

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

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Abstract

This study examined the impact of perceived social support on quality of life and death anxiety in individuals with coronary heart disease. For this purpose, a sample of 100 patients (Male=55, Female=45) with coronary heart disease were selected. Data was gathered through the purposive sampling technique from different hospitals in Islamabad and Rawalpindi. To study the variable of interest, the Multidimensional Scale of Perceived Social Support, translated by Jabeen and Khalid (2010), was used to measure Perceived Social Support, while the Quality of Life, translated by Khan, et al (2003), was used to measure Quality of Life. The level of death anxiety in patients with Coronary heart disease was measured using the Goreja and Pervaz (2000) Death Anxiety Scale. Data was analyzed on SPSS version 21. Perceived Social Support was employed as a predictor, as well as Quality of Life and Death Anxiety as outcomes, in a regression analysis. Perceived social support has a major impact on both quality of life and death anxiety. Furthermore, counselors and psychologists would benefit from this research because it emphasizes the importance of perceived social support, quality of life, and death anxiety in coronary heart patients. It can also add to the literature by emphasizing the importance of perceived social support, quality of life, and death anxiety in patients with coronary heart disease.

Key Words: Perceived Social Support, Quality of Life, Death Anxiety & Patients with Coronary Heart Disease

INTRODUCTION

Coronary heart disease is one of the most serious medical problems of the twenty-first century. The death rate from coronary heart disease is rapidly increasing today (Wong et al., 2014). The Pakistani population is one of the most vulnerable to coronary heart disease in 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. The importance of social support in maintaining one's health cannot be overstated. In recent years, the necessity of social support for maintaining health has grown even more. Patients with heart failure can benefit from social support to better manage their symptoms and improve their quality of life (Bennett et al., 2001).

The lack of social support in patients with heart failure is a predictor of death and re-hospitalization (Murberg, 2004). Social support is essential for a person's physical and emotional well-being, as well as helping them in navigating life (Yildirim & Kocabiyik, 2010). The purpose of this study was to examine how perceived social support impacted patients with coronary heart disease's quality of life and death anxiety. It examines studies on how people perceive social support and how it affects persons with coronary heart disease's quality of life and death anxiety.

Coronary Heart Disease

Coronary heart disease is a disorder in which an infection causes a thick, sticky substance to accumulate inside the coronary arteries. The heart receives oxygenated blood via arteries.

Coronary heart disease causes the heart muscle to deteriorate over time as a result of heart failure and arrhythmia. Heart failure occurs when the heart is unable to pump blood to the rest of the body. Heart rhythm irregularities are known as arrhythmias (Alexandar et al., 2016).

Prevalence: Coronary heart disease is a prominent cause of death and disability in developed countries (Roger, 2007). Despite the fact that the mortality rate of this disease has gradually decreased in western countries over the last several decades, it still accounts for roughly 33% of all deaths in those over the age of 35 years (Rosamond et al., 2008). According to WHO information provided in May 2013, deaths due to coronary heart disease accounted for 111,367 deaths or 9.87 percent of all deaths. The adjusted mortality rate for the general population is 110.65 per 100,000. Pakistan is now ranked number 63 in the world. According to the American Heart Association Statistics Committee, total mortality from coronary heart disease was 102.6 per 100,000 in 2013, according to the Heart Disease and Stroke update (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, is recommended. Medication is carried out to control or lesser cholesterol. After that, the probability of heart attack and stroke is considerably reduced. In the long run, social support has been linked to mortality and the etiology of coronary heart disease (Cohen, 1988). Previous research in Western countries has found a relationship between social support and cardiovascular morbidity and mortality (particularly in coronary heart disease) has been described numerous times (Kuper, et al., 2006). Families, friends, and significant others' attitudes have been demonstrated to be closely linked to coronary heart disease.

Perceived Social Support

Durkheim(1984)gave the idea of social support. It 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 is defined as an exchange of social assets between individuals that enhance health outcomes (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)

"Information that leads a person to believe that he or she is cared for, cherished, and respected, and that he or she is part of a network of shared responsibilities," according to Cobb (1976). "Social support is defined by Chung, et al, (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 & Dzulkipli, 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 claimed that these several strong supportive functions are intertwined and often reflect a single unified factor known as perceived social support (House, 1981). The degree to which an individual trusted, cared for and needed to help other people was measured using perceived social support (Sarason et al., 1986).

Perceived social support is a person's psychological insight that he has to buildup trustworthy bonds with others and that others give up support to them (Celik et al., 2012). Providing social support implies the behaviors and activities that others undertake. In other words, it is thought to be a behavioral evaluation of support. Individual benefits of social support have long been acknowledged, but it is now commonly understood that perceived social support is a stronger predictor of health outcomes. There's also a relationship between mental diseases and low anxiety levels and perceived social support (Celik et al., 2012).

