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# Impact of Preoperative Anxiety on Post-Operative Recovery of Surgery: Mediating Role of Social Support



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**Abstract:** The current study is to find the "Impact of Preoperative Anxiety on Post-Operative Recovery of Surgery Mediating Role of Social Support". A quantitative research design used in the survey method by using a questionnaire. The sample consists of 400 general surgical patients selected through the purposive sampling technique from the surgical wards of hospitals in Bahawalpur (Victoria Hospital, Civil Hospital), Nishter Hospital Multan, DhqMuzaffargarh and Layaah Hospital Pakistan. A priori power analysis calculated by using G\*power analysis 3.1.9 for correlation (Faul, et al., 2007). The Sample size for current study would be 400. These instruments would use to collect the data The Amsterdam Preoperative Anxiety and Information Scale (APAIS), Surgical Recovery Scale (SRS) and Multidimensional Scale of Perceived Social Support (MSPSS). The result indicates that there is positive correlation between Preoperative Anxiety and Postoperative recovery. The result indicates that there is positive correlation between postoperative recovery and social support. The result of linear regression indicates that there is a significant impact of Preoperative Anxiety on Postoperative recovery. Mediation results indicated that preoperative anxiety was found to be positive significant predictor of postoperative recovery. So, mediation was found to be significant. However, the indirect effect of social support was found to be positively significant between preoperative anxiety and postoperative recovery.

Keywords: Pakistan,

### Introduction

### **Background of the Study**

The patient response to surgery has been of interest to investigators for many years. The metabolic responses of four patients with lower limb injury. After the early work on the stress response to accidental injury, attention was turned to surgical trauma and responses to most types of surgery were documented (Desborough, 2000). This research identifies and measures the impacts of pre-operative anxiety on postoperative recovery of general surgical patients.

### **Preoperative Anxiety**

Anxiety, commonly known as the "fear of the unknown" or "fear of what might happen," is a well-known mental state connected with anaesthesia. Anxiety before surgery is extremely common, with reports ranging from 60% to 92% among individuals undergoing no selective surgical operations. There is also a discrepancy in reported incidence between other surgical specialties. Preoperative anxiety is defined as apprehension or nervousness about an upcoming medical procedure, particularly one involving the use of anesthetic (Maranets & Kain, 1999). Patients commonly experience heightened levels of anxiety in the days preceding up to surgery (Yilmaz et al., 2012). However, it has been reported that a higher preoperative level of anxiety increases the risks associated with surgery, such as the morbidity and mortality (Frazier et al., 2003), the delay in wound healing (Christian et al., 2006), longer hospital stays (Stirling et al., 2007), and the need for additional anesthesia and (Maranets & Kain, 1999) analgesics after surgery Patients, as opposed to the general population, were found to have a much higher prevalence of preoperative anxiety by Norris and Baird (1967).

Preoperative anxiety is rather common, despite the fact that both modern surgery and anesthesia are safer than they have ever been (Kaye et al., 2014). Preoperative apprehension is quite common in adult patients, with reported rates ranging from 11% to 80%. Several researchers (Agarwal et al., 2005) came to this conclusion.

Preoperative anxiety is commonly diagnosed during patient evaluations, and the degree of concern varies widely from one individual to the next. Worry before surgery is frequent due to the uncertainty, however patients with significantly elevated levels of anxiety may be dismissed or discounted by preoperative staff. Multiple studies have concluded that patients feel the impact of preoperative anxiety on both physiological and psychological level. 1 Anxiety can affect a person's mental state, emotional state, and conduct. The patient's vital signs may vary because of the patient's anxiety. For a nurse in the pre-op area, this may be the first indicator that their patient is experiencing substantial anxiety.

### **Post-operative Recovery**

When the patient has fully recovered from surgery, all pre-existing conditions should have resolved and normal function should have resumed. When it is most convenient to assess the patient's progress and the severity of their symptoms, than the patient, their doctor, and the institution can all make their own choices. The duration of hospital stay, the number of complications, and the beginning of organ failure were initially determined by clinicians rather than patients as important outcomes along the "better recovery after surgery" route. Patients are not convinced by evidence that the accelerated recovery pathway can shorten their hospital stays or lower their risk of problems.

