giving a description of the current condition of the psychosocial support in the studied community. As highlighted by Rubin and Babbie (2011) a descriptive study tends to find out how the current situation has led to the occurrence of a certain affair. It correlates with cross-section data. Ultimately, this design enabled collection of both objective and subjective information concerning the problem under investigation.

3.3 Participants

Study simple random sampled PPDs who received treatment in the psychiatric unit of Temeke District Hospital in 2020. A total of 80 PPDs were sampled in which 57 were able to answer questions by themselves and 23were presented by their care-givers. PPD and their care-givers were the good source of information in clearly understands how community members hold the concept of psychosocial support for PPDs. It was requested that respondents be at least 18 years old; there were no restrictions placed on the selection of respondents in terms of the age, gender, social status, occupation, or religion of the participants. However, it should be noted that the caregivers in this study were selected to respond for their PPDs who were unable to answer research questions by themselves.

Table 1. Sample Size

Category of respondents	**Sample**
People with psychotic disorders (PPDs)	57
Caregivers	23
TOTAL	80

3.4 Data Analysis

In the questionnaire, participants were asked to rate their opinions on a Likert scale ranging from 1 to 5; with 1 being strongly disagree, 2 being disagree, 3 being neutral, 4 being agree, and 5 being strongly agree. Descriptive analysis was used to analyse numerical information that involved characteristics of respondents, and the extent to which psychosocial supports have been offered to the PPDs. A descriptive statistic was also used to identify the disease prognosis of the selected psychotic patients. In performing descriptive analysis, study used frequency, percents, and means to interpret the results. Interpretations of the mean scores were as follows:- 4.21-5.00 = very often given, 3.41-4.20 = often given, 2.61-3.40 = sometimes given, 1.81-2.60 = rarely given, and 1.00-1.81= almost never given. Qualitative data was translated from Kiswahili to English and subjected to thematic analysis, whereby the researcher grouped related relevant themes that emerged from the interview and drew conclusions.

3.5 Respondents' Profile

The socio-demographic information of the selected respondents was reported in terms of their gender, age brackets, levels of education, and years of residency in Temeke Municipality. As shown in table 2, male respondents accounted for 46.3% of all respondents, while female respondents accounted for 53.7%. Therefore, there were nearly equal numbers of men and females participants. The age ranges of the respondents were then displayed as follows: 26.3 % of the respondents were between the ages of 18 and 30 years old. They were followed by those who were 31-40 years old (22.5%), 41-50 years old (21.3%), 51-60 years old (18.8%), and 60 years and above (11.3%). These data illustrate that the survey gathered opinions from individuals of all generations, beginning with 18-year-olds.

The table (Table 2) continued to show that 40% of respondents had received primary education, 23.7% had tertiary education (college diplomas and university degrees), 20% had secondary education, and 16.3% had no formal education. Majority (61.4 %) of chosen PPDs did not have a job. They were followed by those who were self-employed (17.5%), engaged in the informal private sector (15.8%), working in the government sector (3.5%), and those worked in the formal private sector (1.8%). According to these statistics, the majority of PPDs did not have a regular source of income and hence needed assistance from others to fulfill their daily expenses. In general, 60.4 % of respondents had lived in Temeke Municipality for 15 years or more. 12.1 %, 11.3 %, and 16.3 percent had lived in Temeke for 5-8 years, 9-12 years, and 12-14 years, respectively.

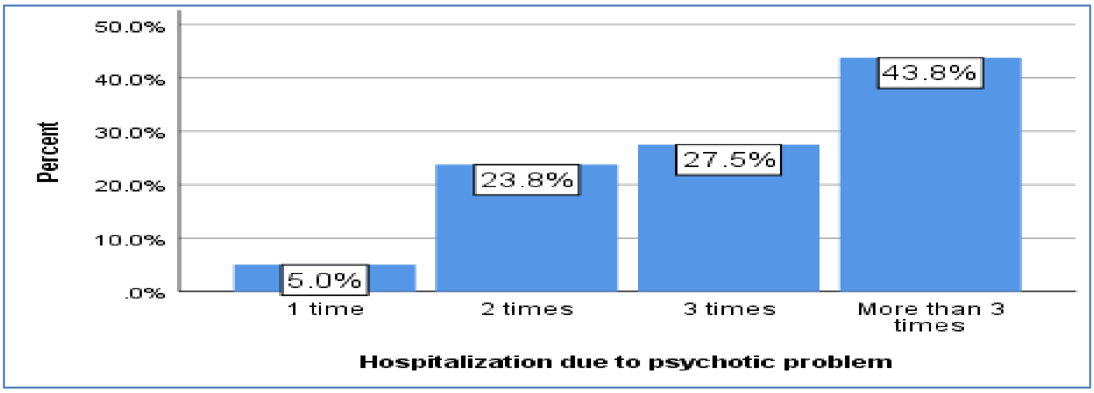
Table 2. Socio-Demographic Characteristics of Respondents

