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Global Journal of Medical, Pharmaceutical, and Biomedical Update

Original Article

Relationship between Death Anxiety and Coping Strategies among Patients of Hepatitis C

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Received : 12 December 2021
Accepted : 06 March 2022
Published : 16 May 2022

DOI
10.25259/GJMPBU_24_2021

Quick Response Code:

ABSTRACT

Objectives: The present study investigated the relationship between death anxiety and coping strategies among the patients with hepatitis C. The study has looked into investigating the gender differences in death anxiety and coping strategies.

Material and Methods: The present study used two standardized scales; the death anxiety scale and brief cope scale were used to collect information from the participants. The snowball sampling technique was used to collect data of clinical groups from different hospitals in Punjab. The present study used a cross-sectional design. A sample of n = 200 patients of hepatitis C, n = 100 males and n = 100 females, were approached from the different hospitals of Rawalpindi, Islamabad, and Gujar Khan. The duration of the study was 10 months that were March 2017–January 2018.

Results: Findings indicated that the death anxiety was high among the patients of hepatitis C, while female hepatitis C patients have a high level of death anxiety than male hepatitis C patients. Moreover, findings suggested that male hepatitis C patients used problem-focused coping strategies more as compared to females; however, female hepatitis C patients use emotion-focused coping strategies as compared to males.

Conclusion: The findings of the study would be helpful for the patients, their caregivers and families, and their doctors and psychologists to better understand the hepatitis C patients' psychological problems caused by their medical illness. These findings would also prove helpful for society on the whole to have awareness about hepatitis C and to learn the ways to better treat the patients of hepatitis C.

Keywords: Coping strategies, Death anxiety, Patients of hepatitis C

INTRODUCTION

Hepatitis C virus is a blood-to-blood virus that affects mostly, the liver. It spreads through blood transfusions, sharing of needles, and unhealthy medical and dental procedures. Although there are some misconceptions about its transmission, it does not transmit through a normal handshake, hugging, or sharing utensils or food with the infected person. Initially, hepatitis C appears with no symptoms, but step by step it caused fever, pale urination and skin, and jaundice. Chronic infection can lead to cirrhosis and liver failure.[1] In chronic HCV infection, circulating HCV RNA persists in many patients even with the presence of affecting antibodies, including more than 90% of patients with chronic disease.[2] According to the studies published in Pakistan, the prevalence of hepatitis C ranges from 0.7 to 20% in Pakistan but according to the WHO's international prevalence report, the prevalence of hepatitis C in Pakistan is 2.4% WHO, 2008.[3]

Risk factors of hepatitis C are found high in Pakistan. No or less information and education about the disease, professional use of infected syringes, history of blood transfusions, drips and injections for medical purposes, and going to street barbers for shave are common risk factors in this regard.[4] Lack of awareness about hepatitis C and its transmission among barbers is common and so is there use of one blade on multiple individuals.[5] Blood transmission is also not safe in Pakistan Jafri.[6]

Gender is also a significant construct studied under the topic of death anxiety for decades. Greater death anxiety among females has been reported by the majority of researchers. A wide number of old studies reported women having greater death anxiety than men.[7] However, some researchers found no gender differences regarding death anxiety but most of the studies show an opposite story. Men's view of death is more cognitive and women become emotional when it comes to death. The study found that older women reported more death anxiety as compared to older men. It was discovered that females[8] have high levels of death anxiety than males. Men may be more practical and work-oriented, while women are more prone to admit troubling feelings than men. Hence, this gender difference in the feeling of death anxiety can be caused by the difference in mental structure and personalities among men and women.[9] Female American students have reported more death anxiety as compared to male American students.[10] It has been also noticed from the previous research that death anxiety does not stay consistent nor changes significantly with time. A person's personal experiences such as religion, physical complaints, any loss, or level of his psychosocial development can affect death anxiety. Its experience varies from person to person and condition to condition and it is still not known which variables play a key role in influencing death anxiety in individuals.[9]

Coping refers to expending conscious effort to solve personal and interpersonal problems and seeking to master, minimize, or tolerate stress or conflict. Psychological coping skills are usually called coping strategies. These are the skills that reduce stress levels but there are some which can increase it. It depends on the type of coping strategies one chooses. Nature of environment, social circumstances, and type of personality are the big determinants of coping strategies used by a person. Conventionally, coping strategies are divided into two types: Problem-focused coping and emotion-focused coping.[11] Problem-focused coping strategies are those which are used to minimize or amend the problematic situation. Problem-focused coping strategies refer to focusing on the problem and trying to solve it without letting the emotions be involved. Further, it can be said that managing the stress in a way that could not make an increase in worry and apprehension. Problem-solving, getting organized, time management, and communication about one's problems are some examples of problem-focused coping.