Patients are often still experiencing symptoms and have not restored to normal function at the time of discharge after major surgery, which is mostly determined by organizational variables and does not correlate well with longer term recovery. It is now common practice to evaluate the success of postoperative enhanced recovery in three distinct phases: immediately after surgery until discharge from the post anaesthetic care unit; after hospital discharge until normal function has been restored; and immediately after normal function restoration. In the beginning, physiological factors have the greatest impact. In phases two and three, pain and the increasingly complex physiology and function play a more central role. The time between 28 and 60 days post-op is known as the "intermediate phase of recuperation." Most significantly influencing the rate of recovery during the intermediate phase are the presence of pain, anxiety, melancholy, physical handicap, and cognitive dysfunction.

The late postoperative healing period typically lasts between three and six months after surgery. The patient may still be experiencing symptoms from the early and intermediate stages of recovery. The patient has completed a full recovery when they are able to perform all of their previous duties and have experienced no residual complications as a result of the surgery. Initially designed by doctors rather than patients, the 'better recovery after surgery' paths put the focus on the patient's experience while in the hospital, including the length of their stay, any complications they encountered, and any early organ failure. The advantages of a shorter hospital stay and fewer complications associated with the enhanced recovery pathway are of limited interest to patients because they rarely return to pre-surgery levels of function and are typically symptomatic upon discharge after major surgery, the timing of which is influenced by organizational factors and correlates poorly with longer term recovery.

A clear definition of the term "postoperative recovery" has yet to be established despite its frequent use. The more common a notion is, the more likely it is to be applied mindlessly. Furthermore, the same idea may be interpreted differently in different disciplines. The period after ambulatory surgery can be divided into three separate phases: the preoperative, postoperative, and recuperation phases (Steward & Volgyesi, 1978; Korttila, 1995). Until patients have fully acquired their vital protective reflexes after aesthetic has been stopped, they are still in the early period.

It is called a "intermediate phase" because it spans the time between when a patient's vital signs have stabilized again and when they are ready to be discharged home. Patients are considered to be in the post-operative period once they have been released from the hospital and will remain in this phase until they have returned to pre-operative health (Steward & Volgyesi, 1978, Marshall & Chung, 1999). These three phases of recovery probably apply to hospitalized patients as well. According to a holistic perspective, postoperative recovery is an increase in functional status and the perception that one is recovering from surgery (Zalon, 2004).

### **Social Support**

In recent years, researchers have paid a lot of attention to the impact of social networks. "Individuals who are less socially isolated or less integrated are less healthy, socially psychologically and physically, and more likely to die," House et al. (1988) write in their review of the findings. There is no unified body of knowledge because researchers used different conceptual and operational definitions of social support, collected cross-sectional data, and used samples that varied in age, gender, and illness experiences. House and colleagues (House & Kahn, 1985; House et al., 1988; House et al., 1988) argue that researchers studying social support should account for at least two and preferably three aspects of social relationships:

(1) the presence and extent of relationships; (2) the organization of social networks; and (3) the functional content and quality of interpersonal connections.

### **Rationale of the Study**

Despite the fact that there is currently no definitive study from previous researches on pre-operative anxiety, post-operative recovery, and social support among general surgery patients, this does not mean that more investigation is not warranted. The current study aims to investigate "the impact of preoperative anxiety on postoperative recovery among general surgery patients in Pakistan via the mediating role of social support." Many Researchers in Pakistan are conducting a survey to assess the mediating impact of social support in reducing preoperative anxiety and promoting postoperative recovery in patients undergoing general surgical procedures. Researchers will utilize questionnaires to quantify pre-operative anxiety, post-operative recovery, and social support by asking a series of questions regarding these factors to a sample of the community.