Emotional support, instrumental/material support, information support, and appraisal support have all been shown to improve disease-related outcomes in patients with Heart Failure (Dekker et al., 2009). Sharing the perspective of caring, cherishing, and trusting others are what emotional support entails. The provision of products and services that the individual needs are referred to as instrumental/material support. The goal of information support is to provide information to persons who are experiencing a difficult situation. Finally, peer support includes self-evaluation support, which involves confirming the accuracy of other people's actions or statements (Langford et al., 1997).

Perceived social support refers to how much support is given in comparison to how much support is actually given (Wills & Shinar, 2000). Any recommendation that assists the supported individual in achieving his or her goals is referred to be social support (Dekker et al., 2009). Individuals are perceived to have social support when they share the benefits of love, friendship, and care for family, friends, and others (Koldi & Salahshouri, 2012). Social support is measured in a variety of ways and expressed in a variety of frameworks. Emotional support from family, companions, and peers may be the first source of social support. Family support tends to be the most influential member of a person's social network since it has a beneficial

impact on Heart Failure-related outcomes such as quality of life, psychosocial capacity, and self-care (Dekker et al., 2009).

Quality of Life

"Individual perceptions of one's living situation in the context of the culture and value systems in which individuals live, as well as objectives, expectations, standards, and concerns," according to the World Health Organization (WHO). Physical health, emotional well-being, independence, social interactions, and their relationship to quiet components of their surroundings are all factors that influence it. In clinical medicine, quality of life refers to the functional impact of illness and treatments on a patient (Schmidt & Bullinger, 2003).

Quality of life is a wide idea that 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. "Prosperity reflects life, as well as the methods by which individuals react and feel about their lives in those places," according to one of the definitions (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 people who are in challenging living situations to retain a decent standard of living. The impact of disease and health treatment on a person's day-to-day activities and prosperity in terms of their ability to adapt is referred to as quality of life (Rummans et al., 2000).

In both research and clinical practice, there has been significant growth in interest in the concept of quality of life since the mid-1970s. The quality of life has become an important criterion for evaluating the efficacy and consequences of social insurance programs (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 possible explanations for the growing interest in medical services for quality of life. One clarification is that the future will be fairer due to improved medical treatments. Accordingly, numerous more individuals are highly expected to have interminable, clinically-controlled infections than with serious ailments. Some argue that, in addition to mortality and severity, quality of life should be considered when evaluating health treatment (Macduff, 2000). The spread and advancement of medical and surgical breakthroughs is the other clarification. With the growing number of treatments accessible, a detailed analysis of the benefit-to-burden ratio of equivalent therapies is now essential. When human services professionals evaluate the benefits of various treatment options, quality of life issues are now taken into account. Thus, quality of life looks into impacts on how policymakers designate medicinal services assets or decide repayment strategies (De Geest & Moons, 2000).

Almost everyone uses the term "quality of life" in some form or another. It can be defined in a variety of ways by individuals and organizations. Despite the fact that one of the most significant aspects of overall quality of life is well-being, there are a variety of factors to

consider, including employment, lodging, schools, and the neighborhood. Culture, traits, and a deep sense of being are equally key parts of overall quality of life, which adds to the unpredictability of their estimation. In any case, researchers have devised effective approaches for conceiving and measuring these numerous areas and their interactions (Whoqol, 1998).

The use of quality of life as a measure of health outcomes in individuals with coronary heart disease has expanded swiftly and drastically. Angina and heart failure side effects, restricted activity limits due to the aforesaid symptoms, physical weakness, and psychological stress linked with chronic stress are all variables that might influence a patient's quality of life during the course of coronary heart disease. Present day medications center on enhancing life expectancy, indications and useful status in addition to the quality of life (Wenger et al., 1984). The importance of quality of life parameters in diagnosing residual dysfunction in long-term survivors and comparing alternative treatment procedures as adjuncts to clinical treatment decisions has been advised (Bradlyn & Pollock 1996).

The concept of quality of life comprises three main characteristics: In the first place, rather than reflecting a country's quality of life, it represents people's life situations and perceptions. Second, it is a multidimensional term that incorporates a variety of facets of life, including lodging conditions, education, commercial business, career balance, and accessibility to organizations and public administrations, as well as their relationships; Thirdly, it integrates empirical data on living conditions with subjective perceptions and attitudes to produce a picture of public life as a whole (Shucksmith et al., 2009).

The sensation of general life satisfaction as decided by the cognitively alert individual whose life is being examined is known as quality of life (Meeberg, 1993). Quality of life can theoretically span a wide range of fields and components. Chronic heart failure disease and its symptoms impair elderly individuals' social contact, psychological well-being, bodily sensations, quality of life, mental health, and functional status (Fotos et al., 2013).

