Effects of Perceived Social Support on Quality of Life and Death Anxiety in Patients with Coronary Heart Disease

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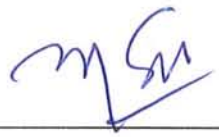

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Dr. Syeda Razia Bukhari
(Supervisor)

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In the name of Allah Almighty, the Most Merciful and Beneficent, First of all, I thank Allah for giving me strength and ability to complete this study. My humble thanks to Him who has always bestowed me far better more than what I observed and helped me at each and every phase of life and always showed me the right direction.

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ABSTRACT

The present study investigates the effects of Perceived Social Support on Quality of life and Death Anxiety in patients with Coronary Heart Disease. For this purpose, the sample of 100 patients (Male=55, Female=45) with coronary heart disease were selected. Data was gathered through purposive sampling technique from different hospitals of Islamabad and Rawalpindi. To study the variable of interest, Multidimensional Scale of Perceived Social Support translated by Jabeen, and Khalid, (2010) was used to assess Perceived Social Support, Quality of life translated by Khan, Akhter, Ayub, Alam, & Laghari, (2003) was used to assess Quality of life and Death Anxiety scale, developed by Goreja and Pervaz, (2000), was used to assess the level of death anxiety in patients with Coronary heart disease. Data was analyzed on SPSS version 21. Pearson productmoment coefficient correlation was computed to find out the relationship between Perceived Social Support, Quality of life and Death Anxiety among patients with coronary heart disease ($P<.05$, $P<.01$). Regression analysis was used to assess Perceived Social Support as a predictor, Quality of life and Death Anxiety as outcome.T tests were used to assess demographic variables (gender and family system). For occupation, education and income one way ANOVA was computed. Results of the demographics indicated that females had higher death anxiety as compared to the males. Patients those living in joint family system perceived more social support as compared to nuclear family system and those who have higher education, personal business and good level of income perceived more social support, improved quality of life and therefore experienced lower level of death anxiety as compared to others. Moreover, this research can be useful for counselors and psychologists; it might be useful for improved quality of life and it may help to decrease death anxiety in coronary heart patients and would contribute to the literature by emphasizing the significance of perceived social support, quality of life and death anxiety in coronary heart patients. Suggestions and limitations for further researches have also been discussed.

INTRODUCTION

Chapter 1

INTRODUCTION

Coronary heart disease is one of the most paramount medical issues of the 21st century. Today there is a quick increase in death because of coronary heart disease (Wong et al., 2014). The Pakistani population is among those having the greatest threats of coronary heart disease around the world (Zahid, Meyer, Kumar, Claussen, & Hussain, 2011). Coronary heart disease can prompt negative changes in mental health, a way of life and social life by the experience of an event. Social support plays an imperative role in preserving health. In recent years, the importance of social support has become even greater for the maintenance of health. Social support can enhance the quality of life and help patients satisfactorily to deal with the symptoms of heart failure (Bennettet al., 2001). The absence of social support is an indicator of death and re-hospitalization in patients with heart failure (Murberg, 2004). Social support helps a person navigate through life and is necessary for maintaining the person's physical and emotional wellbeing (Yildirim & Kocabiyik, 2010).

The objective of this study was to determine the effects of perceived social support on quality of life and death anxiety in patients with coronary heart disease. It discusses about how an individual perceives social support and what is it impact on the quality of life and death anxiety in patients with Coronary heart disease.

Coronary Heart Disease

Coronary heart disease is an infection in which a thick and sticky substance develops inside the coronary arteries. Arteries supply oxygenated blood to the heart. Over the time, heart failure and arrhythmia leads to the weakening of heart muscle with Coronary heart disease. The condition in which heart can't direct blood to the body is called heart failure. The rate of the rhythm of heart is called Arrhythmias (Alexandar et al., 2016).

Prevalence. Coronary heart disease is a noteworthy reason for death and disability in developed countries (Roger, 2007). In spite of the fact that the mortality of this condition has slowly declined in the course of the most recent decades in western countries, it still causes around 33% of all deaths in individuals older than 35

years (Rosamond et al., 2008). The most recent information releases by WHO in May 2013 demonstrated that death because of Coronary heart disease reached 111,367 or 9.87% of total deaths. The adjusted mortality rate is 110.65 for every 100,000 general population. This positions Pakistan at number sixty-three in the world. As per American Heart Association Statistics Committee in 2013, Heart Disease and Stroke update reports that overall mortality from coronary heart disease was 102.6 per 100,000 (Go et al., 2013).

Treatment. There are numerous approaches to treat coronary disease, some of which are listed underneath:

Healthy lifestyle changes. A healthy change in way of life is prescribed for the cure of coronary heart disease. Healthy lifestyle changes are: to maintain a healthy diet and healthy weight. It also includes managing psychological problems, by having a daily schedule of physical movement and exercise and taking medicines that are recommended by the physician.

Physical activity. Mostly walk is recommended for coronary heart disease as an everyday practice.

Medicine. In order to control the level of cholesterol to treat coronary heart disease the above mentioned changes in way of life are recommended. Medication is carried out to control or lesser cholesterol. After that, the probability of heart attack and stroke is considerably reduced.

Social support has been prospectively linked to mortality and has been implicated in the etiology of Coronary heart disease (Cohen, 1988). The association between social support and cardiovascular morbidity and mortality (especially in coronary heart disease) has been reported many times in past researches conducted in western nations (Kuper, Adami, Theorell & Weiderpass, 2006). The attitudes of families, friends, and significant others have been found to be deeply related to the Coronary heart disease.

Perceived Social Support

Durkheim (1984) gave the idea of social support. It was emerged in the nineteenth century. Durkheim was a sociologist who set up the connection between

declining social ties and an expansion in suicide. As an idea, it had developed after sometime, starting with the expression "social bonds" (Durkheim, 1984).

Perceived social support can be defined as being characterized of an exchange of social assets between individuals or groups that improves the health benefits (Brownell & Shumaker, 1984). It is the awareness that social support or help from family friends and important other people is available when someone wants to reach someone else's support in times of need (Uchino, 2006). Researchers have recommended that in managing trauma perceived social support is more useful and powerful than social support (Uchino, 2009).

Cobb (1976) illustrated that social support is "information that influences the subject to believe that he or she is cared for, loved and valued and is a member of a network of shared obligations". Social support is defined by Chung, Moser, Lennie, and Frazier (2013) as the subjective perception of individuals through the help of significant other or social relationships. Social help alludes to the experience of being valued, regarded, nurtured and cherished by others in their own lives (Uchino, 2006). It can originate from a variety of sources, for example, family, companions, teachers, groups, or other social gatherings you have a place with. Social support can appear as material support through others or perceived social support, which is an evaluation of people's trust in the accessibility of sufficient support when required (Yasin & Dzulkifli, 2010).

Perceived social support refers to the "functions provided by the other such as parents, friends and other important people for the individual to provide any type of support such as informational, instrumental, and emotional." It has been argued that these different supporting strong functions are profoundly connected with each other and often form a single underlying factor, summarized as perceived social support (House, 1981).The perceived social support was utilized to direct to the degree to which an individual trusted in, cared for, and needed to support other people (Sarason, Sarason, & Shearin, 1986).

Perceived social support is a person's psychological insight that he has to built up trustworthy bonds with others and that others give support to them (Celik, Akgemci & Didem, 2012). Provided social support implies on the behaviors and activities that others undertake. In other words, it is thought to be a behavioral

evaluation of support. In spite of the fact that the advantages of social support for individual have been acknowledged for a long time, it is acknowledged that perceived social support is especially a better forerunner of health results. It is likewise revealed that there is a positive connection between perceived social support and mental ailments and low levels of anxiety (Celik, Akgemci & Didem, 2012).

Four sorts of social support have been found to impact disease-related results in Heart Failure patients, including emotional support, instrumental/material support, information support, and appraisal support (Dekker, Peden, Lennie, Schooler, & Moser, 2009). Emotional support means sharing the view of caring, cherishing and trusting others. Instrumental/material support alludes to the provision of products and services that the individual needs. Information support is to make information available to people in stressful circumstance. At last, peer support also includes self-assessment support and involves confirming the appropriateness of other people's actions or statements (Langford, Bowsher, Maloney & Lillis,1997).

Perceived social support is support that is presented in comparison to the one actually available (Wills & Shinar, 2000). Social support can be characterized as any suggestion that helps to pursue the objectives of the supported individual (Dekker et al., 2009). Perceived social support as an individual shares the benefits of love, acquaintance, caring for family members, friends, and other people (Koldi & Salahshouri, 2012). Social support has diverse measurements and it is communicated in various frames and many ways. The initial social support may comprise of emotional support from family, companions and peers. An individual's family appears to be the most influential members of the social network, as family support positively affects Heart Failure-related results, including quality of life, psychosocial capacity and self-care (Dekker et al., 2009).

Perceived social and buffering model. Perceived social support is support that an individual believes to be available whether or not the help is really there. The perception of support can be a component of the level of closeness and affection found in one's own relationships. In contrast with actual support, perceived support may be just as essential (and maybe more so) for improving health and wellbeing. In the circumstance, health seems to be more related with perceived social support than the actual social support. Just as actual support, perceived support can build the belief

that one can adapt to current circumstances, decreases emotional and physiological reactions to incidents, and emphatically change one's behavior.

Buffering and direct effect hypothesis. It is hypothesized that social support influences wellbeing in two ways: (1) an indirect, buffering or mediatory course, and (2) a direct main route of action. The stress buffer hypothesis was investigated more frequently than the main effect hypothesis. The Stress Buffer Hypothesis states that a person's interpersonal organization provides the individual with the assets they have to adapt to upsetting occasions and circumstances. Therefore, the supportive and strong parts of help are seen just in upsetting circumstances. That is, the stress buffer theory proposes that social support alleviates (weakens) the associations between distressing life occasions and negative physical or mental challenges, for example, cardiovascular disarranges and depression. Also, supporters of the stress buffering model trusted that support may be compelling if there is a decent and strong condition alteration (i.e., the sort of help given meets the situational requirements). For instance, it can be useful to offer somebody sympathy and consolation when s/he has lost a friend or a family member. To offer someone empathy and reassurance can be supportive. But, empathy can be useless when stress is connected with financial problems.

On the other hand, the main effect hypothesis suggested that social support is helpful, paying little respect to whether one is experiencing a stressful event or not. The main effect hypothesis expresses that the extent of a person's contribution in the social network plays a vital part in the level of social support. In other words, there is an immediate monotone association between social support in the social network and well-being (i.e. the greater the support, the more prominent the well-being). A related idea of social support is social consideration. Social integration is characterized as the participation of an individual in a variety of social connections. Social integration can also relate to the quality of social relationships. For instance, negative social connections can negatively affect health, while positive social connections and collaborations usually have beneficial effects on health and well-being. Previous researches have shown that social inclusion is more of a major effect on one person's relationships with others; it can provide multiple ways to influence health- related behaviors (Cohen & Wills, 1985).

Social support and health. Social support additionally has significant implications for health and well-being. In general, support has been related with great wellbeing and prosperity and enhanced adaptation to particular diseases, for example, cardiovascular illness and tumor. A strong support network has been associated with bringing down death rates, less depression, better medical treatment, greater health behaviors (e.g., lower smoking rates), retention of healthy behavior, lower incidences of cardiovascular disorders, and improved breast cancer adaptation. Furthermore, social support has been connected to adaptation to the operation. That is, patients who had a social encouraging group of people got to bring down measurements of narcotic drugs, indicated less anxiety and were released from the hospital earlier than people who did not have any type of social support.

Conversely, the absence of social support has been related with increased anxiety and depression, an increase in cardiovascular issues, feelings of helplessness and unhealthy behavior (e.g., sedentary lifestyle, ordinary alcohol use). For instance, an absence of parental support anticipated a potential increment in depressive side effects and the beginning of depression in girls. That is, girls who had none or little support from their parents were more likely to suffer from depression than young ladies who had parental support. Women who reported low perceived support likewise have more health issues than those who report elevated amounts of support (Cohen, 2004).

Gender differences in social support. A great part of the early research into gender specific differences in social support utilized self-reporting measures and found that women are more capable supporters than men. For instance, wives affirm their husbands at a higher rate than husbands affirming their wives and offer more help in situations of stress than husbands offer. Also, women will accomplish more housework (alleviating pressure and stress) when the husband has an upsetting day at work. Investigations of strong conduct (that is, checking of steady conduct as opposed to self-announcing measures) among wedded couples have not discovered these gender differences and rather find that husbands and wives offer similar help to each other. Late researches demonstrated that the capacity to give social support is comparative among married couples. It has been proposed that the main difference in gender differences previously found is when spouses provide assistance. For instance, wives offer more prominent support when their husbands encounter more noteworthy

pressure, while ladies, when encountering expanded stress, may not really attended more support. As it were, women are more ready to give greater support than men in troublesome circumstances.

There is evidence that social support can influence men and women in an unexpected way. For instance, widows with help got an enhanced quality of life, more noteworthy prosperity and confidence, while these components were contrarily connected with social support got among widowers. Support got by men can be tempered by their inclinations toward freedom. Men who wanted to be free have a tendency to react more adversely to social support than men who wanted to be independent or addicted. In ladies, the impact of social support does not appear to rely upon the want for independence (Krohne & Slangen, 2005).

Culture and social support. A conceivable determinant in the choice to look for or request social support might be one's own ways of life or the standards that describe that specific culture. Individuals in Eastern societies are less inclined to request social support from their social network than people in Western societies. This social example appears to be illogical, as Eastern societies are more collectivist and emphasize interdependence, while Western cultures are more individualistic and emphasize independence. It seems that individuals in collectivist cultures are those seeking and soliciting assistance from their social encouraging group of people. However, researches have demonstrated that the opposite is true. That is, people in individualistic societies are the individuals who ask for assistance from their social encouraging group of people. The basic purpose behind this outlandish example may be the aftereffect of social standards, for example, social standards that demoralize the utilization of a social encouraging group of people in tackling issues and adapting to pressure (Taylor et al., 2004).

