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Death Anxiety Among Patients with Chronic Physical Diseases

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Abstract

Objective The purpose of this study was to investigate levels of death anxiety among patients with chronic physical diseases and healthy individuals.
Design: Cross-sectional study
Participants: 100 inpatients diagnosed with several chronic physical diseases from Tertiary Care Hospital in Pakistan and 100 Healthy individuals completed the questionnaires between January-April 2019.
Method: A total of 100 patients with chronic physical diseases were recruited from a Tertiary Care Hospital and 100 healthy individuals, matched with several demographic characteristics, completed a self-developed demographic questionnaire and Indigenous Death Anxiety Scale (IDAS, Faiza& Malik,2017). Data were analyzed using Statistical Package for Social Sciences (SPSS) version 22.
Results: Patients with chronic physical diseases possess overall levels of high death anxiety as compared to healthy individuals. Significant differences were also noted for gender and level of religiosity for the clinical group.
Conclusions: The study showed death anxiety as an important factor in patients with chronic physical diseases and holds significance for mental health professionals. Future studies should be carried out to explore interventions to relieve death apprehensions among patients with chronic physical diseases.

Keywords: Chronic Physical Diseases, Death Anxiety, Healthy Individuals

Introduction

Death Anxiety or fear of death is a fundamental issue of living beings(Kandemir, 2020) and becomes more pronounced in threatened situations (Menzies & Menzies, 2020) such as health concerns or physical illness exacerbates death apprehensions (Ring et al., 2020). In today's world chronic health conditions are recognised as an immense burden on the healthcare system likely to increase mortality, morbidity and healthcare expenses (Ferrari et al., 2014). Death anxiety declines an individual's well-being (Robah, 2017) and warrants holistic support for individuals living with chronic health issues Fisher et al., 2022; Kemp and Fisher, 2022).

In normal conditions, human beings possess effective coping techniques to manage the fear of death; high levels of stressors threatened health conditions result in maladaptive coping strategies (Kastenbaum, 2000; Yalom, 2008) resulting in death anxieties. Death anxiety refers to the fear of death (Lehto, & Stein,2009), negative feelings, attitudes and cognitions linked with death or dying (Sharpe, Curran, Butow, & Thewes,2018).

A plethora of research reports associations between physical health conditions and death anxiety (Fortner, Neimeyer & Rybarczyk, 2001; Moreno, De La Fuente Solana, Rico & Fernández, 2009;

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Neimeyer, Wittkowski & Moser, 2004). Also document several demographic variables such as age, gender and religiosity possess linkages with death anxieties (Soleimani, et al.,2016).

Death anxieties among patients with chronic physical diseases produce a negative impact on psychological states, cause mental disorders (Vehling et al., 2021) among patients with chronic physical diseases, hamper advance care planning (Brown et al.,2016) and preparations for the end of life (Krause, Rydall, Hales, Rodin, & Lo, 2015). This produces a pressing need to investigate death anxiety among patients suffering from chronic physical illness and its related demographic factors. It was assumed that:

There would be a significant difference in death anxiety among patients with chronic physical disease and healthy individuals.

There would be a significant difference in demographic variables (gender & self-reported religiosity) among patients with chronic physical diseases.

Method

Participants

A cross-sectional study was conducted from 1 January to 30 April 2019. Inpatients diagnosed with several chronic physical diseases were recruited from a tertiary care hospital, in Pakistan.

Inclusion criteria: (a) patients received disease diagnosis for more than 6 months.
(b) patients aged ≥18 years possess competent language communication capability.
(c) voluntary participation under the principle of informed consent.

Exclusion criteria: (a) patients who failed to complete questionnaires.
(b) patients who were cognitively impaired or had mental disorders.

Healthy individuals were selected via referrals and personal contacts.

Inclusion criteria :(a) age ≥ 18 years, (b) competent language communication capability, (c) consent for voluntary participation and (d) no known history of physical/psychological health conditions.

Measures

1. Demographic Questionnaire: details about gender, age, religious inclination and clinical characteristics (access from medical records) including duration of illness, medical history and details of the disease.
2. Indigenous Death Anxiety Scale (IDAS-63): self-report tool comprises five subscales: Punishment after death(PAD), Loss of Personal and Social Identity (LPASI), Finality of Death (FAD), Lack of Control and helplessness (LOCAH) and General Death of Self (GDS). IDAS shows good indices for psychometric properties for Cronbach alpha =.97, test-retest reliability =.81. Convergent and discriminant validity with Templer's death anxiety scale ($r=.60$, $p<.01$) and Revised life orientation test ($r=-.61$,$p<.01$) respectively (Faiza& Malik,2017).

Procedure

Ethical approvals were sought from the management of the hospital to recruit patients. All participants were informed about study details and only consented participants were taken for the study. Data was collected and simultaneously recorded to analyze using SPSS-23.