### Literature Review

Anxiety is characterised by feelings of unease, concern, fear, tension, and anxiety, among other possible manifestations. It is a reaction to something that is either external or internal, and its symptoms might include behavioural, emotional, cognitive, and even physical manifestations. The preoperative phase is typically cited as one of the most stressful times for surgical patients. It frequently brings on a variety of cognitive, emotional, and physiological responses. The provision of improved surroundings and a higher quality of life for a patient before, during, and after surgery is the primary focus of preoperative nursing care (Sigdel, 2015).

Anxiety in patients prior to surgery is a serious issue that must be addressed. Since the patient's life is at jeopardy, it is natural and logical that he or she would feel anxious about the situation. This is especially true for people who are going under the knife for the first time. Anxiety prior to surgery, on the other hand, has been linked to slower wound healing, a higher requirement for anaesthetics, and poorer recovery results. Doctors generally accept that patients will feel some level of worry in the hours before surgery (Stirling, 2007). Pain after surgery is just one complication that could have been avoided with less preoperative anxiety. Surgical patients frequently report experiencing pain after their procedure, and this discomfort is frequently associated with the patients' preexisting levels of worry. Worrying too much in the days leading up to surgery has been related to a host of negative outcomes, including nausea, vomiting, heart palpitations, hypertension, and even infection. Anxiety before to surgery is a known problem for many people who need medical attention; estimates put the percentage of anxious patients undergoing surgery at 60-80%.

According to Munafo & Stevenson (2001), surgical patients often experience anxiety and worry before and after their procedures. A patient's worry before undergoing surgery, being hospitalised or receiving anaesthesia is known as "preoperative jitters" (Maranets & Kain, 1999). Significant preoperative anxiety is a common patient experience (Pierantognetti et al., 2002). Increased postoperative morbidity and mortality (Frazier et al. 2003), delayed wound healing (Christian et al., 2006, Vileikyte, 2007), lengthened hospital stays (Stirling et al., 2007), and the requirement for additional anaesthesia and analgesics have all been associated to preoperative anxiety (Maranets & Kain, 1999).

Norris and Baird (1967) observed that the prevalence of preoperative anxiety was significantly higher in patients than in the general population. Preoperative nerves persist despite significant decreases in surgical and anaesthetic risks during the past few decades (Nishimori et al., 2002). Between eleven percent and eighty percent of adult patients experience anxiety prior to surgery. It has been reported by Agarwal et al. (2005). Eighty-nine percent of respondents to a survey of persons undergoing neurosurgery reported feeling nervous beforehand (Perks et al., 2009). The majority of patients (66.7%) exhibited moderate anxiety, according to research by Kalkhoran & Karimollahi (2007). Anxiety is common among

surgical patients, according to multiple Turkish studies (Aykent et al., 2007, Yardakc & Akyolcu, 2004, Karanci & Dirik, 2003, Akkas & Gursoy, 2001).

# Hypothesis

Following are the hypotheses covering the above-mentioned objectives of the study:

- 1. There will be significant correlation among pre-operative anxiety, post-operative recovery, and social support.
- 2. There will be pre-operative anxieties have significant influence on the post-operative recovery
- 3. There will be a significant impact of social support on post-operative recovery among general surgical patients
- 4. Social support will mediate the relationship between pre-operative anxiety and post-operative recovery.
- 5. There would be demographic difference in (age, education, residence, family system and socioeconomic status) in terms of preoperative anxiety and post-operative recovery.

# Method

# **Research Design**

For this work the quantitative analysis method has been used. With the true spirit of quantification, cross-sectional research design was employed.

# Participants

The sample consists of 400 general surgical patients selected through the purposive sampling technique from the surgical wards of hospitals in Pakistan Victoria Hospital, Civil Hospita, Nishter Hospital Multan, DhqMuzaffargarh and Layaah Hospital Pakistan. A priori power analysis calculated by using G\*power analysis 3.1.9 for correlation (Faul et al., 2007) to ensure that the study has sufficiently powered for analysis or sufficient sample size was determined 364 with effect size 0.17, power .95 and alpha error .05. The Sample size for current study would 400, 36 participants taken additionally to overcome attrition rate and

biasness.

