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Relation among Hope, Social Support, and Death Anxiety Among Patients with Cancer

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ABSTRACT:

Background: Cancer is a life-threatening illness that can significantly affect patients' psychological well-being. Hope and social support are considered important psychosocial resources that may influence patients' ability to cope with illness and death-related concerns.

Aim: To examine the relation among hope, social support, and death anxiety among patients with cancer.

Methods: A descriptive correlational design was employed. The study was conducted on a convenience sample of 85 patients at the Oncology Clinic of Ain Shams University Hospital, Cairo, Egypt. Data was collected using four tools: Socio-Demographic and Clinical Data Questionnaire, Herth Hope Index (HHI), Multidimensional Scale of Perceived Social Support (MSPSS–Arabic version), and Templer's Death Anxiety Scale (T-DAS).

Results: The majorities of the patients with cancer experienced moderate levels of hope, social support, and death anxiety. Conclusion: A statistically significant positive relationship was found between hope and perceived social support, whereas death anxiety was not significantly associated with either hope or perceived social support.

Recommendation: Psychological counseling should be provided to patients and their families to strengthen families' ability to provide psychological support and help patients cope with death-related concerns and reduce death anxiety.

INTRODUCTION:

Cancer remains one of the most serious global health challenges, not only because of its physical consequences, but also due to the profound psychological burden it places on patients. Among the challenges that patients face in connection with the course of their illness which caused by and also produce elevated levels of anxiety, are the uncertainty about treatment outcomes, the fear of pain, loss of control, the potential impact on body image, the fear of disease recurrence, the concerns about possible complications, the uncertainty about returning to everyday life, and confrontation with mortality (Haj Hashemi et al., 2021). These multiple stressors contribute to heightened psychological vulnerability and intensify patients' anxiety and fear of cancer, extending it into a broader existential fear as individuals are confronted with mortality and the potential loss of life. Kierkegaard (1983) referred to this existential form of fear as “Angst” or “Dread,” a concept that is referred to in social psychology as “Existential Terror” and is also now commonly termed “Death Anxiety” (Becker, 1973).

Death anxiety represents one of the most serious psychological issues affecting patients with cancer. It refers to the profound fear and emotional distress associated with the awareness of mortality and the anticipation of death, or in other words, it is the essential awareness of becoming a non-being, which has been consistently linked to poorer mental health outcomes, reduced coping abilities, and quality of life (Li et al., 2025). In the context of cancer, death anxiety becomes particularly

prominent due to the life-threatening nature of the disease, the uncertainty surrounding its progression, and treatment outcomes. It tends to intensify at different stages of the illness, especially at the time of diagnosis, during routine examinations, and in cases of relapse or disease progression (Hayati et al., 2023). Research has indicated that elevated levels of death anxiety may negatively influence patients' psychological adjustment and overall well-being (Weiss, 2025).

Despite the significant psychological burden and uncertainty, hope plays a vital role in cancer disease, as hope and death anxiety are two deeply intertwined psychological forces that significantly shape the cancer experience. Hope is widely recognized as a protective factor against psychological distress in patients with cancer. It reflects aspects such as; maintaining a sense of purpose, future orientation, inner strength, motivation, and optimism (Zhao et al., 2023). Cultivating hope through spiritual care, social support, and cognitive-behavioral interventions has been linked with better coping with cancer and its treatment process, reduced despair, enhances emotional resilience to adjusting with the challenges of cancer, better quality of life, and significantly mitigates depression and lowers death anxiety (Korkmaz & Lok, 2026).

In recent years, research has gradually focused on the significant impact of social support on the emotional well-being and quality of life of patients with cancer (Çelik et al., 2021; García-Carmona et al., 2021). Social support has been proven to be an effective buffer in alleviating distress, anxiety, and depression particularly during hospitalization and treatment in those patients (Zamanian et al., 2021; Zhu et al., 2023). Perceiving care, value, and support from family members, friends, or significant others contributes to emotional stability and treatment adherence, while peer support interventions can effectively reduce isolation and foster well-being in diverse cultural and clinical settings (Hemming et al., 2024). Budak and Ay Kaatsız (2025) also added that supportive relationships provide emotional reassurance, practical assistance, and a sense of belonging, all of which are essential for patients facing the challenges of cancer diagnosis and treatment.

Current scholarship increasingly highlights the interplay between psychological strengths and existential concerns in cancer care. Both hope and social support appear to function as protective factors against death anxiety, helping patients maintain their well-being and cope more effectively with the illness. A recent meta-analysis reported strong inverse associations between death anxiety and psychosocial resources such as; self-esteem, social support, sense of meaning, and quality of life, with these findings remaining consistent across different cultural contexts (Bennett et al., 2025). Furthermore, therapeutic interventions targeting existential distress have demonstrated significant effectiveness in reducing death anxiety among patients with advanced cancer (Oberth et al., 2025).

SIGNIFICANCE OF THE STUDY:

Cancer is one of the leading causes of mortality in the world, with a prevalence of 10 million deaths per year (Zhang et al., 2022). While studies report that 40–55% of patients with cancer experience significant death anxiety, but those with robust social networks and positive future orientation show better emotional adjustment (Getie, et al., 2025).

Hope, social support, and death anxiety play interconnected roles in shaping the psychosocial well-being of patients with cancer. Evidence suggests that higher levels of hope and stronger perceived social support are consistently associated with lower death anxiety, improved coping strategies, and enhanced quality of life (Yang et al., 2024; Manzour et al., 2026). Despite growing international researches, investigations with Arab populations remain scarce, making it critical to explore these associations in culturally specific contexts. Understanding the interplay among these psychosocial factors can guide the development of targeted interventions to reduce existential distress and support holistic care for patients with cancer.

