The relationship between occupational status, social support, and hope among persons with psychiatric disabilities

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Abstract:

The goal of the research study reported in this paper was to examine the centrality of occupational status, hope, and social support in the rehabilitation process of psychiatrically disabled persons who live in a community. Ninety individuals living in community settings in the northern part of Israel participated in the study. Five scales were used. Significant positive correlations were found between employment and hope, and social support and hope. A multiple regression model of the stepwise type for the prediction of severity of illness as a mediator variable was found to be significant. The results emphasize the importance of social support and supportive employment as major factors in promoting the process of successful rehabilitation in a community. Policy makers should thus promote community programs that encourage social contacts and foster hope.

Index Terms: *occupational status, social support, rehabilitation of persons with psychiatric disabilities*

Until the 1960s, hospitalization was the major means of treatment for persons with psychiatric disabilities, based on the medical paradigm[1,2]. However, policies and practices with regard to this population have been undergoing tremendous changes over the last four decades, starting with the acknowledgment that hospitalization may cause social alienation, and the institutionalization process may not provide for the many needs of the psychiatrically disabled. Today's rehabilitation policy is thus based on the recognition that the optimal way to regain some of the abilities lost due to psychiatric illness is through re-integration into the community. Rehabilitation programs are designed to fulfill these goals in many aspects of life, such as housing, occupation, and social integration[3].

The situation in Israel is similar to that elsewhere in the world; however, here it is only in the last ten years that changes have been taking place and the new practices implemented. Thus, there has been a decrease in the number of hospital beds, a shortening in the length of hospitalizations in psychiatric institutions, and a corresponding trend of establishing community-living arrangements. Still, these programs are not sufficient and scarcely answer the evolving needs of this population[1].

One of the main lessons learned from the experience of treating the psychiatrically disabled in developed countries is that more attention needs to be paid to the development of programs which provide a variety of rehabilitative social programs to enable better social integration into the community[4]. Social integration is one of the main goals in the community-oriented treatment of psychiatrically disabled persons. Liberman[5] claimed that the social integration of this population depends on their level of social functioning. While stressors and factors associated with the disability have a negative influence on their level of functioning, occupational skills,

social support, and hope are factors that may exert a positive influence in this area, and promote the quality of life of the psychiatrically disabled. Liberman and his colleagues have claimed that one of the salient expressions of rehabilitation difficulties is in the social occupational disfunctioning caused by stressors that increase the person's psychological vulnerability. These stressors are physical, such as drug abuse, or social, such as life events; their effects can be modulated by protective factors, drawn from either the individual's personal resources or the social environment. Although medication is a protective factor against biochemical vulnerability, it is still not capable of eliminating the effect of the other vulnerabilities caused by the disability. Thus, emphasis should be placed on psychosocial interventions that strengthen the person's coping capacities, such as employment and social support systems[5,6].

Hope

This study focuses on factors that promote hope through occupational means and social support systems. Hopefulness has been identified as a critical factor in the recovery process of psychiatrically disabled persons, yet mental health staff, and individuals who have been diagnosed as psychiatrically disabled and their families have been challenged to find ways to nurture and foster it [7-9]. The concept of hope has been of interest to psychiatrists and health professionals for decades. Promoting hope in their patients has also been identified as a core nursing function. Although hope is intuitively important to the individual's coping with and recovery from chronic illness, the scientific examination of hope remains in its infancy [9]. Research on the measurement of hope was reviewed in 1995 by Farran, Herth and Popovich[11] in individuals suffering from physical illnesses, such as cancer, cardiac transplants, Alzheimer's disease[12,13]. Holdcraft and Williamson[15] studied the level of hopefulness

in individuals admitted to a psychiatric ward of a general hospital. Their findings revealed that at intake into the hospital ward, the patients' level of hope was lower than the norm that had been previously reported; by discharge, however, their hopefulness level approached the norm. The results of this study, as well as of those whose subjects were patients with physical as opposed to psychiatric conditions, suggest it is not the illness *per se* that affects the level of hope, but rather other factors related to illness, such as symptoms, life situation, and treatment programs.