Workplace social support. The level of social support received from others in the work environment relies upon numerous components, including social aptitudes, correspondence connections, and employee engagement. Like, socially able people or workers get more noteworthy, passionate and instrumental help than the individuals who are not as socially skilled. In any case, numerous examinations demonstrate that a person's encouraging group of people is frequently a system o find individuals outside their work, for example, relatives, spouses, etc. Regardless, work

environment support decidedly predicts the support received. It has additionally been demonstrated that social support directs the connection between long hours and physical health symptoms. In other words, physical wellbeing tends to diminish when a man has long working hours and no social support. Then again, individuals who have a social encouraging group of people tend to be better able to offset the antagonistic impacts of longer working hours (Collins & Feeney, 2004).

Perceived social support influences. The perceived social support and the real social support impact numerous aspects of one's own life. Social help can have either a direct (or essential) impact or a buffering (or intervention) on one's own health. The impact of social support can be generally observed from an impact in the workplace to intimate relationships. Likewise, social support has suggestions for health, stress management and self-esteem. In addition, identity, cultural base and gender can impact or direct the impacts of pressure (Collins & Feeney, 2004).

Perceived social support can enhance the patient's low quality of life with heart disappointment and help them to successfully deal with the manifestations of heart failure (Bennett et al., 2001). Positive social support is related with enhanced quality of life and better results in patients with a coronary heart problem (Lett et al., 2007). Strengthening and expanding social support has been proposed to be a powerful mediation that may enhance the quality of life, and also lessen death and morbidity in patients (Dunbar, Clark, Quinn, Gary, & Kaslow, 2008).

Quality of Life

World Health Organization (WHO) defines quality of life as "the individual perception of one's position in life in the context of the culture and value systems, in which they live, as well as their goals, expectations, standards and concerns. It is a far-reaching concept that is that is complexly influenced by physical health, mental state, and the degree of independence, social relationships, and the relationship to silent features of their environment. The quality of life in clinical medicine represents the functional effects of illness and treatments have on a patient themselves (Schmidt & Bullinger, 2003).

Quality of life is a wide idea which is concerned with the general prosperity in the public arena. In any case, there is now an endless supply of the term in academic

and political talks. Or maybe, the inclination is towards uniqueness. As indicated by one of the definitions, "prosperity reflects living, as well as the manners by which individuals react and feel about their lives in those areas" (Fahey, Whelan & Maitre, 2005).

Quality of Life can be characterized as subjective prosperity. Perceiving the subjectivity of Quality of Life is keyed to understanding this figure. Quality of Life mirrors the distinction, the hole, the expectations and desires of a man and their current experience. Human adjustment is to such an extent that life expectancy is normally changed in accordance with being inside what the individual thinks conceivable. This allows individuals who have troublesome living conditions to keep up a sensible Quality of life. Quality of life has been portrayed as the effect of disease and health care on a person's day by day exercises and prosperity with regards to a person's capacity to adapt (Rummans, Bostwick, Clark & Mayo, 2000).

Since the mid-1970s, interest in the concept of the quality of life has enormously expanded in both research and clinical practice. Quality of life has turned out to be a critical parameter in evaluating the quality and results of social insurance (Bazarganipour et al., 2013). This is particularly true for patients with ceaseless diseases, where the quality of life has turned into a basic focus as a complete cure of the ailment is impossible. There are two conceivable clarifications for the developing interest for the quality of life in medicinal services. One clarification is an expanded future because of enhanced medical treatments. Accordingly, numerous more individuals are highly expected to have interminable, clinically-controlled infection than with serious ailments. Some contend that notwithstanding mortality and severity, quality of life should likewise be utilized to assess health care (Macduff, 2000). The other clarification is the spread and advancement of medicinal and surgical innovations. With the increase in available treatments, a thorough consideration of the benefit-to-burden ratio of equivalent therapies is now required. Quality of life issues are presently included when human services experts assess the advantages of various treatment choices. Thus, quality of life looks into impacts how policymakers designate medicinal services assets or decide repayment strategies (De Geest & Moons, 2000).

The term "quality of life" is common to almost everyone has every sense, academic discipline, individuals and groups can define it differently. In spite of the fact that well-being is a standout amongst the most critical regions of general quality of life, there are different zones, for example, occupations, lodging, schools, and the neighborhood. Parts of culture, qualities and most profound sense of being are likewise key regions of the general quality of life that add to the unpredictability of their estimation. In any case, researchers have created valuable procedures that have conceptualized and measure these different areas and how they identify with each other (Whoqol, 1998).

The estimation of the quality of life as an indicator of health results in patients with coronary heart disease has increased quickly and significantly. In the clinical course of coronary heart disease, there are numerous viewpoints that can influence the quality of life of patients, including side effects of angina and heart failure, constrained exercise limit of the above manifestations, physical weakness and psychological stress related with chronic stress. Present day medications center on enhancing life expectancy, indications and useful status in addition to the quality of life (Wenger, Mattson, Furberg & Elinson, 1984). Quality of life factors have been recommended to be of basic significance in identifying residual dysfunction in long-term survivors and in comparing various treatment protocols as adjuncts to clinical treatment decisions (Bradlyn & Pollock, 1996).

The idea of quality of life has three fundamental attributes: In the first place, it reflects the people's life circumstances and their observations rather than a country's quality of life. Secondly, it is a multidimensional idea, covering different areas of life, for example, lodging conditions, education, business, work-life balance, access to establishments and open administrations, and their interaction; lastly, it brings together objective information on living conditions with subjective perspectives and attitudes to give a depiction of overall being in the public arena (Shucksmith, Cameron, Merridew & Pichler, 2009).

Quality of Life is the feeling of general life satisfaction as determined by the mentally alert individual whose life is being evaluated (Meeberg, 1993). Theoretically, Quality of life can encompass a wide range of domains and components. These may be functioning, including role function (functioning in

various roles such as physical activities and achievement beliefs), degree and quality of social interaction, psychological well- being, physical sensations, quality of life, mental health, and functional status of the elderly were negatively affected by chronic heart failure disease and its manifestations (Fotos et al., 2013). Hornquist (1982) defines quality of life as "a wide range of dimensions of human experience, from vital necessities such as food and shelter, to those associated with the sense of fulfillment and personal satisfaction".

Health Status, Function Status and Quality of Life are three terms that are often used interchangeably to refer to the same area of "health." Guyatt (1993) used the term "health-related quality of life" because many widely appreciated aspects of life in general are not considered "health related", including income, freedom and environmental quality. Quality of life is an attitude that is rooted in the cultural sense of beliefs. It is believed that this changes with the growth and development of the individual. It is reflected in the expression of feelings, emotions, and behaviors, and is considered to be a set of criteria that make choices from different options (Singer, Martin, & Kelner, 1999).

Majani et al., 1999, found that "objective standards of quality of life often have little to do with life satisfaction, while subjective indicators often correlate strongly with global well-being - a more meaningful and sensitive barometer of quality of life". Accordingly, the subjective satisfaction of the patient should always be included in routine assessment and clinical procedures. They are a useful source of information about mental and psychological resources. Quality of life is translated by human contentment and happiness (Bird, Conrad & Fremont, 2000). Aristotle is the first to think that a happy and contented life is the result of the virtues and good deeds of an individual (Fayers & Machin, 2007). Formal variables involved in quality of life are used to define the social well-being of an individual that is considered satisfactory by members of the same culture (Anderson & Burckhardt, 1999). The quality of life is defined by the sociologist and psychologist in terms of individual expectations and to what extent these expectations for life are met. Quality of life generally consists of various dimensions, including physical function, social dimension and environment (Lindqvist & Sjoden, 1998).

Quality of life helps people live a healthy and happy life. Quality of life is a concept that has been so difficult to define and measure over the past three decades (Hagerty et al., 2001). Quality of life is not an experienced life, but the embodiment of life that the individual experiences over time. Quality of life is not just feeling and experience, but also includes the individual's views and judgments on a position and set of actual life events along with the entire society over a period of time (Yousefi, 2006).

Theories of Quality of Life

Maslow's developmental perspective theory. A quality of life hypothesis created from the human advancement viewpoint of Abraham Maslow is introduced. Developed societies involved members who are fundamentally worried about fulfilling higher-order needs (social, esteem and self-satisfaction needs), it is contended; while less created social orders includes individuals who are essentially worried about fulfilling lower range needs (natural and security needs). Quality of Life is characterized as the hierarchical need satisfaction level of most individuals from a specific culture. The higher satisfaction of the majority in a society is the fulfillment of the better quality of life of this society. Organizations are intended to serve the human needs of general public and in this manner the personal satisfaction of the general public. Societal foundations that serve human needs incorporate beneficial, support, authoritative/political and versatile establishments. Each of these sorts of social foundations incorporates a various leveled measurement. It is contended that dynamic increments in personal satisfaction are related with various leveled changes in the social establishment (Sirgy, 1986).

An Integrative Hypothesis of the quality of life. Quality of life implies a decent life and we trusted that a decent life is the same as carrying on with an existence with a high ability. The idea of a decent life can be seen from subjective to the target, where this range fuses various existing personal satisfaction speculations. This spectrum the integrative quality of life hypothesis and talk about the accompanying perspectives in this paper: prosperity, fulfillment with life, bliss, which means throughout everyday life, the natural data framework (adjust), acknowledging life potential, the satisfaction of necessities, and target factors. The logic of life illustrated in this paper tries to gauge the worldwide personal satisfaction with

questions taken from the integrative hypothesis of the personal satisfaction. The hypothesis is a general hypothesis or meta-hypothesis enveloping eight more genuine speculations in a subjective-existential-target range. Different methods of insight of life can pressure different parts of life, however by this idea of bringing such an existential profundity into the wellbeing and sociologies, we accept to have made and essential stride towards another modesty and regard for the extravagance and multifaceted nature of life (Ventegodt, Merrick & Andersen, 2003).

Health-related quality of life. The idea of health related quality of life (HRQOL) and its determinants has developed since the 1980s to catch parts of general quality of life that unmistakably influence physical or emotional well-being.

At an individual level, HRQOL incorporates physical and psychological well-being discernments (e.g., vitality levels, mood) and their correlates - including health dangers and conditions, utilitarian status, social support and financial status.

At community level, HRQOL incorporates group level assets, conditions, strategies and practices that influence the wellbeing discernment and working status of a populace.

In view of a union of logical writing and counsel from its general wellbeing accomplices, Centers for Disease Control and Prevention (CDC) has characterized HRQOL as "the perceived physical and mental health of an individual or group over time"(Center for Disease Control and Prevention, 2000).

The HRQOL develop, in collaboration with a more extensive hover of health accomplices, including social administration organizations, group organizers and business gatherings, enables health authorities to address more extensive regions of sound public strategy to address a typical topic. HRQOL issues are a critical part of general wellbeing checklist and are by and large observed as legitimate pointers of neglected needs and mediation results. Self-evaluated wellbeing status is likewise a more prescient indicator of mortality and bleakness than numerous target wellbeing measures (Dominick, Ahern, Gold & Heller, 2002). HRQOL measures make it conceivable to experimentally substantiate the effect of wellbeing on personal satisfaction and go a long way past the old worldview, which is restricted to what can be seen under the magnifying instrument.

Quality of life and coronary heart disease. Quality of life has stirred enthusiasm for a long time, and already 384-322 BC. Aristotle noticed "the great life" or "being great" to be the same as "being cheerful". Be that as it may, the presentation of this idea, as it is known today and worry for its deliberate and logical assessment is generally new. In wellbeing sciences, a standout amongst the essential advances of late decades has been that patients' perspectives on their disease are as authentic and legitimate as those of medicinal services experts. This has prompted the need to characterize the idea of the health-related quality of life and its evaluation as a method for subjective estimation of its effect on an ailment. Likewise, their treatment is progressively observed as a pointer of advancement and development in medicinal services (Casas, Ramon, & Pereira, 2001).

It is considered as an individual's view of their position in life with regards to the way of life and esteem frameworks in which they live and in connection to their objectives, desires, standards, and concerns (WHOQoL, 1993). The expression "Health-Related Quality of life" (HRQL) was later created to recognize the general quality of life and the prerequisites of clinical pharmaceutical and clinical trials, in this way taking out vagueness. It characterizes it as subjective appraisals of the effect of individuals' present condition of wellbeing, their social insurance and their health advancing exercises on their capacity to accomplish and keep up a level of general working that empowers them to seek esteemed life objectives. Despite the fact that there is a difference about which measurements ought to be incorporated into HRQL evaluations, these creators have indicated that the functional areas that are basic to HRQL include: social, physical, and intellectual capacities, versatility and independence, and passionate well-being (Fitzpatrick, 1996).

HRQL serves as a guide to measuring the impact of a disease on the individual and is described and characterized by the patients themselves as a result of their assessment of their health care (Urzua, 2010). A consistent and undisputed topic in all approaches is that this concept can only be judged by subjective measures. It is precisely their subjective and multidisciplinary nature that has led to their greater use in supplementing the traditional physiological and biological measures of health. Their assessment, however, requires instruments with appropriate psychometric characteristics, prior to their implementation. People with heart failure have a significantly impaired quality of life compared to other chronic diseases as well as a

healthy population. Quality of life reflects the multidimensional impact of a clinical condition and its treatment on the daily lives of patients. Heart failure patients experience various physical and emotional symptoms such as shortness of breath, tiredness, edema, sleep disorders, depression and chest pain. These symptoms limit the daily physical and social activities of the patients and lead to a bad Quality of life. A bad Quality of life is related to high hospital stays and mortality rates. Therefore, Quality of life in patients with heart failure should be appropriately assessed to determine their impact on the daily lives of patients.

Quality of life is subjective and not just reflects objective clinical or physiological status. It mirrors the subjective view of patients about the effect of a clinical disease on their lives. Individuals with comparative states regularly have the distinct impression of their Quality of life, and the outcomes change in light of the patient's subjective perspectives. In an investigation that looked at doctors' forecast of patient wellbeing observation and patient wellbeing related recognition, 51% of cases varied and patients' wellbeing discernment significantly affected medical care. Scarcely any researchers have examined Quality of life from the point of view of patients. In this way, the reason for this investigation was to look into the view of heart failure patients by means of Quality of life (Urzua, 2010).