Aim of the Study:

This study aimed to examine the interrelationships among hope, perceived social support, and death anxiety of patients with cancer through:

1. Assessing the levels of hope.
2. Assessing the levels of social support as perceived by the patients.
3. Assessing the levels of death anxiety.
4. Examining the association among hope, perceived social support, and death anxiety.

Research Questions:

1. What are the levels of hope, perceived social support, and death anxiety among patients with cancer?

2. What is the association among hope, perceived social support, and death anxiety among patients with cancer?

RESEARCH DESIGN:

A descriptive correlational research design was employed to achieve the aim of the study and examine the association among the study variables in patients with cancer.

Study Setting:

The study was conducted at the Oncology Clinic of Ain Shams University Hospital, affiliated with Ain Shams University Hospitals and the Egyptian Ministry of Higher Education and Scientific Research, Cairo, Egypt. The clinic provides comprehensive oncology services for both outpatients attending for diagnosis, treatment, or follow-up without hospital admission, and inpatients requiring hospitalization for intensive treatment or monitoring. It serves a diverse patient population from various regions of Egypt that is equipped with specialized facilities and staffed by a multidisciplinary team of oncologists, nurses, and allied health professionals. Collectively, these features make the clinic an appropriate setting for conducting the study.

Subjects:

All patients with cancer who attended the aforementioned setting during the data collection period and completed the study questionnaires were included until the predetermined sample size was reached.

Sample Type:

A convenience sample of patients with cancer who met the study criteria and agreed to participate was recruited.

Sample Size:

Using the Power Analysis and Sample Size (PASS) version 15 software for sample size calculation and based on findings from a previous study by Heidari et al. (2024), a significant mild negative correlation was reported between death anxiety and both spirituality and religiosity ($r = -0.30$ and -0.33 , respectively). Accordingly, a minimum sample size of 85 patients was required to achieve 80% power to detect a correlation difference of 0.30 between the null hypothesis correlation (0.00) and the anticipated correlation (-0.30), using a two-sided test with a significance level of 0.05.

Tools of Data Collection:

Data was collected using the following tools:

Self-Administrated Questionnaire was divided into four parts:

Part I: Socio-Demographic and Clinical Data Questionnaire:

The socio-demographic and clinical data questionnaire was developed by the researchers in simple Arabic language after reviewing the relevant literature. It was used to collect data regarding patients' age, sex, marital status, residence, family monthly income, educational level, occupation, diagnosis, cancer stage, and duration of illness.

Part II: Herth Hope Index (HHI):

The Herth Hope Index (HHI) was developed by the American Scholar, Herth (1991) to capture the multidimensionality of hope. It has been designed for clinical settings for older adults and patients with cancer. It was employed in the present study without requiring direct permission from the author, in accordance with established academic practice. Previous researches have successfully employed the HHI with similar patient populations, confirming its reliability and validity (e.g., Zhao et al., 2023; Wu et al, 2021).

The HHI comprises 12 items across three subscales: (a) temporality and future, (b) positive readiness and expectancy, and (c) interconnectedness.

Scoring System:

The Herth Hope Index (HHI) uses a 4-point Likert scale ranging from 1 (strongly disagree) to 4 (strongly agree), with total scores ranging from 12 to 48; higher scores indicate greater hope.

The total scores were categorized into three levels:

- Low hopefulness: 12–23
- Moderate hopefulness: 24–35
- High hopefulness: 36–48

Part III: Multidimensional Scale of Perceived Social Support (MSPSS–Arabic Version):

The original English version of the multidimensional scale of perceived social support (MSPSS) is a self-report scale designed by Zimet et al. (1988) to subjectively assess “the adequacy of received emotional social support from three different sources (family, friends, and the significant other). It has been translated in many languages including, Arabic language (Multidimensional Scale of Perceived Social Support, [Arabic-MSPSS]).

An Arabic translation has been validated in Arabic-speaking populations (Merhi & Kazarian, 2012), making it suitable for use in the present study. Permission from the original authors was not required, as the instrument is publicly available and widely used in academic research.

Scoring System:

The Arabic translation of multidimensional scale of perceived social support (Arabic-MSPSS) contains 12 items, each item is rated on a 7-point Likert rating scale (1=very strongly disagree, 7=very strongly agree), with possible scores ranging from 12 to 84; higher scores indicate greater perceived social support.

Total scores were categorized into three levels:

- Low perceived social support: 12–35
- Moderate perceived social support: 36–59
- High perceived social support: 60–84

Part IV: Templer’s Death Anxiety Scale (T-DAS):

The Death Anxiety Scale (DAS) was developed by Templer (1970) to assess anxiety associated with thoughts of death and mortality. The scale includes 15 items such as “I fear dying a painful death” and “I often think about how short life is.” An Arabic version of the T-DAS has been validated in Arabic-speaking populations (Al-Kubaisy et al., 2010), confirming its reliability and suitability for use in this study.

Scoring System:

Responses were recorded on a 5-point Likert scale, with higher scores reflecting greater death anxiety and that the patient was afraid of death. Total scores range from 15 to 75 and are categorized as follows:

- Low death anxiety: 15–30
- Moderate death anxiety: 31–50
- High death anxiety: 51–75

Validity and Reliability:

• Content Validity:

The study instruments were evaluated by five experts in psychiatric-mental health nursing at the Faculty of Nursing, Ain Shams University to assess face and content validity in terms of clarity, relevance, comprehensiveness, and feasibility. No modifications were deemed necessary based on their feedback.

• Tool Reliability:

The Herth Hope Index (HHI) demonstrated good internal consistency across various clinical populations, with Cronbach’s alpha values ranging from 0.82 to 0.91. The Arabic version of the Multidimensional Scale of Perceived Social Support (MSPSS) showed high reliability, with alpha coefficients between 0.88 and 0.91, confirming its suitability for assessing perceived social support among Arabic-speaking populations, while the Arabic adaptation of Templer’s Death Anxiety Scale (T-DAS) exhibited satisfactory internal consistency, with Cronbach’s alpha values ranging from 0.78 to 0.85, supporting its use in evaluating death-related anxiety in clinical and research settings.