Quality of life, according to Hornquist (1982), encompasses "a vast variety of characteristics of human experience, ranging from basic needs such as food and shelter to feelings 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." Because many commonly valued aspects of life, including as money, freedom, and environmental quality, are not considered "health-related," The term "health-related quality of life" was coined by Guyatt (1993). Cultural values support the concept of quality of life. It is believed to change as a person grows and develops.

It manifests itself in the expression of feelings, emotions, and behaviors, and is seen as a set of criteria for selecting among several options (Singer et al., 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 the quality of life.

Accordingly, the subjective satisfaction of the patients should always be included in routine assessments 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 the 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).

People who are healthy and happy are more likely to have a good quality of life. During the preceding three decades, quality of life has proven to be a tough concept to define and quantify (Hagerty et al., 2001). The embodiment of life that an individual experiences over time, rather than a lived existence, is quality of life. Quality of life encompasses not only one's feelings and experiences, but also one's thoughts and judgments on a position and set of actual life occurrences, as well as the entire society over time (Yousefi, 2006).

Coronary Heart Disease and Quality Of Life. People have been interested in quality of life for a long time, going back to 384-322 BC. "Living a splendid life" or "being great," according to Aristotle, is equivalent with "being joyous." Regardless, the current presentation of this concept, as well as the concern for its deliberate and rational evaluation, is relatively new. One of the most significant developments in the field of health sciences in recent decades has been that patients' perspectives on their disease are as authentic and legitimate as those of medical professionals. Similarly, their treatment is increasingly being considered as a sign of medical progress and development (Casas et al., 2001).

It's defined as an individual's sense of their position in the world in relation to their way of life and self-esteem frameworks, as well as their goals, ambitions, standards, and concerns (WHOQoL, 1993). Later on, the term "Health-Related Quality of Life" (HRQL) was coined to distinguish between the general quality of life and the needs of therapeutic medications and clinical trials, thereby removing any ambiguity.

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 disagreements on which variables should be included in HRQL assessments, these studies show that the following functional categories are critical to HRQL: social, physical, and mental capacities, adaptability and independence, and passionate well-being (Fitzpatrick, 1996).

HRQL is a technique for evaluating the impact of an illness on an individual, and it is defined and characterized by patients as a result of their health treatment evaluation (Urzua, 2010). The fact that this idea can only be appraised by subjective measurements is a consistent and indisputable theme in all approaches. Because of their subjective and multidisciplinary nature, they are increasingly being used to enhance standard physiological and biological health assessments. Their evaluation, on the other hand, necessitates the use of instruments with

adequate psychometric properties before they can be implemented. When compared to other chronic conditions and the general population, those with heart failure have a significantly lower quality of life. The complex influence of clinical disease and its treatment on patient daily lives is reflected in quality of life. Shortness of breath, fatigue, edema, sleep problems, depression, and chest soreness are among the physical and emotional symptoms of heart failure. Patients' daily physical and social activities are limited by these symptoms, resulting in a bad quality of life. Long hospital stays and high death rates are related to poor quality of life. As a result, people who suffer heart failure should have their quality of life evaluated to understand how it affects their daily lives.

Quality of life is a subjective concept that is not solely based on objective clinical or physiological facts. It reflects patients' subjective assessments of the influence of a clinical condition on their life. Individuals in similar states frequently have differing evaluations of their quality of life, and the consequences vary depending on the patient's subjective viewpoints. In an investigation that looked at doctors' forecast of patient wellbeing observation and patient wellbeing related recognition, 51 percent of cases varied and patient well-being discernments 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 of patients with coronary artery disease

Patients with coronary heart disease are fascinated by the concept and measurement of health-related quality of life. This disease is not only the world's biggest cause of death, but it also has severe physical, mental, and social effects for those who are affected. In this way, assessing their quality of life is important not only for determining the success of a treatment or surgery but also for identifying specific issues that aren't measured by traditional methods and could be useful in changing or improving treatment or offering alternatives that improve patients' clinical outcomes (Fayers & Machin, 2007).

Instruments for estimating HRQL stand out among other approaches for surveying patients' experiences with their medical issues in areas such as physical, passionate, or social capacity, part satisfaction, agony, and weariness because the treatment of coronary heart disease is fundamentally linked to leading a healthy lifestyle (Asadi-Lari et al., 2003). Choosing the correct instrument to assess HRQL in cardiac patients is a serious challenge in clinical practice, despite tremendous excitement for doing so. When choosing an HRQL assessment tool, specialists or physicians should make sure that the instrument has been established and approved in a population with similar characteristics, and that it covers all of the relevant components of cardiac patients.

To be used with confidence, the apparatus must possess a number of qualities, including legitimacy, or how well they measure what they need to measure; reliability, or how well a measure compares individuals of similar quality of life; and affectability to change, or how well a measure determines how to distinguish significant changes that are appropriate for climatic conditions (Cepeda-Valery et al., 2011). These devices must be completed in the

expansion, that is, they must encompass all perspectives that may be influenced by the disease, and they must be easy to evaluate and comprehend. This last point is especially important in therapeutic settings when speed and ease of use are essential (McDowell & Newell, 1996).