Assessing the quality of life in coronary patients. One area of health care that has been particularly interested in the concept and measurement of health-related quality of life includes patients with coronary heart disease. Not exclusively is this ailment the main source of death around the world, it additionally has huge physical, passionate and social implications for those influenced. In this way, evaluating their quality of life isn't just important to survey the achievement of a treatment or surgery, but also to identify specific problems are not judged by traditional methods and may be valuable to change or enhance treatment, or to offer alternatives that enhance the clinical outcome of patients (Fayers & Machin, 2007). Considering that the treatment of coronary heart disease is essentially connected with driving a sound way of life, instruments for estimating HRQL are outstanding amongst other approaches to survey the experience of patients themselves as for their medical issues in zones, for example, physical, passionate or social capacity, part satisfaction, agony and weariness (Asadi-Lari, Packham, & Gray, 2003). In spite of the acknowledged enthusiasm for surveying HRQL in coronary patients, one of the real issues in clinical

practice is picking the correct instrument. While choosing an HRQL evaluation device, specialists or clinicians should first check that the chosen instrument has genuinely been created and approved in a populace with comparable qualities, and that it covers all perspectives that are imperative in coronary patients.

To be utilized with certainty, the apparatuses must have various attributes, for example, legitimacy or how much they measure what they need to quantify; reliability or the degree to which a measure gives comparative consideration to individuals of equivalent quality of life; and affectability to change or how much a measure figures out how to distinguish noteworthy changes that are proper for clinical change (Cepeda-Valery, Cheong, Lee, & Yan, 2011). In the expansion, these devices must be finished, that is, they should incorporate all perspectives that may be influenced by the disease, and they ought to be anything but difficult to assess and interpret. This last perspective is of most extreme significance in clinical circumstances, as quick and simple use under these conditions is an important characteristic (McDowell & Newell, 1996).

The most generally utilized instruments for estimating the HRQL of coronary patients can be categorized into two sorts: generic and particular. The two kinds have favorable advantages and disadvantages, and the choice to utilize relies upon the sort of mediation to be evaluated and the objectives to be accomplished. All in all, nonspecific apparatuses can evaluate the effect of an extensive variety of patients and ailments on health, and comparisons between the effects of coronary heart and other constant ailments, for example, diabetes or COPD, on HRQL can be drawn. In any case, nonspecific measures are less delicate in perceiving the impact that the particular side effects of coronary illness have on a patient's life.

Health-related quality of life is a vital consequence for patients who are diagnosed with coronary heart disease. Life expectancy persists to get better after a medical treatment of coronary heart disease patients (Krumholz et al., 2005). A study suggested (inverse relationship between death anxiety and quality of life) that if quality of life increases it automatically decreases the magnitude of death anxiety (Soleimani, Lehto, Negarandeh, Bahrami, & Nia, 2016).

Death Anxiety

Death Anxiety is the phenomenon that states that death is basically an unknown experience; fear of death is also a common name, perhaps suggesting that the fact of death, if not the actual experience, is known (Dennis, 2009).

The dimensions of death anxiety include fear of pain, punishment, loneliness and loss of control, fears of the death event, of what happens after death, and of the fear of ceasing as well as fear of the unknown and fear of suffering (Conte, Weiner, & Plutchik, 1982). Collett and Lester (1969) believed that fear of death brought not only their own fears, but also fears in relation to others. They identified four different fears: the fear of dying of themselves, the fear of the death of the self, the fear of dying from others, and the fear of the death of others.

Individuals know about their mortality (Langner, 2006), and patients who have a dangerous illness confront death (Emanuel, Fairclough, Wolfe & Emanuel, 2004). The analysis of a hopeless ailment can incite a profound existential emergency, as the regular daily existence and what's to come are undermined for patients and their families. As an existential issue, mortal dread stems from the conscious awareness to our own mortality (Solomon, Greenberg, & Pyszczynski, 2000) and can be characterized as "negative passionate reactions incited by the suspicion of a state in which the self does not exist" (Tomer & Eliason, 1996).

As per Maddi (1980), death anxiety arises not only from actual confrontation with death, but also from experiences with unwanted endings, time or energy limitations, or unlawful ideals that threaten the meaning of life. At the point when supportive relationships create self-esteem and make sense, a positive theory of life or a reasonable arrangement of convictions builds up permitting the showdown of death without fear (Kalish, 1963). Death anxiety occurs when individuals are confronted with personally threatening illnesses or stressors and are reminded of death by association with death or mourning and are confronted with the perception of alienation or questions about the meaning and purpose of life.

Death Anxiety alludes to fear and tension related with the desire and familiarity with biting the dust, demise and nonexistence. It regularly incorporates enthusiastic, intellectual, and motivational segments that change as per the level of

advancement and socio-cultural life expectancy (Lehto & Stein, 2009). Death Anxiety is related to fundamental brain structures that manage fight-or-flight reactions and record charged explicit and implicit memories (Panksepp, 2004). Psychological measurements of fear can incorporate attention to the importance of death and an assortment of convictions, states of mind, images, and thoughts about death, dying, and what occurs after death (Lehto & Stein, 2009).

Death Anxiety can be experienced deliberately or unwittingly; it can persuade people to ease their fear of death through diversion (Greenberg, Pyszczynski, Solomon, Simon & Breus, 1994). Fear of death is the declaration of the tension between our real state as limited and constrained creatures, and our want to be boundless, eternal creatures that offer a transcendent consciousness.

Death Anxiety or fear of death and/or dying is recognized as an important psychological phenomenon that can affect the perceived quality of life in clinical and non-clinical groups. Concerns about death can exacerbate the negative effects, negatively impact communication, and alienate patients and their loved ones. Fear of death occurs when individuals are confronted with personally threatening illnesses or stressors, who are reminded of death by association with death or mourning and are confronted with the perception of alienation or questions about the meaning and purpose of life.

Theoretical perspectives on death anxiety. Freud was one of the first scholars to manage fear. He called attention to the fact that dread of death mirrors uncertain childhood clashes, not simply the fear of death, as it is doubtful of our capacity to acknowledge mortality. For instance, in his exposition. Freud (1952) noticed that "our unconscious does not have faith in his own particular passing; it carries on like an everlasting one". Freud viewed the unconscious as the basic wellspring of thought and conduct, thus he contended that while we pay lip service to the truth of death, "essentially nobody has confidence in his own death" (p.761).

Present-day theories are more often based on Becker's existential view of death (Furer & Walker, 2008). He pointed out that fear of death is a real and fundamental fear that underlies many forms of anxiety and phobia. Becker argued that humans cope whyith this fear by living in accordance with cultural worldviews, "immortality either literally (i.e., afterlife) or symbolic (i.e., identification with beings

longer and more enduring than an individual life such as nations) "(Strachan et al., 2007, p.1138).

Terror management theory (TMT). Becker's view was that a great part of the vitality of people was centered on the denial of death as a procedure to monitor the fear of death. Becker's work has prompted the improvement of the Terror Management Theory (TMT), which proposes that while individuals look for self-protection, they are additionally mindful of the certainty of death (Pyszczynski, Greenberg, and Solomon, 1999). According to TMT, when individuals are helped to remember their mortality, their requirement for structure and significance increments and this prompts an expanded spotlight on actual and socially esteemed objectives. This hypothesis additionally recommends that those with higher levels of confidence will have more noteworthy resistance to death-related circumstances and those with run down confidence will encounter more noteworthy mortal dread. TMT has directed broad research that gives generous test support to its fundamental theories (Solomon, Greenberg & Pyszczynski, 2004).

Post-traumatic growth theory (PTG). Posttraumatic Growth Theory (PTG), another current fear-of-death theory, recommends that an existence emergency, especially the death of the self or a friend or family member, can prompt constructive changes, for example, a more prominent energy about existence, a moving of needs to characteristic goals and enhanced relational connections (Tedeschi & Calhoun, 2004). Lykins, Segerstrom, Averill, Evans, and Kemeny (2007) looked at TMT and PTG and proposed how these speculations can be accommodated. To put it plainly, PTG recommends that mortality can prompt constructive natural changes (as depicted above), though TMT postulates that mortality builds prompt outward objectives that are personally and culturally estimated. Lykins et al. (2007) laid out a few methodological contrasts between the exploration approaches created by the proponents of the two hypotheses. TMT thinks generally involve experimental manipulations controls of death recollections on a solitary event, such as, a brief presentation of words in connection with death. PTG research usually investigates naturally occurring challenges such as how to deal with major diseases or natural disasters.

Such dangers are uncontrollable and can keep going for a long time, months, or years. Lykins et al., (2007) proposed that these two techniques inspire diverse kinds of handling of death material with here and now introduction in TMT tests, which "advance more protective preparing, for example, diversion and idealistic one-sided evaluations," while the more extended-term circumstances urge PTG to encourage a concentration for members "all alone passing including an envisioned genuine demise, an existence survey and the chance to take the point of view of others"(p. 1089). Lykins et al., (2007) exhibited a progression of three examinations to research these issues and demonstrate that "when individuals experience death over an extended period of time, or in a way that is perfect with their objective structure, they conquer their characteristic protectiveness, or are inherently arranged to be healthier for a long time "(p. 1097). The methodologies examined in the segment on the treatment of this article are more in accordance with the long-term burden of deaths described in the PTG studies.

Death anxiety and medical illness. Noyes, Carney, and Langbehn (2004) point out that the particular disease fears maybe associated with a medical illness or related health threat, and that these fears may be more typical in individuals with medical issues. In the center, we have seen some seriously sick individuals (tumor or unending obstructive aspiratory illness) struggling with incredible fear of death. As anyone might expect, health concerns are higher for people struggling with health dangers or genuine disease and this is upheld by investigation. For instance, a substantial epidemiological investigation of the overall public in Germany, which incorporated a doctor's appraisal of medical issues (Jacobi et al., 2004), demonstrated that weakness was firmly connected with anxiety, depressive and somatoform issues. Studies in North America likewise show that the nearness of an interminable malady is related with a higher rate of nervousness, disposition, and substance issue (Katon & Ciechanoswki, 2002).

Consequently, the rates of these disorders are higher in health care than in the general population. It is important to note, however, that many people with life-threatening or incurable illness are not very fearful of death. In some situations, this may reflect the person's efforts to avoid or deny the reality of impending death, but in other situations this may reflect the person's healthy focus on a well-lived life and the acceptance of the inevitability of death.

However, it is understandable that the fear for some people may increase as they negotiate the challenges of the health care system. Waiting for tests and test results, receiving ambiguous test results, receiving conflicting feedback from various healthcare providers, and so on all add to the uncertainty of the situation. In these cases, the goal of the treatment is often to assist the person in negotiating these challenges, to accept and tolerate the uncertainties associated with a serious illness, and to see the prospect of a calmer and more realistic death. While clinicians may feel better in healthy young people when dealing with health anxiety and fear of dying, they may be less familiar with dealing with patients facing serious health threats, illness and mortality. The treatment strategies discussed later in this article can be adapted to these specific situations and are generally accepted by patients and family members when introduced as part of a supportive relationship and comprehensive treatment approach (Furer, Walker, & Stein, 2007).

Death anxiety and gender differences. Most of the recent and earlier studies on gender differences in fear of dying show that women score higher on death anxiety as compared to men. There can be a number of reasons why women tend to outperform men in dread situations. According to Becker (1973), it is culturally a "heroic" pattern that helps overcome the fear of death. Schumaker, Barraclough, and Vagg (1988) argued that men in many societies aspire to greater achievements and "heroic deeds" than women, thus bringing the necessary "heroism" to overcome the mortal fear. It has also been suggested by some researchers that men and women may vary in specific measurements of fear. Schulz & Aderman, (1979) defined for instance, there are six measurements of fear of death, to be specific: the dread of mortification, the intrusion of objectives, impacts of survivors, the dread of discipline, the dread of not being, and dread of the passing of others. Men were more afraid of interrupting targets, affecting the survivors, while women were more afraid of punishment and afraid of not being

Diggory & Rothman (1961) found that men in relatives were more apprehensive of the outcomes of death than ladies. They also found that women are more afraid of pain when dying. Denger (1974) showed that women rate death emotionally while men rate it cognitively. One can conclude that death has different meanings for both sexes.

Death anxiety and religion. Florian & Snowden (1989) theorized the interaction of culture and religion and the key component of the process that avoids or productively directs the reality of death. Duff & Hong (1995) explored the impact of religiosity on fear. They recommended that fear of death is brought down in gatherings with a high rate of church administrations. This speculation was observationally upheld by information. Another investigation by Powell & Thorson (1991) found that demise was much lower in members with high natural religious inspiration. This examination inspected characteristic religious inspiration as a genuine religious conviction (Powell & Thorson, 1991).

Some religions found the fear of death as a temporary "incident of a continuing existence". On the other hand, some religions confess that the death of the body is like the passing of the self. Hinduism and Buddhism consider the best method to conquer demise to be to acknowledge passing as an essential unavoidable truth (Kubler-Ross, 1975) noticed that religious frameworks have a tendency to lessen the dread of death.

Relationship between variables

Quality of life has been portrayed as the effect of illness and medicinal services on a man's day by day exercises and feeling of prosperity, identified with a person's capacity to adapt (Rummans et al., 2000). As death approaches, vital measurements of the quality of life incorporate physical concerns (torment and side effects) and psychological distress. Social support is an essential part in adjustment to dangerous disease. Social support becomes increasingly vital as the general population moves toward death, and relational communications decrease the fear of death. The perceived positive family support was strongly associated with less fear of death, as seen in a patient study that found better social support among those who had a good prognosis (Dunkel-Schetter, 1984). Further, social support has likewise been identified with bringing down anxiety among cardiovascular patients and, like anxiety, is identified with diminishing coronary heart disease (Idler & Kasl, 1997). For instance, higher self-reported social support has been identified with diminishing anxiety among patients evaluated following myocardial infarction (MI), and social support predicts lessened anxiety and nervousness among patients anticipating coronary artery bypass surgery.