Pilot Study:

A pilot study was conducted on 10% (10 patients) of the total sample to assess the clarity, feasibility, applicability, and time required to complete the study tools. No modifications were necessary; therefore, all patients who participated in the pilot study were included in the main study sample.

Data Collection Procedure:

Data collection was conducted at the previously mentioned Oncology Clinic over a three-month period, from the end of October 2025 to the end of December 2025. Prior to data collection, coordination was carried out with the responsible authorities and healthcare staff to facilitate the implementation of the study and identify eligible participants. Patients who met the study inclusion criteria were approached individually during their clinic visits. The purpose and procedures of the study were explained to them, and written informed consent was obtained from those who agreed to participate. Data were collected through individual face-to-face interviews using the study tools. The researchers provided clarification whenever necessary to ensure that participants fully understood the questionnaire items and completed them accurately. The completed questionnaires were reviewed immediately after each interview to ensure completeness and accuracy of the collected data. Each interview lasted approximately 20–30 minutes, and data collection continued until the required sample size of 85 patients was reached.

Administrative Design:

An official approval letter was obtained from the Dean of the Faculty of Nursing, Ain Shams University, and was submitted to the manager of Ain Shams University Hospital. The researchers then met with the administrators to clarify the aim of the study, obtained formal permission for data collection, and request their cooperation in facilitating access to eligible patients.

Ethical Consideration:

Approval for the study was obtained from the Scientific Research Ethics Committee of the Faculty of Nursing, Ain Shams University. The aim and objectives of the study were explained to the participating patients, and anonymity and confidentiality of their data were assured. Participation was voluntary, with the right to decline or withdraw at any time without any consequences. Written informed consent was obtained from all participants prior to data collection.

Compliance with Ethical Standards:

All research procedures were conducted in full compliance with the ethical guidelines and regulations set by the Scientific Research Ethics Committee at the Faculty of Nursing, Ain Shams University. The study received ethical approval under reference number [25.05.694].

Statistical Design:

Normality was assessed using the Shapiro–Wilk test. The results indicated that total death anxiety was normally distributed ($p = .193$), whereas mean MDSPSS scores and total hope index deviated significantly from normality ($p < .05$). Accordingly, non-parametric statistical tests were used for subsequent analyses.

RESULTS:

Table 1: The table shows that most of the patients were aged between 51–60 years (48.2%), with a mean age of 51.48 ± 7.50 years. Males represented nearly two-thirds of the sample (64.7%). About two-thirds were married (64.7%) and three-quarters lived in rural areas (74.1%). Three-quarters reported sufficient monthly income (74.1%). Secondary education was the most common educational level (65.9%). Regarding occupation, governmental employees (40.0%) and free workers (37.6%) constituted the largest groups.

Table 2: Table 2 presents the clinical data of the patients. Gastrointestinal cancer was the most frequent diagnosis (17.6%), followed by lung cancer (15.3%) and breast cancer (11.8%). More than half of the patients were in stage IV of cancer (51.8%). The duration of illness varied, with 36.5% of patients reporting duration of 3–12 months, indicating a heterogeneous sample in terms of disease progression.

Table 3 and Figure 1: Results in table 3 and figure 1 illustrate that the majority of patients demonstrated moderate positive readiness and expectancy (69.4%) and hope in temporality and future (55.3%). High levels of interconnectedness were reported by more than half of the patients (56.5%), suggesting strong relational and spiritual connections despite illness.

Figure 2: The figure demonstrates the percentage distribution of total Herth Hope Index levels among the studied patients. The majority of patients demonstrated a moderate level of hope (69.4%), while 21.2% reported high hope levels and only 9.4% showed low hope. This indicates that most patients maintained a balanced level of optimism despite their illness, with a relatively small proportion experiencing low hope.

Table 4 and Figure 3: Table 4 and figure 3 illustrate that the majority of patients demonstrated high social support from significant others (45.9%) and family (43.5%) was common, whereas support from friends was mostly moderate (62.4%). These findings indicate that family and close relationships were the primary sources of support for the patients.

Figure 4: The figure explains that most of the patients reported a moderate level of perceived social support (63.5%), while 24.7% experienced high support and 11.8% reported low support. These findings indicate that the majority of patients perceived an acceptable level of social support, with a smaller proportion experiencing insufficient support.

Table 5 and Figure 5: Table 5 and figure 5 describe that moderate levels were predominant across most death anxiety domains, including absolute death anxiety (64.7%) and death-related thoughts (67.1%). However, a high level of fear of the future was reported by half of the participants (50.6%), highlighting significant psychological distress related to uncertainty and prognosis.

Figure 6: The figure shows that the majority of patients experienced a moderate level of death anxiety (68.2%), while 31.8% reported high levels of death anxiety. This indicates that death-related concerns were prevalent among most patients, with nearly one-third experiencing elevated anxiety levels.

Table 6: Spearman's correlation analysis revealed a significant positive relationship between total hope and perceived social support ($\rho = 0.556$, $p < .001$), indicating that higher levels of social support were associated with higher levels of hope. However, no significant correlations were found between death anxiety and either hope

($\rho = -0.042$, $p = .705$) or social support ($\rho = -0.030$, $p = .784$), suggesting that death anxiety may be influenced by other psychological or clinical factors.

