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Impact of Self-Efficacy, Social Support, Medical Coping Modes and Resilience on Death Anxiety

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A B S T R A C T

Purpose— Integrating terror management theory and social cognitive theory, the present study examines the impact of self-efficacy, social support, medical coping modes, and resilience on death anxiety.
Study Design/methodology/approach—Three hundred and eighty-six individuals working in different healthcare sector organizations participated in the survey process for the collection of data, using a simple random sampling technique through a self-administered questionnaire.
Findings— The results of this study revealed that self-efficacy, social support, medical coping modes, and resilience negatively impacted the death anxiety of the individuals working in healthcare sector organizations.
Practical Implications— This highlights the importance of self-efficacy, social support, medical coping modes, and resilience to minimize the death anxiety of the employees, as they feel this situation due to high work pressure and the healthcare working environment.
Originality/Value—The present study contributes to motivational psychology and organizational behavior by explaining the importance of self-efficacy, which strengthens individuals against death anxiety; in parallel, this higher level of social support also enables individuals to deal with a toxic work environment; moreover, medical coping modes help the employees working in healthcare organizations to rebuild their energy, and a higher level of resilience also becomes vital in the situation of death anxiety.

Keywords: Self-Efficacy, Social Support, Medical Coping Modes, Resilience, Anxiety.

JEL Classification Codes: I10, I12, I31

1 | INTRODUCTION

1.1 | Background and Context

The realms of technology, information technology, and social sciences are undergoing incessant transformations and advancements daily (Chughtai, Syed, Naseer, et al., 2024). These alterations and advancements affect human existence and broaden research domains (Chughtai, Syed, Khalid, et al., 2024). The healthcare industry is among the fields where workers have significant challenges owing to numerous causes. The healthcare industry is distinct from other professional settings because of the challenges associated with attending to patients experiencing significant stress, as well as the frequent exposure of staff to high-pressure circumstances in their everyday roles (Khan et al., 2024). The stress, worry, and burnout encountered

by doctors, nurses, and associated health professionals in direct patient contact adversely impact their job effectiveness and health, thereby diminishing their overall quality of life (Bayram Deger, 2024).

Death anxiety refers to a psychological condition characterized by feelings of discomfort, apprehension, or dread triggered by the contemplation of mortality (Lodhi et al., 2014). Death anxiety is a prevalent psychological reaction to the recognition of life's conclusion (Dumitru et al., 2025), and it has garnered heightened interest in recent years owing to its intricate relationships with mental well-being, lifespan quality, and disease-related outcomes (Qin et al., 2025). Research indicates that death anxiety is markedly associated with psychological conditions including sadness and anxiety, and it may worsen physical indicators in those with chronic illnesses by affecting life-related choices and actions (Gomes et al., 2024).

Self-efficacy refers to the conviction that an individual can effectively complete a particular task, as opposed to a general characteristic that influences overall achievement and enthusiasm (Feltz & Chase, 1998). Furthermore, Hwang and Wu (2025) explain that self-efficacy relates to the self-confidence of the individuals through which they becomes enables to deal with adverse circumstances (Rahyuningsih et al., 2022). Self-efficacy is one of the personal resources modifying the disadvantageous belongings of numerous adversities, i.e., nervousness, pressure, stress, and an uncertain future (Szota et al., 2024). Research indicates that this conviction influences a person's cognition, actions, drive, proficiency, and decision-making (Bandura et al., 1997). Additionally, Bandura (1997) identified four primary techniques: learning experiences, virtual experiences, social persuasiveness, and physical and mental states. Depending on the level of efficacy, healthcare professionals may experience different levels of emotional states to control the negativity of death anxiety.

Social support is the encouragement we get from a social group, which simply means it is the support provided by relatives, friends, and important other people of the society (Zhou et al., 2015). Moreover, social support also corresponds to the personal experience of authentic social encouragement that an individual receives, i.e., psychological fulfillment and feelings and sentiments that come from a person's sense of being acknowledged and appreciated (Bian & Jiang, 2025). As emphasized in the key impact theory regarding social support, good views of the standard of social relationships promote self-efficacy, preserve positive feelings, and minimize the potential for emotional and cognitive problems (Uchino et al., 1996). Therefore, perceived social support can be seen as a key psychological asset that buffers the harmful influence of stressful experiences on both mental and physical well-being and considerably decreases the levels of social anxiety among people (Bian & Jiang, 2025).

Medical coping strategies, generally classified as confrontation, avoidance, and resignation, denote the cognitive and behavioral mechanisms patients utilize to address the particular stressors associated with their health issues (Carver et al., 1989). The process of medical coping imposes unique cognitive and behavior-based requirements on patients, requiring a degree of health literacy to comprehend medical knowledge, engage with health care professionals (Zhang et al., 2025), and make informed choices regarding their treatment, which presents challenges not usually encountered in managing typical stressful situations (Berkman et al., 2010). Efficient and empirical medical coping strategies can assist persons in achieving improved recovery and alleviating both physical and psychological fatigue (Hong et al., 2023). Medical coping strategies can facilitate individuals' adaptation to life transitions and obstacles, bolster their self-assurance and

resolve, boost their understanding and application of social assistance, and ultimately augment their resilience (Hong et al., 2023).

