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Exploring the Relationship between Death Anxiety, Psychological Distress, Family Social Support in Patients with Hepatitis C

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Abstract

Hepatitis C, a chronic and potentially life-threatening illness, often evokes profound emotional responses in affected individuals. The aim of the present study was to explore the relationship between death anxiety and psychological distress in patients with Hepatitis C. This study also sought to examine the moderating role of family social support in the relationship between death anxiety and psychological distress. A cross-sectional, purposive sampling technique was employed, involving 240 Hepatitis C patients recruited from government and private hospital settings. Standardized scales were used: the Death Anxiety Scale to measure death anxiety, the Scale of Psychological Distress to measure psychological distress, and the Scale of Family Functioning to measure family social support. Correlation and regression analyses were conducted to examine the associations among these variables. Findings revealed a positive correlation between death anxiety and psychological distress, suggesting that a greater fear of death is associated with higher levels of emotional strain. In addition, family social support was found to be negatively correlated with both death anxiety and psychological distress, indicating a buffering effect in managing emotional challenges. These results underscore the importance of family-centered care in addressing the psychological aspects of Hepatitis C. Strengthening family support systems may serve as a protective factor against death anxiety and psychological distress, ultimately improving the quality of life for affected patients.

Keywords: *Death Anxiety, Psychological Distress, Family Social Support, Patients with Hepatitis C, Life-Threatening Illness.*

Introduction

Death anxiety has long been a central topic in psychological research, particularly due to its profound impact on individuals facing life-threatening illnesses. Defined as the fear or apprehension associated with the awareness of death, death anxiety influences various aspects of mental health and overall well-being. This chapter focuses on death anxiety, psychological distress, and the role of family and social support

among patients with Hepatitis C. A chronic viral infection that continues to affect millions worldwide. Hepatitis C virus (HCV), identified in 1989, belongs to the *Flaviviridae* family and includes over 60 types, classified into six major genotypes. The virus primarily targets hepatocytes and other vulnerable liver cells, often leading to chronic infection characterized by symptoms such as jaundice, malaise, and nausea within weeks of infection (Wong, 2010). Patients with chronic Hepatitis C frequently experience elevated levels of anxiety and depression, often exceeding those observed in patients with Hepatitis B or the general population. These psychological challenges are compounded by concerns about disease progression, social stigma, and treatment side effects.

Death anxiety, considered an anxiety disorder, has been relatively underexplored in clinical treatment research. Evidence suggests that family involvement, social support, and life goals play crucial roles in mitigating death anxiety (Howarth, 2007). Individuals cope with death anxiety in ways that can either positively or negatively influence their psychological and behavioral functioning. Nurses and healthcare providers hold a critical responsibility in assisting patients and their families to manage fears related to death, promoting better emotional and behavioral outcomes (Lehto & Stein, 2009). Research highlights that death anxiety is influenced by multiple factors, including family structure, marital status, cultural context, and self-esteem. For patients with chronic illnesses like Hepatitis C, continuous exposure to health risks triggers persistent death-related anxiety. However, the presence of supportive family members and close social ties can bolster patients' self-esteem and serve as psychological barriers against death anxiety, offering comfort, care, love, and trust (Singh, 2013; Nia et al., 2014).

Psychological distress is a broad term encompassing symptoms ranging from anxiety and depression to behavioral difficulties is a significant concern among Hepatitis C patients. It often arises from unmet goals, low self-efficacy, and social or familial pressures. The distress experienced by these patients not only affects mental health but also contributes to physical complications, highlighting the importance of understanding its underlying mechanisms through various theoretical frameworks including medical, interpersonal, psychodynamic, and cognitive models (Barlow & Durand, 2011). Family and social support are critical in buffering psychological distress. Social support encompasses emotional, instrumental, and informational forms of assistance that help individuals navigate crises and maintain positive self-image. Originating from early observations in health psychology, such as Dr. Joseph Pratt's tuberculosis support groups in 1905, social support has been shown to improve both psychological and physical health outcomes.

This study aims to explore the interrelationships between death anxiety, psychological distress, and family social support in patients living with Hepatitis C, highlighting the moderating role that close social networks play in the psychological well-being of this vulnerable population.

Literature Review

Death Anxiety in Chronic Illness

Death anxiety, defined as the fear or apprehension surrounding death and dying, has been extensively studied in populations with life-threatening illnesses. According to Lehto and Stein (2009), death anxiety is a natural but distressing psychological experience that varies based on individual, cultural, and situational factors. Patients with chronic diseases, such as cancer or hepatitis C, often face heightened existential threats, leading to increased death-related fears and psychological distress.