Perceived social support and quality of life. Heart failure is a disease that leads to low quality of life because basic needs may not be met, body picture changes and there is a lack of self-care and daily life activities, chronic fatigue, sexual dysfunction and anxiety about the future (Archana, & Gray, 2002). Social support can improve the low quality of life of patients with heart failure and help them to effectively treat the symptoms of heart failure (Bennett et al., 2001). The lack of social support is a predictor of mortality and re-hospitalization in patients with heart failure (Murberg, 2004). Social support helps a person to navigate through life and is necessary to maintain the person's physical and emotional well-being (Yildirim & Kocabiyik, 2010). Reasonable support becomes particularly important when individuals cannot meet their own needs, often because of physical limitations or inadequate resources to deal with. Proper and adequate social support can improve the quality of life of people with heart failure (Fahlberg, 2010).

One study reported that people who had less emotional support and lived alone developed psychological stress and were barely able to adhere to treatment regimens, thus worsening their quality of life (Murberg & Bru, 2001). A study of social support done on patients with coronary heart disease reported that social support had a positive impact on lifestyle changes and on the maintenance of treatment (Boutin-Foster, 2005).

One investigation which assessed the quality of life in heart failure patients demonstrated that the patients' social support and quality of life levels were directly associated. It was likewise expressed that there was a modestly huge connection between social support apparent to the patients and physical health sub-scale of quality of life and that the patients required more help when their physical health deteriorated (Bennett et al., 2003). An investigation which analyzed the connection between social support and quality of life in patients with heart failure found that the patients' social support levels were generally high, whereas their quality of life levels were moderate. It was additionally discovered that adjustments in social support were altogether connected with the quality of life (Bennet et al., 2001).

Another examination inspected the quality of life of patients with heart failure and found that the patients' social support levels were moderately high whereas their scores for physical and mental health sub-scales of quality of life were lower than

those of general population. No relationship was found between social network, social support, and subscales of quality of life (Westlake et al., 2002).

Some psychosocial factors, including health related convictions, social support, adapting style and personality type may have significant effects on the quality of life. These impacts may be immediate, or they may be indirect, buffering the negative effect. Actually, these psychosocial elements may be the most intense indicators of personal satisfaction, frequently exceeding the impacts of critical infection related elements, for example, confusion (Rubin & Peyrot, 1999).

Positive social support is related to the enhanced quality of life and better results in patients with coronary heart disease (Lett et al., 2007). Strengthening and expanding social support has been recommended to be a successful intercession that may enhance personal satisfaction, and additionally decrease mortality and dullness, in patients with Heart failure. For instance, the presence of a companion gave significant support when contrasted with those without, as unmarried patients with Heart Failure were at 3.8 times higher at risk of readmission or passing away compared with married patients (Dunbar et al., 2008).

Social support may add to positive wellbeing by two conceivable pathways (Cohen, & Wills, 1985). In the first place, social support may have an immediate and fundamental impact on health-related results, regardless of individual stress level or the presence of a stressful event. Second, social help may have a buffering impact, as it shields people from the hurtful results of an unpleasant situation or occasion. Along these lines, social help may be an interceding or mediating variable which decreases the impacts of pressure. Since the part of social help has been estimated utilizing an assortment of instruments and results changed crosswise over earlier examinations, there is no steady proof to authoritatively bolster either pathway.

One study of the outcome demonstrates that less social support and more noteworthy depressive side effects independently predicted the poorer quality of life. The connection between social support and quality of life was intervened by depressive indications. Neither social support nor depressive side effects directed quality of life (Chung, Moser, Lennie, & Frazier, 2013).

Perceived social support and death anxiety. Social support is a crucial component in adapting to life-threatening diseases. Social support becomes important as people approach death and interpersonal interactions reduce the fear of death. The perceived positive support from the family was closely linked to the lesser fear of dying, as shown in a study of patients where greater social support was observed in those who had a good prognosis (Dunkel-Schetter, 1984).

In Pakistan, an examination inferred that social support may help in reducing the thoughts of death in patients with chronic diseases (Khawar, Aslam, & Aamir, 2013). Moreover, another examination demonstrated that fear of death was a prescient factor of the quality of life. The goal was to estimate the relationship among quality of life, perceived social support and fear of death among cardiovascular patients and think about the contrast of quality of life, perceived social support and death anxiety amongst male and female cardiovascular patients (Bahrami, Moradi, Soleimani, Kalantari, & Hosseini, 2013).

A variety of studies concluded that social support was negatively associated with fear of death (Peterson, 1991). Previous research has shown that social support shields patients from the deadly effects of mental stress and serves as a defense against the increased risk of death (Frasure-Smith et al., 2000). In addition, an association between social support and lower anxiety has been recognized in elderly populations and in cardiac patients (Forsell, 2000). Another recent study also found a significant negative relationship between fear of death and social support (Nejad, Saatchi, & Paydar, 2017).

Social support has been connected with general death anxiety (Young, 2006). The increment in social support has been related with diminishing in overall anxiety (Malinauskas, 2010) while bringing down social support is related with higher death anxiety (Newsom & Schulz, 1996). Death anxiety can be compensated or at least reduced if chronically ill patients receive social support (Lorenzini & Giugni, 2010). Helping the family to financially support the chronically ill could prove essential. Similarly, it can be helpful to overcome the mental and physical strain of chronic illness when a partners and having close friends with whom one can talk may help in overcoming the mental and physical trouble caused by the ceaseless disease. In

general, one can imagine that social support of all kinds is crucial to help patients with chronic illness overcome anxiety about dying.

Patients live with a consistent feeling of danger and attempt to keep away from death musings amid their day by day lives; however, side effects of their infection would actuate fear of death (Adelbratt & Strang, 2000). Social support is a crucial component in adapting to life-threatening diseases. Warm relationships can increase self-esteem and provide a buffer against the fear of death while interrupting such relationships can lead to death concerns (Mikulincer et al., 2002). Affirming the value, care, love, and trust of others strengthen self-esteem in older adults.

Several studies examining social support processes have provided evidence that interpersonal relationships play an important role in protecting people from the deleterious effects of stressors which can lead to depression, distress, and anxiety (Thoits, 1986). Social support can reduce symptoms of anxiety and despair in response to difficult circumstances and stressors (Cohen & Wills, 1985).

Quality of life and death anxiety. Fear of death can occur in difficult circumstances affecting the quality of a person's life (Furer & Walker, 2008) and is increasingly recognized as an important trans-diagnostic construct for mental health and life-adaptation issues (Iverach, Menzies & Menzies, 2014). Sherman Norman, & McSherry (2010) "also identified that fear of death can affect the quality of life of patients with life-threatening illnesses." Importantly, the study found significant inverse relationships between fear of death and quality of life suggesting that mortal anxiety may be a negative influence (Soleimani et al., 2016). Levenson et al (2000), found that as death approached, disability and symptoms increased, but there was no significant decrease in quality of life as death approached.

Based on these indications, reducing mental distress and fear of dying is a fundamental element of end-of-life care and treatment (Lo, et al., 2014). According to Spiegel (1995), both individual and group psychotherapies focus on three key approaches: social support, emotional expression, and cognitive symptom management. These approaches address the psychological consequences of dying, including mortal anxiety, and have been associated with various psychosocial improvements, such as decreased depression and anxiety, improved quality of life, decreased pain, and improved coping skills (Lo et al., 2014).

One study showed that greater fear of death was associated with a lower quality of life (Martens, DeJonge, Cohen, Lett, & Whooley, 2010). A study showed a significant impact of Quality of life on fear of death, with higher Quality of life participants showing a higher mortal fear.

Based on the literature, the relationship between the variables is summarized as; perceived social support is predicted to be positive for quality of life and negative for death anxiety.

Rationale

The present study is an attempt to examine the effects of perceived social support on quality of life and death anxiety in patients with coronary heart disease. Coronary Heart Disease is one of the most paramount medical issues of the 21st century. Now a day there is a quick increase in death because of coronary heart disease (Wong et al., 2014). The Pakistani population has one of the highest risks for Coronary heart disease in current times. Studies have found that social support serves as ameliorating function during times of psychological distress in medical populations (Quinn, Fontana & Reznikoff (1987). The experience of a coronary heart disease event can lead to negative changes in mental health, lifestyle and social life. Social support has been prospectively associated with mortality and implicated in the etiology of coronary heart disease (Cohen, 1988).

The relationship between social support and cardiovascular morbidity and mortality (particularly for coronary heart disease) has been well documented in previous studies conducted in Western countries (Kuper, Adami, Theorell, & Weiderpass, 2006). Reinforcing and increasing social support has been suggested to be an effective intervention that may improve quality of life, as well as reduce mortality and morbidity, in patients (Dunbar, Clark, Quinn, Gary, & Kaslow, 2008). Individuals know about their mortality (Langner, 2006), and patients who have a dangerous illness confront death (Emanuel, Fairclough, Wolfe & Emanuel, 2004). The diagnosis of an incurable disease can provoke a deep existential crisis, as everyday life and the future are threatened for patients and their families.

Literature suggests that social support is one of the most important factor to reduce stress and various kinds of anxieties, for example, death anxiety (Thoits,

1986). Quality of life issues are crucially important, because they may powerfully predict an individual capacity to manage his disease and maintain long term health and well-being. And death seems to be the major stressor in human life because it leads to fear and anxiety. This anxiety is associated with fearful thoughts such as, dying itself is quite painful. The knowledge of inevitable death haunts human beings, and in turn leads to the development of anxiety and fear.

Researches shows that the intensity of such irrational fears is greatly reduced, when individual experience support from family and friends (Berkman, & Syme, 1979). In Pakistani perspective there are few numbers of researches that find relationship between anxiety, depression, psychological well-being and quality of life in patients of chronic illness. Some researches that find relationship between perceived social support, quality of life in diabetic patients, death and perceived social support in elder people, perceived social support and death anxiety in patient with chronic illness and quality of life and psychological distress in coronary heart disease but few researches are available with perceived social support and death anxiety in coronary heart disease patients.

Therefore, the purpose of the present research is to investigate the effect of perceived social support on quality of life and death anxiety in patients with coronary heart disease. The present study aims to fill the research gap in the literature by analyzing the relationship between these variables in the Pakistani cultural context. Another important aspect of the study is that it aims to investigate this relationship between three variables in the context of patients with coronary heart disease.

METHOD

Chapter 2

METHOD

Objectives

The objectives of the present study are:

- To study the role of Perceived Social Support, Quality of life and Death Anxiety among patients with Coronary heartdisease.
- To investigate the role of demographic variables (gender, education, income, & familysystem) with Perceived Social Support, Quality of life and Death Anxiety among patients with Coronary heart disease.

Hypotheses

In order to test the relationship between perceived social support, quality of life and death anxiety in patients with coronary heart disease, following hypothesis areformulated.

1. There would be significant positive relationship between Perceived Social Support and Quality of Life (physical functioning, psychological functioning, social and environmental functioning) in coronary heart disease patients.
2. There would be negative relationship between Perceived Social Support and Death Anxiety in coronary heart disease patients.
3. There would be negative relationship between Quality of Life and Death Anxiety.
4. Perceived Social Support would be the positive predictor of Quality oflife.
5. Perceived Social Support would be the negative predictor of DeathAnxiety.
6. Female will perceived more Death Anxiety as compared tomale.

Operational Definitions

Perceived Social Support. Perceived social support refers to the "functions performed for the individual by significant others, such as parents, friends and significant others who can provide all kind of assistance e.g., informational, instrumental, emotional". These various supportive functions were found to be highly correlated and often form a single underlying factor summarized as perceived social

support (House, 1981). In present study Perceived social support can be operationally defined by using Urdu translated version of Multi-dimensional Scale of Perceived Social Support by Jabeen, & Khalid, (2010). Higher score indicate the presence of higher social support from the particular source and vice versa.

Quality of Life. WHO defines Quality of Life as "individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is broad ranging concept affected in a complex way by persons' physical health, psychological state, and level of independence, social relationships and their relationship to silent features of their environment". Quality of Life in clinical medicine represents the functional effects that an illness and treatment have upon a patient himself or herself (Schmidt & Bullinger, 2003).

In present study Quality of Life can be operationally defined by using Urdu translated version of WHO-QOL BREF by Khan et al.,(2003). The score on the scale can also be taken as an indicator of overall quality of life of the person. The higher score on the scale indicates the better quality of life.

Death Anxiety. Death Anxiety is defined as an anxious feeling or fear of an individual related to his/her death in response to some stressful life events. There are six dimension of Death Anxiety; i.e. concern over suffering and lingering death; subject proximity to death; disturbing death thoughts; impacts on the survival; fear of punishment; fear of dying (Goreja & Pervaz, 2000). Higher score on Death Anxiety Scale indicate high Death Anxiety and low score on Death Anxiety Scale indicate low Death Anxiety (Goreja & Pervaz, 2000).

Sample

A sample of 100 individuals was approached. The sample characteristics include coronary heart disease male =55 and female=45. Education level of patients include primary to M.Phill. The sample was selected from different hospitals from Rawalpindi and Islamabad. Demographic variable include were gender, education, income, family system and occupation.

Table 1

Sample demographic description for the study (N=100).

Variables	*f*	%
Gender		
Male	55	55.0
Female	45	45.0
Family system		
Joint	40	40.0
Nuclear	60	60.0
Qualification		
Primary	22	22.0
Middle	6	6.0
Metric	23	23.0
Intermediate	16	16.0
Bachelors	16	16.0
Masters	16	16.0
Occupation		
Housewife	32	32.0
Business	15	15.0
Midwife	2	2.0
Job	17	17.0
Retired	29	29.0
Teacher	5	5.0
Monthly Income		
Upto 30,000	46	46.0
31,000 to 50,000	14	14.0
51,000 to above	40	40.0

Instruments

Multidimensional Scale of Perceived Social Support (MSPSS). Multi-dimensional Scale of Perceived Social Support has been originally developed by Zimet, (1988) and is translated in Urdu by Jabeen, and Khalid, (2010). In the present study, Urdu translated version of Multi-dimensional Scale of Perceived Social Support was used. This scale is 12-item self-reported measure that measures perceived means of support from three different sources: family (items 3, 4, 8, 11), friends (items 6, 7, 9, 12) andsignificant other (items 1, 2, 5, 10). The alpha Coefficient for the subscales is .85. Maximum score on each sub-scale is 21 and minimum score on each sub-scale is 4. Higher score on each subscale would indicate the presence of higher social support from that particular source and vice-versa.

