An-Najah National University

Faculty of Graduate Studies

QUALITY OF LIFE AND SOCIAL SUPPORT AMONG PALESTINIAN BREAST CANCER WOMEN

By

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This thesis was Defended Successfully on 17/04/2025 and approved by

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Dedication

﴿وَقُلِ ٱعۡمَلُواْ فَسَيَرَى ٱللَّهُ عَمَلَكُمۡ وَرَسُولُهُۥ وَٱلۡمُؤۡمِنُونَۖ﴾[التوبة:105]

بدأنا بأكثر من يد وقاسينا أكثر من هم وعانينا الكثير من الصعوبات، وها نحن اليوم والحمد لله نطوي سهر الليالي وتعب الأيام وخلاصة مشوارنا بين دفتي هذا العمل المتواضع.

إلى منارة العلم الإمام المصطفى إلى الأُمِّي الذي علم المتعلمين، إلى سيد الخلق رسولنا الكريم سيدنا محمد –صلى الله عليه وسلم–.

إلى من احمل اسمه بكل فخر، إلى من سعى وشقى لأنعم بالراحه والهناء، إلى الذي علمني أن أرتقي سلم الحياة بحكمة وصبر إلى (والدي الكريم).

إلى الينبوع الذي لا يمل العطاء، إلى من حاكت سعادتنا بخيوطٍ منسوجة من قلبها إلى أعظم (أم).

إلى مصدر قوتي، الداعم الساند، أرضي الصلبة وجداري المتين إلى من مُدَّت يداه في أوقات الضعف، إلى رفيق الدرب وصديق الأيام جميعاً بِحلْوِها ومُرْها (زوجي الغالي).

أهدي هذا البحث إلى أطفالي الذين وثقوا بي على الدوام، راجيه أن أكون لهم مصدر فخر وقوة دائما.

إلى من كانوا ملجإي ويدي اليمنى، إلى أنيسات الروح والقلب (اخواتي) إلى من هونوا تعب الطريق إلى من شجعوني على المثابره وإكمال المسيرة إلى (أخوتي) .

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Declaration

I I, the undersigned, declare that I submitted the thesis entitled:

QUALITY OF LIFE AND SOCIAL SUPPORT AMONG PALESTINIAN BREAST CANCER WOMEN

I declare that the work provided in this thesis, unless otherwise referenced, is the researcher's own work, and has not been submitted elsewhere for any other degree or qualification.

Student's Name: **Walaa Hani Abdul-Jabbar Abu Sa A'**

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Date: 17/04/2025

List of Contents

List of Tables

List of Figure

List of Appendices

QUALITY OF LIFE AND SOCIAL SUPPORT AMONG PALESTINIANBREAST CANCER WOMEN

By
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Abstract

Background: Globally, the incidence and mortality rates of cancer are ranking withbreast cancer ranking with the leading causes of death for women worldwide, including in Palestine (Devi, 2025; Elshami et al., 2022). This disease greatly affects the quality of life of affected women. Social support, meanwhile, plays an essential role in mitigating challenges and enhancing well-being in daily life.

Aim: the main aim of current study is to assess the quality of life among women diagnosed as breast cancer, evaluate the level of social support they receive, and examine the relationship between (QoL) and social support.

Method: A cross-sectional study design was employed, involving 210 women diagnosed with breast cancer recruited from daycare units in hospitals across the West Bank of Palestine. A questionnaire was used to measure quality of life, the Arabic version of the European Organization for Research and Treatment of Cancer Quality of Life Scale (EORTC-C30), and to assess the support provided to women we used the Multidimensional Perceived Social Support (MPSS).

Results: This study enrolled 210 participants women who have been diagnosed with breast cancer, the mean of age was 50.54 ± 11.83 years, regarding to marital status majority of them were married (72.4%), and (73.8%) were unemployed. (51.4%) of respondents resided in urban, about financial support the majority of them 73.3% depended on their family members. The mean (QoL) score was (52.33), reflecting a moderate level of overall well-being. A significant positive correlation was identified between social support and (QoL) ($r = 0.65$, $p < 0.001$). Furthermore, (78%) of the participants reported moderate to high levels of social support.

Conclusion: This study highlights the critical role of social support in improving the quality of life of women with breast cancer. The findings emphasize the importance of

distinguishing types of social support and implementing tailored interventions to address individual needs effectively. Such personalized strategies are vital for enhancing (QoL) in this population.

Keywords: Breast Cancer, Quality of Life, Social Support, Palestine.

Chapter One
Introduction

1.1 Background

Breast cancer (BC) is defined as a malignant disease characterized by the abnormal growth of breast cells. This type of tumor typically originates in the milk-producing glands of the breast but can spread to surrounding breast tissue or metastasize to other organs in the body (Smith et al., 2014). Currently, (BC) is the most prevalent form of cancer globally, surpassing (CA) lung , and is the 5th cause that lead to mortality of cancer-related worldwide, only in 2020, new diagnosed cases reached nearly 2.3 million., resulting in an estimated 685,000 deaths (Sung et al., 2021).

According to the Palestinian Ministry of Health MoH, 2023, the majority of cancer cases among Palestinian women are BC, with an incidence rate of 36.2 cases per 100,000 women. This is followed by colon cancer, which predominantly affects men, and lung cancer, which ranks third overall. Among children, leukemia is the most prevalent form of cancer. Worryingly, breast cancer cases are expected to escalate further, with projections indicating 4.4 million cases by 2070. In 2020, (BC) was responsible for (24.5%) of all cancer cases among women and accounted for (15.5%) of cancer-related deaths worldwide (Soerjomataram & Bray, 2021).

The psychological impact of breast cancer is profound due to its life-threatening nature, the physical changes resulting from mastectomy, in addition to the complexity of management modalities as surgical management, chemotherapy, radiotherapy, and hormonal therapy. Frequent hospital visits, prolonged waiting times, and financial burdens associated with treatment further exacerbate the stress experienced by patients. These challenges often disrupt social activities, including employment, childcare, entertainment, and daily routines, contributing to higher levels of stress and lower overall quality of life (Gavric, 2015).

Treatment modalities, such as chemotherapy and radiotherapy, frequently cause adverse effects that amplify stress and negatively impact patients' well-being and (QoL). It is worth noting (QoL) for breast cancer patients depends on multiple components that

include their social economic context alongside educational background working status and mental health position and budgetary limitations (Jhajharia et al., 2017).

Mastectomy causes social relationship disruption in women because they become anxious and psychologically unstable due to breast cancer-related embarrassment and shyness. The fears patients experience regarding disease changes and social discrimination and abandonment result in their isolation and sense of loneliness (Sham et al., 2022).

The Centers for Disease Control and Prevention (CDC) provide the definition of quality of life (QoL) as how an individual measures happiness and well-being across various domains of their existence (CDC, 2014). The World Health Organization (WHO) defines quality of life (QoL) as how people evaluate their life position relative to their personal goals and standards and expectations and worries through the lens of their cultural beliefs and values systems. According to the WHO (2014) (QoL) assessment considers an individual's functional ability and social networks as well as personal principles and relationship with environmental surroundings.

According to the (QoL) Research Unit at the University of Toronto quality of life defines the capability of people to achieve fulfillment by accessing important life opportunities. A proper distinction must exist between (QoL) and related terms like living standards and (HRQoL) because researchers frequently mix these concepts together in their professional literature.(QoL)incorporates the evaluation of standards of living that includes material wealth but (HRQoL) concentrates on how health status affects personal well-being (Karimi & Brazier, 2016).

The scientific community divides quality of life (QoL) into four main health dimensions that include physical health and its disease symptoms together with somatic sensations and mental health that combines positive well-being and psychological distress and social health regarding social contacts and functional health which incorporates self-care alongside mobility and social role functioning (Cai et al., 2021).

The (QoL) concept diverges from the public health indicator of health-related quality of life (HRQoL) because it examines health relationships with broader life quality more than (HRQoL) does. Few scholars have attempted to redefine Quality of Life through

distinct domain categories because there exists no single acceptance of its definition and assessment framework. The "Engaged Theory" presents four main domains of (QoL) which include economics culture politics and ecology according to (McDonald & Shaw, 2019).

In general the researchers examine (QoL) as an extensive multidimensional framework which consists of multiple life aspects. Speaking from their work on developing a complete (QoL) questionnaire (Feng et al., 2021) determined ten core (QoL) domains which include physical and mental health and mood and emotions followed by self-perception independence and family life and parent-child relationships financial resources peer relationships and social support academic and professional environments and social acceptance. The assessment of quality of life has gained rising importance throughout the years specifically in health contexts involving different age groups affected by chronic illnesses. Individuals who face such medical conditions use their emotional experiences to drive their (QoL) evaluations because of the complexity involved (Merino et al., 2017).

The main challenge surrounding (QoL) is the lack of a standardized definition. Unlike indicators that can be measured quantitatively, such as gross domestic product, (QoL) is difficult to precisely measure across diverse cultures, regions, and demographics (Tomka, 2020).

Studies conducted on breast cancer patients from various regions, including China and India, consistently indicate that these individuals tend to experience notably lower (QoL) and perceived health status in comparison to their healthy counterparts (Zolnierczuk-Kieliszek et al., 2012). Specifically, the decrement in (QoL) is most pronounced in the domains of physical and psychological well-being. Furthermore, research from India underscores that a substantial majority of breast cancer patients exhibit subpar (QoL), with age being a significant factor; younger patients tend to report poorer (QoL). Occupation status has also emerged as a crucial determinant, with working women generally reporting higher global health status compared to housewives. Interestingly, residence in rural areas appears to be associated with higher (QoL), possibly attributed to enhanced familial and social support networks, as well as a heightened will to persevere among rural respondents (Gupta et al., 2022).

The concept of social support encompasses various dimensions and is often considered a component of the broader framework of social capital, which includes social support and social networks. These aspects can be categorized into structural and functional dimensions, as well as formal and informal types. Nursing care functions as formal support for people who do not have accessible personal relationships (Kent de Grey et al., 2018).

For example about social support previous study carried out in Nigeria that reported that, available social and institutional support networks for breast cancer management of elderly female patients. The research investigated the frequency of breast cancer while evaluating the cultural components that lead to this condition in older patients. The research showed breast cancer is becoming more common among women who have reached senior age yet mortality from the disease continues to increase due to poor knowledge of breast cancer symptoms after women stop having children. The research determined that inadequate public perception combined with age, income, education levels and belief systems serve as main healthcare drivers of breast cancer incidence increases (Anugwom, 2019).

The operational dimension of social support pertains to the presence and size of an individual's social net, as well as the degree of their connectivity within that network. The operational dimension consists of both the number of social connections an individual has and the type of activities they conduct with others through various interactions, Social integration is greatly aided by establishing connections with family, friends, and people in different groups (Kent de Grey et al., 2018).

Furthermore, the particular functions that members of a social network perform—such as offering informational support (such as advice, guidance, and feedback), instrumental support (such as material assistance), and emotional support (such as reassurance, empathy, and affection)—are crucial elements of social support. Therefore, social support includes the nature and accessibility of connections with important people as well as the cognitive and functional qualitative aspects of human relationships. On the other hand, the social network highlights these ties' quantitative and structural features, social support has been demonstrated to have a positive influence on individuals' coping mechanisms, health, and overall quality of life, especially during times of stress. These

benefits have been observed across various populations, including both healthy individuals and those with illnesses. The salutogenic nursing design emphasizes recognizing an character's health means and implementing strategies to enhance their health processes, moving towards the positive end of the disease/ease-continuum (Drageset, 2021).

Social support systems actively enhance daily life for people because they guarantee emotional and psychological well-being while building resilience to enable successful challenge management. Various research studies have shown that social support positively affects (QoL) because it reduces mental stress and enhances the satisfaction of life for cancer patients (Feeney & Collins, 2014).

The research by Ng et al. (2016) demonstrated that Malaysian cancer patients experienced better (QoL) when they received social support. The research confirmed that family support plays a crucial role in improving (QoL) for individuals who have survived cancer.

When cancer patients receive solid social support their condition minimizes symptoms while simultaneously leading to improved mental health outcomes. Patients with cancer typically fear death as well as treatment relapse and abandonment by their peers and worry about their loss of abilities stressing the necessity of emotional and instrumental support to improve their treatment compliance and health condition (Jolly et al., 2021).

Focusing on breast cancer patients Jadidi and Ameri (2022)established through research that family social support establishes a positive connection ($r = 0.773$, $P < 0.001$) with life purposes. Research indicates that improving family support acts as a strong force in boosting (QoL) measurements among (CA) patients.

Sørensen et al. (2020) researched 160 (BC) patients with early-stage cancer to study cancer-related fatigue in a cross-sectional analysis. This study demonstrated social support plays an important role in reducing mental fatigue and cohabitation proves essential for building support networks of patients.

The research team from Celik et al. (2021) studied how social support functions as a barrier between resilience and quality of life in early-stage breast cancer patients from Turkey. Research results show social support functions as a partial mediator between

these two variables because it plays an important role in enhancing both psychological resilience levels and functional quality of life of patients.