### **Demographic Sheet**

This sheet comprises on the respondent name (optional), age, education, residence, family system and socioeconomic status. The researcher designed this sheet according to the understanding of the needs of the required information.

### Instruments

There are three instruments

- 1. The Amsterdam Preoperative Anxiety and Information Scale (APAIS)
- 2. Surgical Recovery Scale (SRS)
- 3. Multidimensional Scale of Perceived Social Support (MSPSS)

The Amsterdam Preoperative Anxiety and Information Scale (APAIS). In 1996, the Dutch company Moermann created the Amsterdam Preoperative Anxiety and Information Scale (APAIS), which consists of 6 items (statements). There is a desire for information and there is worry regarding anesthesia and operation. Using a Likert scale from 1 (not at all) to 5 (very), participants in the study are asked to rate the

# Results

### Table 4.1

*Descriptive Statistics of demographic variables of sample (N=400)* 

degree to which each statement applies to them.

Surgical Recovery Scale (SRS). The Surgical Recovery Scale (SRS) utilized to evaluate how we were doing emotionally and practically after surgery. It has 13 items, 8 of which are graded on a 6-point scale (1 = never, 2 = practically never, 3 = sometimes, 4 = pretty often, 5 = very often, 6 = often). There are six possible responses for each of the next nine to thirteen items: 1 for never, 2 for rarely, 3 for rarely but more often than usual, 4 for almost as often as usual, 5 for frequently, and 6 for never.

*Multidimensional Scale of Perceived Social Support (MSPSS).* Zimet and Farley created the Multidimensional Scale of Perceived Social Support (MSPSS) (1988). This scale is a 12-item self-report assessment tool for gauging the extent to which one feels loved and cared for by one's family, friends, and romantic partner (Zimet et al., 1988). There are four questions that evaluate different types of social support, and respondents could either (1) strongly disagree with the statement, (2) moderately disagree with it, (3) moderately agree with it, (4) remain neutral, (5) moderately agree with it, (6) strongly agree with it, or (7) enthusiastically agree with it.

Demographic va	riables	N	(%)	M(S.D)
Gender		400		1.44 (.496)
	Male	226	56.5	
	Female	174	43.5	
Age		400		2.07 (.703)
	18-30	81	20	
	31-45	208	52	
	46-60	106	26.5	
Family system		400		1.37 (.481)
	Combined	251	63	
	Unmarried	149	37	
Socio economic	status	400		1.87(.481)
	Low	76	19	
	Middle	300	75	
	High	24	6	

The provided table presents descriptive statistics for demographic variables within a sample of 400 individuals. Firstly, in terms of gender distribution, the sample consists of 56.5% males and 43.5% females, with a mean gender score of 1.44 and a standard deviation of 0.496. Regarding age distribution, the sample spans across three age groups: 18-30 (20%), 31-45 (52%), and 46-60 (26.5%), with a mean age score of 2.07 and a standard deviation of 0.703. The family system variable indicates that 63%

# of the sample comes from combined families, while 37% are from unmarried families, with a mean family system score of 1.37 and a standard deviation of 0.481. Finally, the socioeconomic status distribution shows that 19% belong to the low category, 75% to the middle category, and 6% to the high category, with a mean socioeconomic status score 1.87 and a standard deviation of 0.481. These statistics provide a comprehensive overview of the demographic characteristics within the sample.

### Table 4.2

Reliability of Scales

Scales	No. of Items	Cronbach's Alpha
The Amsterdam Preoperative Anxiety and Information Scale	6	.81
Surgical Recovery Scale	13	.84
Multidimensional Scale of Perceived Social Support	12	.92

The results in Table 4.2 the reliability of The Amsterdam Preoperative Anxiety and Information Scale is .81. The reliability of Surgical Recovery Scale is .84 and the reliability of Multidimensional Scale of Perceived Social Support is .92 the reliability for each scale is high.