Quality of life Scale (WHO-QOL BREF). Quality of Life was assessed with the help of WHO-QOL BREF. It is a brief version of WHO QOL-100 (100-item scale), and had four domain scores. The WHO QOL scale consisted of 26 items and comprised of four dimensions physiological functioning (items3, 4, 10, 15, 16, 17, and 18), psychological functioning (items 5, 6, 7, 11, 19 and 26), social functioning (items 20, 21,22) and environmental functioning (items 8, 9, 12, 13, 14, 23, 24 and 25). There were also two items that were examined separately, i.e., an individual's overall perceptions of quality of life and health. The scale was originally developed by WHO and it was adapted and translated in Urdu language by Khan et al., (2003). WHO QOL BREF comprised of 26 items divided in four dimensions. The domain scores are scaled in a positive direction i.e., higher scores denote higher quality of life. The mean scores are then used to calculate the domain score. The overall scores on the scale can also be taken as indicator of overall quality of life of the person reflecting that higher the score better would be the quality of life. The alpha reliability of this scale is .94.

Death Anxiety Scale. The Death Anxiety Scale was developed by Goreja and Pervaz (2000). This scale is based on theoretical model of Templer (1970). The scale is based on the four dimensions identified by the Templer, the rest of two dimensions were identified by the researcher. The scale consisted of 20 items relating to fear of death. The item included in the scale were categorized into six dimensions

of death anxiety, i.e., (1) concern over suffering and lingering death, (2) subjective proximity of death anxiety, (3) disturbing death thoughts, (4) impact on the survivors, (5) fear of punishment, (6) fear of not being. All items were worded positively. Responses are obtained on a five point rating scale. The response categories ranged from 'never'= '1' to 'always' = '5'. Alpha coefficient of the scale was reported .89, for the present study the Death Anxiety Scale was translated into Urdu language by use with Pakistani population so as to eliminate the language problem of aged sample. The scale was translated by five M.Sc student of National Institute of Psychology who had good command of English and Urdu language. On the basis of feedback, those items were selected which conveyed the exact meaning of the originalitems.

Demographic sheet. To obtain data, various demographic characteristics are observed and formulated a comprehensive demographic sheet. Demographic sheet provides comprehensive information required about gender, family system, occupation and monthly income among patients with coronary heart disease.

Procedure

The study was conducted on the sample of 100 Coronary heart disease patients. The data was collected from different hospitals of Rawalpindi and Islamabad. In very First permission was acquired through administration of hospitals. After that a consent form was given to the participants after telling them about the research also if they are not comfortable they will quit at any time. The instructions were given to the participants about how to fill the questionnaire. Also told them if they have any problem they can ask without hesitation. If the participants asked about something related to the questions they were provided by the appropriate answers. They were assured that information provided by them will be kept confidential and will be only use for the research purposes. It took almost 15-20 minutes to complete the questionnaires. At the end of the data collection all participants were thanked for their cooperation. After taking all data, it is entered in SPSS-21 for further analysis and results.

RESULTS

Chapter 3

RESULTS

Data was subjected to analysis by means of Statistical Package for Social sciences (SPSS 21.0 for Windows) for quantitative analysis. In order to achieve the objectives of the present study, appropriate statistical analyses were used to analyze the data. Descriptive statistics were computed for all the measures in the study in order to examine the overall trend of the data. The internal consistency of the scales was determined with the help of Cronbach's alpha reliability coefficient. Pearson Product Moment Correlation was used to determine the relationships between variables of the study. Independent sample *t*-test was computed to ascertain group differences along demographic variables. Linear regression analysis was done to investigate the strongest predictor between variables. The results are presented in tabulated form.

Descriptive, Alpha-coefficient for Study Variables

With a specific goal to show the study results in compressed form alpha-coefficients of perceived social support and its subscale, quality of life sub-scales and Death Anxiety werecalculated.

Table 2

Cronbach's alpha reliability coefficients of the scales and subscales of Multidimensional Scale of Perceived Social Support, Quality of life and Death Anxiety among patients with coronary heart disease(N=100).

Variables	No. of Items				Range		*Skewness*	*Kurtosis*
		M	*SD*	α	Potential	actual		
MPSS	12	5.50	.86	.90	12-84	1.42-6.67	-1.96	5.55
FR	4	5.32	1.10	.86	4-28	1.50-7.00	-1.12	1.23
FA	4	5.79	.98	.83	4-28	1.25-7.00	-2.08	5.97
SO	4	5.41	.91	.75	4-28	1.50-7.00	-1.44	3.19
OQ	2	27.4	6.34	.72	2-10	8 -40	-.36	.39
PHY F	7	84.5	14.9	.66	7-35	44-116	-.47	.29
PSYF	6	82.1	13.9	.69	6-30	44-112	-.33	.45
SF	3	41.8	7.26	.61	3-15	24-60	-.43	.20
ENV F	8	113.2	17.5	.72	8-40	76-152	-.11	-.33
DA	20	52.3	14.3	.96	20-100	26-97	.48	.03

Note: MPSS= Multidimensional Perceived Social Support Scale; FR=Friends; FA= Family; SO= Significant Others; BREF QOL = Quality of Life Scale; OQ= Overall Quality of Life; PHY F = Physiological Functioning; PSY F= Psychological Functioning; SF= Social Functioning; ENV F= Environmental Functioning; DA = Death Anxiety.

Table 2 shows the descriptive, Alpha Coefficient, Kurtosis and Skewness for Multidimensional Scale of Perceived Social Support and its subscales, subscales of Quality of life and Death Anxiety Scale. The internal consistency of all measures is in the acceptable range of the study variable. Reliabilities of multidimensional perceived social support sub- scale is .86, .83, .75 and overall perceived social support scale

reliability is .90. The Alpha Reliability of the subscales of Quality of life i.e., overall quality of life scale reliability is .72, physiological functioning is .66psychological is .69, social functioning is .61, and environmental functioning is .72 and death anxiety scale reliability is .96 this shows that scales are reliable. The values for skewness (asymmetry) and kurtosis lie between -2 and +2 that are considered within acceptable range (George & Mallery, 2010). The values of kurtosis do not lie between -2 and+2 range for death anxiety scale. As far as the skewness of the data is concerned all of the values lie within the range, representing that the data is normally distributed.

Table 3

Correlation between Perceived Social Support, Quality of life, Death Anxiety and their Subscales(N=100).

Variables	1	2	3	4	5	6	7	8	9
MPSS	-	.84**	.87**	.87**	.42**	.49**	.50**	.48**	-.30**
FR		-	.56**	.59**	.41**	.36**	.41**	.29**	-.28**
FA			-	.70**	.25*	.39**	.44**	.50**	-.21*
SO				-	.41**	.51**	.44**	.47**	-.27**
OQ					.57**	.64**	.38**	.51**	-.37**
PHY F					-	.49**	.46**	.24*	-.23*
PSY F						-	.52**	.56**	-.39**
S F							-	.33**	-.16
ENV F								-	-.25*
DA									-

Note: MPSS= Multidimensional Perceived Social Support Scale; FR= friends; FA= family; SO=Significant others; OQ= Overall Quality of life; PHY F= Physiological Functioning; PSY F= Psychological Functioning; SO= Social Functioning; ENV F= Environmental Functioning; DA= Death Anxiety.

Table 3 shows that Perceived Social Support is significantly positively correlated with Quality of life which means that with the increase in social support the quality of life of the individual is also increases. Perceived Social support is negatively correlated with Death Anxiety which indicates that with the social support increases death anxiety of the individual decreases. Quality of life is significantly

negatively correlated with death anxiety which indicates that as quality of life increases death anxiety decreases. All study variable show significant results.

Linear Regression, Perceived Social Support and Death Anxiety

The relationship between perceived social support and death anxiety is explored. Therefore, linear was computed to show the effect of perceived social support on death anxiety.

Table 4

Linear Regression Analysis of Perceived Social Support as a predictor of Death Anxiety (N=100)

	Death Anxiety					
Variable	*B*	*B*	*S.E*	*P*	*95%CI*	
					LL	*UL*
Constant	76.4		9.07	.00	58.3	94.2
MPSS	-100.6	-6.04	45.7	.03	-191.3	-9.85
Friends	30.0	2.29	14.8	.04	.50	59.6
Family	34.0	2.32	15.6	.03	3.06	65.0
Sig. Others	31.9	2.02	15.7	.00	.58	63.2
R^2	.14					
ΔR^2	.10					
F	3.91					

Note: MPSS=Multidimensional Perceived Social Support Scale, S.E = Standard Error, LL= Lower Limit, UL=Upper Limit, CI=Confidence Interval

*p< .05, **p<.01,

Table 4 shows the outcome in which death anxiety is dependent variable and perceived social support and its subscales were taken as independent variables. Results revealed that overall 14% variance in death anxiety is caused by multidimensional perceived social support in which 10% of the prediction in death anxiety was done by perceived social support.

β-values shows significant negative prediction in death anxiety caused by perceived social support. It means that if perceived social support increased in participants it decreases the death anxiety.

Linear Regression of Perceived Social Support and Quality of life and its Subscales

The relationship between perceived social support and quality of life is investigated. Therefore, linear regression was computed to show the effect of perceived social support on quality of life.

Table 5

Linear Regression Analysis of Perceived Social Support as a predictor of Quality of life and its subscales, (N=100).

	Overall quality of life								
Variables	B	β	R^2	ΔR^2	*f*	*P*	S.E	95%CI	
								LL	*UL*
Constant	10.0		.18	.17	22.2	.00	3.72	2.62	17.4
MPSS	3.15	.43					.66	1.82	4.48
Constant	17.0		.11	.10	12.6	.00	2.97	11.1	22.9
Friends	1.94	.33					.54	.86	3.03
Constant	15.1		.10	.09	11.8	.00	3.61	7.96	22.3
Family	2.11	.32					.61	.89	3.33
Constant	10.5		.20	.19	24.7	.00	3.43	3.72	17.3
S. Others	3.11	.44					.62	1.87	4.35

Note: MPSS=Multidimensional Perceived Social Support Scale, S.E = Standard Error, LL= Lower Limit, UL= Upper Limit, CI= Confidence Interval

Simple linear regression is computed with Perceived Social Support is a predictor and Overall Quality of life as outcome variable. The result shows that perceived social support has significant positive effect on Quality of life (β .43, p=.00).

Friend is a subscale of Perceived Social Support is a predictor and Overall Quality of life as outcome variable. The results shows that Perceived Social Support has significant positive effect on Quality of life (β .33,p=.00).

Family is a subscale of Perceived Social Support is a predictor and Overall Quality of life as outcome variable. The results shows that Perceived Social Support has significant positive effect on Quality of life (β .32,p=.00).

Significant others is a subscale of Perceived Social Support is a predictor and Overall Quality of life as outcome variable. The results shows that Perceived Social Support has significant positive effect on Quality of life (β .44, p=.00).

Table 6

Linear Regression Analysis of Perceived Social Support as a predictor of Quality of life and its subscales, (N=100).

			Physiological functioning						
Variables	B	β	R^2	ΔR^2	*f*	*P*	S.E	95%CI	
								LL	*UL*
Constant	43.7		.18	.17	21.8	.00	8.83	26.2	61.3
MPSS	7.40	.42					1.58	4.25	10.5
Constant	54.3		.17	.16	20.5	.00	6.80	40.8	67.8
Friends	5.67	.41					1.25	3.18	8.15
Constant	62.1		.06	.05	6.72	.01	8.75	44.7	9.5
Family	3.86	.25					1.49	.90	6.82
Constant	47.7		.17	.16	20.3	.00	8.27	31.3	64.1
S. Others	6.80	.41					1.50	3.81	9.80

Note: MPSS=Multidimensional Perceived Social Support Scale, S.E= Standard Error, LL= Lower Limit, UL= Upper Limit, CI= Confidence Interval

Simple linear regression is computed with Perceived Social Support is a predictor and Physiological Functioning as outcome variable. The result shows that perceived social support has significant positive effect on physical functioning of Quality of life (β .42, p=.00).

Friend is a subscale of Perceived Social Support is a predictor and Physiological Functioning as outcome variable. The results shows that Perceived Social Support has significant positive effect on physical functioning of Quality of life (β .41, p=.00).

Family is a subscale of Perceived Social Support is a predictor and Physiological Functioning as outcome variable. The results shows that Perceived Social Support has significant positive effect on physical functioning of Quality of life (β .25 p=.01).

Significant others is a subscale of Perceived Social Support is a predictor and Physiological Functioning as outcome variable. The results shows that Perceived Social Support has significant positive effect on physical functioning of Quality of life (β .41, p=.00).

Table 7

Linear Regression Analysis of Perceived Social Support as a predictor of Quality of life and its subscales, (N=100)

	Psychological functioning								
Variables	B	β	R^2	ΔR^2	*f*	*P*	S.E	95%CI	
								LL	*UL*
Constant	38.2		.24	.23	31.5	.00	7.90	22.5	53.9
MPSS	7.97	.49					1.41	5.15	10.7
Constant	57.3		.13	.12	15.1	.00	6.48	44.5	70.2
Friends	4.64	.36					1.19	2.27	7.01
Constant	49.8		.15	.14	17.8	.00	7.75	34.5	65.2
Family	5.57	.39					1.32	2.95	8.19
Constant	39.3		.26	.26	35.9	.00	7.24	24.9	53.7
S. Others	7.91	.51					1.32	5.29	10.5

Note: MPSS=Multidimensional Perceived Social Support Scale, S.E= standard error, LL=lower limit, UL=upper limit, CI=confidence interval

Simple linear regression is computed with Perceived Social Support is a predictor and Psychological Functioning as outcome variable. The result shows that

perceived social support has significant positive effect on Psychological functioning of Quality of life (β .49,p=.00).