Resilience is a mechanism that could lead to good adaptation when faced with challenges in life for people with chronic ailments. It could help them better cope with threatening and challenging situations (Kisomi et al., 2024). Resilience can improve the self-esteem, mental health, and intrinsic resilience of individuals. Those with great resilience have an amazing ability to handle and deal with the problems around their condition (Kisomi et al., 2024). Resilience functions as a critical psychological resource that attenuates death anxiety by strengthening an individual's capacity to tolerate existential uncertainty (Liang & Cao, 2021). Grounded in terror management theory (Greenberg et al., 2014), resilient individuals demonstrate greater emotional regulation, cognitive flexibility, and adaptive coping mechanisms, which collectively buffer against mortality-related distress. Empirical evidence suggests that resilience fosters meaning-making processes, allowing individuals to reframe mortality salience within a coherent existential narrative rather than experiencing it as threatening (Seyedoshohadaee et al., 2020). Furthermore, resilient individuals often exhibit higher self-efficacy and social support utilization, both of which mitigate anxiety responses. Consequently, resilience serves not merely as a protective trait but as an active mechanism reducing the psychological burden associated with confronting mortality.

Social cognitive theory and terror management theory offer complementary lenses for understanding coping in medical contexts. Social cognitive theory Bandura, 1991) emphasizes self-efficacy, observational learning, and reciprocal determinism, positing that patients who perceive greater control over their health behaviors engage in more adaptive coping strategies. Social cognitive theory (Bandura, 1991) explains that self-efficacy is an important mediator between mental processes and behaviors and a defense mechanism against death anxiety (Choi et al., 2022; Hoelterhoff & Chung, 2020). Terror management theory (Greenberg et al., 2014), by contrast, addresses the existential anxiety triggered by mortality salience, particularly acute in medical settings involving illness or diagnosis, arguing that individuals defend against this anxiety through cultural worldview validation and self-esteem maintenance. According to terror management theory, thoughts about death evoke the anxiety of death and this is an inevitable part of the state of humanity (Greenberg et al., 2014). Human cognition is able to understand the vulnerability and limitations of the individual's condition and this results in intellectual fears related to death (Greenberg et al., 2014).

2 | LITERATURE REVIEW

2.1 | Self-Efficacy and Death Anxiety

Self-efficacy, characterized as a person's conviction in their ability to handle challenging or perilous circumstances, has been increasingly posited as an essential psychological asset that influences how healthcare practitioners deal with death-related stressors in their therapeutic work (Bandura, 1977). The correlation between self-efficacy and death fear has garnered increasing interest in healthcare studies, especially among nurses and frontline clinical personnel frequently confronted with patient mortality and end-of-life care scenarios (Zhong et al., 2025). A cross-sectional analysis of clinical nurses in university hospitals investigated the relationships among end-of-life care stress, death anxiety, and self-efficacy, revealing that nurses

experienced death anxiety and end-of-life care stress levels above the median, with increased end-of-life care stress correlating with heightened death anxiety (Choi et al., 2022). The research revealed that nurses without prior education in end-of-life care experienced greater death anxiety compared to their trained counterparts (Zaghamir et al., 2026), and that self-efficacy differed based on marital status and role type (bedside versus administrative), indicating that self-efficacy serves as a potentially adjustable protective factor against death-related distress (Choi et al., 2022). Researchers have shown that providing care for terminally ill patients and handling death-related occurrences often induces worry, fear, exhaustion, helplessness, and guilt in nursing personnel, impacting both their wellness and job performance (Gherman et al., 2022). In this framework, death-coping self-efficacy, a specialized variant of self-efficacy focused on handling death and dying, has been identified as a crucial protective factor (Hoelterhoff & Chung, 2020). A pertinent multicenter investigation involving newly graduated nurses explored the correlation between death-coping self-efficacy and their overall coping mechanisms and levels of death anxiety, supporting the notion that confidence in managing death-related responsibilities is often associated with diminished anxiety (Zheng et al., 2021). A cross-sectional study focusing on midwives in Greece investigated the correlations between perceived self-efficacy and attitudes about mortality (Lin et al., 2022), as well as emotional intelligence, personality traits, and resilience, revealing a reasonably high average self-efficacy score among the participants (Tzamakos et al., 2024). This body of research indicates that the association between self-efficacy and death anxiety spans various healthcare professions instead than being limited to nursing. Social cognitive theory (Bandura, 1991) asserts that self-efficacy serves as a crucial intermediary between thought processes and actions, demonstrating its significance as a defense mechanism against death anxiety (Choi et al., 2022; Hoelterhoff & Chung, 2020). Further, Terror Management Theory posits that fear around death is triggered by ideas pertaining to death and is inherent in all humans, as their cognitive capabilities enable them to comprehend their own fragility and finitude, leading to philosophical apprehensions (Greenberg et al., 2014). Based on the above discussion of the literature, we hypothesize that:

H1: *Self-Efficacy negatively associated with Death Anxiety.*

2.2 | Social Support and Death Anxiety

Anxiety is an uncomfortable sensation marked by discomfort, strain, concern, dread, or trepidation, and it ranks among the most often encountered emotions in humans (Barlow, 2000). It is a usual reaction to stressors and generally endures for a prolonged duration. Moderate anxiety might improve a person's capacity to react to pressing circumstances, whereas extreme anxiety can severely interfere with everyday functioning (Hartley & Phelps, 2012). Death anxiety pertains to the dread or unease linked to the consciousness of one's mortality or the demise of others, constituting a fundamental concept in health psychology, gerontology, and palliative care studies (Zhong et al., 2025). In recent years, a significant amount of research has investigated the role of social support as a protective factor against death fear in various groups, such as cancer patients, elderly individuals, dialysis patients, and community samples impacted by the COVID-19 epidemic (Dumitru et al., 2025; Gomes et al., 2024; Zheng et al., 2021). A 2024 study of dialysis patients in Qazvin City found a high prevalence of death anxiety (48.3%), with social support significantly associated with both resilience and death anxiety, and structural equation modeling confirming that resilience mediated the relationship between

social support and death anxiety (Kisomi et al., 2024). A 2024 study with 155 elderly individuals in Korean long-term care facilities investigated the interplay of death anxiety and social support in influencing end-of-life care preferences, thereby linking death-anxiety research to tangible issues in advance care planning (Joung & Park, 2024). In addition, broader investigations into risk variables have revealed that diminished educational achievement, unfavorable self-assessment of health, and economic difficulties are regularly linked to elevated death fear, elements that likely interact with the presence of social support systems (Guo et al., 2025). A research investigation involving caretakers of older adults living in society under Japan's long-term care insurance framework revealed that diminished care services during the COVID-19 pandemic and proactive care planning significantly impacted caregivers' anxiety regarding death, indicating that interruptions to formal as well as unofficial support systems beyond mere emotional assistance can affect death anxiety among caregiving groups (Kim, 2025). The social cognitive theory (Bandura, 2001) integrates behavioral and cognitive viewpoints to elucidate human behavior. According to the theory, three elements affect human conduct: the individual, the behavior itself, and environmental influences. Significantly, these influencers influence and provoke one another, leading to the notion of triadic reciprocal determinism (Bandura, 2001). Based on this debate of literature, it is hypothesized that:

H2: *Social Support negatively associated with Death Anxiety.*

2.3 | Medical Coping Modes and Death Anxiety

Anxiety about the prospect of death among healthcare workers has become a well-known occupational issue, as physicians in hospital and terminal care environments are constantly exposed to patient demise as part of their everyday work (Rababa et al., 2026). Researchers have defined this occurrence as “momentary distress,” a construct that describes the psychological, intellectual, physical, and behavioral reactions experienced by healthcare professionals when frequently faced with death and dying (Zhong et al., 2025). This higher level of distress is because healthcare personnel are often exposed to patient fatalities, which can impact their lives both personally and professionally (Zaghamir et al., 2026). Death anxiety is a mental condition of anxiety, fear, or unease that occurs when thinking about death (Lodhi et al., 2014). Death anxiety is a frequent psychological response to the knowledge of the end of life (Dumitru et al., 2025) and has been the subject of an increasing number of studies in recent years due to its intricate connections with mental well-being, quality of life, and disease-related outcomes (Qin et al., 2025). Studies reveal that death anxiety is significantly correlated with psychological disorders such as melancholy and anxiety and may increase physical symptoms in patients with chronic diseases by influencing decisions and behaviors related to life (Gomes et al., 2024). Positive and negative coping have quite distinct coping techniques. Those who often choose a constructive coping style do not see alternatives, expectations, and hazards as potential threats, hurts or defeats (Khan, 2025); instead, they see difficult circumstances as personal obstacles. Positive coping in the workplace can lead to positive thoughts and behaviors that foster communicative well-being, professional and personal growth, and more personalized resources and opportunities that enhance competency standards (Maresca et al., 2022). Virtuous and scientific medical coping methods can help patients recuperate more effectively and

lessen mental and physical fatigue (Hong et al., 2023). Medical coping approaches can help people better adjust to life transitions and obstacles, strengthen their trustworthiness and perseverance, boost their usage and mental processes of social support, and eventually successfully enhance their resilience (Hong et al., 2023). Terror management theory (Greenberg et al., 2014) provides a natural structure to analyze death anxiety in healthcare circumstances, and coping tactics are simply the strategies that terror management theory anticipates a patients will employ to cope with that anxiety. Further, terror management theory (Greenberg et al., 2014) suggests that the realization of mortality causes an existential fear that is mitigated by cultural viewpoint prudent investment and self-worth preservation. Based on this, it is hypothesized that:

H3: *Medical Coping Modes are negatively associated with Death Anxiety.*

2.4 | Resilience and Death Anxiety

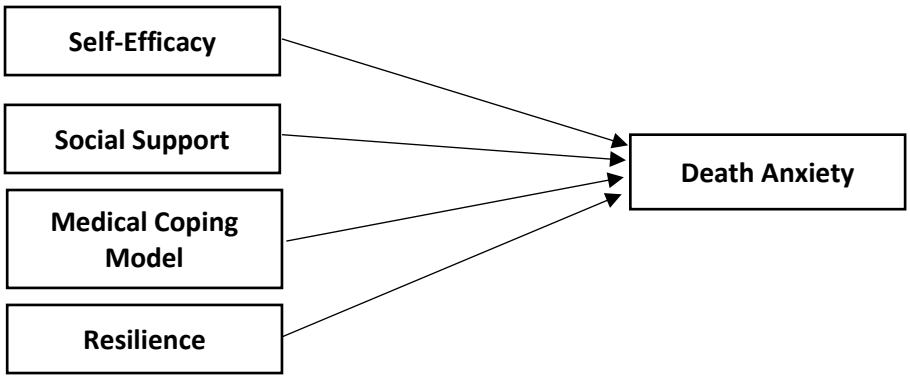
Resilience refers to the capacity for flexibility or psychological adjustment. It may be characterized as an evolving process, abilities, and results of personal growth within particular demographics, contexts, and hazards (Kuldas & Foody, 2022). Resilience can be essential in enhancing mental well-being and addressing psychological issues in challenging circumstances (Zhang et al., 2019). Elevated resilience correlates with a reduction in psychological issues, including despair, anxiety, and preoccupation. In general, resilience is a harmonious concept that allows individuals to demonstrate adaptability throughout challenging situations (Rayatpisheh et al., 2023). A person possessing sufficient resilience does not stifle their emotions, but rather navigates them optimally in challenging situations and proactively seeks a viable resolution. Research indicates that resilience correlates with death fear and longevity (Baldwin et al., 2011), optimism and distress (Haj Hosseini et al., 2018), as well as anxiety (Seyedoshohadaee et al., 2020). Resilience, also characterized as a dynamic process, facilitates positive adaptation in confronting adverse life experiences for individuals with chronic illnesses, hence enhancing their ability to navigate anxiety-inducing and stressful circumstances (Kisomi et al., 2024). Resilience can bolster an individual's self-worth, emotional equilibrium, and personal fortitude. People exhibiting elevated resilience possess an extraordinary capacity to manage the difficulties associated with their health conditions (Kisomi et al., 2024). Death anxiety, a prevalent psychological issue, can be described as fear and apprehension stemming from considerations of one's mortality or the mortality of loved ones, manifesting in unpleasant emotions such as sadness, anxiety, concern, and dread of death (Mohammadpour et al., 2018). The ongoing intensity of death anxiety may lead to detrimental health effects, including physical ailments, diminished resilience, and various psychological conditions, such as melancholy, broad anxiety, phobias, panic attacks, and suicide thoughts (Menzies & Veale, 2022). Concerns over mortality among healthcare professionals have emerged as a prominent occupational challenge, as doctors in hospital and palliative care settings frequently encounter patient fatalities in their daily responsibilities (Rababa et al., 2026). Scholars have characterized this phenomenon as "momentary distress," a concept that encapsulates the psychological, cognitive, bodily, and behavioral responses of healthcare practitioners confronted regularly with mortality (Zhong et al., 2025). This elevated degree of anguish arises from healthcare workers frequently seeing patient deaths, which can affect their lives on both personal and professional levels (Zaghamir et al., 2026). Death anxiety refers to a psychological state characterized by apprehension, dread, or discomfort associated with contemplating mortality (Lodhi et al., 2014). Death anxiety is a common psychological

reaction to the awareness of mortality (Dumitru et al., 2025) and has garnered considerable scholarly attention in recent years because of its complex associations with mental health, quality of life, and health-related consequences (Qin et al., 2025). Research indicates that death anxiety is markedly associated with psychological conditions like depression and anxiety, thereby exacerbating physical manifestations in individuals with chronic illnesses by affecting their choices and actions about life (Gomes et al., 2024). Based on this discussion of literature, it is hypothesized that:

H4: *Resilience is negatively associated with Death Anxiety.*

Figure 1

Hypothesized Conceptual Model



3 | METHODOLOGY & DESIGN

3.1 | Research Design

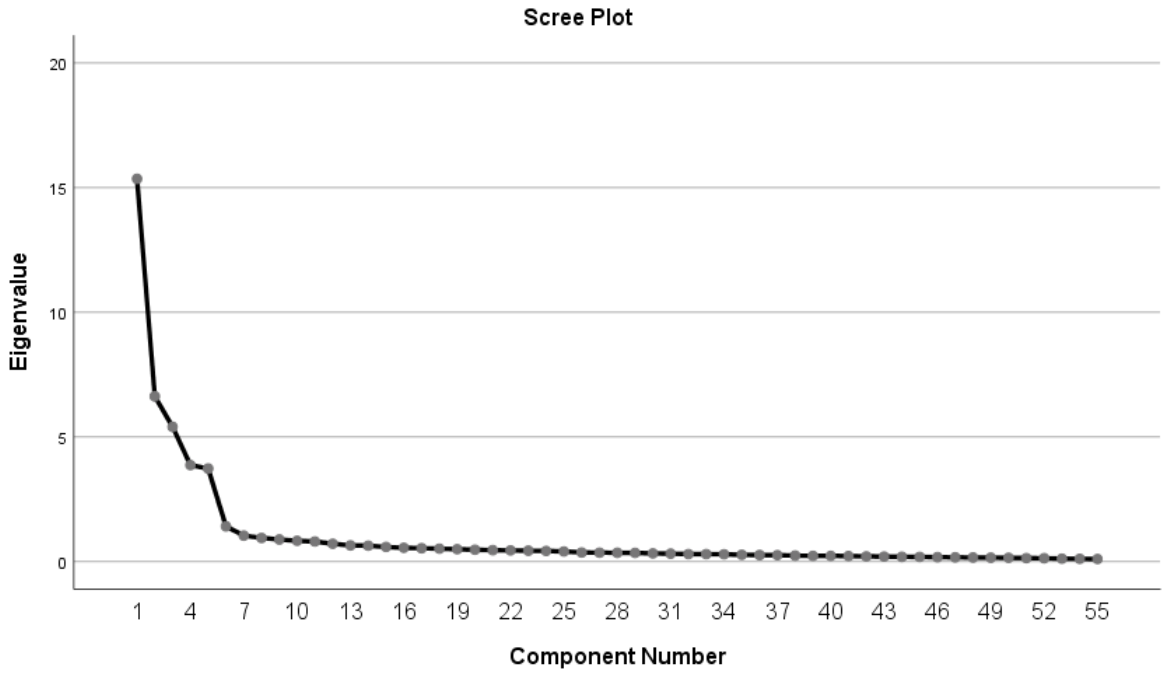
The present study is quantitative in nature, using an exploratory research paradigm, and the data were collected from the employees working in health care sector organizations. A quantitative approach was deemed most appropriate given the study's objective of testing measurable associations between variables through statistical analysis, while the exploratory nature of the paradigm allowed for the identification of patterns and preliminary insights within a relatively underexamined context. The reason for this data collection is that, due to emergencies and higher workload, the individuals working in these organizations face much more anxiety than those in other sectors. Healthcare professionals routinely operate under conditions characterized by emergency response demands, unpredictable patient loads, and extended working hours, all of which contribute to elevated levels of workplace anxiety relative to employees in many other industries. This heightened exposure to stressors makes the healthcare sector a particularly relevant and information-rich setting for examining the phenomena of interest in this research, as it allows for a more pronounced and observable manifestation of the psychological and organizational dynamics under study.