There are two types of instruments that are commonly used to estimate the HRQL of coronary patients: 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. Nonspecific assessments, on the other hand, are less sensitive in detecting the impact of specific side effects of cardiovascular illness on a patient's life.

The health-related quality of life of individuals who have been diagnosed with coronary heart disease is critical. Life expectancy for people with coronary heart disease improves after medical treatment (Krumholz et al., 2005). According to one study (inverse relationship between death anxiety and quality of life), the magnitude of death anxiety reduces as quality of life improves (Soleimani et al., 2016).

Death Anxiety

Death Anxiety is a psychological phenomenon in which death is regarded as a largely unknown experience; fear of death is another common word, implying that the fact of death, though not the actual experience, is known (Dennis, 2009).

Death anxiety includes worries of pain, punishment, loneliness, and loss of control, as well as fears of the death event, what occurs after death, and the fear of ceasing, as well as fear of the unknown and fear of suffering (Conte et al., 1982). According to Collett and Lester (1969), fear of death caused not just personal anxieties, but also fears for others. They discovered four unique fears: fear of dying in one's own body, fear of dying in one's own body, fear of dying from others, and fear of dying of others.

People are aware of their mortality (Langner, 2006), and patients with life-threatening illnesses must confront death (Emanuel, Fairclough, Wolfe & Emanuel, 2004). The diagnosis of a hopeless illness can cause patients and their families to experience a profound existential crisis, since their daily lives and future hopes are compromised. "Negative passionate reactions incited by the suspicion of a condition in which the self does not exist," according to the definition of mortal dread (Solomon et al., 2000). It is the result of our conscious recognition of our own mortality. (Tomer & Eliason, 1996).

According to Maddi (1980), death fear arises not just from actual contacts with death, but also from unwanted ends, time or energy restrictions, or illegal values that undermine life's meaning. When supportive connections promote self-esteem and make sense, a positive theory of life or a logical set of convictions emerges, allowing death to be faced without fear (Kalish, 1963). When people are confronted with life-threatening illnesses or stressors, they are reminded of death through associations with death or grief, and they feel alienated or have

concerns about the meaning and purpose of life.

Death Anxiety refers to the anxiety and fear associated with the desire for, and familiarity with, death, demise, and nonexistence. It usually consists of energetic, intellectual, and motivational parts, which vary according to advancement and socio-cultural life expectancy (Lehto & Stein, 2009). The underlying brain areas that control fight-or-flight reactions and record charged explicit and implicit memories are related to death anxiety (Panksepp, 2004).

Fear can be measured psychologically by considering the significance of death, as well as a variety of beliefs, states of mind, images, and thoughts about death, dying, and what happens after death (Lehto & Stein, 2009). Death Anxiety can be experienced purposefully or inadvertently, and it can cause people to divert their attention away from their fear of dying (Greenberg et al., 1994). The struggle between our existing existence as limited and constricted creatures and our yearning to be limitless, everlasting beings capable of transcendent consciousness is expressed by our fear of death.

Death Anxiety or fear of death and/or dying is regarded as an important psychological phenomenon that can impair the subjective quality of life of both clinical and non-clinical groups. Fears of death can increase negative consequences, hinder communication, and alienate patients and their families. People develop a fear of death when they are confronted with life-threatening illnesses or stressors, when they are reminded of death by connections with death or grief, and when they are confronted with feelings of alienation or concerns about the meaning and purpose of life.

Relationship between the variables

The impact of illness and medical services on a man's everyday activities and sense of well-being, as well as a person's ability to adapt, has been defined as the quality of life (Rumans et al., 2000). As death approaches, physical discomfort (pain and side effects) and psychological suffering are important indicators of quality of life. Social support is essential in adjusting to a life-threatening illness. 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).

Furthermore, social support has been linked to reduced anxiety in cardiovascular patients and, like anxiety, has been linked to a reduction in coronary heart disease (Idler & Kasl, 1997). Higher self-reported social support has been associated with lowered anxiety in patients who have had a myocardial infarction (MI), as well as lower anxiety and unease in patients undergoing coronary artery bypass surgery.

Perceived Social Support and Quality of life Heart failure is a disease that causes a decline in quality of life due to unmet fundamental needs, changes in body image, a lack of self-care and everyday tasks, persistent tiredness, sexual problems, and fear of the future (Archana, & Gray, 2002). Patients with heart failure can benefit from social support. Improve their quality of life and manage their symptoms more effectively (Bennett et al., 2001). A lack of social support is associated with death and re-hospitalization in individuals with heart failure (Murberg, 2004). Social support is important for a person's physical and emotional well-being and helps them navigate through life (Yildirim & Kocabiyik, 2010). Individuals who are unable to meet their own requirements, frequently due to physical limitations or a lack of resources to deal with, require reasonable support. People with heart failure can enhance their quality of life with proper and enough social support (Fahlberg, 2010).