In the study of Landeen et al [9] the surprising finding was the lack of an inverse correlation between symptom severity and hopefulness. This study supports the notion that it is not the illness the person has, or does not have, to which hope is related as much as the feelings associated with the illness experience. Thus, financial issues, social contacts, and the patient's living situation are all factors that are more closely related to hope than is the disease itself.

Social Support:

Stress models define the individual's perceptions of internal and external resources as crucial factors in alleviating stress. Social frameworks, both formal and informal, have been emphasized by many researchers as an external resource with the potential to reduce stress by providing psychiatrically disabled individuals with emotional and tangible support[16-20].

The family and social network are also major factors in the promotion of the recovery process and may constitute a preventive factor to hospitalization[21,22]. In Christensen and colleagues' study[23], a supportive environment was also found to be an essential factor in reducing mortality levels of schizophrenia patients. However, previous research on the social support system of psychiatrically disabled persons has

revealed the existence of deficits in social contacts and that the friendships of these individuals are limited[21,22,24].

In our study we focused on friendship as a major resource for social support.

Employment

The mechanism of career development among people with mental health disorders is explained by the Social Cognitive Career Theory (SCCT) of Fabian[25]. According to SCCT, personal characteristics, illness severity, and environmental factors (family background and social context) combine to shape an individual's career[26]. In this study, we examine the correlation between employment status, friendship, and hope in psychiatrically disabled individuals. Work is generally considered a crucial psychological element in a person's well-being, since the work environment is one of the major resources for social contacts. Thus, people who are employed have a better chance of developing many social contacts[27-28]. In the last two decades there has been a significant move toward improving employment opportunities for disabled persons[29-33]. The rapidly emerging disability consumer movement of the 1970s, as well as international legislative efforts, has exerted considerable influence on federal legislation resulting in an increased emphasis on environmental accessibility, consumer self-advocacy and empowerment, and the provision of independent living services[32]. Despite these developments that provided greater opportunities for the psychiatric disabled to enter and remain in the labor force, in the U.S.A. most of these individuals remain outside it [34].

The key premise of the Social Role Valorization theory, formulated in 1972 by Wolfensberger, is that people's welfare depends extensively on the social role they occupy. If their social roles can somehow be upgraded, their life conditions will usually improve[35,36]. Work is a powerful means for psychiatrically disabled persons to

play a role that is positively valued by others, and is one of the important psychosocial dimensions of their treatment[36]. Furthermore, the work environment replaces the hospital environment and connects the person with reality through interpersonal activities that promote self-esteem, creativity, alleviation of poverty, improvement in quality of life, and inclusion in the community[26,38,39]. The element of employment is therefore a major factor in the planned rehabilitation programs in Israel and many other countries[40,41]. Employment is the first key factor of the Rehabilitation Psychosocial Model, which is based on 10 dimensions[40].

In summary, a review of the literature identified three major factors as being the cornerstones of the rehabilitation process for persons with psychiatric disabilities: employment, social support, and hope. The assumption is that a working, productive person has high self-esteem and good social support, and therefore is hopeful about a successful rehabilitation process.

(Figure no.1)

Method

Subjects

The research population consisted of 90 psychiatrically ill rehabilitants from Haifa and the northern part of Israel, who lived in sheltered community-settings, or with their families. The subjects worked in various settings in the community ranging from the open market to sheltered work centers providing different levels of protection. They were sampled randomly. Nearly 64% of the subjects were male, and 36% were female. The subjects' age distribution was approximately normal, 60% of them being around working age, i.e., 30-49. Nearly 14% were young adults (23-29 years old), and only 4 subjects (4.4%) were aged between 60 and 69. The majority of the subjects, nearly 64%, were single. A similar percentage (14.4%) was either married or divorced.

Nearly 36% of the subjects lived in a private apartment in the community, while nearly 20% lived in sheltered living settings, and a similar number in community-living settings. Most subjects, about 62%, had attained a full high school education and 12 of the subjects (13.3%) an academic education.