3.2 | Target Population and Sampling

The data were collected using a simple random sampling technique, and survey forms were distributed among individuals of private sector health care organizations. Before the circulation of self-administered questionnaires to the respondents, the purpose and objectives of the study were explained, and it was assured that data was used only for the academic purpose only. Using a cross-sectional data collection design, 500 questionnaires were distributed, and 386 responses were collected at the end of the data collection process; the response rate was 77.2%. Harman single-factor analysis was run, and the cumulative percentage was 27.90%, which is less than 50%, demonstrating that there is no issue of common method bias in the data. Further, we ran KMO and Bartlett's test, and we had significant support ($p < .001$) for the data where KMO value of .927.

Figure 2

Scree Plot



3.3 | Measures

3.3.1. Self-Efficacy

A ten-item scale was used to measure the self-efficacy level of the employees. The scale was developed by Schwarzer and Jerusalem (1995); a sample item of the scale is "*I am confident that I could deal efficiently with unexpected events.*" The opinions of the respondents were collected by using a 5-point Likert scale ranging from 1-strongly disagree to 5-strongly agree.

3.3.2. Social Support

A twelve-item scale was used to measure the perception of individuals about social support. The scale was developed by Zimet et al. (1988); a sample item of the scale is "*There is a special person who is around*

when I am in need." The opinions of the respondents were collected by using a 5-point Likert scale ranging from 1-strongly disagree to 5-strongly agree.

3.3.3. Medical Coping Modes

A ten-item scale was adopted from Feifel et al. (1987) to collect the opinions of the individuals about the medical coping modes; a sample item of the scale is "*Do you like talking to your friends and family because you won't have to think about your illness*? The opinions of the respondents were collected by using a 5-point Likert scale ranging from 1-never to 5-very much.

3.3.4. Resilience

A short version scale containing ten items was adopted from Connor and Davidson (2003) to collect the opinions of the individuals about their resilience level; a sample item of the scale is "*Coping with stress can strengthen me*." The opinions of the respondents were collected by using a 5-point Likert scale ranging from 1-strongly disagree to 5-strongly agree.

3.3.5. Death Anxiety

A fifteen-item scale was used to measure the death anxiety level of the employees. The scale was developed by Templer (1970); a sample item of the scale is "*I feel that the future holds nothing for me to fear.*" The opinions of the respondents were collected by using a 5-point Likert scale ranging from 1-strongly disagree to 5-strongly agree.

3.4 | Control Variables

We performed one-way analysis of variance (ANOVA) to find out the variance of demographics with study variables, and by following the values of ANOVA, we controlled the demographics.

4 | RESULTS AND ANALYSIS

4.1 | Demographic Analysis

A total of 386 permanent employees participated in the data collection survey, of which 255 (66.06%) were male, and 131 (33.94%) were female. Age-wise, 245 (63.47%) participants belonged to the age group of 18-30 years, 90 (23.32%) participants were from the age group of 31-40 years, 30 (7.77%) participants were from the age group of 41-50 years, and 21 (5.44%) participants belonged to the age group of 51-60 years. From the perspective of education, 231 (59.84%) participants fell in the educational category 'bachelor and below', and 155 (40.16%) participants fell in the academic category 'master's and above'. Experience-wise, 114 (29.53%) participants hold experience of 1-10 years, 149 (38.60%) participants were with experience of 11-20 years, 90 (23.32%) participants have an experience range of 21-30 years, and 33 (8.55%) participants fall in the experience category of 31-40 years.