Kargar et al. (2022) investigated (QoL) together with social support and coping plans and disease adjustments in (BC) patients who resided in Iran. The researchers concluded that early identification of diseases together with supportive family networks creates positive outcomes for patients adapting to their disease while improving their (QoL).

1.2 Problem Statement

Breast cancer presents a significant health challenge, particularly due to its profound impact on the (QoL) and psychosocial well-being of patients, which is further exacerbated by the physical toll of treatments such as chemotherapy, surgery, and radiation (Goula et al., 2020). These treatments often lead to debilitating side effects, including nausea, fatigue, hair loss, cognitive dysfunction, and sexual dysfunction, which impair daily functioning and overall well-being. For Palestinian women, these challenges are compounded by limited access to healthcare resources, socio-economic constraints, cultural stigmas surrounding cancer, and the psychological burden of living in a region marked by political and economic instability (Titi & El Sharif, 2024). While international studies have highlighted the critical role of social support in improving (QoL) among breast cancer patients, there remains a significant gap in understanding how these dynamics manifest within the Palestinian context (Almuhtaseb et al., 2021). Specifically, little is known about how Palestinian women perceive their (QoL) during and after treatment, the types and extent of social support they receive, and how demographic factors such as age, marital status, employment, and education influence their experiences. This lack of knowledge hinders the development of culturally sensitive interventions tailored to address the unique needs of Palestinian women, who face additional barriers such as restricted healthcare access and financial limitations. Understanding these factors is essential to inform policies and programs that can enhance (QoL), sustain social support over time, and ultimately improve both short-term and long-term outcomes for breast cancer patients in Palestine. This study seeks to address these gaps by examining the relationship between (QoL) and social support among Palestinian breast cancer patients, providing valuable insights to guide targeted interventions and improve patient care.

1.3 Objectives

The main objective of our study are to:

Identify the quality of life of breast cancer patients in the northern West Bank.

Assessing the level of social support received by women with breast cancer in the North of West Bank region.

Investigate the correlation between social support and (QoL) among (BC) patients in the North of West Bank region.

1.4 Research questions

1. What is the degree of the (QoL) between breast cancer patients in the North of West Bank region?
2. What is the level of social support received by women with breast cancer in the Northern of West Bank region.
3. Is there statistically significant relationship between the level of social support that received by breast cancer women and (QoL) in the Northern of West Bank region.

1.5 Study Hypothesis

Hypothesis 1: Social Support and Breast Cancer Patients.

H1: Among breast cancer patients, statistically there is a significant difference in the level of social support they receive in the Northern of West Bank region.

Hypothesis 2: (QoL) and Breast Cancer Patients

H1: Among breast cancer patients, statistically there is a significant difference in the (QoL) level in the Northern of West Bank region.

Hypothesis 3: The relationship between social life and (QoL) among breast cancer patients.

H1: Among breast cancer patients, statistically there is a significant difference in the level of social support they received and (QoL) in the Northern of West Bank region.

1.6 Significance of the Study

Our current study addresses quality of life and social support among women diagnosed with breast cancer in the northern West Bank, as we found gaps in the current literature on this topic.

Conducting such a study provides us with a deeper understanding of the psychological state of this segment of women patients, given the profound impact breast cancer has on their quality of life and overall psychological health.

The main goal focuses on improving patient results through enhanced support structures which boost medication following along with emotional health and an improved perception of the medical journey. In addition to its goals the study aims to empower breast cancer patients and their relatives through the recognition of social support as a vital element during cancer treatment. The study works to create beneficial impacts on region-based breast cancer patients by instructing them to find local support options and teaching family members how to help effectively.

This research is valuable because its results will provide valuable information on breast cancer research while also contributing to improved care for breast cancer patients in the northern West Bank. The study aims to have a tangible impact on all breast cancer patients in the northern West Bank and the rest of the Palestinian territories.

The findings of this study will provide a literature reference for future researchers and encourage them to conduct similar studies focusing on breast cancer patients.

1.7 Variables of the Study

1. Dependent variables: in this current study dependent variable were quality of life and social support.
2. Independent variables: in this study the independent variables were sociodemographic characteristics and breast cancer status among patients women.

1.8 Definitions

1.8.1 Quality of Life (QoL)

Conceptual Definition:

QoL indicates to the extent of which an individual her or his life fulfil a different requirements of the good living. It includes a varied and wide of domains as health status, perception, functioning, life circumstances, happiness, behaviors, symptoms and routine of the life. (Moons et al., 2006; Veenhoven, 2014).

Operational Definition:

For the purpose of this study, (QoL) among Palestinian women with breast cancer is operationally defined as the scores obtained from the Arabic version of the European Organization for Research and Treatment of Cancer Quality of Life Questionnaire (EORTC QLQ-C30, v.3.0). This validated tool measures various domains of (QoL), including physical, psychological, social, and functional well-being, as well as symptom burden and overall health perceptions. Each domain is scored on a scale ranging from 0 to 100, where higher scores indicate better functioning or quality of life, except for symptom scales, where higher scores reflect greater symptom severity. Social support is assessed through specific items within the questionnaire that evaluate emotional, informational, and practical support received by participants from family, healthcare providers, and their community.

1.8.2 Social Support

Conceptual Definition:

Its defined as an individual's perception or experiences of social protection, that is, that he/ she is cared for and valued and that he/ she has become part of social network with contributions and obligations (Ozdemir & Tas Arslan, 2018).

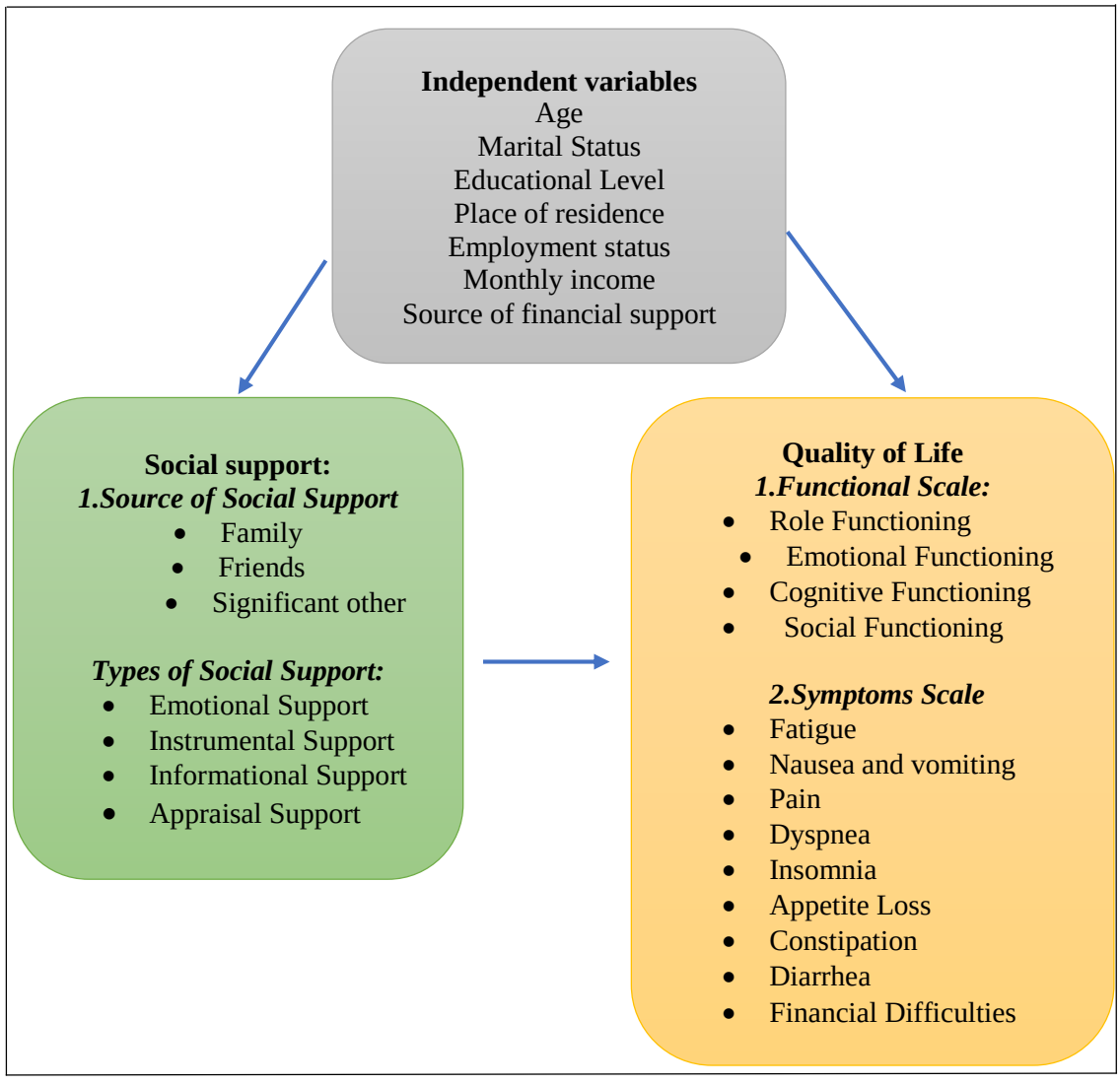
Operational Definition:

In this current study to measure the level of the social support, we used a valid previous questionnaire "Multidimensional Perceived Social Support" MPSS.

1.8.3 Conceptual Framework:

The conceptual framework is a graphical representation of a relationship between the independent and the dependent variables in the study Quality of Life and Social Support Among Palestinian Breast Cancer Women. The independent variables are a sociodemographic parameter (age, marital status, working status, living area, financial support, and the number of siblings) and a breast cancer parameter (stage of cancer and length of time since the diagnosis). Social support and the quality of life (QoL) as measure by EORTC QLQ-C30 are dependent variables. An arrow heading the independent variables into the dependent variables shows that the sociodemographic factors and the status of breast cancer are postulated to affect the levels of both QoL and social supports of the Palestinian women with breast cancer.

Figure 1.1
Conceptual Framework



1.9 Historical Overview of Quality of Life

In the 1980s, consequentialist philosophers began to use QoL to formulate moral judgments, notably in discussions concerning infanticide for severely handicapped infants, and the justification of euthanasia and the withdrawal of life-sustaining treatment. The s saw welfarist philosophers engaging in a new debate, associating QoL with health and happiness. Such philosophers conceptualised QoL and its concepts into subjectivist notions and these resulted as a problem to both definition and measurement of QoL. Although theoretical interest with regard to QoL has since waned, QoL has remained deployed in clinical practice by medical practitioners (Pennacchini et al., 2011; Spagnolo, 2008). The World Health Organization (1997) also defined HRQoL as the perception of a person on his position in life and is formed based on the system of cultural investments and values in which the concerned person lives; it is transformed by personal goals, expectations, standards, and concerns. HRQoL comprises four dimensions: physical and motor functioning, psychological health, social and financial conditions, and somatic experience, which includes such symptoms as pain. Notably, the concept lays a lot of stress on the need to differentiate between a clinically evaluated health condition (non-observable signs-based) and the subjective perception status of such a condition (i.e., HRQoL) by means of an objective and subjective assessment (Group, 1998).

In the 1990s, the term health-related quality of life (HRQoL) was introduced by Schipper and colleagues and defined as personal perception of an illness and its treatment on the functioning of a patient in his or her day-to-day life, then Quality of Life (QoL) term has been gradually becoming more and more impactful in terms of medical and philosophy-related literature of the last forty years. Its emergence in the s and s was driven by new technologies that posed novel questions for clinicians, leading to the adoption of QoL as a parameter for health-related decision-making (Pennacchini et al., 2011)They have pointed out that the health of an individual is very crucial as it can tremendously influence the rest of their life and well-being, consequently becoming a central factor in how such an individual accesses his quality of life. Therefore, in the process of measuring quality of life in a medical context, all healthcare workers should take into account subjectively perceived condition and management of a disease with the patient. In short, HRQoL is the personal evaluation of a patient of his or her circumstance in life during illness and

treatment period (Francesconi et al., 2023). This transformation encouraged researchers to work on the development and testing of measures to gauge health and QoL. But these primordial tools were found to have conceptual and methodological setbacks which made it difficult to be used massively in medicine. Whereas QoL was considered an idiosyncratic enigma by some, others saw its potential to find a place in clinical practice and promote better definitions as well as approaches (Louis et al., 2021).

When considering the efficacy of medical therapy, modern oncology needs to move beyond such established classics as cancer-specific survival and overall survival. It is especially becoming critical to consider the views of patients with regard to their own well being in the aftermath of treatment. Quality of life has emerged as a key success criterion in all forms of treatment but notably with cancer since being in a remission procedure does not necessarily mean a desirable outcome to the patient and the patient quality of life may not be related directly to the probability of their recovery in the long term (Sosnowski et al., 2017).