Measurements

The following five questionnaires were administered to the subjects:

A. A demographic details questionnaire was used to collect data, such as age, gender, and socioeconomic status.
B. A Severity of Illness Questionnaire- consisting of 2 questions was used to assess the number of hospitalizations and duration of last hospitalization.
C. An employment details questionnaire was used to collect data regarding the type of employment (a pre-employment club, a sheltered working place, or dependent employment), hours of work in a day, monthly salary, etc. For the

purpose of statistical analysis, two new elements were added to the employment variables: workplace and conditions.

D. A Friendship Relationships Questionnaire, constructed by Schwartz[42], was used to assess friendships (number of "personal" friends, opposite-sex friends, and non-handicapped friends). The questionnaire consists of 15 multiple choice questions. Four factors were derived from a factor analysis: Number of friends: A coherent variable, the distribution of which was approximately normal. The variable ranges between 0 and 30 with a mean of 4.57 (SD=0.86). Satisfaction with the number of friends: A ranking variable on a scale ranging from 1 to 3, in which a higher grade indicates a higher level of satisfaction. The mean satisfaction was 2.51 (SD= 0.86). The correlation of this variable with the number of friends is r=0.03 (insignificant). Frequency of relationships: This variable was formed to represent the variety of relationship types and their frequency. It was the sum of six items, each ranging from 0 to 6 with a mean of M=3.2 (SD=1.4), higher grades indicating a higher frequency of relationships. The reliability of these items was examined by Cronbach's α and was found to be 0.52. Seeking advice or guidance: A coherent variable ranging from 0 to 6; higher scores indicate more frequent seeking of advice or guidance in person from people in the community. The mean of the variable is M=2.166 (SD=1.22).

E. Miller Hope Scale[43]. The questionnaire consists of 40 items divided into 3 factors: satisfaction regarding myself, mean=3.7 (SD=0.64), internal consistency α=0.92; lack of hope, mean 2.77 (SD=0.64), internal consistency α=0.82; and future expectations, mean=3.83 (SD=0.62), internal consistency α=0.77. The three factors examine the existence of hope through statements,

such as "I hope for a pleasant future," and "I feel loved," arranged into a 5 point scale. The scores range from 40 to 200, with higher scores indicating higher levels of hope. The internal reliability was Cronbach Alpha, $\alpha = 0.93$. The questionnaire's validity was measured by calculating the correlation between the details of the Miller Hope Scale and the details of a questionnaire that measures psychological welfare. The correlation was r=0.71. The questionnaire was translated by the researcher, and the translation was evaluated by three Israeli mental health professionals to determine its suitability in the Israeli reality.

Procedure

After receiving permission from the Ministry of Health to conduct the research, the rehabilitants were approached. The objectives of the research were explained to them, and they consented to taking part in the study. They completed the questionnaires jointly with the researcher.

Results

The first hypothesis was that a positive relationship exists between better occupational status and higher levels of hope in persons with mental illness. Table 1 reveals that the correlations between the different dimensions of employment and the level of hope are insignificant, but there is a tendency which indicates that the higher the subject's scores on dimensions of employment, the higher will be the level of his or her hope.

The second hypothesis was that a positive relationship exists between the level of social support (provided by friends) and the level of hope among persons with mental illness. The table clearly shows that all correlations between the factors of friends' support and hope are significant. In other words, a higher level of friends' support is associated with a higher level of hope among people with mental illness.

Therefore, the second hypothesis was supported by the findings. The fourth dimension, feelings regarding the number of friends, was measured in three degrees only as a categorical variable, and therefore its relationship with the level of hope was associated with a Spearman correlation [r_s= 0.22, $p<0.05$]. The relationship was found to be significant, indicating that more satisfying friendships are associated with a higher level of hope.

The third hypothesis was that a negative relationship exists between the severity of illness and the level of hope among people with mental illness. The third part of Table1 shows that the correlation between the number of hospitalizations and hope was significant. This significant negative relationship indicates that those with a higher number of hospitalizations became less hopeful. There was no significant correlation between the duration of last hospitalization and hope. This hypothesis was therefore partially confirmed.