4.2 | One-way ANOVA

To test the influence of demographics on all study variables. A one-way analysis of variance test was performed, and F-statistic values were reported in Table 01. According to the values shown in Table 01, the influence of gender was significant with SE ($F = 5.61^{*}$, $p<.05$), SS ($F = 9.38^{**}$, $p<.01$), and DA ($F = 13.66^{***}$, $p<.001$), and there was no significant influence of gender on MCM ($F = 1.85$, n.s.) and on RE ($F = 1.29$, n.s.). The second demographic, age, was also found to be significant with SE ($F = 9.39^{***}$, $p<.001$), with SS ($F =$

6.41***, p<.0010), with MCM (F = 4.18**, p<.01), with RE (F = 4.09**, p<.01), and was insignificant with DA (F = 1.19, n.s.). Influence of education was also found significant with SE (F = 35.85***, p<.001), with RE (F = 4.39*, p<.05), and with DA (F = 16.18***, p<.001), and found insignificant with SS (F = 1.74, n.s), and with MCM (F = .13, n.s). Furthermore, the last demographic experience was insignificant with SE (F = 1.28, n.s.), with SS (F = 1.06, n.s.), with MCM (F = 1.53, n.s.), with RE (F = .78, n.s.), and with DA (F = .81, n.s.).

Table 1

ANOVA

	SE	SS	MCM	RE	DA
Gender	5.61*	9.38**	1.85	1.29	13.66***
Age	9.39***	6.41***	4.18**	4.09**	1.19
Education	35.85***	1.74	.13	4.39*	16.18***
Experience	1.28	1.06	1.53	.78	.81

*Note: N=386, SE; self-efficacy, SS; social support, MCM; medical coping modes, RE; resilience, DA; death anxiety, ***p<.001, **p<.01, *p<.05*

4.3 | Descriptive Statistics, Validity, and Reliability

Table 02 shows the values of discriminant and convergent validity, where the validity of the constructs is represented by the CR (composite reliability) and AVE (average variance extracted). Composite reliability (CR) values of all constructs meet the minimum threshold limit of .500, as suggested by (Hair et al., 2019), and values of all constructs for average variance extracted (AVE) also meet the minimum threshold limit of .700, as recommended by (Hair et al., 2019). Further, Table 2 also shows the Heterotrait-Monotrait ratio of correlations (HTMT) values, which meet the threshold limit as suggested by Hair et al. (2019); according to them, if the HTMT values are less than 0.800, then there is no issue of discriminant validity in the data. Table 2 also shows the values of Fornell and Larcker, which also represent the criteria for the validation of the constructs; the diagonal values are higher than the values shown in rows/columns, which shows that there is no issue of validity as per the suggestions of Fornell and Larker (1981).

Table 2

Discriminant and Convergent Validity

	Variables	CR	AVE	HTMT				
				SE	SS	MCM	RE	DA
1	SE	.95	.64					
2	SS	.95	.64	.087				
3	MCM	.94	.63	.516	.124			
4	RE	.96	.71	.367	.091	.265		
5	DA	.95	.55	.442	.135	.406	.416	

Fornell and Larcker Criterion

	Variables	SE	SS	MCM	RE	DA
1	SE	**.741**				
2	SS	.088	**.734**			
3	MCM	.495	.058	**.839**		
4	RE	.353	.025	.253	**.798**	
5	DA	.419	.390	.390	.387	**.801**

Note: N=386, SE; self-efficacy, SS; social support, MCM; medical coping modes, RE; resilience, DA; death anxiety, CR; composite reliability, AVE; average variance extracted

The reliability of all constructs was calculated by following the method suggested by Cronbach (1951), and the reliability values of all constructs are above.70, which are considered good as suggested by earlier researchers (Griethuijsen et al., 2015; Saunders et al., 2012; Sekaran & Bougie, 2010), as shown in Table 03. Moreover, Table 03 also represent the correlation values of all study variables which are significant; where SE positively significantly correlated with SS (r = .39**, p<.01), with MCM (r = .12*, p<.05), with RE (r = .25**, p<.01), and negatively significantly correlated with DA (r = -.35**, p<.01); SS positively significantly correlated with MCM (r = .11*, p<.05), with RE (r = .39**, p<.01), and significantly negatively correlated with DA (r = -.41**, p<.01); MCM significantly positively correlated with RE (r = .11*, p<.05), and negatively significantly correlated with DA (r = -.14*, p<.05); RE significantly negatively correlated with DA (r = -.49**, p<.01).

Table 3

Descriptive Statistics, Validity, and Reliability

	Variables	Mean	SD	1	2	3	4	5	6	7	8
1	Gender	1.34	.474		-.10**	-.09	.12*	.15*	.07	.06	.19**
2	Age	1.55	.855			.16**	-.19**	-.13**	.17**	-.14**	-.08
3	Education	1.40	.491				-.29**	-.07	-.02	-.11*	-.21**
4	SE	5.27	1.191				**(.93)**	.39**	.12*	.25**	-.35**
5	SS	5.49	1.115					**(.94)**	.11*	.39**	-.41**
6	MCM	3.89	1.497						**(.92)**	.11*	-.14*
7	RE	5.43	1.107							**(.95)**	-.49**
8	DA	5.54	.899								**(.93)**

*Note: N=386, SE; self-efficacy, SS; social support, MCM; medical coping modes, RE; resilience, DA; death anxiety, **p<.01, *p<.05*

4.4 | Hierarchical Regression

To find out the direct effect of predictor variables on criterion variables. We control for gender, age, and education as control variables by following the ANOVA results. Results of Table 04 indicate that SE negatively influence the DA where (b = -.23***, SE = .04, p<.001, t-value = -5.96, VIF = 1.13), SS negatively influence the DA where (b = -.31***, SE = .04, p<.001, t-value = -8.31, VIF = 1.04), MCM negatively influence the DA where (b = -.12**, SE = .03, p<.01, t-value = -3.61, VIF = 1.04) and RE negative positively influences the DA where (b = -.038***, SE = .04, p<.001, t-value = -10.76, VIF = 1.03); thus, these results support H1, H2, H3 and H4 of this study.