Objective assessment is determining the actual health status of a person according to facts and figures irrespective of the perception of the individual or his emotions. On the one hand, subjective assessment reveals personal perception of the patient on the situation at hand with a fair concern and bearing in mind the emotional factors thereof. These are assessments of not only what can be termed as negative emotions like anxiety and depression but also the positive part like hope, satisfaction and resiliency (De Walden-Gałuszko, 1997). In order to have a complete picture with regards to the quality of life of a patient, objective and subjective method of evaluations must be used.

1.10 Dimensions of QoL

The aspect of quality of life in breast cancer patients is a complex phenomenon that covers many spheres. According to research, breast cancer may have a huge effect to emotional, social, and role functions. World Health Organization (WHO) uses the definition of QoL as a sense by the individual of his/her place in life within the culture and value systems in which the individual lives as well as in light of his/her aspirations, expectations, norms, and preoccupations (Paterson et al., 2013). This definition highlights the multidimensional nature of QoL, including physical, mental, and social health, cognitive and sexual functions, working ability, and life-long pleasure (Post,

2014). Physical domain usually implies the subjective measurements of state of health and body processes (e.g. fatigue, incontinence, lymphedema) and emotional component includes psychological processes, such as indicators of mood, e.g. anxiety and depression. Sexual quality of life represents opinions toward sexual functions and desires and the social domain will involve effects of disease on social role of that person and how he or she considers the usefulness of social support, all these areas tend to be interconnected (Gavric, 2015).

1.11 Factors influencing QoL

In the past, the quality of life has been known to mean live well which means to have satisfaction with life. In everyday language, however, it is more commonly thought of as a compound statistical metric which takes into consideration many economic, health, and environmental factors affecting the living conditions of an individual or institution. Levine (1991) presented a socio-psychological model of quality of life as an area, of human experience, which has a considerable impact on the person. In this model, the quality of life is considered to be the subjective description of individual relations to his or her place in the world which is conditioned by the cultural environment, personal values, as well as the requirements and expectations and goals set by the world in which individuals live (Levine, 2021).

A number of elements have been revealed as determinants of the quality of existence in women with breast cancer. These include age, education status, performance score, disease stage, and disease status at last follow-up. In other studies, it has been established that QoL is affected by marital status, medical complications, the self-perceived condition, sleep disturbances, depression, and anxiety. Insomnia, fatigue, anxiety, and depression are the two major risk factors of poor QoL even when they persist. Another key determinant of QoL of these women is emotional support of their families. The financial and psychological support is important in enhancing the QoL of breast cancer patients (Al-Sharman et al., 2024; Heidary et al., 2023)

Based on this conceptualization, Saxen and Orley (1997) described some important elements in improving the quality of life of an individual. They are physical well being, mental, level of autonomy, relationships and the living environment around. By the time the research in quality of life took certain shape, its role within the domain of health

improved. In the 1990s, the emphasis was changed on the personal experience of people, their feelings and inner state. At this point, researchers started appreciating not only measurable objective indicators of quality of life but also its subjective component namely, the feeling of a person fulfillment and life content (Saxena et al., 1997; Sosnowski et al., 2017).

Educational level had a positive effect on HRQoL in eight of nine studies and better education was associated with increased disease awareness and adherence to treatment; better levels of education were observed in one research in less-educated patients. With two exceptions, occupation was associated with a positive influence, as employed patients had a better HRQoL on 6 out of 8 studies. The instead study showed more positive results with unemployed patients. HRQoL was pushed in the same direction (i.e., better HRQoL) by income across seven studies since increased income-ease of accessing treatments without worrying about costs. The effect of marital status was unclear with five studies indicating that married women scored higher in HRQoL as a result of social support and two studies indicating that married patients scored low in HRQoL. Lower HRQoL was observed associated with advanced stages of the tumor in nine articles except one which mentioned superior HRQoL in the later stages. Chemotherapy and other treatment therapy decreased HRQoL, continued treatment as well as increasing duration was associated with worse results and breast-conserving surgery and treatment completed were associated with increased HRQoL. HRQoL was decreased in response to other factors, including anxiety, depression, and psychological distress, but increased due to the other factors of optimism, social support, healthy lifestyle, and normal BMI with mixed results on religion (Ngo et al., 2023).

Previously, most women have feared this kind of cancer significantly since social stigma usually follows the diagnosis of such diseases. They can also have a vast impact on their identity and sexual wellbeing and this can end up affecting their psychological wellbeing negatively. As much as contemporary advances in treatment modalities have resulted in reduced mortality and improved survival rates among breast cancer patients, upholding the household of life (QOL) remains one of the ardent issues (Kapoor et al., 2024).

Due to the success of medical advancement in the increase of disease-free survival rates, quality of life (QOL) has gained increased prominence as an issue. How well the healthcare improves or maintains the wellness and every-day functioning of a patient should be used as a measure of the end goal of the healthcare. Although it is ethically appreciated that cancer patients, in most cases, tend to go through severe physical and health problems, the traumatic and life-threatening nature of the disease also impacts various areas of the patient lives to such an extent that they become apprehensive to the physical sphere (Sharma & Purkayastha, 2017).

According to the systematic review that was conducted by Ngo et al. (2023), some of the factors related to health-related quality of life (HRQoL) in breast cancer patients in low- and middle-income countries (LMICs) in Asia were identified. The effect of age was inconsistent with five studies pointing out that older patients had better HRQoL possibly because of well coping mechanism with post-menopausal women, but lower HRQoL in aged patients in two studies. Numerous studies have shown that various sociodemographic factors can impact the social functioning, mental health, and overall quality of life among women diagnosed with breast cancer (Daldoul et al., 2018; Lei et al., 2018). Younger patients often face unique psychosocial challenges, such as emotional distress linked to disrupted life plans and concerns about early mortality. This combination of practical and existential stress tends to lead to poorer social adjustment, increased rates of depression, and reduced quality of life compared to older breast cancer survivors (Firouzbakht et al., 2020; Lei et al., 2018) Additionally, research suggests that higher socioeconomic status is associated with better psychological well-being, more effective social role performance, and improved quality of life for cancer patients (Firouzbakht et al., 2020; Le et al., 2020). In a study involving 400 breast cancer patients, Le and colleagues (2020) found that those with greater socioeconomic resources reported higher levels of satisfaction with post-treatment reconstruction and better mental health outcomes. Regarding disease progression, several studies have indicated that the stage of breast cancer at diagnosis generally does not significantly affect depressive symptoms or quality of life, except in cases of recurrence (Daldoul et al., 2018; Firouzbakht et al., 2020; Wu, 2018).

Theoretical Models of QoL:

In determining the well-being of people who have chronic diseases like cancer, it is very important to understand the theoretical background of quality of life (QoL). There are various models that have been established to conceptualize health-related quality of life (HRQoL) and they lay importance on various dimensions and determinants.

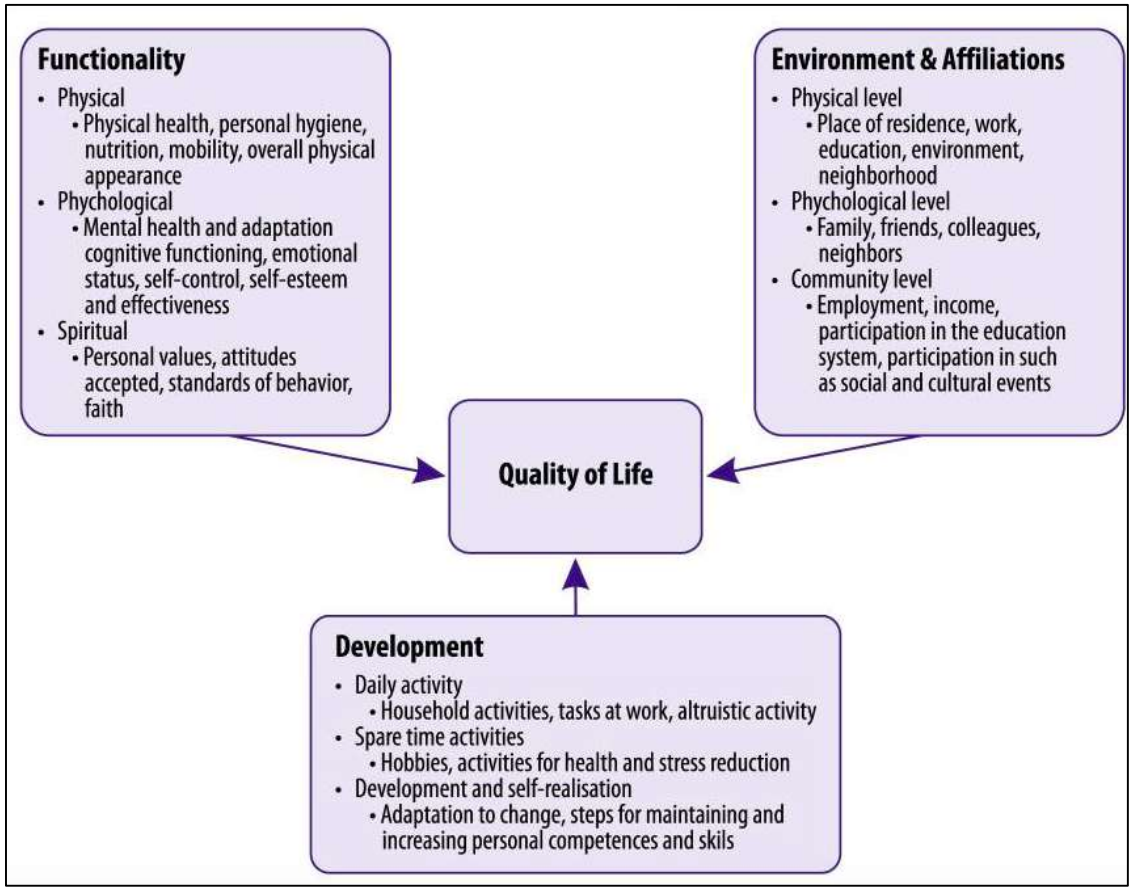
The Centre for Health Promotion Model is one of the most broad models that was established in the University of Toronto. Based on the definition of QoL provided by the World Health Organization, this model views well-being as having three large domains namely Being, Belonging, and Becoming. Being is encompassing physical well-being, mental-well-being, and spiritual convictions. The concept of belonging has a section on physical connections to the environment, social connection and community services. The term becoming implies the attainment of individual pursuits vis-a-vis promotion, productivity, and recreation (Sosnowski et al., 2017). This model is very useful in investigating how breast cancer women preserve their functions, psychologically adjusts, and respond to their societies before and after treatment.

A second, the Contextual Model of Health-Related Quality of Life (CM-HRQoL) was developed by Ashing-Giwa specifically to address cancer patients. It splits QoL determinants into macro and micro levels. Systemic factors featured in the macro level are socioeconomic status, social support, culture, and medical care access. Micro level denotes features at individual level, including illness type and degree, comorbidities, beliefs about health, coping factors, and psychological conditions e.g. depression and optimism. This model brings out the relationship between the structural barriers and individual resiliency in determining the quality of life of cancer patients (Ashing-Giwa, 2005).

Yet another powerful tool is the Wilson and Cleary model which refers biological and clinical variables to a symptom state, the functional state, general health perceptions and the overall quality of life. The approach fills the gap between the biomedical and the psychosocial views by taking into account both objective clinical data and the subjective status of the patient. It has achieved wide usage in QoL studies to elucidate the route of health related processes at the onset of individual perception of wellbeing (Wilson & Cleary, 1995).

All these models focus on the reality that quality of life in breast cancer cancer patients cannot be evaluated simply on disease control or survival, but as a whole experience dependent on personal, social, and systemic forces. Using such frameworks in the Palestinian setting enables an investigator and a practitioner to come up with culturally and contextually applicable QoL determinants in breast cancer patients. Figure (1.1) summarize three models of QoL

Figure 1.2
Summary of theoretical framework



1.12 Dismissions of social support

Social support is a multidimensional concept, which impacts greatly on breast cancer patients both psychologically and physically. Social support has five subtypes, which are explained as practical, financial, informational, emotional and spiritual support (Vijayasiri et al., 2021). Practical support the second type, practical support, is an actual help with day-to-day tasks: transport, housework, or childcare. Financial help includes medical expenses assistance or replacement of the income, which is essential particularly to patients who experience employment breakdown (Tejeda et al., 2017). Informational

support involves giving advice, medical directives, and other details of the same disease-related issues, which most of the time guide the patients to make an informed choice of the form of treatment. Emotional support is where one can express empathy, love, trust, and care which reduce psychological distress and anxiety. Finally, spiritual support entails assistance based on faith, religious or spiritual intervention or reassurance, which is significant especially to people who rely on spirituality in sickness. Evaluation of these five dimensions can be done based on the perceived adequacy whereby support is said to be adequacy whenever what one receives is at the same level or more than what the patient requires. Insufficient provision of any of the above dimensions may have detrimental impacts on any of the outcomes like adherence to treatment, coping capacity and quality of life (Rikard et al., 2016; Rockenbauch & Sakdapolrak, 2017; Vijayasiri et al., 2021). Hence, it is necessary to pinpoint dimensions that are unmet by whom in the network of the patient in order to provide effective intervention and resources.