Emotion-focused coping focuses on managing the negative emotions caused by the problematic situation.[12] There is a vast range of coping skills based on emotional responses such as denial, ventilation of emotions, and seeking emotional support. The effectiveness of these skills depends on the type of emotional-based strategy one uses. A general view is that the use of emotion-focused coping strategies is damaging. Some emotion-focused coping strategies favor avoidance but some reject it. In a study with hepatitis C patients, it was seen that the most commonly used coping style was problem-focused coping. The study more depicted that hepatitis patients who used problem-focused coping more had a low level of depression.

Pakistan is a developing country having many problems regarding economic conditions, education, awareness, employment, and health. Life-threatening diseases such as cancer, HIV, and hepatitis C are spreading fast and health services against these dangerous diseases are limited. These diseases are not only affecting the physical health of the victims but also disturbing psychological, social, educational, and occupational areas of their lives.[13] Very few studies are done to assess the psychological impacts of chronic diseases such as hepatitis C. People in Pakistan are living with different wrong perceptions and beliefs about hepatitis C and its transmission. Some people consider it blasphemy and blame the patients for it.[14] The present study is designed to assess the level of death anxiety among the patients of hepatitis C in the Pakistani population and also examine the coping strategies used by these patients against the above-mentioned problems. This study will be helpful for the patients to know about the death anxiety that they are facing as a consequence of their disease and would also contribute to estimating what type of coping strategies are being used by the patients of hepatitis C in Pakistan to combat these negative consequences. Female hepatitis C patients have a higher level of death anxiety as compared to male hepatitis C patients. Similarly, research also supports the phenomenon that the use of problem-focused coping strategies is common in males as compared to females. There is a need to explore these phenomena in the Pakistani context as gender roles are different in our society. The present study considers all these important factors.

MATERIAL AND METHODS

This study was approved by the Institutional Ethics Committee and written informed consents were obtained from all participants. The main objectives were to study the relationship between coping strategies and death anxiety among patients of hepatitis C.

Participants

In the present study (n = 200; M = 1.50, SD = 0.50), hepatitis C patients both 50% of males (n = 100) and 50% of females

(n = 100) from different hospitals of Rawalpindi and Islamabad (i.e., Pakistan Institute of Medical Sciences, Islamabad, CDA Hospital, Islamabad, and Tehsil Head Quarter, Gujar Khan) were taken as the sample of the study. Patients were taken from the age range of 25 to 60 with the diagnosis of at least 6 months. No specification for education was included in the inclusion criteria; patients from metric to onward were included in the study. Similarly, both married, unmarried, and employed, unemployed patients were included in the study.

Tools

Instruments of the study included the death anxiety scale (DAS) that was originally developed by Afzal[15] and was translated into Urdu language and used by Kausar[16] The translated version of the scale was used in the present study. The scale has 20 items 5-point Likert scale (1 = Never and 5 = Always). Moreover, the Brief Cope scale (BCS) originally developed by Carver[17] was used. The scale has 28 items and 14 subscales having two items each. Response categories are never, very less, seldom, and frequently. A high score indicates more use of coping strategies and a low score indicates less use of those strategies. There are no negative items on the scale. In the present study, the Urdu version of BCS was used to measure the coping strategies. The scale was translated into Urdu.[19]

Procedure

For the present study, data were collected from hepatitis C patients. For this purpose, first of all, permission was taken from the prestigious hospitals. Each patient was approached individually. Informed consent was taken from the patients and they were assured about the confidentiality of the information. They were asked to fill out two questionnaires, that is, DAS and BCS along with a demographic sheet. All questions of the questionnaires were administered individually to all patients and patients were requested to answer accurately. In the end, questionnaires were taken back and patients with thanks from the patients.

RESULTS

[Table 1] shows the psychometric properties of problem-focused coping and emotional-focused coping subscales. Cronbach's alpha reliability value of active coping, planning, and seeking for instrumental support, seeking for emotional support, and venting of emotions indicated adequate reliability. The Cronbach's alpha reliability values of DAS indicated significant reliability and showed skewness distribution <1.

The differences of the two groups in gender (male 100 vs. female 100) had significant statistical differences ($P < 0.05$) subscales of coping strategies and death anxiety.

[Table 2] shows differences between male and female hepatitis C patients on problem-focused coping strategies, emotion-focused coping strategies, and death anxiety. The mean score of females on problem-focused was 8.7 and mean score of males was 16.4 and SD was 2.31 and 1.94. Similarly, the mean scores of females on emotion-focused coping strategies were 14.9 while the mean score of males was 5.04 and SD was 1.29 and 1.20. All variables were significant at $P < 0.000$. Male hepatitis C patients use more problem-focused coping strategies as compared to female hepatitis C patients have been proved. Female patients with hepatitis C had a high score on death anxiety as compared to male patients with hepatitis C.

DISCUSSION

The present study was designed to assess the relationship between death anxiety and coping strategies among patients with hepatitis C. The objectives of the study were to investigate the death anxiety among the patients of hepatitis C and to find out the gender differences in the death anxiety and coping strategies used by the patients.