### Table 4.3

Correlation Analysis

Variable	Preoperative Anxiety	Postoperative recovery	Social support
Preoperative Anxiety	1	.467**	.591**
postoperative recovery		1	.472**
Social support			1

Table 4.3 the result indicates that there is positive correlation between Preoperative Anxiety and Postoperative recovery and the strength of correlation is .467. The result indicates that there is positive correlation between Preoperative Anxiety and Social support and the strength of correlation is .591. The result indicates that there is positive correlation between postoperative recovery and Social support and the strength of correlation is .472.

### Table 4.4

		Coefficien	t			95% C.	Ι
						LL	UL
Predictor	В	В	S EB	Т	Р		
(Constant)	.122	4.767		.024	.981	33.1	43.1
Preoperative Anxiety	.956	.179	.307	5.354	.000		
F	66.8						
R2	.284						

Linear Regression to Show the Impact of Preoperative Anxiety on Postoperative recovery

In table 4.4 the result of linear regression indicates that there is a significant impact of Preoperative Anxiety on Postoperative recovery. R Square is the coefficient of determination (r square value is computed to measure the percentage of variance. In linear regression equation the value of r square (.01 small effect, .09 medium effect and .25 large effect) describes the proportion of the total variability of y scores that is accounted by regression equation). The value of R Square is .284. This value suggests that 28.4% variability in Preoperative Anxiety can be predicted from Postoperative recovery.

### Table 4.5

Linear Regression to Show the Impact of Social support on postoperative recovery

		<u>Coefficien</u>	et			95% C.	I
Predictor	В	В	S EB	Т	Р	LL	UL
(Constant)	.122	4.767		.024	.981	33.1	43.1
Social support	.402	.080	.29	5.05	.000	30.3	44.1
F	95.3						
R2	.223						

In table 4.5 the result of linear regression indicates that there is a significant impact of Social support on postoperative recovery. R Square is the coefficient of determination (r square value is computed to measure the percentage of variance. In linear regression equation the value of r square (.01 small effect, .09 medium effect and .25 large effect) describes the proportion of the total variability of y scores that is accounted by regression equation). The value of R Square is .223. This value suggests that 28.4% variability in Social support can be predicted from Postoperative recovery.

### Table 4.6

Mediation Analysis between pre-operative anxiety and post-operative recovery through social support (N=400)

Antecedent	Consequent								
	social suppo	social support			postoperative recovery				
	Coeff.	SE	Р	Coeff.	SE	Р			
Constant	38.7390	2.49	.000	.112	4.76	.981			
preoperative anxiety	1.32	.099	.000	.955	.178	.000			
social support	-	-	-	.402	.079	.000			
	$R^2 = .349$			$R^2 = .284$					
	F(1,335) =	179.7, <i>p</i> <.	001	F(1,335) = 66.22, p < .001					

Note: Coeff= standardized regression coefficient

The results in table 4.6 indicated that preoperative anxiety was found to be positive significant predictor of postoperative recovery and social support. Whereas social support was found to be significant predictor of postoperative recovery. So, mediation was found to be significant. However the indirect effect of social support was found to be positively significant between preoperative anxiety and postoperative recovery.

### Table 4.7

Independent Samples t-test Comparing Study Variables (Preoperative Anxiety, postoperative recovery and Social support) in Male and female (N=400)

Variable	Male (n = 226)		Female 174)	(n=			95% CI		
	М	SD	М	SD	t (197)	р	LL	UL	Cohen's d
Preoperative Anxiety	24.0	4.46	24.5	5.05	1.2	.220	- 1.52	.351	0.34
postoperative recovery	50.13	11.8	52.033	15.8	-1.3	.17	-4.6	.828	0.23
Social support	71.23	9.52	72.57	9.79	1.2	.20	-3.4	.75	0.33

The results in table 4.7 show that there are no difference in Male and female on Preoperative Anxiety, postoperative recovery and Social support as there is very low difference in mean and value of standard deviation.