According to one study, those who lacked emotional support and lived alone experienced psychological stress and struggled to stick to treatment regimens, lowering their quality of life (Murberg & Bru, 2001). A study of social support on individuals with coronary heart disease found that it had a substantial impact on lifestyle changes and medication adherence (Boutin-Foster, 2005). One study examined the relationships between social support and quality of life in heart failure patients. It was also stated that there was a significant relationship between the patients' perceived social support and the physical health sub-scale of quality of life, and that as the patients' physical condition worsened, they required more assistance (Bennett et al., 2003). The patients' social support levels were typically high, but their quality of life was modest, according to a study that looked into the relationship between social support and quality of life in heart failure patients.

Another research examined at heart failure patients' quality of life and found that while they had modest levels of social support, both physical and mental health sub-scales of quality of life ratings were worse than the general population. There was no relationship found between the subscales of the social network, social support, and quality of life (Westlake et al., 2002). Some psychological elements can have a substantial impact on quality of life, such as health-related convictions, social support, adaptive style, and personality type.

These effects may be direct or indirect, buffering the negative impact. 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 associated to a higher quality of life and improved outcomes in people with coronary heart disease (Lett et al., 2007). Strengthening and broadening social support in people with heart failure has been proposed as a helpful intervention that may promote personal happiness while also minimizing mortality and dullness.

For example, having a companion provided tremendous assistance when compared to those who did not, as single patients with Heart Failure were 3.8 times more likely to be readmitted or die than married patients (Dunbar et al., 2008).

There are two possible pathways for social support to contribute to positive wellbeing (Cohen,

& Wills, 1985). First and foremost, regardless of individual stress levels or the presence of a stressful event, social support may have an immediate and basic impact on health-related outcomes. Second, social support may have a buffering effect, as it protects people from the negative consequences of an unpleasant condition or occasion. Along these lines, social support may act as an intervening or mediating variable, reducing the effects of pressure. There is no consistent evidence to authoritatively support either pathway because the role of social support has been estimated using a variety of instruments and results have varied throughout previous studies.

According to one study, having less social support and having more noticeable depressive side effects were both associated with a lower quality of life. The relationship between social support and quality of life was interfered by depressive symptoms. Social support or depressive side effects had no effect on the quality of life (Chung et al., 2013).

Death Anxiety and Perceived Social Support Adapting to life-threatening diseases require a lot of social support. As people get closer to death, social support becomes more vital, and interpersonal interactions help to lessen death anxiety. According to a study of patients, increased social support was observed in those who had a favorable prognosis, and this was associated to a lower fear of dying (Dunkel-Schetter, 1984).

Researchers in Pakistan found that social support can assist people with chronic conditions have fewer thoughts of death (Khawar et al., 2013). In addition, another study found that fear of death was a predictor of life quality. The researchers intended to examine if there was a relationship between quality of life, social support, and death anxiety in cardiovascular patients, as well as if there were any differences in quality of life, social support, and death anxiety between male and female patients (Bahrami et al., 2013).

Social support has been associated to a lower risk of death in a number of studies (Peterson, 1991). Previous research has demonstrated that social support shields patients from the lethal effects of mental stress and lowers their risk of death (Frasure-Smith et al., 2000). Furthermore, in elderly populations and cardiac patients, a connection between social support and reduced anxiety has been revealed (Forsell, 2000). Another recent study found that fear of death and social support have a substantial negative relationship (Nejad et al., 2017).

Social support has been connected with general death anxiety (Young, 2006). The increment in social support has been related to diminishing overall anxiety (Malinauskas, 2010) while bringing down social support is related to 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, having a spouse and close friends with whom one can communicate can be beneficial in overcoming the mental and physical burden of chronic illness. In general, social support of all kinds is likely to be critical in helping people with chronic illness in overcoming their fears of dying.

Patients have a consistent sense of danger and try to avoid thinking about death in their daily life; nonetheless, side effects of their sickness can cause fear of death (Adelbratt & Strang, 2000). Adapting to life-threatening diseases requires social support. Warm interactions can boost self-esteem and act as a buffer against death fears while interrupting such relationships might cause death concerns (Mikulincer et al., 2002). In older adults, affirming the value, caring, love, and trust of others boosts self-esteem.

Several research exploring social support mechanisms have found that interpersonal relationships protect people against the negative impacts of stressors, which can lead to depression, distress, and anxiety (Thoits, 1986). In the face of adversity and stress, social support can help to alleviate symptoms of anxiety and despair (Cohen & Wills, 1985).

