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RESEARCH PAPER

The Comparative Study on Interpersonal Rejection Sensitivity, Death Anxiety and Qual-ity of Life among Type 1 And Type 2 Diabetics

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ABSTRACT

A comparative study was conducted to examine the differences in interpersonal rejection sensitivity, death anxiety, and quality of life among individuals with type 1 diabetes and type 2 diabetes. The age range of participants was 18-40 years (N=300). The population was selected using purposive convenient sampling. The inclusion criteria for selecting participants were individuals diagnosed with diabetes and falling within the specified age range. Individuals with any other diagnosed psychological problems or taking psychotropic medication were excluded from the study. Data was collected using a consent form, demographic forms, the Interpersonal Rejection Sensitivity Scale (IRSS), the Death Anxiety Inventory-Revised (DAI-R), and the WHO Quality of Life Scale. The collected data was analyzed using the Social Science Statistical System (SPSS) with an unrelated t-test. The findings revealed that individuals with Type 1 diabetes reported significantly higher levels of death anxiety ($p < 0.05$, MD = 6.79) and interpersonal rejection sensitivity ($p < 0.05$, MD = 3.53) compared to those with Type 2 diabetes. However, no significant difference was found in the overall quality of life between the two groups ($p = 0.705$). The study's implications included promoting social support and providing resources to help patients manage these factors and cope with negative emotions. The research findings were intended to assist in developing intervention plans and strategies to manage these psychological factors and improve the quality of life of individuals with diabetes.

Keywords: Interpersonal Rejection Sensitivity, Death Anxiety, Quality of Life

Introduction

Diabetes is a chronic, metabolic condition where blood sugar levels remain unusually high, which can gradually harm vital organs such as the heart, kidneys, eyes, nerves, and blood vessels (WHO, 2023). The worldwide rate of diabetes type 1 has grown significantly over the past three decades irrespective of economies of the countries (IDF, 2021). This type of diabetes is a chronic illness that used to be known as juvenile or insulin-dependent diabetes because the pancreas stops naturally producing sufficient insulin (ADA, 2022). The treatment of diabetes is impossible in the absence of scenario-free access to affordable drugs, especially insulin, which is used to sustain the lives of patients (WHO, 2023). To meet the increasing burden of non-communicable diseases, global health authorities have made the goals to reduce the increasing trends of diabetes as well as those of the obesity by 2025 (World Health Assembly, 2013). Currently, the population of diabetes globally is over 422 millions that exist mostly in low- and middle-income nations. Diabetes directly accounts each year to about 1.5 million deaths (WHO, 2023). This is a scary tendency that points to the rising trends and cases of diabetes cases, as well as consistent increase in its rates worldwide (IDF, 2021).

Death anxiety (DA) has been recognized as a distress, fear, or apprehension about the threat of death or dying (Neimeyer, 2000). Carpenito-Moyet (2008) refers to DA as the

condition of trepidation in individuals who have faced terminal or irreversible health disorders. This feeling of anxiety is often noted in individuals who are dealing with long illnesses that have unpredictable outcomes (Morin, 2011). Although there is universal presence of death anxiety, it is more likely to occur in older adults in which cases they are more likely to face death related events (Fortner & Neimeyer, 1999). Having an anxiety to deal with is a key concern because it will facilitate the improvement of mental health within the old individuals and ensure they have a decent life in the process (Wong et al., 1994). Death anxiety gets increased in patients with chronic disease such as diabetes who fear that their illness may get worse and result in life threatening complications. This mental distress is linked to poor life quality of type 1 and type 2 diabetic patients (de AraUjo et al., 2020).

Interpersonal rejection sensitivity describes the likeliness of an individual to be afraid, anticipate, and overestimate social rejection in interpersonal situations. This affective predisposition may severely hurt both psychological well being and the level of enjoyment of life as a whole (Downey & Feldman, 1996; Leary, 2001). According to interpersonal rejection theory, individuals develop a very strong emotional reaction to such things like shame and social pain when they feel that others are excluding them or those people are rejecting them (Leary, 2001). Individuals with high reject sensitivity would tend to interpret even neutral social interaction as negative, which in turn results in reported emotional distress, avoidance of interactions and self-esteem decreases. This is of great concern to patients with diabetes, particularly type 2, as they are continually faced with stigmatization by the society on their diabetes condition. The apprehension of social rejection and judgment leads to mental stress and the worsening of the quality of life (Browne et al., 2018). Diabetes also has serious psychosocial implications in addition to being a medical issue. Studies have indicated that the individuals affected often face discrimination, social exclusion, and emotional difficulties, which can eventually cause increased anxiety and depression (Fisher et al., 2018).