The level of death anxiety was also high among the patients with hepatitis C, it was also proved from the previous studies that death anxiety was a big psychological problem among the patients suffering from chronic diseases. Several researchers found that, in contrast to healthy controls, patients with hepatitis C showed evidence of mental weakness, basically in attention and higher supervisory function. The higher levels of anxiety and distorted quality of life were the foremost problems among the patients with hepatitis.

Gender differences in death anxiety were significantly high among females than males. Many studies identified the same results on death anxiety but some studies suggest that there was no difference in death anxiety among males and females, but most of the work done with Western and even Eastern population indicates that women show a greater level of death anxiety as compared to men. Researcher[2] did research with cardiac patients and suggested that female cardiac patients reported greater death anxiety than male cardiac patients. Females were thought to view death emotionally, whereas males' view of death is more cognitive.[20]

A study conducted[2] showed consistent outcomes with the studies carried out in America, that females described greater levels of death anxiety as compared to males.[9] As far as, the Pakistani population was concerned, death anxiety in females was justifiable. Pakistan is a developing country, where health services are very limited. People from rural areas had to come to big cities for treatments. Education and awareness regarding diseases such as hepatitis C are very low and treatment is very expensive. People believed in what they heard from others despite what the reality was. Most of the females stay at home, were illiterate, and know nothing about

Table 1: Psychometric properties of problem-focused coping strategies and emotion-focused coping strategies subscales of brief cope scale and death anxiety scale (*n*=200).

Subscales	No. of items	M	SD	α	Range		Skew
					Actual	Potential	
Active	2	4.86	2.44	0.79	1–4	2–8	0.03
Planning	2	3.61	1.45	0.66	1–4	2–7	0.65
Instrumental	2	4.15	1.55	0.73	1–4	2–8	0.05
Problemfoc	2	12.62	4.41	0.74	1–4	6–2	–0.06
Emotionsupp	2	4.97	1.55	0.85	1–4	2–8	0.05
Venting	2	5.01	2.69	0.94	1–4	2–8	0.00
Emotionfoc	2	14.52	6.01	0.87	1–4	6–24	–0.03
DAS	20	41.79	10.07	0.84	20–100	24–81	0.79

Active; Active coping. Planning; planning. Instrumental; seeking instrumental support. Problemfoc ; problem-focused coping strategies. Emotionsupp; seeking emotional support. Venting; venting of emotions. Emotionfoc; emotion-focused coping strategies

Table 2: Differences between male and female hepatitis C patients on coping strategies and death anxiety.

Scales	Females (*n*=100)		Males (*n*=100)		t (df)	P-value	95% C		Cohen's
	M	SD	M	SD			LL	UL	d
Problemfoc	8.7	2.31	16.4	1.94	25.49 (198)	0.000	-8.30	-7.1	72.80
Emotionfoc	14.9	1.29	5.04	1.20	55.8 (198)	0.000	9.51	10.2	7.91
DAS	43.72	10.43	39.64	9.95	2.86* (198)	0.005	1.32	7.19	0.400

*P<0.01, M: Mean. SD: Standard deviation

the disease. They just think that they could and they will die because of this disease. Hence, anxiety increased with this thinking. As it was a common misconception that hepatitis can spread by a handshake and eating with the patients, or using their utensils, most of the people reported this type of discrimination from families and coworkers. Some males also reported that they were labeled as drug abusers or chain smokers by others after the diagnosis of hepatitis C.

Male hepatitis C patients used problem-focused coping strategies more as compared to emotion-focused coping. Mean differences showed males scored high on problem-focused coping strategies while females' scores were low on it. Research indicated that males use problem-focused coping strategies as compared to females. Male subjects tended to use problem-focused coping more, as compared to female subjects. The correlation between death anxiety and coping strategies revealed a significant relationship among the domains of coping strategies and death anxiety.[21] Findings indicated that male patients used problem-focused coping strategies more as compared to female patients and female patients used emotion-focused coping strategies at the most.

CONCLUSION AND RECOMMENDATIONS

Data and number of patients were relatively small in the present study and data were collected from only three hospitals. Two of the questionnaires used in the study were originally developed abroad, so translated versions were used. Patients' fatigue, anxiety, and other psychological and financial problems were also a limitation. The study could produce more significant and comprehensive results if a large number of data would have been taken, and more hospitals were approached. Only gender differences were found on death anxiety and coping strategies, these variables could be studied with other demographics such as education, marital status, and socioeconomic status. Similarly, these variables could be studied with another more prevailing disease in Pakistan such as diabetes, cancer, or dengue virus, and a comparison between these diseases and hepatitis C could be made. Future researchers can study hepatitis C in relation to socioeconomic status, using more comprehensive and detailed questionnaires and with the help of interviews. More significant results can be produced by controlling the effects of intervening variables such as fatigue, anxiety, and stress.

Declaration of patient consent

Institutional Review Board (IRB) permission was obtained for the study.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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How to cite this article: Taj A, Loona MI, Khurshid M, Yousuf A. Relationship between death anxiety and coping strategies among patients of hepatitis C. Glob J Med Pharm Biomed Update 2022;17:3.