The model assumes that the level of hope can be predicted according to the state of employment and level of social support as independent variables, and the severity of illness as a mediator variable. The model depicted in Figure1 hypothesizes a completely mediated relationship. The proposed model was tested using a series of hierarchical regression analyses (see Table 2) as suggested by Baron and Kenny[44] to examine whether the inclusion of the severity of illness variable significantly affected the relationship between employment status and level of friends' support and hope. Based on the results presented in the equations of Table 2, we first examined the relationship between the independent variables and hope. The regression model results presented in Table 2 (Model 1) show that individuals who have the support of friends, as expected, tended to feel more hope (β =0.41, $p<0.01$). The next step was to show that the severity of illness mediates the relationship between employee status

and friends' support and hope. In model 3 the addition of severity of illness did not eliminate the significance of the friends' support for predicting hope, but it did reduce it ($\beta = 0.24$, $p<0.05$). In addition, the inclusion of the severity of illness variable did not affect the non-significant relationship between employment status and hope.

Comment

All the variables were united into a research model that examined the relationship between hope, personal variables, and environmental variables. The personal variables included demographic variables and dimensions of the illness (number of hospitalizations, and duration of the last hospitalization). The environmental factors included employment status and the level of social support.

Although a general trend was found in the relationship between the employment status of the person and his or her level of hope, the significant relationship which had been predicted was not found. One reason may be that the majority of the study group was working only in sheltered employment centers, and they spent their working hours with others with disabilities. Furthermore, employment at sheltered centers is not perceived by the employees as a "real work," and most of the work there is unprofessional, boring and without challenge, and is minimally remunerated[45]. In other research, where different employment programs were studied, those who worked in the open market or in supported employment programs had higher levels of self-esteem and life satisfaction[26, 46, 47].

Social support was found to be related to a greater feeling of hope among the study participants, and a lesser severity of illness. The more social support individuals have, the less severe are their illnesses and the higher their levels of hope. This result corroborates with those of other studies that indicate a positive relationship between social support and hope, optimism and high quality of life. Social support is a major

factor in adaptation to community life and promotes the recovery process of the psychiatrically disabled[20, 22,24,48,49]. As previously mentioned, in some studies[23] social support was found to be a major factor in preventing death among schizophrenic patients. Most of the participants in the study enjoyed strong social support on different levels. All individuals who participated in the study reported that they have someone to whom to turn for advice or support. This is a very important element in the promotion of feeling hope and of well-being.

The assumption that the severity of the illness is significantly correlated with hope was partially confirmed. The correlation between the number of hospitalizations and hope was significant, and the fact that other variables associated with the illness were not related to hope can be explained by the fact that the subjects had learned to accept their illness, and in the sheltering environment of their community settings they had learned to develop hope and optimism[9]. It can be seen that the hypothesis of the mediation model was partly confirmed. Social support was significantly related to hope, but severity of the illness partially mediated this relationship. The influence of having the support of friends has been examined in many studies[22, 24, 50]. As found in these studies, social support is one of the major factors in successful coping with stress situations and serves as a powerful tool in reducing the perceived severity of illness and promoting hope. In many of these studies, social support was the most significant factor in the well-being of the studied population[48,49].

These findings confirm the importance of hope in the rehabilitation process. When individuals are able to develop trust in someone, despite stressful life events they become hopeful, which helps them cope and make the necessary changes in their life that lead to a successful adjustment to their illness. Hope, therefore, can be attained with the help of staff, families, and friends.

The study limitations are three-fold. The participants in the study lived in Haifa and communities in northern Israel. The results thus reflect only the situation in Israel, and cannot be generalized to other countries. Secondly, most of the participants in the study were working in sheltered employment centers, and only few were working in the open market. These factors may have affected the participants' level of hope.