Table 1: Socio-Demographic Data among the Studied Patients (n=85)

Variable		No.	%
Age group	30 ≤ 40 years old	9	10.6
	41 ≤ 50 years old	26	30.6
	51 ≤ 60 years old	41	48.2
	> 60 years old	9	10.6
Mean ± SD		51.48±7.502	
Sex	Male	55	64.7
	Female	30	35.3
Marital status	Single	20	23.5
	Married	55	64.7
	Divorced	5	5.9
	Widowed	5	5.9
Residence	Urban	22	25.9
	Rural	63	74.1
Family monthly income	Not enough	22	25.9
	Enough	63	74.1
Education	Enough	22	25.9
	Illiterate	0	0.0
	Primary	8	9.4
	Secondary	56	65.9

Occupation	Diploma	9	10.6
	University	12	14.1
	Free	32	37.6
	Governmental	34	40.0
	Housewife	9	10.6
	Retired	10	11.8

Table 2: Clinical Data of the Studied Patients (n=85)

Variable		No.	%
Diagnosis	Bone	5	5.9
	Brain	4	4.7
	Breast	10	11.8
	GI	15	17.6
	Head & Neck	1	1.2
	Liver	1	1.2
	Lung	13	15.3
	Lymphoma	4	4.7
	Others	26	30.6
Cancer stage	Stage II	13	15.3
	Stage III	28	32.9
	Stage IV	44	51.8
Duration of illness	<3 months	17	20.0
	>36 months	16	18.8
	12–36 months	21	24.7
	3–12 months	31	36.5

Table 3: Distribution of Herth Hope Index Domains Levels among the Studied Patients (n = 85)

Herth Hope Index Domains	Low		Moderate		High	
	No.	%	No.	%	N o.	%
Temporality and future	18	21.2	47	55.3	20	23.5
Positive readiness and expectancy	13	15.3	59	69.4	13	15.3
Interconnectedness	6	7.1	31	36.5	48	56.5

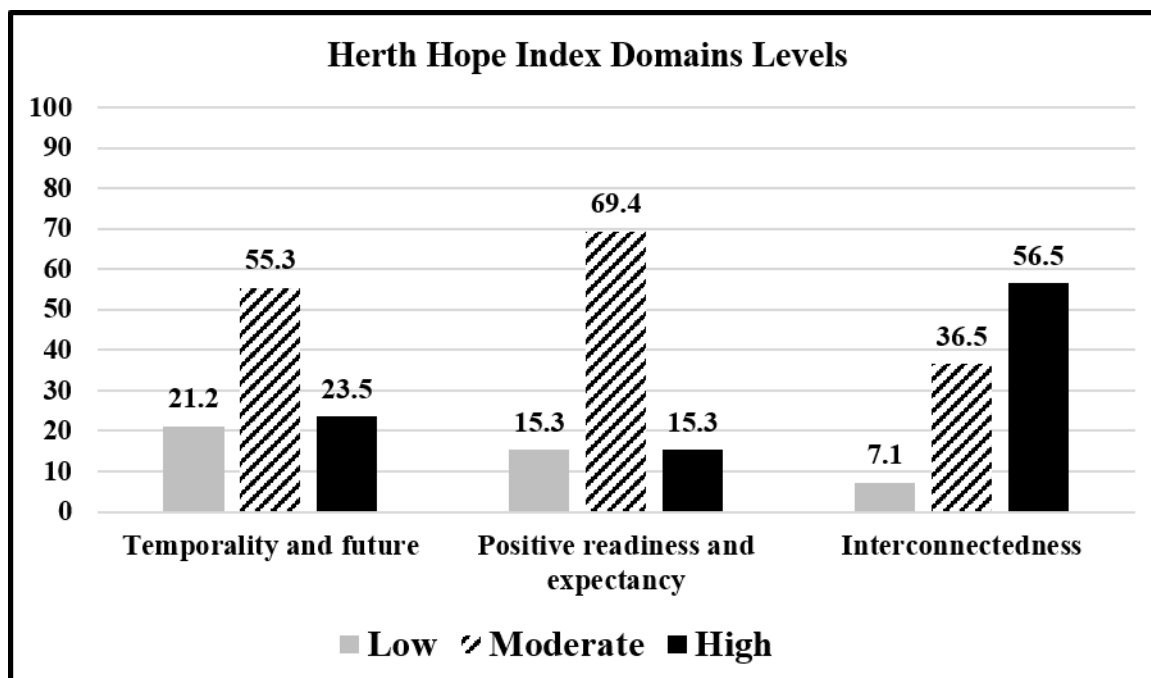


Figure 1: Percentage Distribution of Herth Hope Index Domains Levels among the Studied Patients (n = 85)

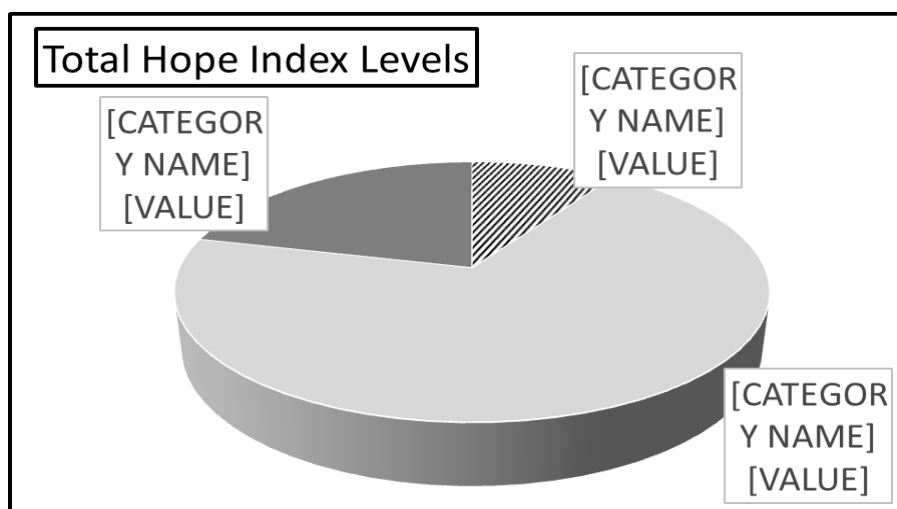


Figure 2: Percentage Distribution of Herth Hope Index Levels among the Studied Patients (n=85)