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Results

Table 1 *Demographic variables for patients with Chronic Physical Health Disease and Healthy Individuals (N=200)*

Demographic Variables	Patients with Chronic Physical Health Disease (n=100)	Healthy Individuals (n=100)
	Frequencies (*f*)	Frequencies *(f)*
Gender		
Men	58	56
Women	42	44
Self-Reported Religiosity		
High	36	39
Low	64	61
Chronic Physical Diseases		
Diabetic Miletus	26	
Asthma	34	
Arthritis	10	
Cancer	16	
Ischemic Heart Disease	14	

Table 1 shows the demographic characteristics of Participants.

Table2

Comparison of Death Anxiety between Patients with Chronic Physical Disease and Healthy Individuals (N=200)

Measures	Patients with Chronic Physical disease (n=100)		Healthy Individuals (n=100)			
	M	SD	M	SD	*t*	*p*
IDAS	148.55	37.37	134.8	42.10	2.42	.02*
PAD	46.80	12.59	42.16	13.78	2.48	.01*
LPASI	35.09	12.25	31.68	12.96	1.91	.03*
FOD	31.66	8.21	29.26	9.12	1.95	.04*
LOCAH	18.92	6.47	15.88	7.15	3.15	.002**
GDS	16.08	4.90	15.90	5.87	.235	.814(*ns)*

Note. IDAS= Indigenous Death Anxiety Scale; PAD = Punishment after Death; LPASI= Loss of Personal and Social Identity; FOD= Finality of Death; LOCAH= Lack of Control and Helplessness; GDS= General Death of Self. $p<.05$*, $p<.01$**

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Table 3 *Gender Differences for Death Anxiety Among Patients with Chronic Physical Disease (N=100)*

Measures	Men (n=58)		Women (n=42)			
	M	SD	M	SD	*t*	*p*
IDAS	14.62	6.09	17.67	5.11	2.634	.010**

Note. IDAS= Indigenous Death Anxiety Scale; $p<.05$*, $p<.01$**

Table 4

Death Anxiety Among Patients with Chronic Physical Disease for self -reported religious inclinations (N=100)

Measures	Low (n=64)		High (n=36)			
	M	SD	M	SD	*t*	*p*
IDAS	39.83	14.10	46.31	12.33	2.30	.023*

Note. IDAS= Indigenous Death Anxiety Scale $p<.05$*

Discussion

The objective of the study was to compare levels of death anxiety among patients with chronic physical disease and healthy individuals and its related factors among patients. Results suggest an overall higher level of death anxiety among the clinical group as compared to healthy individuals, consistent with prior research which indicated positive relationships between physical illness and death apprehensions (Fortner & Neimeyer, 1999; Fortner, Neimeyer & Rybarczyk, 2001; Moreno, De La Fuente Solana, Rico & Fernández, 2009).

Higher levels of death anxiety's subscales related to Punishment after death (PAD) and Loss of personal and social identities (LPASI) are possibly explained by the fact patients perceive that a physical disease is a form of punishment for spiritual problems(Baldacchino, 2006) punishment after death due to one's sins produces a higher level of death anxiety (Top, Sarac, & Yasar, 2010) among patients. Also, patients with physical problems face multiple challenges, i.e., loss of self-identity, low self-esteem, stereotype, and concern about family and children; concern related to loss of self and meaning creates death anxiety (Singh,2013).

Death fears related to Loss of control and Helplessness (LOCAH) and Finality of Death (FOD) among patients are attributed towards several factors related to chronic health conditions such as a decline in perceived functional abilities (Buchanan., Milroy, Baker, Thompson & Levack.2010) physiological side effects of medicines, the self-perceived burden on others (Tang et al., 2016). Also, patients with chronic health complaints experience painful surgical procedures, and fear of complicated outcomes associated with surgical procedures creates negative emotions and death anxiety among patients (Kayahan,&Sertbas,2007).

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Female patients with chronic physical illness showed higher death fears as compared to males affirms earlier investigations (Çinar,2015) possibly explained by social gender roles and the emotional approach adopted by females towards death (Yildiz,2014).

Patients with greater religiosity showed higher levels of death anxiety possibly denoting the fact that religious individuals tend to be highly engaged in death-related thoughts (Maltby & Day, 2000). Interestingly, religiosity is positively linked with death fears when religious teachings focused on punishment after death (Florian & Kravitz, 1983) rather than focusing on love for God and peaceful life after death (Rigdon & Epting, 1985).

Findings hold significance for mental health professionals to design therapeutic interventions for chronically ill physical patients to reduce levels of death apprehensions. The outcomes demand cautious generalisations owing to the small sample size, reliance on self-report measurement tools and selective inclusions of admitted patients.

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