Several studies have shown that death anxiety correlates strongly with depression, anxiety disorders, and diminished quality of life. For instance, a meta-analysis of 41 studies on cancer survivors revealed strong associations between death anxiety, fear of recurrence, and psychological disorders, especially among younger patients and those undergoing active treatment (Li et al., 2024). These findings emphasize the relevance of death anxiety as a transdiagnostic factor influencing mental health outcomes in chronic illness

populations. In patients with Hepatitis C, research indicates that death anxiety is influenced not only by the physical symptoms of the disease but also by stigma, uncertainty about prognosis, and side effects of antiviral treatments. Studies from Pakistan suggest that individuals using emotion-focused coping strategies report higher death anxiety, with women disproportionately affected (Howarth, 2007). Similarly, co-infection research has demonstrated that even asymptomatic patients experience elevated death-related worries due to perceived helplessness and existential threats.

Psychological Distress and Its Theoretical Foundations

Psychological distress broadly refers to emotional suffering characterized by symptoms such as depression, anxiety, irritability, and behavioral disruptions. It is a prevalent concern among individuals with chronic illnesses, including Hepatitis C, due to ongoing health challenges and psychosocial stressors.
Various theoretical models offer perspectives on psychological distress:

Medical Model: This perspective views psychological distress as a neurological or biochemical disorder requiring medical intervention (Barlow & Durand, 2011). It treats distress similarly to physical illnesses, emphasizing biological underpinnings.

Interpersonal Theory: Highlights the role of dysfunctional social interactions and unsatisfactory relationships as causes of psychological distress (Lehto & Stein, 2009). In this model, the quality of interpersonal connections significantly influences mental health.

Psychodynamic Theory: Emphasizes unconscious processes and past experiences, particularly childhood conflicts, that shape present distress and maladaptive coping (Barlow & Durand, 2011).

Cognitive Theory: Focuses on negative and distorted thought patterns that perpetuate emotional suffering. Patients with psychological distress often harbor dysfunctional beliefs about themselves, their environment, and the future, leading to a vicious cycle of negativity and impaired functioning.

Among patients with Hepatitis C, psychological distress is often exacerbated by factors such as fear of disease progression, social isolation, economic burdens, and treatment side effects. The interplay between these stressors and individual coping mechanisms determines the severity of distress experienced.

The Role of Family and Social Support

Social support is recognized as a vital protective factor that can buffer the effects of stress and reduce psychological distress. It is typically categorized into three types:

Emotional Support: Expressions of empathy, love, trust, and care.

Instrumental Support: Tangible aid such as financial assistance, transportation, or help with daily tasks.

Informational Support: Advice, guidance, and information to assist in problem-solving.

Research has demonstrated that robust social support networks improve patients' psychological well-being and health outcomes. In the context of chronic illness, family support is particularly critical, as it fosters a sense of security, self-worth, and coping capacity (Singh, 2013). For Hepatitis C patients, social support helps mitigate death anxiety and psychological distress by providing comfort and reducing feelings of isolation. Family members and close friends serve as vital sources of emotional and practical assistance, enhancing patients' resilience in facing the disease's challenges. Conversely, lack of support can intensify feelings of helplessness, anxiety, and depression (Nia et al., 2014).

Cultural Influences and Coping

Culture significantly shapes the experience and expression of death anxiety and psychological distress. Collectivist cultures, which emphasize interconnectedness and family involvement, may exhibit stronger correlations between death anxiety and depression, as individuals are more attuned to social roles and familial expectations. In contrast, individualist cultures might experience different patterns of coping and emotional responses. Furthermore, cultural beliefs about death, stigma associated with illness, and traditional support structures influence how patients manage their psychological distress. In many societies, high self-respect and cultural values act as protective factors against overwhelming death anxiety.

Research Gaps

Few studies have particularly examined people with Hepatitis C, despite the fact that death dread and psychological distress are increasingly recognized in patients with chronic illnesses. By investigating the psychological difficulties that this susceptible group faces, this study fills that gap. Furthermore, little research has been done on the moderating role that family social support has in the association between psychological distress and death dread. Developing focused interventions that improve mental health and quality of life requires an understanding of these processes.

The study's conclusions highlight the value of family-centered healthcare strategies. The study provides insightful information for caregivers, legislators, and healthcare professionals by emphasizing the protective function of family social support. In the end, bolstering family support networks might operate as a buffer against psychological distress and death dread, improving psychosocial treatment for patients with Hepatitis C and other chronic conditions.

- To examine the relationship between death anxiety, psychological distress and family social support in patients with hepatitis C.
- To investigate the role of family social support as a moderator in the relationship between death anxiety and psychological distress.