The results emphasize the importance of social support for persons with psychiatric disability who are required to live in the community where they feel isolated and alienated. Policy makers should promote community programs that encourage inclusion and social contacts. Employment programs should focus more on supportive employment and new models of employment that promote initiation, productivity, and challenges, by initially matching the amount of assistance the individual needs and the type and intensity of the assistance proposed. Another clinical issue is how to identify and foster hope among clients who are overwhelmed by depression, uncertainty, or fear. Future research should focus on the effects of different types of treatment and employment models on the inducing of hope and on promoting quality of life for psychiatrically disabled persons who live in the community.

References

1. Aviram A. Social integration of chronic persons with psychiatric illness. *Social Security.* 2001; *61*: 42-61. (In Hebrew).
2. Menon M.S. Psychiatrique réhabilitation: Curent trends. *Nimhans Journal.* 1996; 14(4): 295-305.
3. Hafner H. Psychiatric rehabilitation: General issues. *Eur Psychiatry.* 1996; 11(2*)*: 39-50.
4. Cotterill A, Thomas S. A typology of care episodes experienced by people with schizophrenia in an English town. *Soc Sci Med*. 1993; 36(12):1587-95.
5. Liberman RP. Psychosocial treatments for schizophrenia. *Psychiatry*. 1994; 57 (2):104.
6. Liberman RP, Kopelowicz. A Basic elements in biobehavioral treatment and rehabilitation of schizophrenia. *Int Clin Psychopharmacol*. 1995;9 (5):51-58.
7. Adams S, Partee D. Hope: The critical factor in recovery. *J Psychosoc Nurs Ment Health Serv*. 1998; 36(4): 29-32.
8. Anthony W, Cohen M, Farkas M. *Psychiatr Rehabil J.* Boston: Center for Psychiatric Rehabilitation;1990.
9. Landeen J, Pawlick J, Woodside H, Kirkpatrick H, Byrne C. Hope, quality of life, and symptom severity in individuals with Schizophrenia. *Psychiatr Rehabil J*. 2000; 23(4): 364-369.
11. Farran CJ, Herth KA, Popovich JM. Hope and hopelessness: Critical clinical constructs. Thousand Oaks, CA: Sage Publications;1995.
12. Fehring RJ, Miller JF, Shaw C. Spiritual Well-Being, Religiosity, Hope, Depression, and Other Mood States in Elderly People Coping With Cancer. *Oncol Nurs Forum*. 1997; 24(4): 663-671.

13. Tollett JH, Thomas SP. A theory-based nursing intervention to instill hope in homeless veterans. *ANS Adv Nurs Sci*. 1995; 18 (2): 76–90.

15. Holdcraft C, Williamson C. Assessment of hope in psychiatric and chemically dependent patients. *Appl Nurs Res*. 1991; 4: 129-134.

16. Dunst CJ, Trivette CM, Deal AG. *Enabling and Empowering Families: Principles and Guidelines for Practice.* Cambridge, MA: Brookline Books; 1988: 146, 157.

17. Hanson MJ, Hanline MF. Parenting a child with a disability: A longitudinal study of parent stress and adaptation. *Journal of Early Intervention.* 1990;14: 234-248.

18. Kazak AE. Families with physically handicapped children: Social ecology and family system. *Fam Process*. 1986; 25: 265-281.

19. Raif, R. (1991). Out-of-home placement, social support and willingness to apply for out-of-home placement among young parents with developmental disabilities. M.A. Thesis, School of Social Work, Bar-Ilan University, Ramat-Gan, Israel. (In Hebrew).

20. Shtanger V. Locus of control, and the use of support system in mothers of young children with developmental disabilities. M.A. Thesis, School of Social Work, Bar-Ilan University, Ramat-Gan, Israel;1997. (In Hebrew).

21. Furukawa TA, Harrai H, Hirai T, Kitamura T, Takahashi K. Social support questionnaire among psychiatric patients with various diagnoses and normal controls. *Soc Psychiatry Psychiatr Epidemiol.* 1999; 34(4):216-222.