1.13 Factors Influencing on social support

In general, cancer (including breast cancer) and its symptoms have far-reaching effects on a person's cognitive, emotional, spiritual, psychological, and social health. They cause diverse changes in patients' personal lives, daily activities, work, relationships with family and friends, and their role in society (Atinafu et al., 2023; Ng et al., 2016). The concepts of social support perceived by cancer patients are influenced by a number of major factors, as have been identified in the given document. There is a great role of economic status whereby patients with low economic background report much less social support than patients in upper-middle background and this has a marked association in family and friends and significant others supports subscales (Biswas et al., 2024). Perceived social support is also impacted by family size such that patients with bigger families (five or more friends or family members) have reported to receive much social support when compared to those whose families are smaller with a very strong statistical relationship with total perceived social support. Survival of children is yet another important condition since patients with their children as companions experience two times as many social support opportunities than those without (Įürük et al., 2020). Also, the presence of emotional support by spouses considerably increases the amount of perceived social support, with the patients who get such support experiencing it at a greater degree than those who lack it. Matrimony and living conditions also provide

further impact as spouses have significant ranking higher when it comes to family support on the scale, especially the living arrangement of patients and the percentage association is very close between the two sides (Brito et al., 2021). There is also specific sources of support that has a significant association with total perceived social support i.e. emotional support from spouses, friends and neighbors, companionship with spouses, children and neighbors, and advice-related support with the treatment team. These perceptions are also framed within the social-cultural background of where cultural norms and stigmas towards cancer have an impact on how patients with cancer are willing to seek or disclose their ill health, supporting the idea that support of afflicted friends and relatives remains family-centric in this environment with family members as the major providers of emotional to which patients are financially, companionship and other impacted more likely to be willing to provide their support(Biswas et al., 2024).

Theoretical model of Social support

Theoretical models on the effects of social support on individuals are best elucidated in multiple theories especially on stressful events in life experiences, such as breast cancer. Two dominant models are the "buffering support" model and the "main support" model (Drageset, 2021). According to the buffering model, social support has only positive effects when the situation is characterized by great stress, in which case it can counter the adverse effects of negative health. The main support model suggests that social support is beneficial regardless of stress levels, positively influencing physical and mental health independently of stressful events (Verdugo & Schalock, 2024). The stress-illness vulnerability theory also provides a broad framework, where social support acts as a mediating factor that can ameliorate the stress of cancer treatment (Kornblith et al., 2001). This theory suggests that social support can directly influence adjustment by providing reassurance or advice .

Relationship Between QoL and social Support

According to previous studies about the relationship between QoL and social support in patients with breast cancer indicated that there is a high positive correlation between social support and QoL in a patient with cancer. Multidimensional analysis of the research conducted by Ruiz-Ruiz-Rodríguez et al. (2022)showed that satisfaction with social support, informational support provided by friends and emotional support by

partners indicated a positive correlation between social social support and QoL. In this study, it was highlighted that certain kind of support was specifically informational one that boosts the overall health, whereas partner support was found to improve the coping skills of patients and therefore improve the overall functioning as well as symptoms. This implies that social support is a decisive protective agent, which saves psychological and physical aggravation of cancer and thus improves QoL levels.

On the same note, Celik et al. (2021) sought to establish the mediating variable of social support in the relationship that existed between resilience and QoL in Turkish breast cancer patients at its early stage. This showed that there was a partial mediation between psychological resilience and functional QoL since their findings showed that there was a negative correlation between functional QoL and both resilience and social support. Social support as one of the protection factors influence was brought out in the study as a factor which assists patients to deal with stress thereby improving psychological well-being and maintain physical and mental health. This mediation effect highlights the main importance of social support as a bridge between the resilience and better QoL outcomes.

The work by Khok et al. (2024) also supported the findings by systematic review and meta-synthesis, which also ranked social support networks as an important resilience protective factor. The review has observed that fulfilling social interactions minimize loneliness, fearfulness, and depression, hence resilience and enhancement of QoL among cancer patients and survivors. This implies that a well-developed social support system relieves psychological pains, as well as promotes an increased QoL in patients through the capacity to reduce the hardships of cancer diagnosis.

A path analysis of breast cancer patients in Taiwan, which was done by Sun et al. (2023), further confirmed that greater social functioning leads to a reduced depression level and better QoL. The research brought out the impact of sociodemographic variables comprising of age, religion, income and severity of the disease on the social functioning which also influence the QoL. This points to the fact that social support, being one of the aspects of social functioning is very instrumental in the alleviation of depressive symptoms and general well-being.

Caldiroli et al. (2025) in turn, concentrated on the resilience as a mediator of QoL in cancer patients with hematological malignancies, but observed a positive correlation between resilience and QoL, where social support indirectly played its role in enhancing resilience. Even though the main topic of the study was resilience, it implied that social support could be reinforced through the means of interventions, which would consequently increase the level of resilience, positively affecting the QoL due to the elimination of bad influence of demographic and psychological factors such as depression.

Lastly, Voskanyan et al. (2024) have carried out an umbrella review of the available evidence related to psychosocial predictors, such as social support, and their relationship to QoL in cancer survivors. The review established that social support has a potent impact on the well-being with differences depending on sociodemographic, clinical, and cultural issues. Such a wide view supports the concept that social support is another crucial determinant of life quality, which can be applied in clinical practice and the future establishment of specific interventions to positively influence cancer care.

Altogether, the research indicates the positive correlation with social support of QoL within cancer patients, especially those having breast cancer. Social support implies increased psychological strength, lower levels of depressive and anxiety symptoms, and improved functioning, which results in the improved QoL. Certain forms of support, e.g., emotional and informational support by family, friends, and partners are especially useful in shielding the cancer-linked stressors. These results reflect the fact that special psychosocial measures of increasing the strengths of social support networks to enhance QoL are needed, and special emphasis should be placed on cultural and demographic context, which defines these associations.

1.4 Previous studies

Vaca-Cartagena et al. (2025) conducted a multicenter prospective cohort study to evaluate changes in the breast cancer-related quality of life of young women with breast cancer. Results showed that the large number of young women survivors of breast cancer are victims of poor QoL over the time course and especially those places or domains in reference to sexual health and outlook in life and hair loss.

Myers et al. (2025) conducted research on the health-related quality of life among women with breast cancer when a COVID-pandemic was taking place in the two countries Ireland and Canada (Qu beh C). The findings demonstrated that the HR-QoL in women with BC had an improvement between pandemic and post-pandemic periods in general. Nevertheless, in both the contexts, women with greater levels of stress related to COVID demonstrated slower returns to HR-QoL.

Janabi et al. (2025) conducted a cross-sectional study to assess the Quality of Life of breast cancer patients undergoing chemotherapy in Jordan. The results showed that social functioning and the overall score of quality of life was very high while emotional functioning scored lower. Insomnia and fatigue were the most observed symptoms which were followed by pain and loss of appetite. The research indicated the relevance of the chemotherapy in the life of the patients and the importance of providing emotional and psychological support in enhancing the quality of life of the patients.

El Battioui et al. (2025) conducted a cross-sectional study to assess the health-related quality of life (HRQoL) of breast cancer survivors during adjuvant hormone therapy (AHT) in the Northern Region of Morocco. The findings revealed that younger women (< years) had lower scores on the emotional well-being subscale. Mood pill: Negative predictors of emotional quality of life showed their strongest effects with the presence of irritability and mood swings. Social HRQoL was supported by items on social support in both age groups, which showed positive effect on survivors.

Wang et al. (2024) conducted a systematic review to identify the influencing factors of social isolation among cancer patients. It was found that social isolation of cancer patients was determined by their demographic features, cancer-related, physical, psychological, social health statuses, coping styles, and the degree of social support and socialization.

Rahman et al. (2024) conducted a cohort study to investigate health-related quality of life (HRQL) and its relationship to optimism and social support among Australian women following a cancer diagnosis. The results noted that there is a close relationship between optimism, social support, and HRQL in the survivors of cancer. The HRQL may improve through the psychosocial support and by responding to behavioral and socioeconomic issues as well as other health situations related to optimism and social support.

Heidary et al. (2023) conducted a systematic review to integrate qualitative studies on the Quality of Life (QoL) of women with breast cancer. The results indicated that physical, spiritual, and psychological dimensions of QoL were the frequent problems among cancer-free women and patients with metastatic cancer. Other primary issues about cancer were perception of cancer and social life in cancer-free in women, but in the metastatic group, overall survival and future and life of their children were the points of interest. Women having metastatic cancer were more vulnerable in their coping ability than cancer-free women.

In a previous cross-sectional study that conducted in Tunisia to assess the (QoL) among (BC) women through a survey (EORTC (QoL)- C30), the findings of this study revealed that over health score was 77.5, this results indicated that (BC) patients have good emotional and physical functioning, while in the terms of sexual functioning and body image the results reported a declining (Chouchane et al., 2022)

Through a systematic review encompassing 45 studies published between 2001 and 2020, Solikhah et al. (2023) conducted a bibliometric assessment of research outcomes interrelated to the impact of social support on the (QoL) among (BC) patients. The study highlighted that social support has a significant positive association with psychological adjustment and adherence to cancer treatment, as demonstrated by various studies. While the majority of the research affirms this association, one study found no link between social support and suicide following a cancer diagnosis. Notably, China, the USA, and Hong Kong are among the leading contributors to research exploring social support in this context. The bibliometric analysis also identified key domains of support required by (BC) patients, including instrumental, financial, informational, and emotional support. These findings provide valuable insights into the strategies needed to enhance the survival rates and overall well-being of breast cancer patients.

The research by Jadidi and Ameri (2022) included 84 Iranian women with (BC) to establish connections between family social support networks and quality of life measurements. For data collection purposes the authors employed a social support questionnaire. The participants showed an average social support score of 39.35 ± 9.51 together with an average (QoL) score of 29.5 ± 7.49. According to ANOVA results the studied sociodemographic variables were not associated with either social support score

or (QoL) scores. The research found a substantial relationship between social support measures and (QoL) assessment results ($r = 0.773$, $P < 0.001$). Cancer women experience better quality of life when family social support levels increase according to these findings.

Khalid & Majeed (2022) conducted a cross-sectional research involving 80 Pakistani women diagnosed with (BC) who assessed optimism levels and marital support dimensions. The researchers obtained information using a questionnaire form. Statistical results from this research showed optimism has a positive link with negative dyadic coping behaviors and various (QoL) measurements except for physical well-being. Each subscale of the Dyadic Coping Inventory (DCI) demonstrated a strong relationship with the (QoL) subscales according to the research findings. The participants' quality of life experienced statistical change based on educational attainment socioeconomic position and cancer stage combined with post-illness employment status and monthly earnings and optimism levels. The research evaluation concludes that quality of life has a direct connection to negative dyadic coping mechanisms as well as an association with optimism. The (QoL) experienced by people with (BC) depends significantly on their educational background alongside their economic status and cancer stage and their income as well as professional level after illness diagnosis and their degree of optimism.

In Malaysia Sham et al. (2022) conducted a cross-sectional study to assess the (QoL) and social support among 259 (BC) patients using (QoL)-C30 and MPSS questionnaire. The results of this study found that, the Malaysian women with breast cancer had a high global (QoL); they even performed well in role and physical functioning aspects. Furthermore, the amount of social support available to the patients especially from their families was also established as favouring. It has been possible to determine the presence of a positive correlation between (QoL) and social support on the basis of the coefficient obtained ($rs = 0.25$) which reflects the statistically significant value at '0. 05'. As indicated in the study, there is a call for intense effort to improve on the (QoL) of (BC) patients through proper intervention.

In their cross-sectional study, Kargar et al. (2022) evaluated 120 (BC) patients from February to August 2020. The findings revealed that patients had high functional scale scores for both body image (78.61 ± 26.69) and future perspective (55.27 ± 26.71). They

reported substantial distress linked to hair loss (49.16 ± 38.88) on the symptom scale. Family members accounted for the majority of the mean total social support score, which was 45.71 ± 9.92. The "reasonable efforts" coping approach was most frequently used by patients (4.07 ± 0.35). Breast cancer patients showed a high degree of illness adjustment and received significant social support, as shown by the illness adjustment mean score of 150.91 ± 16.29. But they were still struggling with issues of body image and hair loss.

To assess social support influences on quality of life aspects in BC-diagnosed Iranian women Zamanian et al. (2021) ran a survey-based cross-sectional research. The research estimated participation from 223 women during the time period from October 2014 through May 2015. The study showed that Iranian women diagnosed with (BC) scored with high average levels of total social support (TSS) and separate social support types (SSTs) from EIS with 76.01 ± 26.05 to AS with 80.08 ± 24.06. The quality of life scores obtained from women with breast cancer exhibited positive correlations with all types of social support and positive social interaction specifically predicted physical well-being. The predictive performance of PSI extended across all (QoL) outcomes making PSI superior to other assessed factors at predicting (QoL). The research demonstrated that positive social interaction (PSI) significantly affects the different aspects of quality of life for women diagnosed with breast cancer.