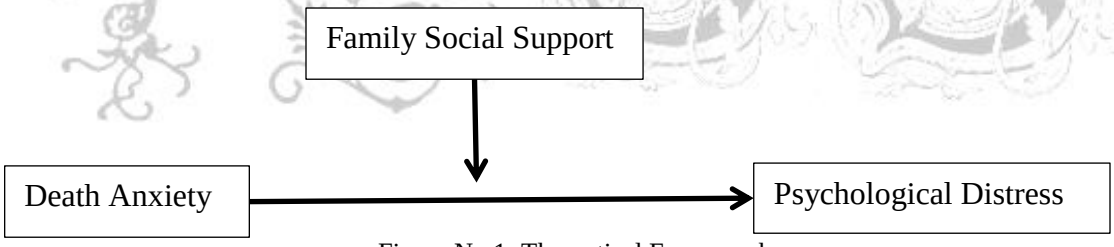

Figure No 1: Theoretical Framework

Hypothesis

1. There is positive relationship between death anxiety and psychological distress.
2. Family social support moderates the relationship between death anxiety and psychological distress.

Methods

Research Design

This study used cross-sectional research design, including postal and online surveys using non-purposive sampling method.

Procedure

First of all, permission from the authors of the tools was obtained for use in the present research. Official permission from different government institutes was also taken to collect the sample. Informed consent was obtained from patients who were willing to participate. Patients were requested to provide correct information. A demographic information sheet was constructed to collect information including age, gender, birth order, degree, department, father's occupation, mother's occupation, and monthly income. After filling out the demographic sheet, patients were given a booklet containing the study measures. They were briefed about the objectives of the study and were encouraged to ask any questions regarding any confusion they might have had. Upon completion of the booklet, patients were thanked for their participation. Finally, scores from the three scales were computed quantitatively.

Participants

A total of 240 patients with Hepatitis C (N = 240) were included in the study. Data were collected from different government and private hospitals.Respondents belonged to both joint and nuclear family systems. The sample also represented individuals from different socioeconomic backgrounds and included both male and female participants.

Inclusion Criteria

- Participants were aged between 18–50 years.
- Only Hepatitis C patients were included.
- Participants having any other medical illness were excluded.

Exclusion Criteria

- Patients above 50 years and below 18 years of age were excluded.
- The psychiatric population was excluded.

Table 1: Descriptive Statistics of studied variables

Variable	category	Frequency	Percent
Hepatitis Type	c	240	100.0
Gender	male	112	46.7
	female	128	53.3
	Total	240	100.0
Marital Status	married	211	87.9
	un married	29	12.1
	Total	240	100.0
Socio Economic Class	upper	25	10.4
	middle	84	35.0
	lower	131	54.6
	Total	240	100.0
Benefit from treatment	yes	146	60.8
	no	94	39.2
	Total	240	100.0
Current Condition	better	37	15.4
	normal	86	35.8
	worst	116	48.3
	Total	240	99.6

Operational Definitions

Death anxiety: Death anxiety refers the fear of and anxiety related to the anticipation, and awareness, of dying, death, and nonexistence. It typically includes emotional, cognitive, and motivational components that vary according to a person's stage of development and socio cultural life experiences (Lehto & Stein, 2009).

Psychological distress: Psychological distress is a general term that is used to describe unpleasant feelings or emotions that impact your level of function. A general term for the end result of factors (psychogenic pain, internal conflicts andexternal stress) that prevent a pers on from selfactualisation and connecting with significant others.

Family and social support: The term "social support" often appears in discussions of relationships. Social support means having friends and other people, including family, to turn to in times of need or crisis to give you a broader focus and positive self-image. Social support enhances quality of life and provides a buffer against adverse life events.

Social support can take different forms:

- Emotional (sometimes called non-tangible) support refers to the actions people take to make someone else feel cared for.
- Instrumental support refers to the physical, such as money and housekeeping.
- Informational support means providing information to help someone.

One of the earliest studies on the physical and psychological health benefits of social support (Pollak, 2013), an internist from Boston, gathered a group of tuberculosis patients together to educate them about hygiene in relation to their illness. This "support group" provided early evidence of the power of psychological support in physical health and healing.

Measures

Death Anxiety Scale: Death Anxiety Scale was was developed by Conte et al., (1982). Death Anxiety Scale consisted of 15 statements, answered on a 3-point Likert-type scale (ranging from "not at all" to "very much". Higher scores indicates higher level of death anxiety.