Quality of life (QoL) is in general considered to be a significant measuring of overall well-being and satisfaction of an individual in certain spheres of life. These involve physical and mental health, personal relationships, the surrounding context of environmental and the capability to participate in daily activities. According to the World Health Organization (1997), quality of life can be defined as how an individual sees himself regarding his/her location in life in reference to the cultural and value systems he lives in, his expectations, goals, and concerns.

One of the things that may seriously reduce the quality of life of an individual is death anxiety. It should be noted that the mentioned form of anxiety is usually characterized by consistent fear, anxiety, and worries about death, which can aggravate or create mental disorders such as depression and overall anxiety levels (Iverach, Menzies, & Menzies, 2014). People with depressing thoughts of death are unlikely to enjoy their every day life; this is because they lose out in the activities that will make their life complete (Abdel-Khalek, 2005). Coping strategies are central to the determination of quality of life in such cases as the chronic illness namely diabetes. According to the research, people who engage in adaptive coping methods such as finding an emotional support system and adapting to problem-solving in a practical manner, tend to have a better psychological well-being and life satisfaction (Skovlund et al., 2014). On the contrary, maladaptive coping can lead to deteriorating emotional health.

Studies have revealed that death anxiety may adversely affect the quality of life of a person. According to a study that was published in the Journal of Affective Disorders, it was revealed that death anxiety led to a reduced quality of life among patients with major depressive disorder (Yalom, 2008). These results indicate to the fact that managing of death anxiety is a relevant element of the procedure of enhancing the lifestyle of those with severe ailments. You should appeal to relatives and friends, a mental wellness specialist, or a palliative care unit, in case of difficulty coping with death anxiety.

The problem of social exclusion also contributes to the decline of the quality of life. The social exclusion theory may be used in explaining that those who are feeling rejected or outcast in social groups may feel emotionally bad such as being sad, lonely or isolated (Baumeister & Leary, 1995). The incidents of these experiences drastically affect not merely the mental well-being but also cut self-esteem and complicate the formation of significant relationships (Williams, 2007). To the healthcare professionals, it is crucial to learn about the dynamics so that they can create the intervention that will assist socially marginalized patients to regain access to the emotional state and make the overall life easier and more pleasant.

Literature Review

The World Health Organization (2016) defines Diabetes Mellitus is a long-term health condition that develops when the pancreas does not produce enough insulin or when the body cannot properly utilize the insulin it produces. This disruption in insulin regulation leads to elevated blood glucose levels, which can, over time, impair the normal functioning of various bodily systems. A confirmed diagnosis of diabetes is essential and requires both clinical evaluation by a physician and supportive diagnostic tests. While Type 1 and Type 2 diabetes may present with overlapping symptoms—such as increased thirst, frequent urination, unexplained weight loss, and recurrent infections—Type 1 diabetes often has a more acute onset (Ramachandran, 2014; IDF, 2019). In many cases, elevated blood glucose levels alone are considered sufficient for diagnostic confirmation (ADA, 2018). In the South Asian region, diabetes continues to rise at an alarming rate. According to the 2013 National Prevalence Survey, Pakistan reported a diabetes prevalence of 6.8%. By 2019, the IDF ranked Pakistan fourth among the top 10 countries with the highest number of adults (aged 20–79) with diabetes, estimating around 19.4 million cases. This figure is projected to rise to 26.2 million by 2030 and may reach 37.1 million by 2045. The prevalence among those aged 65 and older was recorded at 2.6 million in 2019, with expected increases to 3.8 million by 2030 and 6.4 million by 2045. Data from the Second National Diabetes Survey of Pakistan (2016–2017) shows a significant provincial variation: Sindh (19.4%), Punjab (16.9%), Balochistan (16.3%), and Khyber Pakhtunkhwa (11.1%).