Almuhtaseb et al. (2021) conducted a Palestinian research using a qualitative method to understand how patients perceived their support network and which kind of help they experienced during illness from January 2015 through April 2015. The research sought to determine two main questions about who provides assistance to these women throughout their illness. Respected authorities from Dunya Women's Cancer Center in Ramallah Governorate along with Beit Jala Government Hospital in Bethlehem Governorate brought together 36 female participants to conduct the study. Women in the occupied Palestinian area who suffered from breast cancer primarily received help from their families whose primary supporter was their spouse. The collective structure of Palestinian culture along with barriers to accessing cancer treatment influence how much help patients need. The helping services of financial aid and childcare along with assistance for household duties amounted to functional support but emotional support professionalized as companionship through trust and care and assurance types of aid. A

challenge existed in locating reliable informational support so families acted as intermediaries between patients and physicians for the necessary exchanges.

Numerous (BC) patients participated in a Greek study during December 2018 to February 2019 where researchers examined differences in social support measurements between subjects receiving chemotherapy currently and those who finished their treatment two years ahead of time according to Goula et al. (2020). The research investigated 74 (BC) female patients through two separate groups that included 41 active chemotherapy participants and 33 patients who completed chemotherapy two years earlier. Research results indicated that women who finished chemotherapy two years ago had a better health-related quality of life than women undergoing chemotherapy currently yet social support evaluations remained similar between the two groups. Quality of life decreased with patient age progression in the phase of chemotherapy treatment but social support improved among patients two years after finishing chemotherapy. These findings suggest that (QoL) improves over time, highlighting women's ability to cope with challenging situations. Social support remains crucial during both periods.

In Nepal Shrestha et al. (2017) carried out a cross-sectional research from December 2015 through August 2016 to check (QoL) and social support levels and mental health of Nepalese (BC) women. Telephone interviews served as the method for distributing questionnaires to participants. The research outcomes demonstrated (BC) women obtaining mean linear scores of positive global health and functioning scales (82.08 and 69.06) with good social support (mean score of 85.03) but low anxiety and depression scores of 7.01 and 4.85. A significant proportion of (40.93%) tested positive for depression and (52.34%) showed positive results for anxiety during the screening process. Observations revealed that married women residing with their husbands experienced fewer cases of borderline and abnormal moods but nuclear family structures led to higher depression rates. Individuals with mental health scores below the mean marker and above the mean scores in global health and social support showed better mental health status ($p < 0.05$). Wives married to their husbands demonstrated less occurrence of borderline and abnormal moods but nuclear family women exhibited more cases of depression. Results demonstrated the existence of significant correlations between individuals who scored their global health and social support above-mean alongside their below-mean anxiety ($p < 0.05$). These participants additionally displayed

normal mood patterns. Breast cancer patients frequently go undiagnosed with depression based on this research thus requiring routine psychiatric evaluations together with follow-up assessments. Counseling services aimed at providing better support for patients' family members and spouses would probably yield beneficial results.

1.10 Summary

A review of the literature reveals that, while studies have been conducted in various countries exploring the association between (QoL) and social support among (BC) patients, there is a noticeable gap in research specifically addressing this topic in Palestine. Several reviews have concluded that social support significantly positively impacts the psychological adjustment, adherence to cancer treatment, and overall (QoL) of (BC) patients. Family members, particularly husbands, are often perceived as the most supportive sources, providing both emotional and functional support. However, accessing reliable informational support can be challenging in the occupied Palestinian territory. Previous Research findings demonstrate that social support has significant importance for breast cancer patients regarding their mental health quality of life and well-being thus further studies in this field should continue within Palestine.

Chapter Two
Methods

2.1 Introduction

This chapter explains the research procedures and tools used in this study. It describes the study methodology, identifies the setting, participants, sampling method, sample size, describes the instruments (questionnaires) used to collect data from respondents and data collection and statistical analysis are used to output the study findings.

2.2 Study Design

This study utilizes descriptive, cross-sectional design, which is suitable for describing variables of the study as they naturally occur without interference from the researcher. This design of the studies are generally applied on a population at a point of time or over a short period (Coggon et al., 2009). Also, cross sectional designs examine the correlation between variables; they are economical, quick and managed easily (Polit & Beck, 2004).

2.3 Study Setting

This study was carried out in several health institutions (hospitals) in the northern West Bank that deal with (BC) patients as follow:

- National Hospital (Al Watani) - Nablus
- An-Najah University Hospital - Nablus
- Shaheed Dr. Thabet Thabet Governmental Hospital - Tulkarem
- Shaheed Dr. Khalil Suleiman Governmental Hospital - Jenin

These healthcare facilities are known for providing comprehensive medical care and support services to (BC) patients in the North West Bank.

2.4 Study Period

The study conducted over a period of 7 months, from January 2024 to July 2024.

2.5 Population of the Study

Population of this study involved of female breast cancer patients who are currently receiving medical care and treatment at the selected healthcare facilities within the North West Bank. The participants were women ≥ 18 years.

2.5.1 Sampling method

The sampling method used is a method for recruiting participants for a study. Purposive sampling allows researchers to involve respondents according to particular criteria that ally with objectives of the study.

2.5.2 Sample Size

With a (50%) response rate, (5%) margin of error, and (95%) confidence level, the sample size was determined using Raosoft® (Sample Size Calculator; Raosoft inc.). The population under consideration consisted of 500 community women who had been diagnosed with BC. There were 218 community women in the sample, 8 questionnaires were removed from the study due to missing information and the withdrawal of some women from the study to be the final number of respondents 210.

2.6 Eligible Criteria

2.6.1 Inclusion Criteria

- Female (BC) patients aged ≥ 18 years were enrolled in the study.
- Participants must have been diagnosed with breast cancer for more than 6 months to ensure a sufficient duration of experience with the disease and its psychosocial impact.
- Participants receiving medical care and treatment at the selected healthcare facilities within the North West Bank as mentioned before.

2.6.2 Exclusion Criteria

- Male (BC) patients were not included from the study due to the focus on women's psychosocial experiences.
- Participants diagnosed with breast cancer for less than 6 months will be excluded to ensure an adequate understanding of the disease's psychosocial impact.
- Participants below 18 years of age will be excluded from the study.

- Unwillingness to Participate: Participants who express unwillingness or inability to participate in the study will not be included.
- Participants with severe cognitive impairment that may hinder their ability to comprehend and respond to the study materials will be excluded.
- Patients in a terminal stage of (BC) or those undergoing end-of-life care because their psychosocial experiences may differ from those in early stages.

2.7 Data Collection Instruments

The researchers conducted a quantitative assessment using established valid and dependable tools to measure (QoL) and social support among women suffering from BC. The following tools were employed:

The European Organization for Research and Treatment of Cancer Quality of Life Questionnaire Core 30 (QLQ-C30) stands as a widely used assessment tool which was created for evaluating (QoL) across patients with. The questionnaire calculates multiple essential aspects which include physical, emotional, and social functioning to generate a complete picture of patient well-being (Greimel et al., 2006).

To validate the content of the QLQ-C30, a study was conducted on 113 cancer patients from Europe and the United States, the finding demonstrated that the QLQ-C30 conceptual framework properly identified the main conceptual elements which patients frequently reported. The findings demonstrate robust evidence that supports the QLQ-C30 as a valid measure to assess localized-to-advanced cancer patients from the perspective of functional health together with symptom load and health-related quality of life (Cocks et al., 2023).

Arabic Version:

A translated Arabic version of the EORTC QLQ-C30 served this study because it enabled (BC) patients to respond to the questionnaire accurately within their native tongue. The version has accomplished cross-cultural adaptation for Arabic (BC) patients according to the requirements of this population (Jassim & AlAnsari, 2020).

Reliability and Validity:

Numerous cultural and linguistic studies have proven the EORTC QLQ-C30 to possess outstanding reliability together with validated measures. A considerable body of research shows that this survey demonstrates consistent measurement of the targeted construct because its items test the same concept reliably. The questionnaire shows excellent test-retest reliability which proves that it maintains consistent measurement capabilities across different periods of time. The EORTC QLQ-C30 shows extensive validity performance through thorough testing against alternative quality-of- life measurement methods which confirms its status as a complete tool for patient well-being assessment (Jassim & AlAnsari, 2020).

The Multidimensional Scale of Perceived Social Support (MSPSS):

As a commonly used assessment instrument it gives individuals a way to rate their received support from different sources which include their friends and family along with their significant other. Through investigating perceived social support in multiple domains the tool provides essential information about accessible social support availability to participants (Zimet et al., 1988).

Arabic Version:

The MSPSS Arabic version served as the research tool for this investigation according to Fayad and Kazarian (2013). Researchers adapted this version of the tool through extensive linguistic and cultural processes to precisely reflect social support perceptions of people within the northern West Bank governorates' particular cultural framework. Through linguistic and cultural adaptation participants now have an effective means to share their perception in their mother tongue.

The MSPSS proves to possess reliable and valid results when applied to various cultural groups and demographics. The scale maintains high consistency across its items which demonstrates that all elements accurately measure this particular construct. Furthermore the measure demonstrates successful test-retest reliability which indicates that scores remain stable during repeated assessments. The MSPSS scale achieves effective validity tests by proving its strong convergent validity and discriminant validity when evaluated against different measures of social support (Wongpakaran et al., 2011).

Arabic version validity and reliability:

The McDonald's omega values between 0.94 to 0.97 indicate that the Arabic Multidimensional Scale of Perceived Social Support (MSPSS) along with its subdomains displays excellent internal consistency. A confirmatory factor analysis (CFA) validated the model by accepting its acceptable fit. Various evaluation criteria showed that gender-specific analysis supported the three conceptual levels of measurement invariance. The MSPSS dimensions showed no gender-related differences between male and female participants. This demonstrates the tool maintains consistent results across both genders. Convergent validity was established by demonstrating significant positive correlations between all three MSPSS sub-scores and the total score with resilience and posttraumatic growth scores (Fekih-Romdhane et al., 2023).

2.8 Ethical considerations

Approval to conduct the study was obtained from the Institutional Review Board of Al-Najah University (Ref: Mas Jan. 2024/11)**.** As for collecting data from the previously mentioned health centers, approval was obtained from the Palestinian Ministry of Health and the administration of Al-Najah University Hospital. As for the respondents, their consent was taken from the Consent Form after explaining the purpose of the study, and that all data provided are confidential and for the purpose of scientific research. Also, any participant has the right to withdraw from the study without restriction.

2.9 Data Analysis

Using the proper statistical methods, the gathered data was examined. Demographic data and scores on social support and quality of life criteria were compiled using descriptive statistics. The associations between social support and quality of life were investigated using inferential statistics, including regression models and correlation analysis. The p value was considered less than 0.05.

Chapter Three

Results

3.1 Introduction

This chapter in our current study aims to discuss the findings obtained from the research, which sought to determine the (QoL) of (BC) patients, as well as the level of social support they received in the North West Bank. In addition our study explored the correlation between (QoL) and social support among (BC) patients

This current study included 210 female patients diagnosed with BC. The data were meticulously analyzed to address the primary objectives of the investigation. The findings presented in this chapter provide a comprehensive understanding of the (QoL) and social support experienced by Palestinian women with BC, as well as the factors influencing these aspects at the time of the study.

3.2 Normality

Kolmogorov-Smirnov test (K-S) of normality was conducted to determine whether Quality of Life subscales and social support scale data are normally distributed. The findings suggest that we must reject the null hypothesis for these scales and conclude that data are not normally distributed p <0 .05. Table 3.1 shows further details.

Table 3.1
Tests of Normality

Scale	Shapiro-Wilk				
	Statistic	P.value	Statistic	df	Sig.
Physical Functioning	.127	.000	.976	210	.001
Role Functioning	.307	.000	.783	210	.000
Emotional Functioning	.146	.000	.946	210	.000
Cognitive Functioning	.201	.000	.904	210	.000
Social Functioning	.133	.000	.934	210	.000
Fatigue	.227	.000	.885	210	.000
Nausea and Vomiting	.135	.000	.923	210	.000
Pain	.322	.000	.769	210	.000
Dyspnea	.321	.000	.804	210	.000
Sleep disturbance	.327	.000	.770	210	.000
Appetite loss	.273	.000	.779	210	.000
Constipation	.226	.000	.799	210	.000
Diarrhea	.274	.000	.806	210	.000
Financial impact	.250	.000	.832	210	.000
Total MSPSS	.073	.008	.979	210	.004

3.3 Demographic Characteristics

About 210 women diagnosed with (BC) participated in the study. The mean age was 50.54 ± 11.83 years, about (72.4%) were married, more than two-thirds (73.8%) were unemployed. About half (51.4%) live in the city, and the majority (73.3%) depend on their families for financial support. The mean number of brothers 3.15 ± 1.78, and the mean number of sisters 3.61 ± 2.45. Other related information is shown in table 3.2.