Table 4: Distribution of Perceived Social Support Domains Levels among the Studied Patients (n= 85)

Perceived Social Support Domains Levels	Low		Moderate		High	
	No.	%	No.	%	No.	%
Significant others	8	9.4	38	44.7	39	45.9
Family	7	8.2	41	48.2	37	43.5
Friends	26	30.6	53	62.4	6	7.1

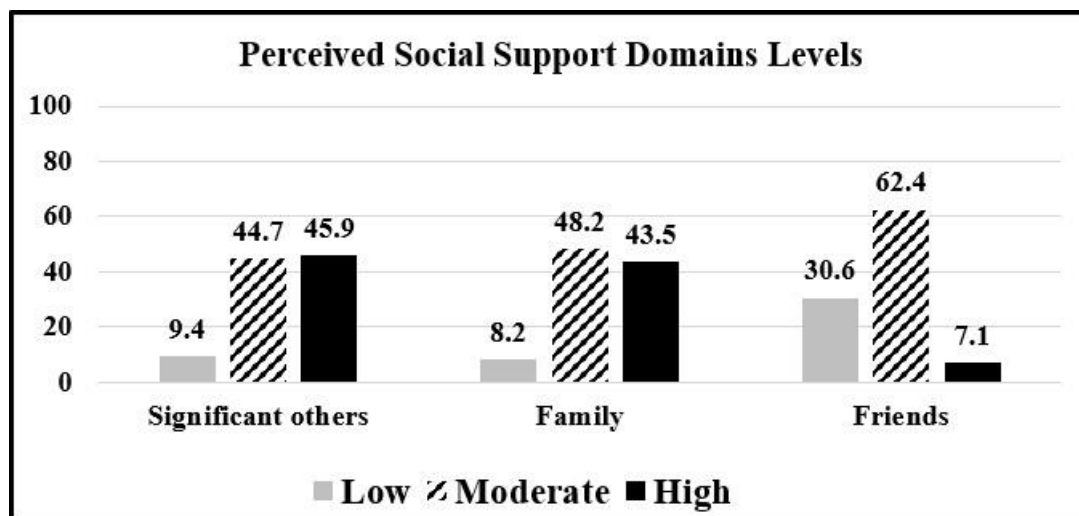


Figure 3: Percentage Distribution of Perceived Social Support Domains Levels among the Studied Patients (n = 85)

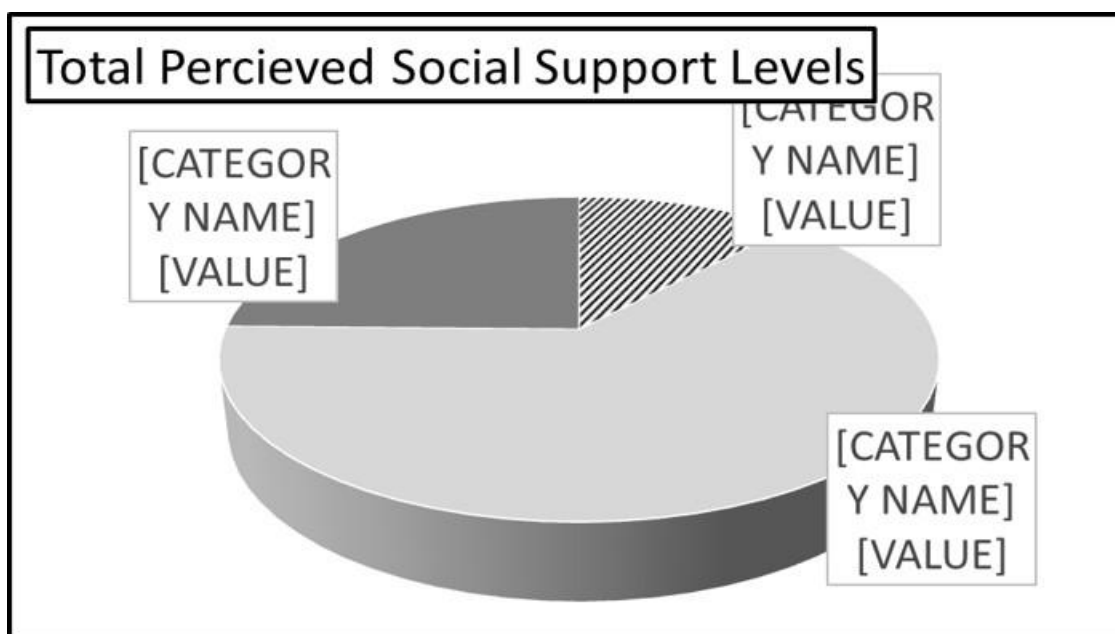


Figure 4: Percentage Distribution of Perceived Social Support Levels among the Studied Patients (n=85)

Table 5: Distribution of Death Anxiety Domains Levels among the Studied Patients (n= 85)

Death Anxiety Domains	Low		Moderate		High	
	No.	%	No.	%	No.	%
Absolute death anxiety	0	0.0	55	64.7	30	35.3
Fear of patience and pain	8	9.4	48	56.5	29	34.1
Death related thoughts	0	0.0	57	67.1	28	32.9
Time passing and short life	7	8.2	45	52.9	33	38.8
Fear of future	8	9.4	34	40.0	43	50.6