Characteristics		**PPDs**	**Caregivers**	**Total**
Gender	Female	23 (40.4%)	14 (60.9%)	37(53.7%)
	Male	34 (59.6%)	9 (39.1%)	43(46.3%)
	Total	**57 (100%)**	**23 (100%)**	**80 (100%)**
Age bracket	18-30yrs	17 (29.8%)	4 (17.4%)	21(26.3%)
	31-40 yrs	15 (26.3%)	3 (13%)	18(22.5%)
	41-50 yrs	12 (21.1%)	5 (21.7%)	17(21.3%)
	51-60yrs	9 (15.8%)	6 (26.1%)	15(18.8%)
	Above 60 yrs	4 (7.0%)	5 (21.7%)	9(11.3%)
	Total	**57 (100%)**	**23 (100%)**	**80 (100%)**
Level of education	No Formal Education	9 (15.8%)	4 (17.4%)	13(16.3%)
	Primary education	19 (33.3%)	13 (56.5%)	32(40%)
	Secondary education	12 (21.1%)	4 (17.4%)	16(20%)
	Tertiary education	17 (29.8%)	2 (8.7%)	19(23.7%)
	Total	**57 (100%)**	**23 (100%)**	**80 (100%)**
Employment status	Not employed	35 (61.4%)	2 (9.1%)	37(46.8%)
	Self employed	10 (17.5%)	10 (45.5%)	20(25.3%)
	Employed in informal private sector	9 (15.8%)	7 (31.8%)	16(20.3%)
	Employed in formal private sector	1 (1.8%)	2 (9.1%)	3(3.8%)
	Employed in government sector	2 (3.5%)	1 (4.5%)	3(3.8%)
	Total	**57 (100%)**	**22 (100%)**	**79 (100%)**
Residential duration	5-8 years	14 (24.6%)	2 (8.7%)	16 (20%)
	9-12 years	8 (14%)	3 (13%)	11(13.8%)
	12-14 years	13 (22.8%)	3 (13%)	16(20%)
	15 years and above	22 (38.6%)	15 (65.2%)	37(46.3%)
	Total	**57 (100%)**	**23 (100%)**	**80 (100%)**

4. Analysis of the Findings

4.1 Hospitalized Due to Psychotic Disorders

In the graph 1, it is shown that 43.8 % of the sampled patients had been hospitalised more than three times owing to psychotic issues. 27.5 % three times, 23.8 % twice, and 5% just once. It can be said that the selected PPDs had a poor prognosis for the psychotic disorders because the majority of them had been hospitalised many times (more than three times). As a result, these PPDs had a gap in their ability to acquire appropriate medicine and maintain drug adherence. This gap can be explained by psychosocial supports provided to them by community members.



Graph 1. Hospitalized Due to Psychotic Disorders

4.2 Psychological Supports Offered by Community to PPDs

The findings in the Table 3 shows that members of the community were rarely providing psychological supports to those suffering from psychotic disorders (weighted mean of 1.92). They could offer PPDs the following psychological therapies on a rare basis: conflict resolution or conflict management counseling (mean 2.26) and stress management counseling (mean 2.1), motivation to deal with life's challenges (mean 1.94), occupational counseling (mean 1.9) cognitive-behavioural therapy (mean 1.88), as well as financial management counseling (mean 1.88). According to the findings, social interaction counseling (mean 1.55) was nearly never provided to the sampled PPDs by members of their communities.