Table 3.2
Sociodemographic data of respondents (n = 210)

Variable	Frequency	Percent
Social Status		
Single	31	14.8
Married	152	72.4
Widow	23	11.0
Divorce	4	1.9
Working Status		
Working	55	26.2
Not Working	155	73.8
Living Area		
City	108	51.4
Refugee Camp	26	12.4
Village	76	36.2
Financial Source		
Family	154	73.3
My work	43	20.5
No support	13	6.2

3.4 Quality of life

In our current study the findings found that, the (QoL) among women diagnosed with BC, as gauged by the QLQ-C30 summary score, was found to be 52.33, indicating a moderate overall well-being in this population.

Functional scales and symptoms scales/items make up the QLQ-C30 (Table 3.3). A higher score on a functional scale, which ranges from 0 to 100, indicates a higher level of functioning.

The Functional scales contain Physical Functioning (45.76 ± 18.43), Role Functioning (36.19 ± 26.39), Emotional Functioning (43.27 ± 24.79), Cognitive Functioning (39.84 ± 23.67), and Social Functioning (52.65 ± 29.73).

Symptoms scales scores from 0-100, a higher score resembles a higher level of symptoms. The symptoms scales contain Fatigue (29.85 ± 14.97), Nausea and Vomiting (53.87 ± 32.08), Pain (29.85 ± 17.78), Dyspnea (52.14 ± 27.69), Sleep disturbance (31.58 ± 27.91), Appetite loss (39.76 ± 39.77), Constipation (44.82 ± 40.75), Diarrhea (55.60 ± 39.60), and financial impact (59.06 ± 34.30).

Table 3.3
QLQ subscales mean score

Item	M	SD
Functional scales		
Physical Functioning	45.76	18.43
Role Functioning	36.19	26.39
Emotional Functioning	43.27	24.79
Cognitive Functioning	39.84	23.67
Social Functioning	52.65	29.73
Symptoms scales		
Fatigue	29.85	14.97
Nausea and Vomiting	53.87	32.08
Pain	29.85	17.78
Dyspnea	52.14	27.69
Sleep disturbance	31.58	27.91
Appetite loss	39.76	39.77
Constipation	44.82	40.75
Diarrhea	55.60	39.60
Financial impact	59.06	34.30

M, mean; SD: Standard deviation

3.5 Functional and symptoms (QoL) scales relationship with Demographic characteristics

Average functional scales (physical functioning, role functioning, emotional functioning, cognitive functioning, and social functioning) and symptoms scales (fatigue, nausea and vomiting, pain, dyspnea, sleep disturbance, appetite loss, constipation, diarrhea, and financial impact) were compared between patients who worked and those who did not. This was done using a Mann-Whitney U test (Table 3.4).

The findings pointed that there were significant differences between groups, the working patients (mean rank = 130.91) had significantly higher financial impact scores than non-working group (mean rank = 96.48), U = 2865.000, p = .000. Other scales were not statistically significant (p > .05).

A Kruskal-Wallis H test (Table 3.4) was performed to compare average functional scales (Physical Functioning, Role Functioning, Emotional Functioning, Cognitive

Functioning, and Social Functioning) and symptoms scales (Fatigue, Nausea and Vomiting, Pain, Dyspnea, Sleep disturbance, Appetite loss, Constipation, Diarrhea, and financial impact) between different social status groups.

The average functional scales (physical, role, emotional, cognitive, and social functioning) and symptoms scales (fatigue, nausea and vomiting, pain, dyspnea, sleep disturbance, appetite loss, constipation, diarrhea, and financial impact) were compared across various social status groups using the Kruskal-Wallis H test (Table 3.4).

Furthermore, the results of the Kruskal-Wallis test showed that the various social status groups' Cognitive Functioning scores differed significantly from one another. The mean rank cognitive functioning score was 131.95 for singles, 104.75 for married, 64.67 for widows, and 163.63 for divorced people ($\chi 2(3) = 20.833$, p =.000).

Similarly, a Kruskal-Wallis H test showed that there was a statistically significant difference in Dyspnea score between the different social status groups. $\chi 2(3) = 10.320$, $p = .016$, with a mean rank dyspnea score of 92.92 for singles, 106.13 for married, 103.85 for widow, and 188.50 for divorce.

Other scales did show statistically significant relationship with social status ($p > .05$).

The living area was statistically significant only with the Financial impact as indicated by Kruskal-Wallis H test. $\chi 2(2) = 9.287$, $p = .010$, with a mean rank financial impact score of 116.73 for patients living in city, 96.70 for patients living in village, and 84.58 patients living refugee camp.

Other scales did show statistically significant relationship with living area ($p > .05$).

The average functional and symptom scales (physical functioning, role functioning, emotional functioning, cognitive functioning, and social functioning) and sleep disturbance, appetite loss, constipation, diarrhea, and financial impact were compared across various financial support groups using the Kruskal-Wallis H test.

A Kruskal-Wallis H test showed that there was a statistically significant difference in Fatigue score between the different financial support groups, $\chi 2(2) = 5.984$, $p = .050$,

with a mean rank fatigue score of 106.38 for patients who have family source, 113.55 for patients who have work as financial source, and 68.42 for patients who did have support.

Similarly, the Kruskal-Wallis test indicated that there was a significant difference in nausea and vomiting score between the different financial support groups. $\chi 2(2) = 9.566$, $p = .008$, with a mean rank nausea and vomiting score of 107.44 for patients who have family source, 113.38 for patients who have work as financial source, and 56.50 for patients who did have support.

A Kruskal-Wallis H test showed that there was a statistically significant difference in Appetite loss score between the different financial support groups $\chi 2(2) = 11.369$, $p = .003$, with a mean rank appetite loss score of 103.12 for patients who have family source, 125.83 for patients who have work as financial source, and 66.42 for patients who did have support.

Also, there was a statistically significant difference in Financial impact score between the different financial support groups. $\chi 2(2) = 16.602$, $p = .000$, with a mean rank financial impact score of 100.81 for patients who have family source, 133.56 for patients who have work as financial source, and 68.31 for patients who did have support.

Other scales did show statistically significant relationship with financial support ($p > .05$).

The functional scales (physical functioning, role functioning, emotional functioning, cognitive functioning, and social functioning) and symptoms scales (fatigue, nausea and vomiting, pain, dyspnea, sleep disturbance, appetite loss, constipation, diarrhea, and financial impact) were compared to age using Spearman's correlation.

There was a negative correlation between Physical Functioning and age, $r(208) = -.387$, $p = .000$, also between Role Functioning and age, $r(208) = -.160$, $p = .000$, between Social Functioning and age, $r(208) = -.195$, $p = .004$, between pain and age, $r(208) = -.144$, $p = .036$, between dyspnea and age, $r(208) = -.314$, $p = .000$, and between appetite loss and age, $r(208) = -.189$, $p = .006$. Other scales were not statistically significant with age ($p > .05$).

The functional measures (physical functioning, role functioning, emotional functioning, cognitive functioning, and social functioning) and symptoms measures (fatigue, nausea and vomiting, pain, dyspnea, sleep disturbance, appetite loss, constipation, diarrhea, and financial impact) were compared with the number of brothers using Spearman's correlation.

There was no significant correlation (p >.05) between the number of brothers and [functional and symptom measures].

The association between the number of sisters and the functional scales (physical functioning, role functioning, emotional functioning, cognitive functioning, and social functioning) and symptoms scales (fatigue, nausea and vomiting, pain, dyspnea, sleep disturbance, appetite loss, constipation, diarrhea, and financial impact) was assessed using Spearman's correlation.

The number of sisters and [functional and symptom scales] did not significantly correlate (p >.05).

Table 3.4
Functional and symptoms (QoL) scales relationship with Demographic characteristics

	Age	Social Status	Working Status	Living Area	Financial Support	Brothers	Sisters
Item	P value	P value	P value	P value	P value	P value	P value
Functional scales							
Physical Functioning	0.000	0.152	0.084	0.743	0.118	0.329	0.843
Role Functioning	0.020	0.039	0.074	0.328	0.209	0.700	0.721
Emotional Functioning	0.927	0.877	0.104	0.254	0.320	0.576	0.212
Cognitive Functioning	0.064	0.000	0.577	0.276	0.776	0.215	0.454
Social Functioning	0.004	0.474	0.448	0.842	0.192	0.439	0.266
Symptoms scales							
Fatigue	0.069	0.872	0.960	0.312	0.050	0.322	0.054
Nausea and Vomiting	0.052	0.817	0.124	0.171	0.008	0.631	0.274
Pain	0.036	0.460	0.070	0.891	0.137	0.539	0.514
Dyspnea	0.000	0.016	0.143	0.392	0.296	0.128	0.799
Sleep disturbance	0.571	0.981	0.222	0.184	0.182	0.825	0.527
Appetite loss	0.006	0.391	0.440	0.234	0.003	0.899	0.231
Constipation	0.535	0.355	0.519	0.135	0.146	0.406	0.802
Diarrhea	0.200	0.475	0.105	0.758	0.176	0.128	0.883
Financial impact	0.117	0.702	0.000	0.010	0.000	0.798	0.399

3.6 Multidimensional Scale of Perceived Social Support (MSPSS) (relationship between (QoL) and Social support)

The mean score of MSPSS was 5.13 ± 1.03. The mean scores of MSPSS subscales were the significant other subscale 5.84 ± 1.12, family subscale 5.68 ± .95, and friends subscale 3.87 ± 1.99.

When investigating the level of support in each subscale, results showed (78.1%) had high support in the significant other subscale, similarly high support (77.1%) in family subscale, and (31.9%) high support in friends' subscale. Overall MSPSS has (53.4%) showed high level of support. Further details are shown in Table 3.5.

Table 3.5
Overall MSPSS and subscales level of support

Item	M	SD
Significant other subscale		
Low Support	3	1.4
Moderate Support	43	20.5
High Support	164	78.1
Family subscale		
Low Support	3	1.4
Moderate Support	44	21.1
High Support	162	77.5
Friends subscale		
Low Support	72	34.3
Moderate Support	71	33.8
High Support	67	31.9
Overall MSPSS		
Low Support	4	1.9
Moderate Support	92	44.7
High Support	110	53.4

3.7 MSPSS relationship with demographic variables

According to compare average MSPSS between working and non-working patients. The results indicated that there was a significant difference between groups, the working patients (mean rank = 120.43) had significantly higher financial impact scores than non-working group (mean rank = 100.20), U = 3441.500, p = .034.

According to compare the difference between MSPSS and different social status groups. The results indicate non-significant difference, $\chi 2(3) = 5.455$, p = .141. Additionally, the same test was conducted to determine whether there is an effect of living area on the level of MSPSS. The results indicate non-significant difference, $\chi 2(2) = 2.861$, p = .239.

A similar result was obtained when the test was performed to determine whether there is an effect of financial support on the level of MSPSS. The results indicate non-significant difference, $\chi 2(2) = 3.315$, $p = .191$.

According to evaluate the relationship between MSPSS and age. The relationship between MSPSS and age was not significant, $r(208) = -.086$, $p = .217$. Also, between MSPSS and number of brothers, the relationship between MSPSS and number of brothers was not significant, $r(208) = .070$, $p = .316$. And between MSPSS and number of sisters, the relationship between MSPSS and number of sisters was not significant $r(208) = -.074$, $p = .283$.

3.8 Functional and symptoms scales relationship with MSPSS

Functional scales (physical functioning, role functioning, emotional functioning, cognitive functioning, and social functioning) and symptoms scales (fatigue, nausea and vomiting, pain, dyspnea, sleep disturbance, appetite loss, constipation, diarrhea, and financial impact) were compared with MSPSS using Spearman's correlation.

The findings found that, there was statistically significant relationship between Physical Functioning and MSPSS, $r(208) = .275$, $p = .000$, between Role Functioning and MSPSS, $r(208) = .274$, $p = .000$, between Emotional Functioning and MSPSS, $r(208) = .177$, $p = .010$, between Social functioning, $r(208) = .270$, $p = .000$, between nausea & vomiting and MSPSS , $r(208) = .237$, $p = .001$, between pain and MSPSS, $r(208) = .264$, $p = .000$, between sleep disturbance and MSPSS, $r(208) = .182$, $p = .008$, and financial impact and MSPSS, $r(208) = .237$, $p = .001$. Other scales were not statistically significant relationship with MSPSS ($p > .05$).

Hypothesis Test:

Hypothesis 1: Social support among (BC) patients

H_1: There is a significant difference in the level of social support received by (BC) patients in the North of West Bank.

Results: The Kruskal-Wallis H rest pointed anon significance difference in level of social support (MSPSS) among different social status groups (X^2 (3)=5.455 p=.141). Therefore we fail to reject the Null hypothesis (H_0).

Hypothesis 2: (QoL) and (BC) patients.

$H_{1:}$ Thee is a significant difference in the degree of (QoL) among (BC) patients in the North of West Bank.