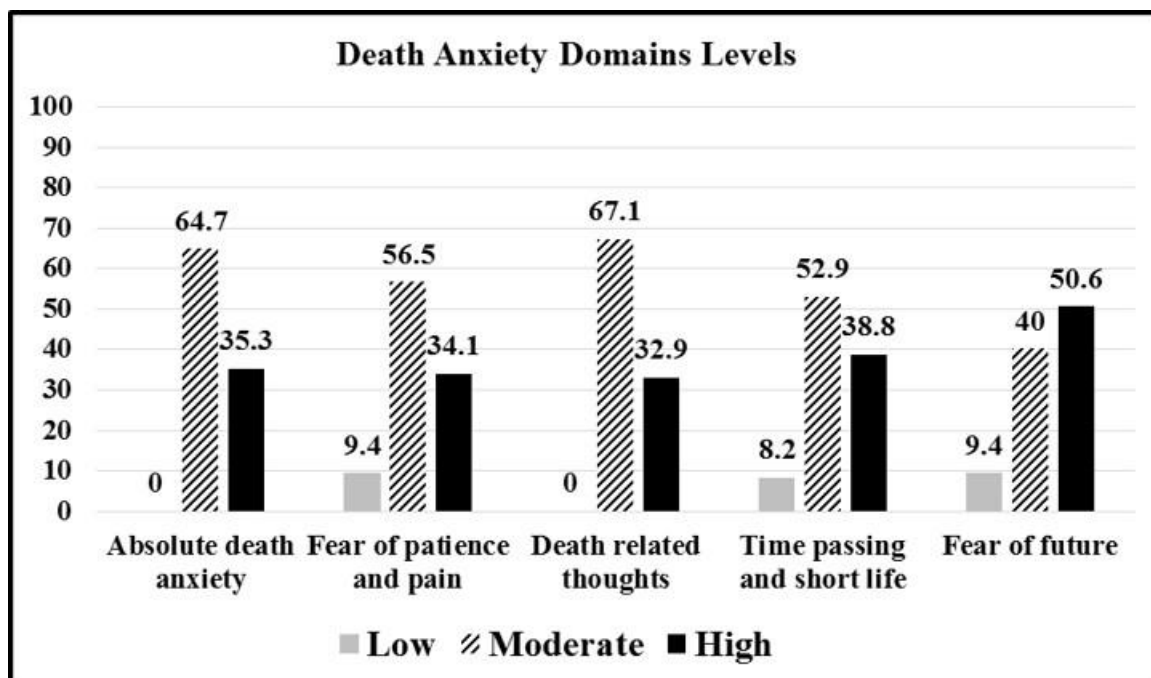


Figure 5: Percentage Distribution of Death Anxiety Domains Levels among the Studied Patients (n = 85)

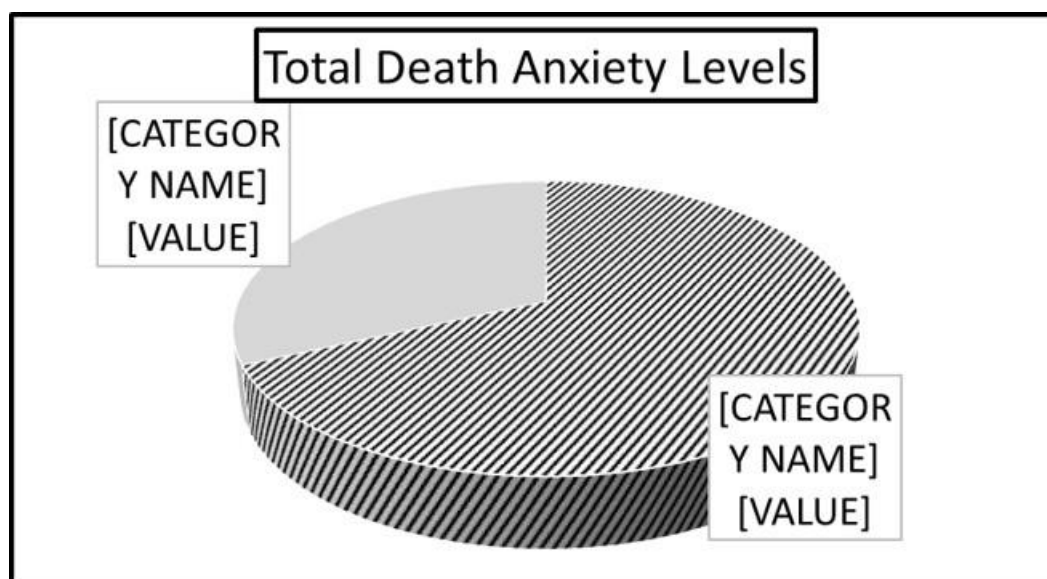


Figure 6: Percentage Distribution of Death Anxiety Levels among the Studied Patients (n=85)

Table 6: Correlation Matrix between Hope, Perceived Social Support, and Death Anxiety among the Studied Patients (n=85).

Variables		hope index	MDSPSS	death anxiety
hope index	Spearman's rho		.556**	-.042
	p value		.000	.705
MDSPSS	Spearman's rho	.556**		-.030
	p value	.000		.784
death anxiety	Spearman's rho	-.042	-.030	
	p value	.705	.784	

DISCUSSION:

Cancer is a life-threatening disease that often exposes patients to considerable psychological distress, including concerns related to death and uncertainty about the future. Such psychological challenges may affect patients' emotional well-being and adaptation to illness (Chan et al., 2025). In this context, hope is considered a crucial psychological resource that helps patients cope with the burden of cancer and maintain a positive outlook toward the future. Previous studies have shown that hope is positively associated with psychological adjustment among oncology patients (Tao et al., 2022). Perceived social support also plays a significant role in enhancing emotional resilience and strengthening hope through supportive relationships with family and others. However, despite these supportive factors, many patients with cancer continue to experience varying levels of death-related anxiety due to the serious nature of the disease and its uncertain prognosis (Budak & Ay Kaatsız, 2025).

Regarding the socio-demographic profile of the studied patients, the majority were of the middle-age, predominantly male, and married. Most participants lived in rural areas, reported sufficient monthly income, and had secondary education. In addition, governmental employees and free workers represented the largest occupational groups among the studied patients.