Friend is a subscale of Perceived Social Support is a predictor and Psychological Functioning as outcome variable. The results shows that Perceived Social Support has significant positive effect on Psychological functioning of Quality of life (β .36, p=.00).

Family is a subscale of Perceived Social Support is a predictor and Psychological Functioning as outcome variable. The results shows that Perceived Social Support has significant positive effect on Psychological functioning of Quality of life (β .39 p=.01).

Significant others is a subscale of Perceived Social Support is a predictor and Psychological Functioning as outcome variable. The results shows that Perceived Social Support has significant positive effect on Psychological functioning of Quality of life (β .51, p=.00).

Table 8

Linear Regression Analysis of Perceived Social Support as a predictor of Quality oflife and its subscales, (N=100).

			Social	Functioning					
Variables	B	β	R^2	ΔR^2	*f*	*p*	S.E	95%CI	
								LL	*UL*
Constants	18.4		.25	.24	33.7	.00	4.08	10.3	26.5
MPSS	4.25	.20					.73	2.80	5.71
Constants	27.1		.17	.16	20.9	.00	3.29	20.5	33.6
Friends	2.77	.41					.60	1.56	3.97
Constant	22.8		.19	.18	23.9	.00	3.93	15.0	30.6
Family	3.27	.44					.67	1.95	4.60
Constant	22.8		.19	.18	23.8	.00	3.95	15.0	30.6
S Others	3.51	.44					.72	2.08	4.94

Note: MPSS=Multidimensional Perceived Social Support Scale, S.E= standard error, LL= Lower Limit, UL = Upper Limit, CI= Confidence Interval

Simple linear regression is computed with Perceived Social Support is a predictor and social Functioning as outcome variable. The result shows that perceived social support has significant positive effect on Social functioning of Quality of life (β.20, p=.00).

Friend is a subscale of Perceived Social Support is a predictor and Social Functioning as outcome variable. The results shows that Perceived Social Support has significant positive effect on Social functioning of Quality of life (β .41, p=.00).

Family is a subscale of Perceived Social Support is a predictor and Social Functioning as outcome variable. The results shows that Perceived Social Support has significant positive effect on Social functioning of Quality of life (β .44 p=.01).

Significant others is a subscale of Perceived Social Support is a predictor and Social Functioning as outcome variable. The results shows that Perceived Social Support has significant positive effect on Social functioning of Quality of life (β .44, p=.00).

Table 9

Linear Regression Analysis of Perceived Social Support as a predictor of Quality of life and its subscales, (N=100)

	Environmental functioning								
Variables	B	β	R^2	ΔR^2	*f*	*P*	S.E	95%CI	
								LL	*UL*
Constant	58.6		.23	.23	30.6	.00	9.99	39.8	78.4
MPSS	9.92	.48					1.79	6.36	13.4
Constant	88.4		.08	.07	9.14	.00	8.39	71.7	105.0
Friends	4.66	.29					1.54	1.60	7.72
Constant	60.7		.25	.25	34.0	.00	9.14	42.5	78.8
Family	9.07	.50					1.55	5.99	12.1
Constant	63.4		.23	.22	29.2	.00	9.35	44.8	81.9
S. Others	9.21	.47					1.70	5.83	12.6

Note: MPSS=Multidimensional Perceived Social Support Scale, S.E= standard error, LL=lower limit, UL=upper limit, CI=confidence interval

Simple linear regression is computed with Perceived Social Support is a predictor and Environmental Functioning as outcome variable. The result shows that perceived social support has significant positive effect on Environmental functioning of Quality of life (β .48, p=.00).

Friend is a subscale of Perceived Social Support is a predictor and Environmental Functioning as outcome variable. The results shows that Perceived Social Support has significant positive effect on Environmental functioning of Quality of life (β .29, p=.00).

Family is a subscale of Perceived Social Support is a predictor and Environmental Functioning as outcome variable. The results shows that Perceived Social Support has significant positive effect on Environmental functioning of Quality of life (β .50 p=.01).

Significant others is a subscale of Perceived Social Support is a predictor and Environmental Functioning as outcome variable. The results shows that PerceivedSocial Support has significant positive effect on Environmental functioning of Quality of life (β .47, p=.00).

Gender Differences across Study Variables

Gender differences were also analyzed to see the differences between male (n=55) and female (n=45) on perceived social support, quality of life and death anxiety. So, Independent sample t-test was computed to investigate whether the difference between male and female on Perceived Social Support, Quality of life and Death Anxiety.

Table 10

Mean, Standard deviation and t value for gender differences on Perceived Social Support, Quality of life and Death Anxiety (N=100)

Variables	Male (n=55)	Female (n=45)			95%CI		Cohen's d
	M (SD)	M (SD)	t(df)	P	UL	LL	
MPSS	5.56(.92)	5.43(.79)	.75	.45	.47	-.21	0.15
FR	5.39 (1.06)	5.24(1.14)	.66	.51	.58	-.29	0.13
FA	5.85 (.97)	5.71(.99)	.67	.50	.52	-.25	0.14
SO	5.45 (.94)	5.35 (.87)	.59	.55	.47	-.25	0.11
OQ	27.8 (6.53)	26.8 (6.12)	.79	.43	3.54	-1.5	0.15
PHY F	85.9(14.35)	82.8 (15.7)	1.03	.30	9.10	-2.86	0.20
PSYF	84.0(14.25)	79.7 (13.3)	1.55	.12	9.86	-1.19	0.31
SF	43.1(7.20)	40.3 (7.12)	1.92	.05	5.63	-.08	0.39
ENV F	113.5(18.8)	112.9(16.1)	.16	.87	7.61	-6.47	0.03
DA	49.8 (16.3)	55.3 (11.0)	-1.91	.05	.21	-11.1	0.39

Note: MPSS= Multidimensional Perceived Social Support Scale; FR = Friends; FA = Family; SO = Significant Others; BREF QOL = Quality of Life Scale; OQ= Overall Quality of Life; PHY F = Physiological Functioning; PSY F= Psychological Functioning; SF = Social Functioning; ENV F = Environmental Functioning; DA = Death Anxiety; CI = Confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit.

Table 10 illustrates the results of t-test for comparison of male and female mean differences on Perceived Social Support, Quality of life, Death Anxiety and their subscales. There is no significant gender difference on perceived social support and quality of life. However, there is a significant difference exist related to the social domain of the quality of life and on death anxiety there is a significant difference.

Results show that female experience more death anxiety as compared to the males. Cohen's effect size value (d = 0.39) reflects the main difference here moderate effect, and results of the social domain of the quality of life show that male experience good quality of life in social domain as compared to female. Cohen's effect size value(d=0.39).

Family System across Study Variables

Family systems were also analyzed to see the differences between nuclear (n=60) and joint (n=40). So, Independent sample t-test was computed to investigate the difference between nuclear and joint on study variables.

Table 11

Mean, Standard deviation and t value for family system on Perceived Social Support, Quality of life and Death Anxiety (N=100)

Variables	Nuclear (n=60)	Joint (n=40)			95%CI		Cohen's d
	M (SD)	M (SD)	t(df)	P	UL	LL	
MPSS	5.41(.86)	5.66(.84)	-1.42	.15	.09	-.59	0.29
FR	5.18(1.14)	5.54(.99)	-1.63	.10	.07	-.80	0.33
FA	5.70(1.01)	5.92(.93)	-1.07	.28	.18	-.61	0.22
SO	5.35(.92)	5.49(.90)	-.74	.45	.23	-.51	0.15
OQ	27.7(6.05)	27.6(6.82)	-.25	.79	2.24	-2.91	0.01
PHY F	84.5(14.2)	84.6(16.2)	-.02	.98	6.04	-6.17	0.00
PSYF	80.6(13.7)	84.4(14.2)	-1.32	.18	1.86	-9.40	0.27
SF	41.7(7.45)	42.1(7.07)	-.24	.80	2.59	-3.32	0.05
ENV F	112.4(16.03)	114.5(19.8)	-.57	.56	5.08	-9.20	0.11
DA	54.5(14.9)	48.9 (12.9)	1.96	.05	11.4	-.06	0.04

Note: MPSS = Multidimensional Perceived Social Support Scale; FR = Friends; FA = Family; SO = Significant Others; BREF QOL = Quality of Life Scale; OQ= Overall Quality of Life; PHY F = Physiological Functioning; PSY F= Psychological Functioning; SF= Social Functioning; ENV F= Environmental Functioning; DA = Death Anxiety; CI = Confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit.

Table 11 illustrates the results of t-test for comparison of gender differences on Perceived Social Support, Quality of life, Death Anxiety and their subscales. There

is no significant difference on perceived social support and quality of life. However, there is a significant difference on death anxiety. Result shows that an individual who lives in nuclear family system experience more death anxiety as compared to the joint family system. Cohen's effect size value (d = 0.04) reflects the main difference here moderateeffect.

Mean Differences

To compare the mean differences of Participant's occupation along perceived social support, quality of life and death anxiety one-way ANOVA was performed, only for significant F- value of post hoc analysis was done to check the differences between groups for respective variables (see Tables 12, 13,14)

Table 12

One WAY Analysis across differences along Occupations (N = 100)

Variable	Housewif		Business		Midwife		Job		Retired		Teacher		*f*	*P*	*I-J*	*D(i-j)*	*95%CI*	
s	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*					*LL*	*UL*
MPSS	5.51	.69	5.82	.41	3.62	1.70	5.53	.90	5.47	1.04	5.35	.57	2.52	.03	1<3	1.89*	.06	3.71
															2<3	2.20*	.31	4.08
															4>3	1.90*	.03	3.78
															5>3	1.85*	.01	3.68
FR	5.42	1.04	5.75	.52	3.50	1.76	5.36	1.24	5.16	1.20	4.95	.73	1.93	.09				
FA	5.87	.80	5.96	.45	3.62	1.94	5.80	.85	5.82	1.13	5.30	1.55	2.52	.03	1>3	2.25*	.17	4.32
															2>3	2.34*	.19	4.48
															4>3	2.18*	.05	4.31
															5>3	2.20*	.11	4.28
SO	5.25	.80	5.76	.56	3.75	1.41	5.42	.93	5.43	1.03	5.80	.81	2.27	.05	2>3	2.01*	.00	4.02
OQ	26.6	6.63	29.6	2.94	20.0	5.65	27.2	8.74	27.4	5.73	28.8	5.21	1.05	.39				
PHY F	84.0	16.0	85.0	10.0	78.0	2.82	85.6	15.8	84.9	15.4	83.2	22.5	.11	.98				
PSYF	78.5	14.5	85.1	14.0	64.0	22.6	82.5	14.7	84.8	12.1	86.4	9.20	1.61	1.1				
SF	40.1	7.70	45.0	4.89	32.0	11.3	43.5	7.46	41.3	7.03	44.8	5.21	2.17	.06				
ENV F	112.5	16.1	122.2	16.0	94.0	25.4	116.7	17.5	110.3	19.1	104.8	9.12	1.86	.10				
DA	55.3	10.5	49.4	15.0	67.5	6.36	57.9	19.6	47.5	13.3	44.0	8.74	2.50	.03				

Note: MPSS= Multidimensional Perceived Social Support Scale; FR=Friends; FA= Family; SO= Significant Others; BREF QOL = Quality of Life Scale; OQ= Overall Quality of Life; PHY F = Physiological Functioning; PSY F= Psychological Functioning; SF= Social Functioning; ENV F= Environmental Functioning; DA = Death Anxiety*$p < .05$.**$p < .01$.

Table 12 illustrates significant results (F =2.52, p <.05) for Multidimensional Perceived Social Support. Results revealed that participants belonging from personal business perceived more social support as compared to participants from other occupation. Participants belonging from personal business also perceive more social support from family (F =2.52, p < .05) as compare to friends and from significant others. Results indicates that participants belonging from teacher occupation perceive more social support (F =2.27, p = .05) as compared to other occupations participants.

Table 13

One Way Analysis across differences along Education (N=100)

Variables	Primary		Middle		Metric		Intermediate		Bachelors		Masters		*f*	*P*	*I-J*	*D(i-j)*	*95%CI*	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*					*LL*	*UL*
MPSS	5.02	1.24	5.62	.42	5.46	.80	5.69	.79	5.80	.49	5.67	.58	2.18	.06				
FR	4.73	1.42	5.20	.69	5.39	1.06	5.68	.88	5.68	.72	5.31	1.08	2.06	.07				
FA	5.32	1.33	6.16	.70	5.79	.96	5.93	.87	6.03	.43	5.84	.94	1.44	.21				
SO	4.97	1.20	5.50	.52	5.22	.91	5.45	.82	5.70	.65	5.87	.59	2.50	.03	2<7	-.89*	-1.77	-.02
OQ	25.0	6.55	27.3	7.33	24.1	5.71	29.0	6.45	31.0	4.50	29.7	5.45	3.94	.00	2<6	-5.90*	-11.7	-.04
															4<6	-2.00*	-8.31	4.31
															6>4	6.82*	1.01	12.6
PHY F	79.2	14.1	94.6	15.3	80.3	14.8	87.7	17.1	87.0	7.51	89.0	17.3	2.05	.07				
PSYF	77.0	14.7	79.3	18.6	77.9	11.3	81.5	14.5	91.4	12.9	88.0	9.96	3.41	.00	2<6	-14.4*	-27.5	-1.35
															4<6	-13.5*	-26.5	-.55
SF	38.0	7.06	38.6	7.86	41.5	7.00	43.5	9.10	45.0	4.73	43.5	5.63	2.62	.02	2<6	-7.00*	-13.8	-.12
ENV F	107.4	20.8	123.3	10.5	105.3	15.5	114.7	16.7	124.5	16.7	117.0	11.3	3.72	.00	2<6	-17.1*	-33.4	-.77
															4<6	-19.1*	-35.3	-2.99
DA	56.8	14.7	52.8	8.37	53.5	14.0	49.3	15.2	50.0	15.2	50.0	15.0	.74	.59				

Note: MPSS= Multidimensional Perceived Social Support Scale; FR=Friends; FA= Family; SO= Significant Others; BREF QOL = Quality of Life Scale; OQ= Overall Quality of Life; PHY F = Physiological Functioning; PSY F= Psychological Functioning; SF= Social Functioning; ENV F= Environmental Functioning; DA = Death Anxiety; CI = Confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit.*$p < .05$.**$p < .01$.