Results: The results indicated significant difference in various (QoL) scales

Hypothesis 3; Relationship between social support and (QoL) among (BC) patients.

H_1: There is a significant association between the level of social support that receive by (BC) patients and (QoL) in the North of West Bank.

Results: The spearman's correlation analysis showed statistically significant relationship between various (QoL) scales and MPSS. There is a significant relationship between physical functioning and MPSS (r (208)=.275 p=.000) , between role functioning and MPSS r(208)=.274. p=.000). Therefore we reject the Null hypothesis because there is a significant relationship between social support and (QoL).

Chapter Four

Discussion

4.1 Introduction

In our current study, conducted within female previously diagnosed with (BC) in various hospitals located in the northern West Bank, we included 210 participants. The study aimed to explore social support and (QoL) within (BC) patients and to examine the correlation between social support and (QoL) in these women.

4.2 RQ: How is the degree of (QoL) among breast cancer patients in the North West Bank?

4.2.1 (QoL) among (BC) patients

In our current research, the findings concluded that the (QoL) among women diagnosed with BC, as examined by the QLQ-C30 summary score, had a mean of 52.33, indicating moderate overall well-being in this population. This score is notably lower compared to other studies. For example, a Malaysian study that carried out by Sham et al. (2022) reported a higher (QoL) mean of 73.68, while a Saudi study by Imran et al. (2019) found a mean of 67.45. Similarly, another Malaysian study by Ganesh et al. (2016) reported a (QoL) mean of 65.7. Previous worldwide breast cancer studies indicated the average QLQ score amounted to 66.5 while UK patients scored 66.8 and Germans reached 65.5 and Turks received 66.6. Breast cancer patients in Bahrain as an Arab Gulf country scored 63.9 (QoL) but patients in Eastern China scored 53.8 according to Chen et al in 2018. Our research demonstrates that West Bank women received a (QoL) score in line with moderate quality that was lower than observed scores throughout various international studies. The research disparity likely stems from political stress as well as security challenges which affect Palestinian women who have breast cancer during diagnosis. The combination of social, political and economic conditions seems to lead Palestinian women with breast cancer to have lower (QoL) perceptions.

4.2.2 QLQ subscales mean score

In our study, the mean scores for the functional scales of the QLQ-C30 questionnaire revealed varying levels of functioning among respondents, with Social Functioning (SF) showing the highest mean score (52.65, SD = 29.73), followed by Physical Functioning (PF) at 45.76 (SD = 18.43). The mean scores for Emotional Functioning (EF), Cognitive Functioning (CF), and Role Functioning (RF) were 43.27 (SD = 24.79), 39.84 (SD = 23.67), and 36.19 (SD = 26.39), respectively. These results suggest that while social and physical functioning were relatively better, emotional, cognitive, and role functioning were lower compared to the other scales.

In comparison with prior studies, our results ally with the work of Ganesh et al. (2016), where cognitive functioning scored the highest, followed by role and physical functioning, but our study showed much lower mean scores across all functional scales. In contrast to Ganesh et al.'s findings, where social functioning was the least affected, our study reported it as the highest functional scale. Similarly, in the symptom scales, our study identified fatigue (29.85, SD = 14.97) as a significant concern, echo results from both Ganesh et al. (2016) and Islam et al. (2022), where fatigue was one of the most distressing symptoms. However, our study also observed high scores for nausea/vomiting (53.87, SD = 32.08), which contrasts with Ganesh et al.'s study, where nausea/vomiting was less prevalent.

Financial impact (59.06, SD = 34.30) emerged as the most significant distressing symptom in our research, similar to findings in Islam et al. (2022) and Sham et al. (2022), where financial difficulties were a major challenge. However, in contrast to previous studies, the mean score for diarrhea in our study (55.60, SD = 39.60) was notably higher, suggesting regional or cultural differences in the perception or experience of certain symptoms.

Overall, while some of our study findings are congruous with prior studies, significant differences in specific areas, particularly functional and symptom scales, highlight the potential impact of demographic and regional factors on shaping patients' experiences and perceptions of quality of life.

4.3 RQ 2: What is the level of social support received by breast cancer patients in the North West Bank region?

In our current study, the findings revealed that the level of social support among (BC) patients in the West Bank, as measured by the MSPSS, showed that (53.4%) of participants informed a high level of support. The mean score of the MSPSS was 5.13 ± 1.03. The mean scores for the MSPSS subscales were as follows: significant other subscale, 5.84 ± 1.12; family subscale, 5.68 ± 0.95; and friends subscale, 3.87 ± 1.99. The level of support in each subscale showed that (78.1%) of participants reported high support in the significant other subscale, (77.1%) in the family subscale, and (31.9%) in the friends subscale.

Our study findings indicated that social support was moderate, with (53.4%) of respondents reporting moderate levels of support. The research by Sham et al. (2022) showed (85.7%) of students receiving support which indicates our participants experienced lower social support than theirs. The studies showed family members provided the highest support as their main perceived social support source although the participants in Sham et al. (2022) reported higher support levels overall. The studies by Shrestha et al. (2017) and Zamanin et al. (2021) showed different levels of social support scores between them. Shrestha et al. (2017) identified social support score at 85.03 whereas Zamanin et al. (2021) recorded it at 76.01. The study of Kargar et al. (2022) revealed total social support means at 45.7 which was slightly lower than our findings. The participants scored family support as high but evaluated friend support as low in this study.

Research conducted by Jadidi & Ameri (2022) demonstrated social support evaluation at 39.35. Olamuyiwa and Alabere (2022) conducted research in Nigeria and discovered that participants perceived their social support to be at (62.5%) parallel to our study's results. Family members provided extensive support to breast cancer patients according to study findings which matched our study results. Similarly, the results of the Turkish study by Ayik and Saritas (2022) were closer to ours, with a score of 55.6, showing a similar pattern of high perceived social support from family and low support from friends.

Based on the findings from our study and others, it is evident that the perceived social support from family is higher compared to support from friends. This suggests that family plays a central role in supporting the patient and is an integral part of the treatment plan.

The results also revealed statistically significant relationships between several factors and the MSPSS. Specifically, there were significant correlations between:

- Physical Functioning and MSPSS, r(208) = .275, p = .000
- Role Functioning and MSPSS, r(208) = .274, p = .000
- Emotional Functioning and MSPSS, r(208) = .177, p = .010
- Social Functioning and MSPSS, r(208) = .270, p = .000
- Nausea & Vomiting and MSPSS, r(208) = .237, p = .001
- Pain and MSPSS, r(208) = .264, p = .000
- Sleep Disturbance and MSPSS, r(208) = .182, p = .008
- Financial Impact and MSPSS, r(208) = .237, p = .001

5.4 Correlation between (QoL) and social Support

Is there a significant association between the level of social support received by (BC) patients in the North West Bank region and their (QoL)?

Our current study reported a relationship between (QoL) scales and social support, particularly in relation to disturbance, appetite loss, constipation, diarrhea, and financial impact, as measured by the MSPSS.

Table 4.1
Correlations Between Factors and MSPSS

Factor	Correlation Coefficient (r)	Sample Size (n)	p-value
Physical Functioning	0.275	208	0.000
Role Functioning	0.274	208	0.000
Emotional Functioning	0.177	208	0.010
Social Functioning	0.270	208	0.000
Nausea & Vomiting	0.237	208	0.001
Pain	0.264	208	0.000
Sleep Disturbance	0.182	208	0.008
Financial Impact	0.237	208	0.001

Olamuyiwa & Alabere (2022) indicated in their study that the correlation between Health-Related Quality of Life (HRQoL) and MSPSS was positive (Pearson correlation coefficient < 0.29) and statistically significant ($p < 0.05$). A Chinese study by Ban et al.

(2021) found that the mean MSPSS score was 60.6, with social support positively correlated with (QoL) ($r = 0.472$, $p < 0.01$).

Additionally, the Multidimensional Scale of Perceived Social Support (MSPSS) and physical functioning showed a strong positive connection ($r = .275$, $n = 208$, $p = 0.000$) in the current study. This implies that improved physical functioning was probably experienced by people who reported having more social support. The TPSST and (QoL) both showed a positive and statistically significant link in Sham et al.'s study, suggesting that more support is good for all facets of health.

Social support demonstrates typically beneficial results on breast cancer patient quality of life according to Solikhah et al. (2023) through enhanced psychological adjustment and better therapeutic adherence.

Our findings support Zamanin et al. (2021) that social support among (BC) patients remains high because women benefit greatly from their positive social relationships for enhanced overall quality of life. Multiple studies conducted in Norway and Iraq together with China and Saudi Arabia and Ethiopia found evidence that social support creates a major influence on (QoL) (Haugland et al. (2016); Imran et al. (2019); Shen et al. (2020); Wondimagegnehu et al. (2019).

Our study and similar research indicate social support shares a significant relationship with (QoL) based on their connected variables. Social support proves essential in enhancing (QoL) among all cancer patients as well as those diagnosed with breast cancer.

4.5 Recommendations

Working to improve the quality of life of breast cancer patients by implementing effective measures and strategies in partnership with health institutions, local community organizations, and the environments of patients and their families.

A Specific Social Support Plan Development: Designing cultural-based social support initiatives for breast cancer patients that recognize their unique economic status and social settings.

Psychosocial Interventions should be adopted as a healthcare system which provides social support networks for (BC) patients.

Professional healthcare providers should receive training about the significance of social support for (BC) patients to improve patient care.

Calling on policy-makers in the Palestinian health system to focus on the psychological, social, and quality-of-life needs of breast cancer patients, just as they focus on their health needs.

Conducting awareness campaigns to raise awareness in the Palestinian community about the importance of social support for (BC) patients and its impact on their health, psychological state, and (QoL).

Boosting Symptom Management: increase focusing about the requirement for optimal symptom management, specifically for gastrointestinal and respiratory complaints. Tailored treatments, such as antiemetics , pain management plans, and respiratory therapy, should be prioritized. The results showed revealed notable symptom scores for Nausea and Vomiting (53.87), Dyspnea (52.14), and Diarrhea (55.60), highlighting the need for targeted symptom control programs.

Longitudinal Studies on Social Support and (QoL): Conducting longitudinal studies to better understand the impact of social support on the long-term (QoL) for (BC) survivors.

4.6 Limitation

1. Time Constraints: Limited time available for conducting the study.
2. Difficulty in Reaching Respondents: Difficulty in reaching respondents from outside the governorate due to restrictions on movement between governorates, which are influenced by the political situation and the occupation's imposed limitations.
3. Lack of Comprehensive Studies: There is a lack of studies that simultaneously address both quality of life and social support; most studies have focused on each dimension separately.
4. Limited Access to Data: Limited access to data due to a lack of response from women who were part of the study.
5. Study Design: As a quantitative study, the design does not allow respondents to fully express their feelings and experiences, which a qualitative study would provide.

List of Abbreviations

Abbreviations	Explanation
BC	Breast Cancer
CDC	Center for Disease Control and Prevention
EORTC QLQ-C30	The European Organization for Research and Treatment of Cancer Quality of Life Questionnaire Core 30
FQ	fatigue questionnaire
K-S	Kolmogorov-Smirnov test
MPSS	Multidimension Perceived Social Support
QoL	Quality of Life
RQ	Research Question
SOC	Sense of Coherence
SPS	The Social Provisions Scale
SSTs	social support types
TSS	total social support
WHO	The World Health Organization

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Appendices

Appendix (A)

Questionnaire in English

Faculty of Graduate Studies

Community Mental Health Nursing Program

Quality of Life and Social Support Among Palestinian Breast Cancer Women

Section one: Demographic data

Age:----------

Marital status: ☐ single ☐ Married or widowed

Work: ☐ work ☐ not work

District: ☐ city ☐ village ☐ camp

Who support you financially:

Parents ☐ I work, ☐ no financial support ☐

Number of sisters----------

Number of brothers----------

Section 2: Quality of Life

Please: Put a (x) on the answer you think is appropriate

	Question	Not All	A little	Quite a Bit	Very Much
1	Do you have any trouble doing strenuous activities, like carrying a heavy shopping bag or a suitcase?				
2	Do you have any trouble taking a long walk?				
3	Do you have any trouble taking a short walk outside of the house?				
4	Do you need to stay in bed or a chair during the day?				
5	Do you need help with eating, dressing, washing yourself or using the toilet?				

During the past week:

	Question	Not All	A little	Quite a Bit	Very Much
6	Were you limited in doing either your work or other daily activities?				
7	Were you limited in pursuing your hobbies or other leisure time activities?				
8	Were you short of breath?				
9	Have you had pain?				
10	Did you need to rest?				
11	Have you had trouble sleeping?				
12	Have you felt weak?				
13	Have you lacked appetite?				
14	Have you felt nauseated?				
15	Have you vomited?				
16	Have you been constipated?				
17	Have you had diarrhea?				
18	Were you tired?				
19	Did pain interfere with your daily activities?				
20	Have you had difficulty in concentrating on things, like reading a newspaper or watching television?				
21	Did you feel tense?				
22	Did you worry?				
23	Did you feel irritable?				
24	Did you feel depressed?				
25	Have you had difficulty remembering things?				