As regard the patients' clinical data, the present study revealed that gastrointestinal and lung cancers represented the most frequently reported diagnoses among the studied patients. From the researchers' perspective, the predominance of gastrointestinal and lung cancers in the current study may be linked to some factors such as; dietary habits, smoking, environmental and climatic factors, and/or chronic infections, which remain common in developing populations and may contribute to their higher incidence in clinical oncology settings. Consequently, these systemic and contextual factors likely influenced the predominance of these cancer types among the studied patients.

The finding is consistent with global epidemiological reports indicating that gastrointestinal and lung cancers remain among the most prevalent cancer types worldwide (Sung et al., 2021; Poirier et al., 2019). Conversely, other studies conducted in oncology settings reported that breast cancer was the most common diagnosis among patients, particularly in samples with a higher proportion of female participants (Siegel et al., 2023; Bray et al., 2024). Such discrepancies may be attributed to differences in study populations, geographical variations in cancer epidemiology, and the clinical specialization of the healthcare facilities.

Regarding cancer stage, the current findings indicated that more than half of the patients were diagnosed at stage four. The researchers believe that the high proportion of stage four cases observed in the present study may reflect delays in healthcare-seeking behaviour, limited awareness of early symptoms, and limited utilization of early detection services among the studied population.

The result is consistent with studies reporting that patients in many developing countries often present with advanced-stage cancer due to delayed diagnosis, limited awareness of early symptoms, and restricted access to screening services (Allemani et al., 2018). In contrast, several studies conducted in high-income countries reported higher proportions of patients diagnosed at earlier stages due to the effectiveness of early detection and screening programs (Siegel et al., 2023; Bray et al., 2024). These differences may reflect variations in healthcare infrastructure, accessibility of screening services, and public health awareness.

With respect to the duration of illness, the present findings showed variability among the studied patients, with the largest proportion reporting disease duration of 3–12 months. From the researchers' viewpoint, the heterogeneity in illness duration observed in the current study reflects differences in diagnostic timing, cancer type, and access to treatment, which may directly influence patients' levels of hope, perceived social support, and death-related anxiety.

The finding is in agreement with previous research suggesting that many oncology patients experience the greatest psychological adjustment challenges during the first year following diagnosis, a period characterized by treatment initiation, uncertainty about prognosis, and significant emotional adaptation (Weiss, B. 2025; Chan et al., 2025). However, other studies have reported longer illness durations among oncology samples, particularly among long-term survivors or patients undergoing prolonged treatment regimens (Henselmans et al., 2022). These differences may be explained by variations in cancer type, treatment modalities, and survival outcomes.

In relation to Herth Hope Index domains levels among the studied patients, the current study found that most patients demonstrated moderate levels of hope across the HHI domains, with the highest proportions in temporality and future and positive readiness and expectancy, while interconnectedness showed relatively higher levels of high scores. This pattern

suggests that, although patients with cancer may maintain a balanced outlook toward the future, many rely on relational and spiritual connections as sources of hope during the illness trajectory.

The current results may be attributed to several contextual factors. First, the variability of disease severity and treatment experiences among patients can generate fluctuating emotional responses, whereby hope remains neither minimal nor maximal but moderately sustained. Second, patients in the current setting may have limited access to formal psychosocial support programs, which are known to enhance hope more significantly. Finally, cultural norms that emphasize endurance and reliance on family and spiritual beliefs may foster interconnectedness as a more salient source of hope compared to individual future orientation.

The results are consistent with recent research indicating that moderate levels of hope are common among oncology patients, particularly during active treatment phases as in the study of Li et al. (2021) who reported that patients undergoing chemotherapy exhibited moderate hope levels due to fluctuating physical symptoms and psychological stress. Similarly, Nierop-van Baalen et al, (2020) found moderate hope dimensions among advanced cancer patients, emphasizing the role of adaptive coping in maintaining hope despite disease burden.

In contrast, some studies have reported higher overall hope levels among cancer populations, particularly when strong psychosocial interventions or support programs are in place as shown in Arefian et al. (2024) study that observed high levels of hope in breast cancer survivors who participated in structured psychosocial support groups. Hira et al (2025) reported predominantly high hope scores among patients engaged in comprehensive palliative care services. These discrepancies may be due to differences in study settings, the availability of supportive care, cultural factors, and the timing of assessment relative to treatment phases.

As regard perceived social support domains levels among the studied patients, the current study illustrates that the majority of patients perceived social support from different sources. High social support from significant others and family was common, whereas support from friends was mostly moderate. These findings indicate that family and close relationships were the primary sources of support for the patients. This means that patients perceive support from these sources as essential for their life.

In congruence with the current result, Doran et al., (2019) indicated that patients tend to perceive friends and family, including their partners as main sources of support. Additionally, Ginter and Braun, (2019) considered support from family and friends as essential to cope with the diagnosis and treatment. This is also congruent with Neris et al., (2020) and Zhang et al., (2020) who have analyzed other sources of support, and did not include health professionals as sources of support, despite being a source in constant and close contact with patients throughout the disease.

Regarding perceived social support levels, the current study indicates that most of the studied patients reported a moderate level of perceived social support, while about one-quarter experienced high support and the rest of the patients experience low support. These findings indicate that the majority of patients perceived an acceptable level of social support, with a smaller proportion experiencing insufficient support. This may reflect the nature of Egyptian society, where strong family ties and community support often provide a foundation for perceived care. This study results are congruent with Zanotto, et al. (2025) who reported that five themes were identified: coping together in the family; being concerned about others; giving and receiving support; needing to share the experience; and negotiating independence. The results highlighted that the illness affected a whole network of closest relationships, and that coping was not an individual task.

Poor, moderate, and strong levels of social support were reported among cancer patients in a previous study (Atinafu, 2023). This difference may be attributed to the availability of family support for patients' medical conditions in the current study. It may also be explained by variations in socio-demographic characteristics between the study samples, as some individuals may live alone or lack support from family members and friends. Previous findings indicated that socio-demographic factors are important determinants of perceived social support among patients diagnosed with cancer. Factors such as family size, marital status, social interactions, and access to information may influence individuals' perceptions of social support.