Rationale

The purpose of this research is to examine if perceived social support has an impact on quality of life and death anxiety in individuals with coronary heart disease. One of the most serious medical challenges of the twenty-first century is coronary heart disease. 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. In medical populations, studies have demonstrated that social support has an ameliorating effect during times of psychological distress (Quinn, Fontana, & Reznikoff) (1987). A coronary heart disease incident might result in negative mental health, behavioral, and social life. Social support has been connected to mortality in the past and has been connected to the etiology of coronary heart disease (Cohen, 1988).

In previous research conducted in Western countries, the relationship between social support and cardiovascular morbidity and death (especially for coronary heart disease) has been well demonstrated (Kuper et al., 2006). It has been proposed that reinforcing and enhancing social support is an effective strategy that can improve patients' quality of life while also lowering mortality and morbidity (Dunbar et al., 2008). People are aware of their mortality (Langner, 2006), and patients with life-threatening illnesses must confront death (Emanuel et al., 2004). Patients and their family may face a tremendous existential crisis if they are diagnosed with an incurable disease, as their daily lives and futures are threatened.

According to the literature review, one of the most essential factors in reducing stress and various types of anxieties, such as death fear, is social support (Thoits 1986). Quality of life issues is crucial because they can indicate a person's ability to manage his illness and maintain long-term health and wellbeing. Death appears to be the most stressful event in human life, causing fear and anxiety. This anxiety is linked to fearful thoughts such as the fact that dying is a painful experience. Human beings are haunted by the knowledge that death is unavoidable, which leads to anxiety and fear.

According to researches, the intensity of such irrational fears is considerably decreased when people receive support from their family and friends (Berkman, & Syme, 1979). Only a few studies in Pakistan have found a relationship between chronic illness patients' anxiety, depression, psychological well-being, and quality of life. There are a few studies that show a

relationship between perceived social support and quality of life, death and perceived social support in the elderly, perceived social support and death anxiety in chronic illness patients, and quality of life and psychological distress in patients with coronary heart disease, but there are few studies on perceived social support and death anxiety in patients with coronary heart disease.

As a result, the purpose of this research is to examine how perceived social support affects the quality of life and death anxiety in people who have coronary heart disease. The goal of this research is to fill a vacuum in the literature by examining the relationship between these variables in the context of Pakistani culture. Another essential component of the research is that it will look into the relationship between three characteristics in individuals with coronary heart disease.

METHOD

Objectives

The following are the study's goals:

- To investigate how perceived social support impacts the quality of life and death anxiety in people with coronary heart disease.

Hypothesis

1. In coronary heart disease patients, there would be a significant positive relationship between quality of life (psychological functioning, social, environmental functioning, and psychological functioning).
2. There would be a negative relationship between Perceived Social Support and Death Anxiety in coronary heart disease patients.
3. Perceived Social Support would be a positive predictor of Quality of life.
4. Perceived Social Support would be a negative predictor of Death Anxiety.

Sample

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

Table1*Sample demographic description for the study(N=100).*

Variables	<i>f</i>	%
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
Monthly Income		
Upto30,000	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). The Multi-dimensional Scale of Perceived Social Support was established by Zimet (1988), and Jabeen and Khalid translated it into Urdu (2010). In this study, the Multi-dimensional Scale of Perceived Social Support was translated into Urdu. This self-reported 12-item scale assesses perceived support from three sources: family (items 3, 4, 8, 11), friends (items 6, 7, 9, 12), and significant other (items 6, 7, 9, 12). (items 6, 7, 9, 12). (Items 1–2, 5, and 10). The abbreviations (alpha) The coefficient for the subscales is.85. A maximum score of 21 points and a minimum score of 4 are assigned to each sub-scale. A higher score on each subscale implies that your friends and family are more supportive for you.

Quality of life Scale (WHO-QOL BREF)

Quality of life was evaluated using the WHOQOL BREF. It was a shortened version of the WHO QOL-100 with four domain scores (100-item scale). Physiological functioning (items 3, 4, 10, 15, 16, 17, and 18), psychological functioning (items 5, 6, 7, 11, 19 and 26), social functioning (items 20, 21, and 22), and environmental functioning (items 20, 21, and 22) were the four categories of the WHO QOL scale (items 8, 9, 12, 13, 14, 23, 24 and 25). Two additional variables were also assessed: a person's general perceptions of quality of life and health. The World Health Organization (WHO) developed the scale, which Khan et al. adapted and translated into Urdu (2003). The WHO QOL BREF is divided into four dimensions and consists of 26 dimensions. The domain scores are listed in increasing order of quality of life, with higher values indicating a higher quality of life. The domain score is then calculated using the mean scores. The overall scores on the scale can be used to assess a person's overall quality of life, with a higher score indicating a higher quality of life. This scale has a .94 alpha reliability.