26	Has your physical condition or medical treatment interfered with your family life?				
27	Has your physical condition or medical treatment interfered with your social activities?				
28	Has your physical condition or medical treatment caused you financial difficulties?				

For the following questions please circle the number between 1 and 7 that best applyed to you

How would you rate your overall health during the past week?

7 (Excellent)	6	5	4	3	2	1 (Very Poor)

How would you rate your overall quality of life during the past week?

7 (Excellent)	6	5	4	3	2	1 (Very Poor)

…….

Section Three: Multidimensional Scale of Perceived Social Support

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the “1” if you Very Strongly Disagree

Circle the “2” if you Strongly Disagree

Circle the “3” if you Mildly Disagree

Circle the “4” if you are Neutral

Circle the “5” if you Mildly Agree

Circle the “6” if you Strongly Agree

Circle the “7” if you Very Strongly Agree

There is a special person who is around when I am in need.	1	2	3	4	5	6	7
There is a special person with whom I can share my joys and sorrows	1	2	3	4	5	6	7
My family really tries to help me.	1	2	3	4	5	6	7
I get the emotional help and support I need from my family	1	2	3	4	5	6	7
I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7
My friends really try to help me.	1	2	3	4	5	6	7
I can count on my friends when things go wrong	1	2	3	4	5	6	7
I can talk about my problems with my family.	1	2	3	4	5	6	7
I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
There is a special person in my life who cares. about my feelings	1	2	3	4	5	6	7
My family is willing to help me make decisions	1	2	3	4	5	6	7
I can talk about my problems with my friends.	1	2	3	4	5	6	7

Appendixes (B)

Questionnaire in Arabic

جودة الحياة والدعم الاجتماعي لدى النساء الفلسطينيات المصابات بسرطان الثدي

الجزء الاول : المعلومات الديمغرافية:

العمر :

الوضع الاجتماعي : ☐ اعزب . ☐ متزوج او ارمل

العمل : ☐ اعمل ☐ لا اعمل

مكان السكن: ☐ مدينة ☐ مخيم ☐ قرية

من الداعم المادي لديك : ☐ الاهل ☐ لدي وظيفة ☐ لا يوجد داعم مادي

عدد الاخوة الذكور:----------

عدد الاخوة الاناث:----------

الجزء الثاني: جودة الحياة

من فضلك: ضع علامة (×) على الإجابة التي تراها مناسبة

	السؤال	إطلاقا	قليلا	بما فيه الكفاية	كثيرا جدا
1	هل لديك صعوبة في بذل مجهود جسدي شاق (متعب) مثل حمل كيس مشتريات ثقيل أو حقيبة؟				
2	هل لديك صعوبة بالمشي لمسافة طويلة؟				
3	هل لديك صعوبة بالمشي لمسافة قصيرة خارج البيت؟				
4	هل تحتاج للبقاء في السرير أو الكرسي خلال اليوم؟				
5	هل تحتاج للمساعدة في الأكل أو ارتداء الملابس أو الاغتسال أو استخدام المرحاض؟				

خلال الأسبوع الماضي:

	السؤال	إطلاقا	قليلا	بما فيه الكفاية	كثيرا جدا
6	هل كنت محدودا/ مقيدا عند القيام بعملك أو نشاطات يومية أخرى؟				
7	هل كنت محدودا/ مقيدا في ممارسة هواياتك أو نشاطات في اوقات الفراغ؟				
7	هل شعرت بضيق بالنفس؟				
9	هل شعرت بأي ألم؟				
10	هل كنت بحاجة للراحة؟				
11	هل عانيت من مشاكل في النوم (أرق/ صعوبة في النوم/ نوم متقطع)؟				
12	هل شعرت بالضعف؟				
13	هل فقدت شهيتك للطعام (القدرة على الآكل)؟				
14	هل شعرت بالغثيان (اللعيان)؟				
15	هل تقيأت؟				
16	هل عانيت من إمساك				
17	هل كان لديك إسهال؟				
18	هل كنت متعبا؟				
19	هل عانيت من ألم ثر سلبًيا على نشاطاتك اليومية؟				
20	هل كان لديك صعوبة بالتركيز في بعض الأمور مثل قراءة الجريدة أو مشاهدة التلفاز؟				
21	هل شعرت بالتوتر؟				
22	هل شعرت بالقلق؟				
23	هل شعرت بالانزعاج؟				
24	هل شعرت باكتئاب ؟				

25	هل كانت لديك صعوبة بتذكر الأشياء؟				
26	هل حالتك الجسدية أو علاجك الطبي أثّر سلبي على حياتك العائلية؟				
27	هل حالتك الجسدية أو عالجك الطبي أثّر سلبي ا على حياتك الاجتماعية؟				
28	هل حالتك الجسدية أو عالجك الطبي أديا إلى مشاكل مالية؟				

الجز الثالث: مقياس الدعم الاجتماعي المتعدد الأبعاد

التعليمات: اقرأ كل عبارة بعناية وحدد كيف تشعر بشأن كل عبارة استعمل المقياس أدنى من واحد إلى سبعة لتقييم كل بند من البنود من خلال وضع دائرة على الرقم المناسب

اذا كانت اجابتك **اعترض بشده** ضع دائرة حول رقم **(1)**

اذا كانت اجابتك **اعترض باعتدال** ضع دائرة حول رقم **(2)**

اذا كانت اجابتك **اعترض قليلا** ضع دائرة حول رقم **(3)**

اذا كانت اجابتك **حيا دي** ضع دائرة حول رقم **(4)**

اذا كانت اجابتك **اوافق قليلا** ضع دائرة حول رقم **(5)**

اذا كانت اجابتك **اوافق باعتدال** ضع دائرة حول رقم **(6)**

اذا كانت اجابتك **اوافق بشدة** ضع دائرة حول رقم **(7)**

هناك شخص مميز بجانبي عندما أحتاجه	1	2	3	4	5	6	7
هناك شخص مميز استطيع أن أشارك أفراحي وأحزانني معه	1	2	3	4	5	6	7
عائلتي تحاول مساعدتي	1	2	3	4	5	6	7
أنال مساعدة عاطفية ودعم من عائلتي	1	2	3	4	5	6	7
هناك شخص مميز هو / هي مصدر حقيقي للراحة لي	1	2	3	4	5	6	7
أصدقائي يحاولون مساعدتي.	1	2	3	4	5	6	7
بإمكاني الاعتماد على أصدقائي عندما تجري الأمور بشكل سيئ	1	2	3	4	5	6	7
بإمكاني التحدث عن مشاكلي مع عائلتي	1	2	3	4	5	6	7
عندي أصدقاء استطيع أن أشاركك أفراحي وأحزانني معهم	1	2	3	4	5	6	7
هناك شخص مميز في حياتي يهتم بمشاعري	1	2	3	4	5	6	7
عائلتي ترغب في مساعدتي لاتخاذ القرارات	1	2	3	4	5	6	7
استطيع أن أتحدث عن مشاكلي مع أصدقائي	1	2	3	4	5	6	7

نموذج موافقة:

تحية طيبة، أنا ولاء أبو صاع، طالبة ماجستير في برنامج تمريض الصحة النفسية المجتمعية في جامعة النجاح الوطنية، أقوم بإجراء دراسة حول "جودة الحياة والدعم الاجتماعي لدى النساء الفلسطينيات المصابات بسرطان الثدي". تحت اشراف الدكتور عدنان سرحان.

عزيزتي: أدعوك للمشاركة في هذه الدراسة لأغراض البحث العلمي وذلك بتعبئة هذا الاستبيان الذي يستغرق من 20 –25 دقيقة، حيث جميع المعلومات المقدمة التي ستقدمينها ستكون سرية للغاية ودون الحاجة إلى معرفات شخصية.

إن مشاركتك طوعية، ويحق لك الانسحاب في أي وقت دون شروط أو قيد.

للاستفسار رقم الجوال:6378-362-59 972+

ملاحظة: يتكون هذا الاستبيان من ثلاثة أجزاء، الجزء الاول المعلومات الديمغرافية للمشاركة، الجزء الثاني: عن جودة الحياة للمشاركة، والجزء الثالث مقياس الدعم الاجتماعي.

توقيع المشترك:.....

توقيع **الباحث** : .....

التاريخ: .....

Appendixes (C)

Institutional Review Board

An-Najah National University
Faculty of Medicine & Health Sciences
Institutional Review Board

جامعة النجاح الوطنية
كلية الطب وعلوم الصحة
لجنة اخلاقيات البحث العلمي

Ref: Mas. Jan. 2024/11

IRB Approval Letter

Title of Research:

Quality of Life and Social Support Among Palestinian Breast Cancer Women

Submitted by:
Wala'a Hani Abdul-Jabbar Abu Sa'A

Supervisor:
Adnan Sarhan

Approved:
4th Jan. 2024

Your Study Title **"Quality of Life and Social Support Among Palestinian Breast Cancer Women"** reviewed by An-Najah National University IRB committee and was approved on 4th Jan. 2024.

Hasan Fitian, MD

IRB Committee Chairman

IRB Institutional Review Board

Nablus - P.O Box :7 or 707 | Tel (970) (09) 2342902/4/7/8/14 | Faximile (970) (09) 2342910| E-mail : IRB@najah.edu

جامعة النجاح الوطنية
كلية الدراسات العليا

جودة الحياة والدعم الاجتماعي لدى النساء الفلسطينيات المصابات بسرطان الثدي

إعداد
ولاء هاني أبو صاع

إشراف
د. عدنان سرحان

قدمت هذه الرسالة استكمالا لمتطلبات الحصول على درجة الماجستير في تمريض الصحة النفسية المجتمعية،
من كلية الدراسات العليا، في جامعة النجاح الوطنية، نابلس–فلسطين.
2025

جودة الحياة والدعم الاجتماعي لدى النساء الفلسطينيات المصابات بسرطان الثدي

إعداد
ولاء هاني أبو صاع
إشراف
د. عدنان سرحان

الملخص

الخلفية: إن معدلات الإصابة بالسرطان والوفيات الناتجة عنه في ازدياد سريع على مستوى العالم، ويُعد سرطان الثدي من بين أهم أسباب الوفاة لدى النساء سواء عالميًا أو في فلسطين، مما يجعله يشكل تحديًا كبيرًا لجودة الحياة بين النساء. يلعب الدعم الاجتماعي دورًا حاسمًا وأساسيًا في حياة الفرد اليومية.

الهدف: تهدف هذه الدراسة إلى تقييم جودة الحياة بين النساء المصابات بسرطان الثدي، وتقييم مستوى الدعم الاجتماعي الذي يتلقينه، والتحقيق في العلاقة بين جودة الحياة والدعم الاجتماعي.

المنهجية: تم استخدام تصميم مقطعي في الدراسة بين 210 نساء تم تشخيصهن بسرطان الثدي في وحدات الرعاية النهارية في مستشفيات الضفة الغربية بفلسطين. لقياس جودة الحياة والدعم الاجتماعي بين النساء المصابات بسرطان الثدي، استخدمت الدراسة النسخة العربية من استبيان "منظمة الأبحاث والعلاج الأوروبية لجودة الحياة (EORTC QLQ-C30) "لجودة الحياة، واستبيان "الدعم الاجتماعي المدرك(MPSS)" للدعم الاجتماعي.

النتائج: شاركت في الدراسة حوالي 210 مريضة تم تشخيصهن بسرطان الثدي. كان متوسط العمر 50.54 ± 11.83 عامًا، وكانت حوالي (72.4%) من المشاركات متزوجات، وأكثر من ثلثيهن (73.8%) عاطلات عن العمل. حوالي نصف المشاركات (51.4%) يعشن في المدن، وغالبية المشاركات (73.3%) يعتمدن على عائلاتهن في الدعم المالي. أظهرت النتائج أن جودة الحياة بين النساء المصابات بسرطان الثدي بلغت 52.33، مما يشير إلى مستوى متوسط من الرفاهية العامة في هذه الفئة. كما أظهرت النتائج

وجود ارتباط إيجابي كبير ($p < 0.001,\ r = 0.65$) بين الدعم الاجتماعي وجودة الحياة بين مرضى سرطان الثدي. وأفاد (78%) من المشاركات بمستويات دعم اجتماعي متوسطة إلى عالية.

الخلاصة: تشير نتائج الدراسة الحالية إلى وجود تطبيقات عملية لزيادة جودة الحياة لدى مرضى سرطان الثدي من خلال توظيف مفهوم الدعم الاجتماعي. تُظهر التمايز في أنواع الدعم الاجتماعي والحاجة إلى تدخلات محددة أن هناك حاجة إلى اتصالات فردية عالية لتعزيز جودة الحياة للمرضى.

الكلمات المفتاحية: سرطان الثدي، جودة الحياة، الدعم الاجتماعي، فلسطين.