People with Type 1 diabetes complain of social stigmatization and rejection, and this is a factor that leads to shame, social withdrawal, and emotional suffering (Sparapani et al., 2016; Tilden et al., 2012). These problems might be further aggravated by the necessity to use visible signs of disease treatment such as glucose monitors or insulin pens and could be even worse in social contexts. Similarly, individuals with Type 2 diabetes, and particularly those who are overweight, are often stigmatized based on weight, which can elevate their psychological burden, degrade their self-care motivation, and diminish the quality of life as a whole (Thomas et al., 2019; Puhl & Heuer, 2009). Dominant psychological constituents, including worry, estimable stress, and pity symptoms, have been associated with less advantageous glycemic control and poorer QoL among diabetic patients (Lopez-Patton et al., 2021; Polonsky et al., 2015). Social support is one of the protective factors that might lessen the emotional load and improve the outcomes related to diabetes health (Holt et al., 2019). Nevertheless, the inequality in access to highly developed medical technologies and healthcare resources is still another critical barrier, particularly in conditions of limited resources. A research by Sparapani et al. (2016) showed that adolescents diagnosed with Type 1 diabetes tend to experience a sense of rejection or judgment based on their diagnosis. The respondents expressed emotional discomfort of being treated differently by peers and the inconveniences associated with the treatment of their condition using injections or glucose monitors.

According to the American Psychological Association, interpersonal rejection sensitivity (IRS) is the increased response to social rejection, including the ability to sense it. It is thus a psychological characteristic that can have severe consequences on emotional stability and social functioning, especially among individuals with chronic diseases such as

diabetes. Citizens who have IRS noted to have lower self esteem, they feel more isolated and more susceptible to anxieties as well as depression. Stigma and social burden of managing the disease may exacerbate the condition of IRS in the complicated context of diabetes, especially Type 1 (Gonzalez et al., 2011). It is proved that rejection, guilt, and shame are common among people with Type 1 diabetes and can have a significant negative effect on the treatment compliance and mental health (Fisher et al., 2016; Sirois & Kitner, 2015). Also, fears that are diabetes-specific, e.g., fear of hypoglycemia, and emotional fatigue may further diminish QoL. Nevertheless, it has been found that physical and emotional outcomes correlate with higher social support and self-compassions (Smith et al., 2017; Johnson & Lee, 2018). Even though there is no direct evidence that IRS and QoL are interconnected in the context of diabetes, the results of the studies conducted in chronic illness groups indicate that the increase in IRS is associated with worse physical and psychological health consequences (Vowles et al., 2014; Lackner et al., 2013). Social support has a powerful role in mitigating the negative consequences of stress and promoting healthier self-care habits. In contrast, perceived rejection can erode these support systems, heightening emotional distress and increasing susceptibility to mental health issues (Sturt et al., 2006; Fisher et al., 2010). IRS also moderates how social support impacts health, as seen in patients with asthma or chronic obstructive pulmonary disease (Ritz et al., 2013; Nguyen et al., 2015). Interventions that focus on strengthening supportive networks and reducing sensitivity to social rejection can be beneficial in improving overall well-being and quality of life in diabetic individuals (Uchino, 2006; Trief et al., 2011; Liu et al., 2012). While stigma and social rejection affect both Type 1 and Type 2 diabetics, their experiences often differ based on age at onset, treatment needs, and public perceptions (Browne et al., 2013).

Material and Methods

Research Design

The present research used comparative research design. Surveys was used to obtain the comparison of interpersonal rejection sensitivity, death anxiety and quality of life among type 1 and type 2 diabetics.

Participants

A sample of (N= 300) was collected by using purposive convenient sampling by non-random sampling technique. The population was selected for the study fall into the age range of 18-40. Population selected from various private and government hospital in Karachi, both male and female.

Measures

Informed Consent Form

The participants were given an informed consent form to ensure their permission to participate in this research, which is a procedure used to inform the participants about the objective of the research. A brief introduction to the research topic and goal of the research was included in the consent form. A confidentiality declaration that addresses the degree, if any, to which the confidentiality of participant breaches was considered and guarantees the results of breaches will remain private.

Demographic Information Form

Participants was asked to fill in the demographics which asks for the details of participants (such as their age, gender, semester, socioeconomic status, birth order, interest in the field, and motivation).

The Interpersonal Rejection Sensitivity Scale (IRSS)

The Interpersonal Rejection Sensitivity Scale (IRSS), developed by Rohner et al. (2020), is a standardized tool consisting of 13 items that assesses how sensitive a person is to potential rejection in their relationships with others.