Table 3. Psychological Supports Offered by Community to PPDs

Supports	Almost never	Rarely	Sometimes	Often	Very often	Total	Mean
Conflict resolution counselling	24(30%)	21(26.3%)	28(35%)	4(5%)	3(3.8%)	80 (100%)	2.26
Stress management counselling	27(33.8%)	23(28.7%)	25(31.3%)	5(6.3)	0	80(100%)	2.10
Motivation to deal with the challenges of life	24(30%)	39(48.8%)	16(20%)	1(1.3%)	0	80(100%)	1.94
Occupational counselling	32(40.5%)	25(31.6%)	21(26.6%)	0	1(1.3%)	79(100%)	1.90
Cognitive-behavioural counselling	33(41.3%)	30(37.5%)	12(15%)	4(5%)	1(1.3%)	80(100%)	1.88
Financial management counselling	35(43.8%)	30(37.5%)	10(12.5%)	4(5%)	1(1.3%)	80(100%)	1.82
Social interaction counselling	56 (70%)	11(13.8%)	8 (10%)	3(3.8%)	2(2.5%)	80(100%)	1.55
Weighted mean							**1.92**

It was acknowledged that the patients seldom received stress management counselling, occupation counseling and financial management counseling. For many PPDs, chronic stress makes it difficult to do everyday tasks, concentrate, or think clearly. Respondents mentioned the following in regard the mentioned psychosocial therapies:

because of the stressors, some days might feel so overwhelming that it's difficult to deal with everyday duties, concentrate, or think clearly" (PPDs, 38 years old).

Due to a lack of money, I find it difficult to pay my expenses. In addition, I spend more money than I make, which is a problem for me" (PPDs; 38 years old). "Because I didn't have any money, my relationship with my partner did not last. Initially, I spend all of my money on her, but when my finances deteriorated, she broke up with me. Problems stemmed mostly from poor financial management" (PPDs; 34 years old). "There have been no visitors, even close relatives, come to see and speak with him [refers to PPD]. He fills neglected and this has been stressing him" (caregiver, 44 years old).

Cognitive-behavioural counseling is another helpful psychosocial therapy to help PPDs to cope with stressors. Through this therapy, PPDs may learn to be less critical of them and recognise that it's okay to let go of some of their obligations without deeming oneself a loser. But the therapy was rarely offered by neighbourhood people. Participant mentioned that "Until now, no one has ever advised me on how to communicate with my family and other people of the community. I just try to stop myself from dwelling on the negative aspects of my disease situation" (PPDs; 28-year-old).

4.3 Socially Supports Offered By Community to PPDs

The summary of descriptive results in table 4 revealed that chance for engaging in peer group conversations were available in occasionally (mean 2.72), similarly, the faith or spiritual encouragement (mean 2.70). Social factors that were rarely offered were inclusion in social conferences (mean 2.41), meditational support (mean 2.16),basic needs support (mean 2.12), employment support (mean 1.63) and education and training support (mean 1.21). In general, community people were rarely providing social supports to PPDs (weighted mean 2.13).

Table 4. Socially Supports Offered By Community to PPDs

Supports	Almost never	Rarely	Sometimes	Often	Very often	Total	Mean
Peer group conversation	16(20%)	15(18.8%)	34(42.5%)	5(6.3%)	10(12.5%)	80(100%)	2.72
Spiritual encouragement	15(18.8%)	16(20%)	30(37.5%)	16(20%)	3(3.8%)	80(100%)	2.70
Involvement in social conferences	22(27.5%)	21(26.3%)	21(26.3%)	14(17.5%)	2(2.5%)	80(100%)	2.41
Meditational support	25(31.3%)	23(28.7%)	21(26.3)	8(10%)	0	77(100%)	2.16
Basic needs support	31(38.8%)	15(18.8%)	29(36.3%)	3(3.8%)	2(2.5%)	80(100%)	2.12
Employment support	44(55%)	24(30%)	10(12.5%)	2(2.5%)	0	80(100%)	1.63
Education and training support	67 (83.8%)	9(11.3%)	4(5%)	0	0	80(100%)	1.21
Weighted mean							**2.13**

Generally, the selected PPDs reported a lack of enough love and emotional support from their peers. They were rarely included in the peer group talks and rarely invited in the social conferences. Due to these, they have become unstable emotionally. They mentioned that "being homesick is a form of distress that needs the presence of other people. But on a daily basis, I find myself separated from my peers at school and at home. Because of this, I'm unable to perform at a high level in both the classroom and the community. Since then, I've lost my self-confidence in the classroom and my academic performance has suffered greatly" (PPDs; 21-year-old). "Here, I'm seen as a lower-class member of the community, and my classmates treat me as such. This resulted in a greater sense of isolation and depression " (PPDs; 35 years old). "They don't invite me to community gatherings because I constantly have disagreements with other members in such meetings. One day, I got into an argument with other mourners and they chased me around the funeral home... I believe it was as a result of my illness" (PPDs, 57 year-old). For spiritual assistance, most of the PPDs said that they would get it, but not always. They said:

I like to go to the mosque and the sheikh always urges me not to miss prayers. If it were not for the sheikh to inspire me from time to time I would not have been going to the mosque" (PPDs, 29 years old). "I stopped going to church a long time ago. My relatives do not want to go with me in the church and in any invitation. I am always at home guard and making sure the house is safe when all have gone to the church. My life stopped because of his illness. I can’t do anything and am just isolated” (PPDs, 35-years old). Social issues that were generally not supported by the community members were medical bill, basic need support (meal, clothes and shelter), employment support, and education or training supports. The following were mentioned in regard to these social supports: Relapsed four months later when medicine ran out for him (the patient reported).We didn't have enough cash to get him medication and he became violent and disruptive at home" (Caregiver, 51-years old). "Every day, she depends on medicine. I have no one to whom I may access help for her medical costs. It's only me and her mother as her parents" (Caregiver, 61-years old). "When I was 16 years old, in the second school, I suddenly developed this mental illness. I had to drop out of school, but now I like to go to a technical school to improve my skills but no one to pay for my tuition fee. The family has been spending a lot of money for my treatments" (PPDs, 26-years old). "This illness has driven my family and me further into poverty because I can't afford to take care of myself. I do get jobs, but I easily lose them, either by being fired or self-resignation. You know, I become like a child sometimes, and I don’t know what I want at the moment" (PPDs, 26-years old).

4.4 Regression Model of the Study

Multiple linear regression analysis was used to determine how the main variables related to one another. The frequency of hospitalisation of PPDs due to psychotic issues was the dependent variable, and the predictor variables were the psychological and social supports provided to the PPDs by community members. The results in table 5 indicated that there was a strong relationship between psychosocial supports and hospitalisation (p-value < 0.0001). Additionally, there was a significant inverse relationship between psychological support and hospitalisation (B =-0.365; p-value = 0.025). In which, it was found that increasing community members' psychological supports by one unit could reduce hospitalisation by 0.365 units. Likewise, there was a significant negative relationship between hospitalisation and social supports (B= -0.22; p-value = 0.038), suggesting that one unit increase in social supports could decrease hospitalisation of PPDs by 0.22 units.

Table 5. Regression model of the study

	Unstandardized Coefficients		t	Sig.
	B	Std. Error		
(Constant)	4.175	0.469	8.900	0.000
Psychological supports	-0.365	0.160	-2.288	0.025
Social supports	-0.220	0.104	-2.115	0.038

5. Discussion and Conclusion

When a psychotic patient has been hospitalised at least three times, it is understood that psychotic recovery has a bad prognosis (Verma, et al., 2019). The key reason for a poor prognosis can be a lack of proper psychosocial support. The fact that the vast majority (almost two-third of them) of the sampled patients had been hospitalised at least three times suggests that they lacked sufficient psychosocial assistance. In general, the study found that PPDs were getting little motivation from their community members to cope with the stresses of living with psychotic disorders. The psychosocial supports are vital for the well-being of PPDs because it helps them engage in the activities of daily life, feel socially secure and lead to better prognosis of the disease. PPDs may benefit from psychological therapies in many ways. They can help them solve personal and interpersonal conflicts, alleviate mental health symptoms associated with those psychotic challenges, and develop coping mechanisms for future conflict. If the patient could be welcomed and understood by the community, he or she would have the courage to make changes in his or her life; nevertheless, the more he or she (is) mocked, the more probable he or she would get agitated and relapse.

5.1 Implication and Recommendation

Community members should be educated to helps individuals with psychotic disorders, in their communities, to discover the things they want and need to achieve in their life, as well as the areas in which they need to improve their abilities. They should also be educated on how to manage behaviour of PPDs instead of shouting at them and discriminating them. Psychosocial support may help PPDs to begin to break troublesome patterns of behaviour or alter unhelpful thinking processes that fuelling undesirable behaviours in them. These PPDs can benefit the development of themselves, their families, and the country as a whole when they receive adequate assistance to enhance their mental health.

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