In table 13 results produced a significant results (f = 2.50, p <.05) for the Significant others subscale of Multidimensional Perceived Social Support. Results show that participants who have masters' education perceived more social support as compared to people who have below masters' degree. And also produced significant results on quality of life domains, (f =3.94, p < .05) has well on overall quality of life, significant results (f = 3.41, p<.05) on psychological quality of life and in social domain of the quality of life have also significant results (f = 2.62, p<.05) for those who have bachelors education as compared to the others.

Table 14

One Way Analysis across differences between Incomes

Variables	Upto 30,000		31,000 to 50,000		51,000 or above		*f*	*p*	*I-J*	*D(i-j)*	*95%CI*	
											LL	*UL*
	M	*SD*	*M*	*SD*	*M*	*SD*						
MPSS	5.26	1.03	5.39	.87	5.82	.48	5.01	.00	1<3	-.55*	-.99	-.12
FR	4.90	1.27	5.26	1.11	5.82	.55	8.60	.00	1<3	-.91*	-1.45	-.37
FA	5.59	1.17	5.75	1.03	6.03	.61	2.19	.11				
SO	5.29	1.05	5.16	.85	5.63	.71	2.11	.12				
OQ	25.1	6.00	27.1	7.04	30.1	5.50	7.44	.00	1<3	-4.97*	-8.11	-1.83
PHY F	81.7	14.4	87.1	21.8	86.9	12.4	1.52	.22				
PSYF	78.7	12.6	81.2	15.0	86.4	14.1	3.48	.03	1<3	-7.72*	-14.9	-.55
SF	39.2	6.72	42.2	8.69	44.8	6.28	7.11	.00	1<3	-5.58*	-9.19	-1.97
ENV F	105.	916.6	115.	113.4	121.	116.5	9.49	.00	1<3	-15.2*	-23.7	-6.66
DA	53.0	13.4	56.7	17.2	49.9	14.3	1.27	.28				

Note: MPSS= Multidimensional Perceived Social Support Scale; FR=Friends; FA= Family; SO= Significant Others; BREF QOL = Quality of Life Scale; OQ= Overall Quality of Life; PHY F = Physiological Functioning; PSY F= Psychological Functioning; SF= Social Functioning; ENV F= Environmental Functioning; DA = Death Anxiety; CI = Confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit.

*$p < .05$. **$p < .01$.

In table 14 produced a significant results (F =5.01, p <.05) for Multidimensional Perceived Social Support. Results show that persons who belongs to 51,000 or above income perceived more social support as compared to people

related to below income group. Persons who belongs 51,000 or above income also perceive more social support from friends ($F = 8.60$, $p < .05$) as compare to family and in significant others support. And in overall quality of life significant result shows ($f = 7.44$, $p < .05$) from those who belongs to the 51,000 or above income. And also show significant results in the psychological domain ($f = 3.48$, $p < .05$), social ($f = 7.11$, $p < .05$), and environmental domain ($f = 9.49$, $p < .05$) is better in quality of life who belongs to 51,000 or above income.

DISCUSSION

Chapter 4

DISCUSSION

The current research is designed to investigate the Effects of Perceived Social Support on Quality of life and Death Anxiety in patients with Coronary Heart Disease. The goal of the study is to determine the relationship among perceived social support, quality of life and death anxiety and to find out the role of several demographic variables in association to perceived social support, quality of life and death anxiety in patients with coronary heart disease. It was hypothesized that Perceived Social support, Quality of life and Death anxiety are significantly related to each other. Further it was also hypothesized that perceived social support would be a positive predictor of quality of life. It was also hypothesized that perceived social support would be negative predictor of death anxiety.

To find out the psychometric accuracy of the scales used in the research alpha reliabilities were calculated. It is clear that the values of reliability for all the scales used in the current study were seen to be good i.e. the Cronbach α reliability for multidimensional perceived social support scale (MPSS), (α=.90) and reliabilities of sub-scales of MPSS are friends (α=.86), family (α=.83), and significant others (α=.75). Alpha reliability for WHO QOL-BREF and its subscales, Overall QOL is α=.72, physiological functioning is α=.66, psychological functioning α=.69, social functioning is α=.61 and environmental functioning is α=.72. Alpha reliability for death anxiety isα=.96.

Regarding the hypothesis testing, the first hypothesis is that Perceived Social Support would be positively related with Quality of life which means the high level social support is also supreme level of the quality of life of the individual. The findings revealed that there is highly significant positive relationship between perceive social support and quality of life, supported the study hypothesis. It means when friends, family and significant others provide better social support and help the person, individual perceive more social support and it will also enhance the quality of life. Previous researches indicated that changes in social support were significantly associated with quality of life (Bennett et al., 2001). Further research indicates that positive social support is associated with improved quality of life and better outcomes

in patients with coronary heart disease (Lett et al., 2007).Perceived social support was an important factor for better Quality of life (Ng et al., 2015).Reinforcing and increasing social support has been suggested to be an effective intervention that may improve quality of life as well as reduce mortality and morbidity, in patients with Coronary heart disease (Dunbar et al., 2008).

Perceived Social support would be negatively related with Death Anxiety is the second hypothesis of the present study which indicates that when the social support increases, death anxiety of the individual decreases. The results revealed that Perceived Social Support is significantly negatively related with Death Anxiety hence, the hypothesis is confirmed. It means when an individual perceived more social support from friends, family and significant others, and spend time with them and not live in loneliness it will automatically decrease the level of Death Anxiety. Previous researches show that increase in Social Support has been associated with decrease in overall Death Anxiety (Malinauskas, 2010 & Young, 2006). Further researches reported that Perceived positive support from family was strongly related to lower death anxiety as seen in a study of patients, where a greater social support was seen in those who had good prognosis (Dunkel-Schetter, 1984).A plethora of studies concluded that social support was negatively associated with death anxiety (Peterson, 1991). Further recent research also determined significant negative relationship between the death anxiety and social support (Nejad et al., 2017).

Regarding the third hypothesis is that Quality of life would be negatively related with Death Anxiety which indicates that when quality of life increases it automatically decreases the level of death anxiety. It means that when an individual physical, psychological, social functioning are good and better support provided by the others and live in good environment and socially adjust it will enhance the quality of life and individual live better life it automatically decrease the level of Death Anxiety. The present study of the results finding shows that Quality of would be negatively related with Death Anxiety has supported the study hypothesis. Previous research found that significant inverse relationship between death anxiety and quality of life (Soleimani et al., 2016). All study variables show significant results. Higher anxiety is predictive of worse quality of life among patients with cardiovascular disease (Mayou et al., 2000). Sherman et al., 2010 also identified that fear of death can affect the quality of life of patients with life-threatening illnesses.

The fourth hypothesis is Perceived Social Support would be the positive predictor of Quality of life. The present findings show the significant results on Perceived Social Support and its subscale as a predictor and Quality of life and its subscale as an outcome have been proved. When an individual perceived more social support from family, friends and significant others and spend time with them it will enhance the quality of life. Previous researches reported that social support was significantly associated with quality of life (Bennet et al., 2001). Subscales of Perceived Social Support is also the positive predictors of quality of life in domains (physiological, psychological, social and environmental functioning) are significant result. Previous researches reported the quality of life in heart failure patients indicated that the patients' social support and quality of life levels were moderate. It was also stated that there was a moderately significant relationship between social support perceived by the patients and physical health sub-scale of quality of life, and that the patients needed more support when their physical health deteriorated (Bennett et al., 2001).

The fifth hypothesis states the "Perceived Social Support would be the negative predictor of Death Anxiety". Thus the present study results indicate that Perceived Social Support cause decrease in death anxiety, which means when an individual Perceived Social Support it will predict decrease in death anxiety. Previous recent research also determined significant negative relationship between the fear of death and social support (Nejad et al., 2017).Further study concluded that social support was negatively associated with death anxiety (Peterson, 1991). Subscale of Perceived Social Support also negatively associated with death anxiety. Previous researches reported that Perceived positive support from family was strongly related to lower death anxiety as seen in a study of patients, where a greater social support was seen in those who had good prognosis (Dunkel-Schetter, 1984).

In this study, to assess the gender differences used Independent sample t-test for the comparison of male and female mean differences on Perceived Social Support, Quality of life, Death Anxiety and their subscales. The findings of the present research indicate that female show more death anxiety as compared to the male has been proved. Therefore, sixth hypothesis that female would perceive more Death Anxiety as compared to the male has been proved. Femalesare more sensitive and they are more likely to internalize their problems as compared to male, so they might

perceivemore death Anxiety as compared to males. Previous researches report that females experience higher death anxiety as compared to the males (Hui, Chan, & Chan, 1989). The study shows that there is a significant difference exists related to the social domain of the quality of life. Previous research indicates that classification differences, women had worse physical and social functioning than did men (Riedinger et al.,2001).

Significant differences among the family system with the study variables. Family systems were also analyzed to see the differences between nuclear and joint. So, t-test was computed to investigate whether the difference between nuclear and joint on Perceived Social Support, Quality of life and Death Anxiety. Result shows that there is no significant difference found in family system on Perceived social support and quality of life. It means that when an individual perceived social support it will enhance quality of life whether a person a live in joint and nuclear family system. It might be not effect on the individual. But on death anxiety the results show significant differences. According to the results people living in nuclear family system reveal more death anxiety as compared to those living in joint family system. It means when a person with serious illness cause death anxiety but in a joint family system person spend time with their family members and especially spend time with their grandchildren. A person feels happy and live better quality of life it will automatically decrease death anxiety and when an individual live in nuclear family system not spend much time with them and feel lonely might be cause death anxiety. Previous research reported that Heart patients living in nuclear family systems have greater fear of death and higher depression than those living in joint family systems (Fatima, & Shafiq, 2017).

In this study to assess the occupation, income and education effect on Perceived Social Support, quality of life and death anxiety among patients with coronary heart disease. To compute the findings used one way ANOVA across occupation, education and income. The present study findings shows significant results on Perceived Social Support that person who belongs to personal business perceive more social support as compared to people related to the other occupations and less death anxiety. And those who have masters education perceive social support with significant others and better overall quality of life and also better social, psychological and environmental functioning. According to the Pakistani perspective

the person income up to 30,000 consider lower socio-economic status, 31,000 to50,000 consider middle status and above 51,000 considered high socio-economic status (Husain, & Mahmood, 2001). The present study result shows that who belongs to upper class family perceived more social support and especially from friends and quality of life is also better as compared to the middle or lower socio economic status. It means that when a person high education, personal business and earn more income, perceive social support and improve quality of life and perceive less death anxiety.

Conclusion

The findings of the study revealed that Perceived Social Support is positively related with Quality of life and negatively associated with the Death Anxiety in patients with Coronary heart disease. The Perceived Social Support positively predicts Quality of life and negatively predicts Death anxiety in patients with Coronary heart disease. Hence, it is concluded that perceived social support improve the quality of life and decrease the level of death anxiety in patients with coronary heart disease. According to the demographic variables (gender, education, family system), the study findings show that women perceive higher death anxiety and those who have higher education, personal business and good level of income perceived more social support and improve quality of life and level of death anxiety be decrease.

This study reveal that, social support is effective, and further dimensions of perceived social support i.e. friends, family and significant others play a significant role to improve the quality of life and decrease the death anxiety in patients. Further, study show significant gender differences on death anxiety. Perceived social support have great impact on patient's health and improve quality of life. It is also realizes that need of education, advice, information, counseling, motivation are essential for the patients have having coronary heart disease. The present observation on perceived social support, quality of life and death anxiety will be useful in planning services for the coronary heart patients in Pakistan and in other countries of similar socio-cultural setting.

Limitation and Suggestion

The following limitation however should also be noted while evaluating the study findings. There are also some suggestions for the future research.

1. Limited time was available to conduct the research also the sample was too small to complete the requirement of study.
2. The sample of present research was only consisted of individuals from Rawalpindi and Islamabad in future researches data must be taken from different cities.
3. In order to overcome the limitations some suggestions for the future research are advised. The time of the research should be increased. The sample size could be increased for better generalization for the findings in future researches.
4. Mediation and Moderation can be conducted in order to expand the researchanalysis.

Implications

1. This research can be useful for the counselors and psychologist to overcome specific problems related to research.
2. The research findings showed that perceived social support as a (friends, family and significant others) might be useful for improved quality of life and help to decrease death anxiety in patients and improve psychological and physical health so it is recommended that doctors can apply these tips to improve the health of heart patients.
3. This research would contribute to the literature by emphasizing the significance of perceived social support on quality of life and death anxiety in coronary heartpatients.
4. To study the perceived social support, quality of life and death anxiety leads to better understanding in the etiology of quality of life and death anxiety and to enhance social support especially to a heart patients.