Table 4

Direct Effects

Variable	Death Anxiety															
	Model-1 (Self-Efficacy)				Model-2 (Social Support)				Model-3 (Medical Coping Modes)				Model-4 (Resilience)			
	b	SE	t-value	VIF	b	SE	t-value	VIF	b	SE	t-value	VIF	b	SE	t-value	VIF
Gender	.27***	.09	2.96	1.02	.21**	.09	2.43	1.04	.31***	.09	3.28	1.02	.28***	.08	3.39	1.02
Age	.01	.05	.14	1.06	.01	.05	.15	1.05	-.04	.05	-.81	1.07	.02	.05	.46	1.05
Education	.19*	.09	2.07	1.11	.31***	.09	3.61	1.03	.33***	.09	3.59	1.03	.26***	.08	3.21	1.04
SE	-.23***	.04	-5.96	1.13												
SS					-.31***	.04	-8.31	1.04								
MCM									-.12**	.03	-3.61	1.04				
RE													-.38***	.04	-10.76	1.03
R2	*.15*				*.21*				*.12*				*.29*			
Adjusted R2	*.14*				*.20*				*.16*				*.28*			
F	*16.74****				*25.73****				*17.29****				*38.30****			

*Note: N=386, SE; self-efficacy, SS; social support, MCM; medical coping modes, RE; resilience, DA; death anxiety, ***p<.001, **p<.01, *p<.05*

5 | DISCUSSION

Drawing on terror management theory and social cognitive theory, the present study examines the impact of self-efficacy, social support, medical coping modes, and resilience on death anxiety. The first hypothesis of this study predicted that there is a negative influence of self-efficacy on death anxiety, and the results of this also support this hypothesis by explaining that when individuals feel confident, they can deal with death anxiety (Zheng et al., 2021). The findings of this study are also in line with the results of previous studies (Hoelterhoff & Chung, 2020), which explain that a higher level of self-efficacy enables individuals to control the negative thinking that leads to death anxiety (Zhong et al., 2025). Anchored in Bandura's social cognitive theory (Bandura, 1991), self-efficacy empowers humans to perceive daunting situations, such as life-threatening diseases or medical emergencies, as surmountable rather than insurmountable, thus mitigating the psychological anguish linked to the awareness of mortality (Hoelterhoff & Chung, 2020). People possessing elevated self-efficacy are more likely to partake in preventative health practices and demonstrate increased assurance in managing end-of-life issues, which is associated with less death phobia (Szota et al., 2024). The second hypothesis of this study proposed that social support has a negative impact on death anxiety, and the findings of this study also provide support for the acceptance of this model. These results are also in line with the findings of earlier studies, which explained that when individuals are interconnected with each other in society through this mechanism, they feel strengthened, which ultimately enables them to overcome the death

anxiety level of the individuals (Chukwuorji et al., 2020; Huang et al., 2022). Social support acts as an auxiliary shield, functioning through both emotional and practical avenues. The presence of compassionate connections, be they familial, peer-oriented, or occupational, affords individuals a sense of belonging and comfort that alleviates the loneliness frequently associated with facing mortality (Huang et al., 2022). Research in health psychology regularly reveals that perceived social support mitigates the severity of death-related anxieties by cultivating a sense of safety and collective coping, especially in patients confronting life-threatening conditions like cancer or cardiovascular disease (Kisomi et al., 2024). The third hypothesis of this study predicted that medical coping modes were negatively related to death anxiety, and the findings of this study also provide support. The results of this study also elaborate that when individuals know the choices which they need to make to minimize the level of death anxiety (Ahmead et al., 2024; Zeng et al., 2021). Confrontational coping, defined by proactive involvement with the illness and its consequences, is typically linked to improved psychological adaptation and less death terror, as it fosters a sense of control (Zeng et al., 2021). Conversely, avoidance coping characterized by denial or emotional repression often intensifies anxiety over time, as unaddressed anxieties reemerge during periods of stress. Coping strategies characterized by fatalism or helplessness are associated with increased death fear, indicating a perceived lack of control over one's situation (Zhang et al., 2025). The final hypothesis of this study predicted that resilience negatively related with death anxiety, and findings of this study also provide support for this hypothesis. The results of this study elaborate that higher level of resilience enables the individuals to adapt new things through which they deal uncertain circumstances and decrease the chances of death anxiety (Hoelterhoff & Chung, 2017; Wang et al., 2023). Resilience, understood as the capacity to adapt positively in the face of adversity, integrates and amplifies the protective effects of the aforementioned constructs (Hoelterhoff & Chung, 2017). Resilient individuals are more likely to reframe mortality-related threats through a growth-oriented lens, drawing on internal strengths and external resources to maintain psychological equilibrium.