Death Anxiety Scale

Goreja and Pervaz developed the Death Anxiety Scale (2000). The theoretical concept of Templer is the foundation for this scale (1970). The scale is based on Templer's four dimensions, with the researcher determining the remaining two dimensions. On the scale, there were 20 items that related to death fears. The items on the scale were divided into six groups: (1) fear of pain and lingering death, (2) subjective proximity of death anxiety, (3) disturbing death thoughts, (4) consequences for survivors, (5) fear of punishment, and (6) fear of not existing.

All of the items were presented in a positive manner. A five-point rating scale is used to gather data. 'Never' = '1' to 'always' = '5' were the response categories. The scale's alpha coefficient was reported. .89, the Death Anxiety Scale was translated into Urdu for usage with the Pakistani community in order to overcome the language barrier in the older sample. The scale was translated by five National Institute of Psychology M.Sc. students who were fluent in English and Urdu. The items that expressed the exact meaning of the original items were chosen based on feedback.

Demographic sheet

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

Procedure

The study comprised a total of 100 participants with coronary heart disease. The data was collected from different hospitals in Rawalpindi and Islamabad. At very First permission was acquired through the administration of hospitals. After that, a consent form was given to the participants after telling them about their search also if they are not comfortable they will quit at any time. The instruction was given to the participants about how to fill out 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 with the appropriate answers. They were convinced that any information they submitted would be kept private and used solely for research purposes. It took almost 15-20 minutes to complete the questionnaires. . All participants were thanked for their participation at the completion of the data collection. After the collection of all data, it is entered into SPSS-21 for further analysis and results

RESULTS

The Statistical Package for Social Sciences was used to analyze the data statistically (SPSS 21.0 for Windows). The data was evaluated using proper statistical procedures in order to meet the study's objectives. To assess the overall trend of the data, descriptive statistics were generated for all of the variables in the study. Cronbach's alpha reliability coefficient was used to assess the scales' internal consistency. Pearson Product Moment Correlation was used to determine the correlations between variables in the study. To identify group differences across demographic factors, an independent sample t-test was employed. Using linear regression analysis, the strongest predictor between variables was investigated. The data is presented in a table format.

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 were calculated.

Table2

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			α	Range		<i>Skewness</i>	<i>Kurtosis</i>
		<i>M</i>	<i>SD</i>		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
PHYF	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

ENVF	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.

Table3

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**	-.37**
PHYF						-	.49**	.46**	.24*
PSYF							-	.52**	.56**
SF								-	.33**
ENVF									-
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.

Table4

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

Overall quality of life								
Variables	B	β	R ²	ΔR^2	f	P	S.E	95%CI

							<i>LL</i>	<i>UL</i>
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	.003	.61	7.96 22.3
Family	2.11	.32					.61	.89 3.33
Constant	10.5		.20	.19	24.7	.003	.43	3.72 17.3
S. Others	3.11	.44					.62	1.87 4.35

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

Table5

Perceived Social Support as a Predictor of Quality of Life and its Subscales: A Linear Regression Analysis, (N=100)

Physiological functioning								
Variables	B	β	R^2	ΔR^2	f	<i>P</i>	S.E	95%CI
								<i>LL</i> <i>UL</i>
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	18.75	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: S.E= Standard Error, LL= Lower Limit, UL=Upper Limit, CI=Confidence Interval, MPSS=Multidimensional Perceived Social Support Scale,

Table6

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		7.9022.5	53.9
MPSS	7.97.49							1.415.15	10.7
Constant	57.3			.13.12	15.1	.00		6.4844.5	70.2
Friends	4.64.36							1.192.27	7.01
Constant	49.8			.15.14	17.8	.00		7.7534.5	65.2
Family	5.57.39							1.322.95	8.19
Constant	39.3			.26.26	35.9	.00		7.2424.9	53.7
S. Others	7.91.51							1.325.29	10.5

Note: S.E= standard error, LL=lower limit, UL=upper limit, CI=confidence interval,

MPSS=Multidimensional Perceived Social Support Scale,

Table7

Linear Regression Analysis of Perceived Social Support as a predictor of Quality of life 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

Table8

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

Table9

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

Variable	Death Anxiety					
	<i>B</i>	<i>B</i>	<i>S.E</i>	<i>P</i>	<i>95%CI</i>	
					<i>LL</i>	<i>UL</i>
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, CI=Confidence Interval * $p < .05$, ** $p < .01$, LL= Lower Limit, UL=Upper Limit

DISCUSSION

The purpose of this study is to examine how perceived social support affects the quality of life and death anxiety in people with coronary heart disease. The purpose of this research is to examine the relationship between perceived social support, quality of life, and death anxiety in patients with coronary heart disease, as well as the role of various demographic factors in these relationships. According to the study, perceived social support, quality of life, and death anxiety are all linked. Furthermore, it was hypothesized that perceived social support would be a positive predictor of quality of life.