Kessler Psychological Distress Scale (K10): This scale was developed by Kessler et al., (2003). Each item is scored from one ‘none of the time’ to five ‘all of the time’. Scores of the 10 items are then summed, yielding a minimum score of 10 and a maximum score of 50. Low scores indicate low levels of psychological distress and high scores indicate high levels of psychological distress.

McMaster Family Assessment Device (FAD): This scale was developed by Epstein et al., (1983). This scale consists of 60-item self-report questionnaire that measures family functioning across seven dimensions: Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, Behavioral Control, and General Functioning. Developed from the McMaster Model of Family Therapy, the FAD uses a 4-point scale for responses, where higher scores indicate poorer family functioning, and is used for screening, identifying specific problem areas, and assessing treatment effectiveness.

Ethical Consideration

It was assured to the participants that their confidentiality will be maintained and their information will only use for research purpose. Informed consent was obtained before data collection.

Result

Table 2: Descriptive Statistics and Cronbach's Alpha for the scales of death anxiety, psychological distress and family social support (N=240)

Variables	*K*	*α*	*M*	*SD*	*Range*		*Skewness*	*Kurtosis*
					Actual	*Potential*		
Death Anxiety	15	.92	19.97	6.75	10-30	0-30	-.539	-1.43
Psychological Distress	10	.94	24.18	6.01	21-50	10-50	1.01	.134
Family Social Support	60	.92	203.38	43.4	100-195	60-240	-1.54	.564

Table 2 shows alpha coefficients, descriptive statistics and normality statistics for all the studied variables. Normality statistics shows that skewness and kurtosis are in the acceptable range for claim of normality of data. The alpha coefficient of scales lies within 0.92 and 0.94 indicate that they are reliable.

Table 3: Correlation Coefficient for the scales of death anxiety, psychological distress and family social support (N=240)

	Variables	1	2	3
1	Death Anxiety	-----	.254**	-.004
2	Psychological Distress	-----	-----	-.148*
3	Family Social Support	-----	-----	-----

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

Results in table 3 indicates that there is significantly positive relationship between death anxiety and psychological distress, which reveals that as death anxiety increases psychological distress increases. Furthermore, it also indicated that family social support is negatively correlated with psychological distress, which reveals that participants with higher family social support tend to better regulate their stress, also less likely to experience death anxiety.

Table 4: Moderating impact of Family Social Support on relationship between death anxiety and psychological distress among employees (N=240)

Predictor				*Psychological distress*	
				95% CL	
	B	*Se*	*p*	*LL*	*UL*
Constant	8.30	6.93	0.23	-5.35	-21.9
Death Anxiety	0.99	0.33	0.00	0.33	1.64
Family Social Support	0.05	0.03	0.01	-0.01	-0.11
Death Anxiety x Family social support	-0.00	0.00	0.02	-0.00	-0.00
R^2	0.10				
ΔR^2	0.01				

Table 4 revealed the moderating role of family social supportin the relationship between death anxiety and psychological distress. A moderating effect was shown by the statistically significant interaction between death anxiety and family social support (*B* = -0.00, SE = 0.00, p =.02, 95% CL [-0.00, -0.00]). In addition to the main effects of the predictors, this interaction explained 1% more of the variance in psychological distress (ΔR2 =.01). 10% of the variation in psychological discomfort was explained by the overall model (R2 =.10). These results imply that social support within the family acts as a protective factor, mitigating the impact of death dread on psychological suffering.

Discussion

The current study aimed to explore the relationship among death anxiety and psychological distress among patients with Hepatitis C, and to investigate the moderating role of family social support. The results provide important insights into the psychological difficulties faced by people with this chronic and potentially fatal condition, supporting both of the hypotheses that were put out.

Psychological distress and death anxiety were found to be strongly positively correlated, which is consistent with Hypothesis 1. Anxiety, despair, and emotional instability were among the psychological distress symptoms that were more prevalent in patients who expressed greater levels of death-related worries. These findings are consistent with earlier studies that shown that chronic illnesses, especially those thought to be fatal, increase mortality-related anxieties and lead to a greater psychological load (Abdel-Khalek, 2012; Iverach et al., 2014). People's mortality dread and mental distress can be made worse by Hepatitis C-related concerns like uncertainty about the disease's course, possible consequences (such liver failure or hepatocellular cancer), and the stigma attached to the condition.

More significantly, the study found that the association between psychological distress and death anxiety was considerably mitigated by family social support, supporting Hypothesis 2. Psychological pain and mortality concern were less closely associated in patients who felt more supported by their families. On the other hand, there was a greater positive correlation between the two conceptions among those who felt less supported by their families. This research emphasizes how social support can act as a buffer to reduce stress and psychological issues in situations involving health (Cohen & Wills, 1985). According to Thoits (2011) and Uchino (2009), family support seems to offer patients emotional comfort, aid with treatment regimens, and a feeling of purpose and connection, all of which may help them deal with their anxieties of dying.