22. Rudnick A, Kravetz S. The relations of social support-seeking to quality of life in Schizophrenia. *J Nerv Ment Dis. 2001; 189*(4): 258-262.

23. Christensen AJ, Dornink R, Ehlers SL, Schultz SK. Social environment and longevity in Schizophrenia. *Psychosom Med*.1999; 61: 141-145.

24. Bengtsson-Tops A, Hansson L. Quantitative and qualitative aspects of the social network in Schizophrenic patients living in the community, Relationship to sociodemographic characteristic and clinical factors and subjective quality of life. *Int J Soc Psychiatry.* 2001; 47(3): 67-77.

25. Fabian, E.S. (2000 Fabian, E.S. (1992). Supported employment and the quality of life: Does a job make a difference? *Rehabil Couns Bull. 36(2),* 84-97.

26. Waghorn G, Chant D, King R. Work-related self-efficacy among community residents with psychiatric disabilities. *Psychiatr Rehabil J.* 2005; 29(2): 105-113.

27. Kavanagh DJ, Waghorn G, Jenner L. Demographic and clinical correlates of comorbid substance use disorders in psychosis: multivariate analyses from an epidemiological sample. *Schizophr Res*. 2004; 66: 115-124.

28. Schalock RL. Reconsidering the conceptualization and measurement of quality of life. In R. L. Schalock (Ed.), *Quality of life: Vol. I. Conceptualization and measurement*. Washington, DC: American Association on Mental Retardation;1996: 123–139.

29. Cook J, Leff S, Byler C. Results of a multisite randomized trial of supported employment for individuals with severe mental illness. *Arch Gen Psychiatry.* 2005; 62: 505- 512.

30. Hill J, Seyforth J, Banks P, Wehman P, Orelove F. Parent / guardian attitudes toward the working conditions of their mentally retarded children. *Except Child*. 1985; 54(1): 9–24.

31. Kiernan WE, Stark JA.. Pathways to Employment for Adults with Developmental Disabilities. Baltimore: Paul H. Brookes Company; 1989.

32. Rojewski JW. Occupational and Educational aspirations and attainment of young adults with and without LD 2 years after high-school completion. *J Learn Disabil*. 1999; 32: 533-552.

33. Rusch FR. Competitive Employment Issues and Strategies. Baltimore: Paul H. Brooks; 1986.

34. New Freedom Commission on Mental Health..Achieving the Promise: transforming Mental Health Care in America: Final Report. Rockville, MD.: *US Department of Health and Human Services.* DHHS publication SMA-03-3832; 2003.

35. Wolfensberger W. The principle of normalization in human services. Toronto: National Institute on Mental Retardation; 1972.

36. Wolfensberger W. A brief overview of Social Role Valorization. Ment Retard. 2000; 38: 105-123.

37. Taller, Y. 2000 Taller, Y. (2001). What will happen to the rehabilitation system? Rehabilitation policy in U.S.A. and Israel in historical perspective. *Social Security, 61,* 27-41. (In Hebrew).

38. Fabian ES. Supported employment and the quality of life: Does a job make a difference? *Rehabil Couns Bull*. 1992; 36(2): 84-97.

39. Freedman RI, Lynch-Fesko S. The meaning of work in the lives of people with significant disabilities: consumer and family perspectives. *The Journal of Rehabilitation.* 1996; 62(3): 49-55.

40. Lachman M. Psychosocial rehabilitation in Israel: A turning point. *Society and Welfare.* 1998; 18(1): 46-63.

41. Taller Y. What will happen to the rehabilitation system? Rehabilitation policy in U.S.A. and Israel in historical perspective. *Social Security*. 2001; 61: 27-

41. (In Hebrew).

42. Schwartz SH. Beyond individualism/collectivism: New cultural dimensions of values. In: U. Kim, H.C. Triandis, C. Kagitcibasi, S.C. Choi and G. Yoon, Editors, *Individualism and collectivism: Theory, methods, and applications*, Sage Publications, Thousand Oaks; 1994: 85–119.