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), ($\alpha=.90$) and reliabilities of sub-scales of MPSS are friends ($\alpha=.86$), family($\alpha=.83$), and significant others($\alpha=.75$). Alpha reliability for WHO QOL-BREF and its subscales, Overall QOL is $\alpha=.72$, physiological functioning is $\alpha=.66$, psychological functioning $\alpha=.69$, social functioning is $\alpha=.61$ and environmental functioning is $\alpha=.72$. Alpha reliability for death anxiety is $\alpha=.96$.

Perceived social support is related to a higher level of personal quality of life, implying that a high level of social support is likewise related to a higher level of personal quality of life. The findings supported the study hypothesis, demonstrating a significant positive relationship between perceived social support and quality of life. It implies that when a person's friends,

family, and significant others provide better social support and assistance to a person, that person experiences more social support, which improves their quality of life. Changes in social support have been proven in prior studies to have a significant impact on quality of life (Bennett et al., 2001). According to another study, positive social support is related to a higher quality of life and better outcomes in people with coronary heart disease (Lett et al., 2007). Perceived social support was a key component in improving quality of life (Ngetal.,2015). In patients with Coronary heart disease, reinforcing and enhancing social support has been suggested as an effective intervention that may enhance quality of life while also reducing mortality and morbidity (Dunbar et al., 2008).

Death Anxiety is negatively related to perceived social support, implying that as social support improves, the individual's death anxiety decreases. The results showed that Perceived Social Support is highly associated with Death Anxiety, confirming the hypothesis. It implies that a person's degree of Death Anxiety diminishes when he or she has higher social support from friends, family, and significant others, spends time with them and does not live alone.

Previous studies have associated an increase in social support with a reduction in overall death anxiety (Malinauskas, 2010 & Young, 2006). Further studies revealed that perceived positive family support was highly related to reducing death anxiety, as evidenced by a study of patients in which those with a favorable prognosis had more social support (Dunkel-Schetter, 1984). Numerous studies have found a negative relationship between social support and death anxiety (Peterson, 1991). Recent research has also found a significant negative relationship between death anxiety and social support (Nejad et al., 2017).

Further Quality of life would be negatively related to Death Anxiety which indicates that when the 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 is provided by the others and live in a good environment and socially adjust it will enhance the quality of life and individual lives better life it automatically decreases the level of Death Anxiety. The current study's findings show that Quality of Life is negatively associated with Death Anxiety, which supported the study hypothesis. A prior study found a significant negative relationship between death anxiety and quality of life (Soleimani et al., 2016). The study's variables all showed significant results. More anxiety is associated with a lower quality of life in those with cardiovascular disease (Mayou et al., 2000). According to Sherman et al., 2010, fear of death can affect the quality of life of patients with life-threatening conditions.

Furthermore, the current study's findings revealed that Perceived Social Support and its subscale as a predictor, as well as Quality of Life and its subscale as an outcome, had significant results. When a person receives more social support from family, friends, and significant others and spends time with them, their quality of life improves.

Previous research has been associated social support to a higher quality of life (Bennet et al., 2001). In domains, subscales of perceived social support are also significant predictors of quality of life (physiological, psychological, social, and environmental functioning). Previous studies on the social support and quality of life of heart failure patients revealed low levels of social support and quality of life. The physical health subscale of quality of life was found to

be significantly related to patients' views of social support, with patients demanding more assistance as their physical condition deteriorated (Bennett et al., 2001)

On the other hand, perceived social support is a negative predictor of death anxiety. Perceived Social Support is associated to a reduction in death fear, according to the findings of this study, implying that when a person receives Perceived Social Support, they would experience a reduction in death anxiety. Recent research has also found a significant negative relationship between fear of death and social support (Nejad et al., 2017). In later research, social support was found to be negatively associated with death anxiety (Peterson, 1991). A subscale of Perceived Social Support was similarly negatively related to death anxiety. Previous research has indicated that positive family support is strongly related to lower death anxiety, as evidenced by a study of patients who had increased social support and had a better prognosis (Dunkel-Schetter, 1984).

Conclusion

According to the findings of the study, perceived social support is positively correlated with Quality of Life and negatively associated with Death Anxiety in patients with Coronary Heart Disease. Perceived social support positively predicts quality of life in individuals with coronary heart disease, whereas death anxiety negatively predicts quality of life. As a result, it is argued that perceived social support enhances the quality of life and reduces death anxiety in people with coronary heart disease.

This study found that social support is effective and that other forms of perceived social support, such as friends, family, and significant others, can help patients improve their quality of life and lower their fear of death. In addition, the study showed gender variations in death anxiety. Perceived social support has a significant impact on a patient's health and quality of life. It also understands the need of education, advice, information, counseling, and inspiration for people who have heart disease.

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