In relation to death anxiety domains levels, the current study illustrates that moderate levels of death anxiety were predominant across most domains, including absolute death anxiety and death-related thoughts. However, a high level of fear of the future was reported by half of the participants, highlighting significant psychological distress related to uncertainty and

prognosis. In congruence with the current study results, Vehling (2017) revealed that absolute death anxiety in patients with cancer involves intense fear, panic, and dread regarding mortality, affecting about half of those with advanced disease. In the line with these results, it can be said that death anxiety among patients with cancer may be characterized by persistent thoughts about death, pain, and the end of life, often exacerbated by fear of cancer recurrence, existential distress, fear of future, and inadequate pain management.

Regarding the total death anxiety levels among the studied patients, the current study findings revealed that the majority of patients experienced a moderate level of death anxiety, while nearly one-third reported high levels. This suggests that death-related concerns were prevalent among most patients. Such findings may reflect the psychological burden associated with life-threatening illnesses such as cancer, as patients may experience anxiety about death due to inadequate pain management, deterioration in health status, feelings of hopelessness, and persistent thoughts about the end of life.

The current study findings are consistent with those of Soleimani et al. (2020), who reported that death anxiety is among the most common psychological problems experienced by patients with terminal illnesses such as cancer. Their findings also indicated that death anxiety among patients with cancer is generally moderate and may be influenced by socio-demographic factors, including region, type of cancer, sex, and marital status. Furthermore, their review, which included studies involving various types of cancer, demonstrated that cancer patients commonly experience moderate levels of death anxiety. Similarly, Bibi and Khalid (2020) reported that patients exhibited moderate levels of death anxiety.

Consistent with the study findings, Hong et al. (2022) reported that evidence from different studies demonstrated that patients with cancer frequently experience death anxiety. Shakeri et al. (2024) also indicated that a cancer diagnosis is often a distressing experience for patients because it is closely associated with death and uncertainty regarding the treatment process and its outcomes, which may contribute to heightened death anxiety.

Regarding the correlation between hope and perceived social support among the studied patients, the current study revealed a significant positive relationship between total hope and perceived social support, indicating that greater perceived social support was associated with higher levels of hope. This finding underscores the pivotal role of social support in promoting psychological well-being among patients with cancer. By alleviating feelings of loneliness and emotional vulnerability, social support may buffer the adverse effects of stress and psychological distress. Such support may instill a sense of security and connectedness, sustain hope, and enhance patients' ability to adapt to and cope with the demands of their illness.

Consistent with the present findings, Liu et al. (2025) reported that social support indirectly influenced decisional conflict through hope and psychological resilience. They also indicated that adequate support from relatives, friends, and healthcare professionals may enhance patients' sense of hope.

Regarding the correlation between perceived social support and death anxiety among the studied patients, the current study revealed no significant relationship between the two variables, suggesting that death anxiety may be influenced by factors other than social support. This finding may be attributed to the multifaceted nature of death anxiety, which is often associated with a range of psychological, clinical, and illness-related factors. Concerns related to disease progression, symptom burden, uncertainty about the future, and fear of death may have exerted a stronger influence on patients' anxiety than perceived social support. Therefore, social support alone may not have been sufficient to alleviate the existential concerns and fears associated with life-threatening illness among the studied patients.

The current findings are inconsistent with those reported by Khanbabai Ghaleie (2024), who found a significant negative association between social support and death anxiety. Similarly, Gui et al. (2025) reported a negative association between family support and death anxiety among patients with breast cancer. These discrepancies may be attributed to differences in study population characteristics, cultural contexts, and the types of support available to patients. Support may be delivered through various forms, including emotional and tangible assistance, and the availability and effectiveness of these forms may vary across settings. Such variations may partly explain the inconsistent findings regarding the relationship between support and death anxiety.

Regarding the correlation between hope and death anxiety among the studied patients, the current study revealed no significant relationship between the two variables, suggesting that death anxiety may be influenced by factors beyond hope alone. This finding may be attributed to the multifactorial nature of death anxiety, which is often associated with various

psychological, clinical, and illness-related factors. Concerns related to disease progression, symptom burden, uncertainty about the future, and fear of death may have exerted a stronger influence on patients' death anxiety than hope.

The current findings are inconsistent with those reported by Korkmaz & Lok (2026), who found a moderate negative correlation between hope and death anxiety among patients with cancer. This discrepancy may be attributed to differences in participants' characteristics, disease-related factors, cultural backgrounds, and psychological responses to illness across the study populations.

CONCLUSION:

Based on the findings of the present study, it can be concluded that:

- The majorities of the patients with cancer experienced moderate levels of hope, social support, and death anxiety.
- A statistically significant positive relationship was found between hope and perceived social support, whereas death anxiety was not significantly associated with either hope or perceived social support.

The findings highlight the important role of social support in fostering hope among patients with cancer. However, death anxiety may be influenced by other psychological or clinical factors, indicating the need for comprehensive psychosocial care in oncology settings.

RECOMMENDATIONS:

1. Routine assessment of hope, perceived social support, and death anxiety should be integrated into the psychological evaluation of patients with cancer in oncology settings.
2. Oncology healthcare professionals, particularly nurses, should develop and implement supportive interventions aimed at enhancing hope and strengthening patients' social support systems.
3. Family members and significant others should be actively involved in the care process, as they represent the primary sources of support for patients with cancer.
4. Psychological counselling should be provided to patients and their families to strengthen families' ability to provide psychological support and help patients cope with death-related concerns and reduce death anxiety..
5. Educational programs and psychosocial support initiatives should be established to increase patients' awareness of coping strategies that enhance hope and emotional well-being.
6. Further research is recommended to explore other psychological and clinical factors that may influence death anxiety among patients with cancer using larger and more diverse samples.

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