The findings also emphasized a number of pertinent psychosocial and demographic factors linked to death anxiety. It's interesting to note that, in contrast to some earlier research that suggested women experienced higher degrees of death dread, male patients reported higher levels of death anxiety. The current sample's male participants showed higher levels of subjective proximity to death, existential anxiety, and intrusive death-related thoughts. These results imply that the way death anxiety appears in people with chronic illnesses may be influenced by gender-specific experiences and coping strategies.

There was also an unanticipated trend in educational level. The current study indicated that death anxiety rose with education, despite previous studies suggesting that those with lower educational attainment may have higher levels of death fear (due to poor access to health information or coping mechanisms). One explanation would be that those with more education are more conscious of the consequences of illness, which could exacerbate existential worries. Additionally, it was discovered that as educational attainment increased, perceived social support decreased. People may be less likely to ask for or perceive assistance from others in cultural environments where higher education values independence and self-reliance.

Another important aspect that came to light was marital status. Patients who were married expressed greater fear about dying than those who were single. Fear of mortality and the repercussions of one's possible absence may be heightened by increasing familial duties, emotional commitments, and worry about

dependents. These results are in line with earlier studies that highlighted the impact of perceived health, subjective wellbeing, and family cohesiveness on death fear levels.

One important protective element was found to be social support, particularly from close family members. According to this study, patients who felt their family were supporting them more had less psychological distress and anxiety about dying. In the face of chronic disease, social support has been shown to improve psychological resilience and speed up recovery. On the other hand, death worry might hinder healing by interfering with mental health and treatment compliance. Therefore, fostering psychological adjustment in Hepatitis C patients may benefit greatly from the integration of psychosocial therapies that improve perceived social support.

Since death worry is frequently unspoken or unidentified, it is essential to use particular screening instruments in clinical evaluations to find patients who might be experiencing existential anxiety. It's possible that conventional quantitative metrics fall short in capturing the cultural and human subtleties of death-related issues. Utilizing qualitative evaluation techniques, such narrative approaches or open-ended interviews, may help generate more focused therapy interventions and offer deeper insights into patients' experiences.

Notwithstanding the study's significant contributions, some limitations must be noted. Participants' answers might have been impacted by social desirability bias, which is introduced by the use of self-report measures. Furthermore, inferences regarding causality are not possible due to the cross-sectional design. Longitudinal designs should be taken into account in future studies to examine how these associations change over time. Generalizability may also be enhanced by increasing the sample size and including a range of demographic groupings. Furthermore, the validity of the results would be improved with the inclusion of multi-informant data (such as family members or medical professionals).

Limitations of the Current Study

- The data collection period was limited to six months, which may have introduced unforeseen biases.
- The findings cannot be generalized to other groups, industries, or countries due to the restricted scope of the study.
- The study did not classify participants based on city or type of patient, which may have limited the depth of analysis.

Future Directions

- Future studies could classify participants across different cities or types of patients to provide more comprehensive insights.
- Researchers may explore the relationship between religiosity and death anxiety to broaden the understanding of influencing factors.
- Death anxiety among physically ill elderly individuals remains underexplored; future studies are encouraged to investigate this group in greater depth.

Implications of the current study

- Healthcare providers should assess both physical and psychological needs of Hepatitis C patients, including screening for death anxiety and psychological distress.
- Family-based interventions such as counseling, psychoeducation, and support groups can strengthen coping and reduce emotional strain.
- Public health strategies should integrate family-centered psychosocial programs to improve care for chronically ill populations.

- Future studies should build on these findings through longitudinal and intervention-based designs to further explore psychosocial factors in chronic illness.

Conclusion

The quality of life of patients suffering from hepatitis C is significantly affected. This decline is mainly due to extra hepatic effects, common symptoms and fear of this disease. The main worry among patients is whether it can be cured or not, about the side effects during treatment and normal life span after successful completion of treatment. It is not only the health but social, financial, sexual and family life of the patients is adversely affected due to the virus. People with hepatitis C report less confidence in their current health and more concern about their health in the future. It is the duty of treating physicians and their team to assess the effects of hepatitis on the quality of life of patients and counsel them properly and regularly, so that they can improve their quality of life. There has to be emotional connect between the treating team and patients which will definitely prove to be turning factor in successful completion of treatment and thus increasing quality of life needy patients who are suffering from this deadly disease

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