43. Miller JF, Powers M. Development of an instrument to measure hope. *Nurs Res*. 1988; 37(1): 6–10.

44. Baron MR, Kenny DA. The moderator- mediator variable distinction in social psychological research: conceptual, strategic, and statistical considerations. *J Pers Soc Psychol*. 1986; 51(6): 1173-1182.

45. Katz S. Quality of life of persons who are employed in sheltered vocational settings in the Northern Israel. M.A. Thesis, School of Social Work, University of Haifa, Israel; 2001 (In Hebrew).

46. Griffin DK, Rosenberg H, Cheyney R, Greenberg B. A comparison of self-esteem and job satisfaction of adults with mild mental retardation in sheltered workshops and supported employment. *Education and Training in Mental Retardation and Developmental Disabilities.* 1996; 12: 147-157.

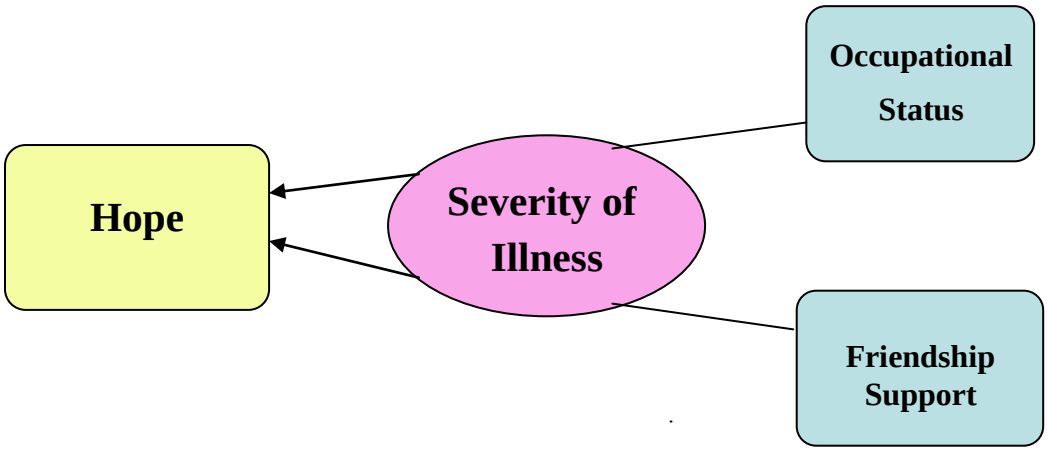
47. Mosely C. Job satisfaction research: Implications for supported employment. *J Assoc Pers Sev Handicaps.* 1988; 13: 211-219.

48. Cohen-Levi D. The relationship of non-formal support and successful aging of persons with intellectual disability. *Gerontology*. 2005; 34: 35-47. (In Hebrew).

49. Mead S, Hilton D, Curtis L. Peer support: A theoretical perspective. *Psychiatr Rehabil J*. 2001;25(2): 134-141.

50. Davidson L, Stayner D. Loss loneliness and the desire for love, Perspectives on the social lives of people with schizophrenia. *Psychiatr Rehabil J*. 1997; 20(3): 3-12.

Figure No. 1


Occupational Status
Hope
Severity of Illness
Friendship Support

Variable **Employment Conditions**	**Hope**
Years in present framework	0.15
Hours of work per day	0.09
Monthly pay	0.19
Satisfaction with pay	0.21
Satisfaction with work	0.13
Social Support	
Number of friends	0.24*
Quantity	0.35**
Asking for advice or guidance	0.39**
Severity of Illness	
Number of hospitalizations	-0.44**
Duration of last hospitalization	0.01

*p<0.05 **p<0.01

Table 1. Correlations between occupational status, social support and severity of illness to the level of hope:

	Models		
Independent variables	1	2	3
Social support	0.41**		0.24*
Employment state	0.08		0.05
Severity of illness		- 0.44**	-0.46**
Model F	4.28**	4.7**	5.77**
R^2	0.17	0.19	0.34

*p<0.05 **p<0.01

Table 2: results of regression analysis