5.1 | Practical and Theoretical Implications

The interplay between self-efficacy, social support, medical coping strategies, resilience, and death fear holds significant theoretical importance when analyzed via the dual perspectives of Social Cognitive Theory (SCT) and Terror Management Theory (TMT). From the perspective of SCT, self-efficacy functions as a crucial cognitive process by which individuals manage their emotional and behavioral reactions to dangers associated with mortality. Bandura's triadic reciprocal causation framework asserts that personal beliefs, environmental influences, and behaviors are in constant interplay; in the context of death anxiety, this implies that individuals possessing robust self-efficacy beliefs are more adept at employing adaptive coping strategies, accessing social support, and reinterpreting alarming health information as controllable, thus alleviating psychological distress. This conceptual expansion enhances the relevance of SCT beyond conventional areas of behavioral modification, integrating existential and clinical psychology, and framing self-efficacy as an adaptable focus for intervention instead of an immutable characteristic. TMT provides a divergent yet harmonious interpretation, suggesting that fear of death stems from the distinctly human consciousness of mortality set against primal self-preservation instincts. TMT posits that humans cope with existential dread by employing cultural worldviews and self-esteem-boosting strategies that mitigate death-related thoughts. In

this context, social support and resilience serve as both immediate and distant safeguards: social connections validate an individual's worth within a significant cultural story, whereas resilience denotes an ingrained ability to maintain self-worth under existential peril. Medical coping mechanisms connect with TMT by demonstrating how confrontational vs. avoidant techniques represent varying levels of effective terror management—confrontational coping implying a robust symbolic defense, whereas avoidance may signify a compromised anxiety-buffering system.

The ramifications for healthcare practitioners are significant. Initially, strategies aimed at bolstering patient self-efficacy, including organized psychoeducation, directed mastery experiences, and verbal encouragement, could function as economical methods for alleviating death anxiety in palliative and chronic illness contexts. Secondly, healthcare systems ought to emphasize the development of strong social support networks, acknowledging that professional interactions can serve as perceived sources of support when practitioners employ sympathetic, patient-focused communication techniques. Third, comprehending a patient's primary medical coping style enables healthcare providers to customize psychological assistance; individuals demonstrating deterministic or avoidant behaviors might gain from specific cognitive-behavioral strategies that encourage confrontational involvement without causing excessive distress. Ultimately, programs designed to enhance resilience, such as mindfulness-based stress reduction and meaning-centered therapies, ought to be incorporated into standard care processes for individuals with terminal or chronic illnesses, as these methodologies correspond with SCT's focus on adaptive self-regulation and TMT's emphasis on maintaining psychological stability in the presence of mortality awareness.

5.3 | Future Research Directions

Notwithstanding the theoretical and practical insights presented in this discourse, various limits merit attention. Primarily, a significant portion of the current work investigating self-efficacy, social support, medical coping strategies, and resilience concerning death anxiety predominantly utilizes cross-sectional methods, hence limiting the capacity to establish causal inferences about the directionality of these associations. Longitudinal studies are essential to determine if resilience and self-efficacy serve as precursors that diminish death anxiety over time, or if reduced death anxiety enhances psychological resourcefulness. Secondly, most research in this field has been performed on particular clinical groups, such as individuals with cancer or cardiovascular ailments, which constrains the applicability of results to wider contexts, including elderly populations without terminal illnesses or those undergoing anticipatory grief. Third, dependence on self-reported metrics for variables like coping strategies and resilience may introduce biases, such as social desirability and restricted introspective accuracy, thereby undermining the accuracy of identified correlations. Future investigations ought to emphasize longitudinal and experimental methodologies to delineate more explicit causal relationships among these constructs. Furthermore, cross-cultural studies are essential, considering that death fear and coping strategies are probably influenced by culturally ingrained perspectives, as indicated by Terror Management Theory, while a significant portion of current research is based on Western clinical populations. Researchers ought to investigate other moderating factors, including religiosity, spirituality, and socioeconomic position, that could affect the intensity of the connections among self-efficacy, social support, and death dread. Moreover, intervention-focused research utilizing randomized controlled trial methodologies would significantly bolster the evidence foundation, enabling scholars to assess the

effectiveness of particular initiatives aimed at improving self-efficacy, enhancing social support, and providing resilience training to mitigate death anxiety. Ultimately, the incorporation of mixed-methods strategies, merging quantitative evaluations with qualitative investigations of patients' lived experiences, may produce deeper, more intricate understandings of the psychological processes related to death anxiety and guide more comprehensive, patient-focused healthcare solutions.

6 | CONCLUSION

The current examination highlights the complex characteristics of death anxiety as a psychological occurrence influenced by the interaction of self-efficacy, social support, medical coping strategies, and resilience. Utilizing Social Cognitive Theory and Terror Management Theory, this discourse has illustrated that humans are not merely passive recipients of existential anxiety but rather proactive agents who can modulate their psychological reactions to mortality awareness through cognitive, social, and behavioral mechanisms. Self-efficacy serves as a vital factor in adaptive functioning, thereby allowing people to confront mortality-related challenges with a sense of control instead of despair. Social support enhances this internal asset by offering relational and emotional safeguards that validate self-worth and alleviate loneliness. Medical coping mechanisms elucidate the behavioral routes by which people manage illness-related stressors, revealing that confrontational measures are more beneficial than avoidant or fatalistic methods. Resilience, consequently, amalgamates these elements, functioning as an adaptive ability that maintains psychological stability amidst existential pressure.

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