### Table 4.8

Independent Samples t-test Comparing Study Variables ((Preoperative Anxiety, postoperative recovery and Social support) in Combined and Nuclear (N=400)

Variable	Combined $(n = 251)$		Nuclea 149)	ar (n=	95% CI				
	М	SD	М	SD	t (197)	р	LL	UL	Cohen's d
Preoperative Anxiety	24.0	4.63	24.1	4.90	1.12	.220	- 1.52	.351	0.34
postoperative recovery	52.13	13.8	48.9	13.8	-1.33	.17	-4.6	.828	0.23
Social support	71.2	10.52	72.57	9.9	1.12	.20	-3.4	.75	0.33

### Table 4.9

Analysis of Variance Comparing age group (N=400).

		Sum of	Df	Maan Sawana	Б	<b>C</b> :~
Variable		Squares	DI	Mean Square	Г	51g.
Preoperative Anxiety	Between Groups	206.494	3	68.831	3.113	.026
	Within Groups	8710.350	394	22.107		
	Total	8916.844	397			
postoperative recovery	Between Groups	1626.753	3	542.251	2.917	.034
	Within Groups	73057.162	393	185.896		
	Total	74683.914	396			
Social support	Between Groups	153.627	3	51.209	.548	.650
	Within Groups	31099.435	333	93.392		
	Total	31253.062	336			

The results in table 4.9 show that there is no difference in age group on Social support. The results show that there is no difference in age

group on Preoperative Anxiety and postoperative recovery.

### **Table 4.10**

Analysis of Variance Comparing Socioeconomic Status (N=400).

Variable		Sum of Squa	resDf	Mean Square	F	Sig.
Preoperative	Between Groups	158.405	2	79.203	3.583	.029
Anxiety	Within Groups	8775.585	397	22.105		
	Total	8933.990	399			
postoperative	Between Groups	818.124	2	409.062	2.177	.115
recovery	Within Groups	74401.385	396	187.882		
	Total	75219.509	398			
Social support	Between Groups	369.237	2	184.619	1.997	.137
	Within Groups	30969.121	335	92.445		
	Total	31338.358	337			

The results in table 4.10 show that there is no difference in age group on Social support and postoperative recovery. The results show that there is no difference in age group on preoperative anxiety.

### Discussion

The current study is to find the impact of preoperative anxiety on post-operative recovery of surgery mediating role of social support. These following hypotheses are in study:

H1. There will be significant correlation among pre-operative anxiety, post-operative recovery, and social support

The result indicates that there is positive correlation between Preoperative Anxiety and Postoperative recovery. The result indicates that positive correlation there is between Preoperative Anxiety and Social support. The result indicates that there is positive correlation between postoperative recovery and Social support. This research found that the levels of preoperative anxiety experienced by patients undergoing laparoscopic hysterectomy were strongly connected with the levels of postoperative pain experienced by these same patients, which is to say, worrying before surgery increases the likelihood of experiencing discomfort afterward. Anxiety before surgery increases the severity of the discomfort

afterwards. That agrees with the findings of other research done before (Suffeda et al., 2016).

Acute postoperative pain was a predictor of continued discomfort after being released from the hospital (Kain et al., 2000). Anxiety played a significant role in the intensity of postoperative pain, and an increase in pain further elicited a fear response, perpetuating the painful and distressing cycle. Anxiety can increase pain, while pain can increase anxiety (Spivey et al., 2018). Patients with a greater level of anxiety made up around 42%, whereas those with good social support made up about 64%. The results show that people felt less anxious before surgery they had more social when support. Consequently, it is the responsibility of the healthcare provider to recognize anxious individuals, encourage open communication about their experiences, and help them spend more time with their loved ones.

H2. There will be pre-operative anxieties have significant influence on the post-operative recovery.

The result of linear regression indicates that there is a significant impact of Preoperative Anxiety on Postoperative recovery. According to Kopp, preoperative worry does not have an immediate effect on the speed of recovery after surgery. Anxiety, in fact, affects coping behavior, and so indirectly affects surgical recovery. Preoperative anxiety is reduced in patients who have strong social networks that include family and friends (Kopp, 2003).

H3. There will be a significant impact of social support on post-operative recovery among general surgical patients.