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APPENDICES

Appendix - A

Informed Consent

میں شائلہ خورشید قومی ادارہ نفسیات قائداعظم یونیورسٹی اسلام آباد کی ایم ایس سی کی طالبہ ہوں اور اپنی ڈگری کے حصول کے لیے ایک ریسرچ کر رہی ہوں جس
مریضوں میں سماجی حمایت کی وجہ سے مرتب ہونے والی ذہنی اور نفسیاتی کیفیات اور تبدیلیوں کو جانچنا ہے۔ یہ ایک ایسا ادارہ ہے جو تدریس و تعلیم کے ساتھ ان
مسائل پر بھی ریسرچ کرتا ہے۔ موجودہ ریسرچ بھی اسی سلسلے کی ایک کڑی ہے۔ جس کے لیے ہمیں آپ کا تعاون درکار ہے۔

آپ کی خدمت میں کچھ سوالنامے پیش کیے جا رہے ہیں۔ آپ سے درخواست ہے کہ سوالنامے کے ساتھ دی گئی ہدایات کو غور سے پڑھیں اور ان کی روشنی میں جو
سے درخواست ہے کہ آپ ممکنہ حد تک ایمانداری سے جواب دیں۔

آپ کو یقین دلایا جاتا ہے کہ آپ کی معلومات صیغہ راز میں رکھی جائے گی اور صرف تحقیقی مقاصد کے لیے استعمال کی جائیں گی۔ برائے مہربانی کوئی بھی بیان خالی
تمام بیانات کے متعلق اپنے جوابات کا اظہار ضرور کریں۔

آپ کے تعاون کا شکریہ۔

اگر آپ اس تحقیق کا حصہ بننا چاہتے ہیں تو نیچے دی گئی جگہ پر دستخط کریں۔

دستخط:

ذاتی دستخط: Shaila

نیشنل انسٹیوٹ آف سائیکالوجی، قائداعظم یونیورسٹی اس

ذاتی کوائف

نام _____ عمر: _____

جنس: مرد _____ عورت _____

پیشہ: _____ _____

ماہانہ آمدنی: _____ تعلیم: _____

ازدواجی حیثیت: شادی شدہ _____ غیر شادی شدہ _____

بیماری: _____ مدت بیماری _____ موجودہ علاج _____

خاندانی نظام: مشترکہ _____ انفرادی _____

Multidimensional Percieved Social Support Scale (MPSS)

ان بیانات میں سے جو آپ کو اپنی شخصیت کے مطابق محسوس ہو، اس کے سامنے بنے ہوئے مناسب خانے میں درست (✓) کا نشان لگائیں۔

نمبر شمار	بیانات	یقینی اختلاف	پُرزور اختلاف	تھوڑا اختلاف	پتہ نہیں	تھوڑا متفق
1	ایک خاص شخص ہے جب مجھے اس کی ضرورت ہوتی ہے وہ میرے آس پاس ہوتا ہے۔					
2	ایک ایسا شخص موجود ہے جس کے ساتھ میں اپنی خوشیاں اور دکھ بانٹ سکتا/سکتی ہوں۔					
3	میرے گھر والے واقعی مدد کرنے کی کوشش کرتے ہیں۔					
4	میرے گھر والے وہ جذباتی مدد اور سہارا مہیا کرتے ہیں جس کی مجھے ضرورت ہوتی ہے۔					
5	ایک خاص شخص موجود ہے جو حقیقتاً میرے سکون کا باعث ہے۔					
6	میرے دوست حقیقتاً میری مدد کرنے کی کوشش کرتے ہیں۔					
7	کچھ غلط ہو جانے پر میں اپنے دوستوں پر انحصار کر سکتا/سکتی ہوں۔					
8	میں اپنے گھر والوں سے اپنے مسائل پر بات کر سکتا/سکتی ہوں۔					
9	میرے ایسے دوست ہیں جن کے ساتھ میں خوشیاں اور غم بانٹ سکتا/سکتی ہوں۔					
10	میری زندگی میں ایک خاص شخص ہے جو میرے احساسات کا خیال رکھتا ہے۔					
11	کسی بھی فیصلے پر پہنچنے کے لئے میرے گھر والے میری مدد کے لئے تیار ہیں۔					
12	میں اپنے مسائل کے بارے میں اپنے دوستوں سے بات کر سکتا/سکتی ہوں۔					

WHO QOL-BREF

برائے مہربانی ہر سوال کو غور سے پڑھیں اور پچھلے دو ہفتوں کے دوران اپنے احساسات کی روشنی میں سکیل میں دیئے گئے اس نمبر پر دائرہ لگائیں جو آپ کے احساسات کی بہترین ترجمانی کرتا ہوں۔

	بہت خراب	خراب	نہ خراب نہ اچھی	اچھی	بہت ا
1۔آپ اپنے معیار زندگی کو کس سطح پر پاتے ہیں؟	1	2	3	4	5

	بہت غیر مطمئن	کافی حد تک غیر مطمئن	نہ مطمئن نہ غیر مطمئن	مطمئن	بہت مط
2۔آپ اپنی صحت کے بارے میں کس حد تک مطمئن ہیں؟	1	2	3	4	5

مندرجہ ذیل سوالات ان تجربات سے متعلق ہیں جو پچھلے دو ہفتوں کے دوران آپ پر گزرے۔

	بالکل نہیں	معمولی مقدار میں	درمیانی مقدار میں	کافی مقدار میں	انتہائی مقدا
3۔جو کام آپ کو کرنے کی ضرورت ہے آپ کا جسمانی درد اس میں کس حد تک رکاوٹ بنتا ہے؟	1	2	3	4	5
4۔آپ کو اپنی روزمرہ زندگی میں کام کرنے کے لئے طبی علاج کی کتنی ضرورت ہے؟	1	2	3	4	5
5۔آپ زندگی سے کتنا لطف اندوز ہوتے ہیں؟	1	2	3	4	5
6۔آپ کس حد تک اپنی زندگی کو بامعنی محسوس کرتے ہیں؟	1	2	3	4	5

	بالکل نہیں	معمولی	درمیانہ/درمیانی	بہت	بہت ز
7۔آپ میں توجہ مرکوز کرنے کی صلاحیت کتنی اچھی ہے؟	1	2	3	4	5
8۔آپ اپنی روزمرہ زندگی میں خود کو کتنا محفوظ محسوس کرتے ہیں؟	1	2	3	4	5
9۔آپ کا طبعی ماحول کتنا صحت مند ہے؟	1	2	3	4	5

مندرجہ ذیل سوالات ان تجربات سے متعلق ہیں جو پچھلے دو ہفتوں کے دوران آپ پر گزرے۔

	بالکل نہیں	تھوڑا سا/تھوڑی سی	کچھ حد تک	بہت حد تک	مکمل
10۔کیا آپ روزمرہ زندگی کے لئے کافی توانائی رکھتے ہیں؟	1	2	3	4	5
11۔کیا آپ اپنی جسمانی شکل وصورت کو قبول کر پاتے/پاتی ہیں؟	1	2	3	4	5

	بالکل نہیں	تھوڑا سا/تھوڑی سی	کچھ حد تک	بہت حد تک	مکمل
12۔کیا آپ کے پاس اپنی ضروریات پوری کرنے کے لئے کافی رقم ہے؟	1	2	3	4	5
13۔آپ کو روزمرہ کی زندگی کے لئے درکار معلومات کتنی میسر ہیں؟	1	2	3	4	5
14۔آپ کو فرصت کے لمحات گزارنے کے مواقع کس حد تک میسر ہیں؟	1	2	3	4	5
15۔آپ اپنے آپ کو کسی کام کے لئے جسمانی طور پر آمادہ کر پاتے ہیں؟	1	2	3	4	5

مندرجہ ذیل سوالات میں پوچھا گیا ہے کہ آپ نے اپنی زندگی کے مختلف پہلوؤں کے بارے میں گزشتہ دو ہفتوں کے دوران کتنا اچھا اور مطمئن محسوس کیا۔

	بہت غیر مطمئن	کافی حد تک غیر مطمئن	نہ مطمئن نہ ہی غیر مطمئن	مطمئن	بہت مط
16۔آپ اپنی نیند سے کتنے مطمئن ہیں؟	1	2	3	4	5
17۔آپ اپنی روزمرہ زندگی کے معمولات ادا کرنے کی اہلیت سے کتنا مطمئن ہیں؟	1	2	3	4	5
18۔آپ کام کے لئے اپنی استعداد سے کتنا مطمئن ہیں؟	1	2	3	4	5
19۔آپ اپنے آپ سے کتنا مطمئن ہیں؟	1	2	3	4	5
20۔آپ اپنے ذاتی تعلقات سے کتنا مطمئن ہیں؟	1	2	3	4	5
21۔آپ اپنی جنسی زندگی سے کتنے مطمئن ہیں؟	1	2	3	4	5
22۔آپ اپنے دوستوں سے ملنے والے سہارے سے کتنے مطمئن ہیں؟	1	2	3	4	5
23۔آپ جس جگہ رہتے ہیں وہاں کے حالات سے کتنا مطمئن ہیں؟	1	2	3	4	5
24۔آپ طبی سہولیات تک اپنی رسائی سے کتنا مطمئن ہیں؟	1	2	3	4	5
25۔آپ اپنے ذرائع آمدورفت سے کتنا مطمئن ہیں؟	1	2	3	4	5

	کبھی نہیں	شاذ و نادر	بعض اوقات	اکثر اوقات	ہمیشہ
26۔آپ کو کتنی بار منفی احساسات جیسا کہ افسردگی، مایوسی، اضطراب، ڈیپریشن ہوتے ہیں؟	1	2	3	4	5

Appendix-E

Death Anxiety Scale

ذیل میں دیئے گئے بیانات کو غور سے پڑھیں۔ ہر بیان کے سامنے پانچ درجات دیئے گئے ہیں۔ آپ سے درخواست ہے کہ ہر بیا
دیئے گئے درجات میں سے اُس درجہ پر نشان لگائیں جو آپ کی شخصیت سے زیادہ مطابقت رکھتا ہے۔

نمبر شمار	بیانات	ہمیشہ	اکثر	کبھی کبھار	بہت کم
1	اگر چہ میں کوئی میت / لاش دیکھ لوں تو کئی دنوں تک خوفناک خیالات میرے ذہن میں آتے رہتے ہیں۔				
2	جب میں سوچتا / سوچتی ہوں کہ قیامت کے دن مجھے اپنے اعمال کے لئے خدا کے سامنے جوابدہ ہونا ہے تو مجھ پر خوف غالب ہو جاتا ہے۔				
3	میں جنازہ دیکھ کر بہت زیادہ پریشان ہو جاتا / جاتی ہوں۔				
4	میں اپنی موت کے تصور سے بے چین ہو جاتا / جاتی ہوں۔				
5	میں سوچتا / سوچتی ہوں کہ معلوم نہیں وہ کون سی بیماری ہے جو میرے لئے موت کا باعث بنے گی۔				
6	میں مرتے وقت ہونے والی تکلیف کے بارے میں سوچ کر پریشان ہو جاتا / جاتی ہوں۔				
7	موت کے بارے میں خیالات مجھے پریشان کرتے ہیں۔				
8	میں موت سے اُس وقت خوفزدہ ہو جاتا / جاتی ہوں جب میں آخرت میں اپنے گناہوں کی سزا کے بارے میں سوچتا / سوچتی ہوں۔				
9	جب قبرستان کے پاس سے گزرتا / گزارتی ہوں تو پریشان ہو جاتا / جاتی ہوں۔				
10	یہ احساس مجھے پریشان کر دیتا ہے کہ میں مرنے کے بعد بہت سی چیزوں سے محروم ہو جاؤں گا / گی۔				
11	میں کسی بڑے آپریشن کے لئے بے ہوشی سے ڈرتا / ڈرتی ہوں۔				
12	بعض اوقات جب میں موت کا خیال اپنے ذہن سے نکال سکتا / سکتی تو میں پریشان ہو جاتا / جاتی ہوں۔				
13	جب میں بیمار ہو جاتا / جاتی ہوں تو موت کے بارے میں سوچتا / سوچتی ہوں۔				

14	یہ سوچ کہ مرنے کے بعد میں اپنے عزیزوں کا خیال نہیں رکھ سکوں گا/گی مجھے پریشان کر دیتی ہے۔				
15	جب میں سوچتا/سوچتی ہوں کہ زندگی کتنی مختصر ہے تو میں پریشان ہو جاتا/جاتی ہوں۔				
16	کچھ لمحات ایسے بھی ہوتے ہیں کہ جب میں اپنی موت کے بارے میں سوچ کر بہت پریشان ہو جاتا/جاتی ہوں۔				
17	میں موت کے بعد دوزخ میں جانے سے خوفزدہ رہتا/رہتی ہوں۔				-
18	جب لوگ مجھ سے موت کے بارے میں بات کرتے ہیں تو میں گھبرا جاتا/جاتی ہوں۔				-
19	میرے لئے یہ جاننا کہ میری زندگی بس چند ماہ باقی ہے بہت خوفناک تجربہ ہوگا۔				
20	جب میں قبر کے اندھیرے کے بارے میں سوچتا/سوچتی ہوں تو خوفزدہ ہو جاتا/جاتی ہوں۔				

Multidimensional Scale of Perceived Social Support (MSPSS)

The Multidimensional Scale of Perceived Social Support (MSPSS) is a brief research tool designed to measure perceptions of support from 3 sources: Family, Friends, and a Significant Other. The scale is comprised of a total of 12 items, with 4 items for each subscale. My colleagues, Nancy Dahlem, Sara Zimet, Gordon Farley, and I (Gregory Zimet) first published on the MSPSS in the Journal of Personality Assessment in 1988.

Across many studies, the MSPSS has been shown to have good internal and test-retest reliability, good validity, and a fairly stable factorial structure. It has been translated into many languages, including Urdu, Hebrew, Tamil, Danish, Farsi (Persian), French, Italian, Korean, Lithuanian, Hausa, Norwegian, Simplified Chinese, Traditional Chinese, Slovene, Malay, Slovak, Spanish, Swedish, Polish, Portuguese, Romanian, and Thai. For linguistically-validated translations, consider using TransPerfect.

The MSPSS is free to use. Please simply credit the following paper (and any others that are relevant), if you use the scale:

Zimet GD, Dahlem NW, Zimet SG, Farley GK. The Multidimensional Scale of Perceived Social Support. Journal of Personality Assessment 1988;52:30-41.

MSPSS.pdf

[illegible]@iu.edu

Appendix- G

Fwd: QoL

Inbox x

Psychiatry Department SIMS
to me

My apologies for a delayed response. Please find attached the Quality of life scale and the scale. Take care

Regards

Dr. M. Nasar Sayeed Khan

Professor of Psychiatry
President,Pakistan Psychiatric Society
Corresponding address: 13-B, Aibak Block Garden Town Lahore, Pakistan.

---------- Forwarded message ----------
From: **Psychiatry Department SIMS** <psychiatry.sims@gmail.com>
Date: Mon, Aug 1, 2016 at 7:44 AM
Subject: QoL
To: amtulrehmanmufti@outlook.com

My apologies for a delayed response. Please find attached the Quality of life scale and the scale. Take care

Regards