The result of linear regression indicates that there is a significant impact of Social support on postoperative recovery. 56 male cardiac bypass patients were studied to determine how preoperative anxiety and postoperative recovery were affected by the presence or absence of spouses' natural social support (aged 38-69 yrs). Ss were categorized into two groups: those who reported high levels of spousal support while in the hospital, and those who reported low levels of support and those who had a generally positive or negative perception of the quality of their marriage at the time of surgery (defined in terms of frequency of visits). They also compared Ss to a control group of 16 single males who had had coronary bypass surgery. Patients who were married and had a strong support system at the hospital need less pain medication and healed faster than those who did not. Perceived marital quality, on the other hand, played a minor role (Kulik, 1989).

H4. There will be significant impact of preoperative anxiety on post-operative recovery through mediating role of social support.

Mediation results indicated that preoperative anxiety was found to be positive significant predictor of postoperative recovery and social support. Whereas social support was found to be significant predictor of postoperative recovery. So, mediation was found to be significant. However the indirect effect of social support was found to be positively significant between preoperative anxiety and postoperative recovery.

H5. There would be demographic variables difference in (age, education, residence, family system and socioeconomic status) in terms of preoperative anxiety and post-operative recovery through mediating role of social support.

The results show that there are no difference in

Male and female on Preoperative Anxiety, postoperative recovery and Social support. The results show that there are no difference in Combined and Nuclear on Preoperative Anxiety, postoperative recovery and Social support. The results show that there is no difference in age group on Social support. The results show that there is no difference in age group on Preoperative Anxiety and postoperative recovery. The results show that there is no difference in age group on Social support and postoperative recovery. The results show that there is no difference in age group on Preoperative Anxiety. Patients undergoing surgery typically experience higher levels of anxiety than those undergoing any other type of procedure. Thus, preoperative anxiousness is a major issue. Mean (SD) preoperative anxiety levels were 24.35 9.317, with 42.1% of participants reporting high levels and 57.9% reporting low levels. Results from the study by Yilmaz et al. using the ASSQ showed that the mean preoperative anxiety score was comparable to those found in a previous study by (Karanchi & Dirik, 2003), albeit slightly high (Yilmaz et al., 2011).

This research found a statistically significant (p0.05) correlation between preoperative anxiety and socioeconomic status, prior surgical experience, and operation type. Age, gender, marital status, and level of education were the other demographic factors that were not linked to preoperative worry. However, previous research has shown the correlations (Yilmaz et al., 2011). Consistent with previous research, the current study explains that patients with prior operative experience reported a low level of preoperative anxiety. Patients in this study who were undergoing gynaecological surgery reported high levels of preoperative anxiety. Previous research confirmed the result (Bander et al., 1990).

### Conclusion

The current study is to find the impact of preoperative anxiety on post-operative recovery of surgery mediating role of social support. The result indicates that there is positive correlation between Preoperative Anxiety and Postoperative recovery. The result indicates that there is positive correlation between Preoperative Anxiety and Social support. The result indicates that there is positive correlation between postoperative recovery and Social support. The result of linear regression indicates that there is a significant impact of Preoperative Anxiety on Postoperative recovery. The result of linear regression indicates that there is a significant impact of Social support on postoperative recovery. Mediation results indicated that preoperative anxiety was found to be positive significant predictor of postoperative recovery and social support. Whereas social support was found to be significant predictor of postoperative recovery. So, mediation was found to be significant. However the indirect effect of social support was found to be positively significant between preoperative anxiety and postoperative recovery.

### Limitations

This study had these limitations. All of the evaluations in this study relied on self-report, which poses potentially intrusive questions to participants. Because of this, there may have been bias in the study because some participants may not have been completely honest in their responses to the questionnaires.

### **Suggestions for Future Studies**

Some suggestions are given below that can be supportive in future research. Sample size should be increased. Random sampling and other sampling techniques can use for further research. Qualitative analysis through interview can use for better research findings. For deep insight of my research topic new comers in this topic should use longitudinal or may be experimental design to infer the causal relationship among concerning variables.

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