WHO Quality of Life Scale

WHOQOL is a quality-of-life evaluation created by the WHOQOL Group in collaboration with fifteen worldwide field centers. The WHOQOL-BREF scales are made up of 26 items. There are five possible answers to these questions. The overall QOL score should be between 4 and 20. Physical, mental, social, and environmental scales are included in article 8. The scale includes elements from two categories: general QOL and overall health

The Death Anxiety Inventory-Revised (DAI-R)

The Death Anxiety Scale (DAS) originally developed by Templer (1970) is a 15-item self-report measure designed to assess anxiety related to thoughts and experiences of death. In its adapted form, the scale uses a 5-point Likert format ranging from 1 (strongly disagree) to 5 (strongly agree).

Procedure

The procedure of the present study was carried out in multiple steps. Initially, permission to conduct the research was obtained from the Institute of Professional Psychology. Afterwards, permission from the respective scale authors was secured to use their scales in the research. The questionnaire was handed individually to the participants. The questionnaire included a consent form at the beginning as well as demographic information. Data was collected from private and government hospitals for the research. The data collection began once permission was obtained from the respective government and private institutes through an official permission letter. Following this, participants were selected through purposive convenience sampling. The collected data was analyzed using SPSS (Statistical Package for the Social Sciences). Furthermore, the consent form, demographic information sheet, Guilt and Shame Proneness Scale Questionnaire, and WHO Quality of Life Scale were attached in the index.

In this research, no deceptive approaches were used in the collection of data. Participants were fully informed about their rights and the requirements for participating in the study. All participants were informed that their participation was entirely voluntary and that they could withdraw their data at any moment they desired. It was also explained that their responses would remain confidential and that the data would be kept anonymous when used. Consent was obtained to ensure their voluntary participation. They also had the right to inquire about the outcome of the study. In accordance with the moral duty to shield research participants from any physical or psychological harm, it was ensured that the participants were not mistreated or subjected to any emotional

Results and Discussion

The research findings were calculated by conducting statistical analysis using Statistical Package for Social Sciences (SPSS 26).

Table 1
Frequency of Demographics of Participants (N =300)

Variables	M	SD	f	%
Age	34.83	8.78		
Gender				
Male			171	57

Female	129	43
Education		
Matric	21	7
Intermediate	61	20.3
Undergraduate	130	43.3
Post Graduate	88	29.3
Marital status		
Single	102	34
Married	186	62
Divorced	6	2
Widow	6	2
Occupation		
Student	49	16.3
Job	187	62.3
Jobless	64	21.3
Which type of diabetes you have??		
Type 1	150	50
Type 2	150	50
Which type of medication do you take?		
Insulin	125	41.666
Tablets	171	57
Both	4	1.333
How many years you have been diagnosed with diabetes?		
1 to 6 years	130	43.3
7 to 12 years	95	31.7
12 to 18	44	14.7
18 above	29	9.7
25 above	2	0.7

Notes: f = Frequency, % = percentage of responses

The Table 1 provides the demographics of the participants with age, gender, education, marital status, occupation, type of medication and type of diabetes.

Table 2
Psychometric Properties for Scales and Subscales of Quality of life, Interpersonal Rejection Sensitivity, and Death Anxiety (N =300)

Variable	M	SD	SK	K	Range
Quality of Life					
Physical Health	13.55	2.65	-0.25	-0.355	4-20
Physiological	13.20	2 23	-0.70	0.376	5-25
Social	14.00	2.77	-0.60	0.55	3-15
Environment	12.86	2.69	-0.34	0.617	8-40
Interpersonal Rejection	25.96	7.61	0.25	-0.683	11-44
Death Anxiety	44.96	8.44	-0.40	0.988	19-70

Notes: M= Mean, SD= Standard Deviation, SK = Skewness, K = Kurtosis

The Table 2 provides psychometric properties including reliability of scale and subscales of Quality of life scale, interpersonal rejection sensitivity and Death anxiety. The value of both skewness and kurtosis represents the normal distribution of the data.

Table 3
Cronbach Alpha of Variables (N =300)

Variable	α
Quality of Life	0.902
Interpersonal Rej Sensitivity	0.917
Death Anxiety	0.775

Table 3 shows, Cronbach alpha reliability coefficient the variables under study. Cronbach alpha was also interpreted resulting in coefficients reliability being within the acceptable range. Reliability of Quality of Life Scale (α=.902) and interpersonal rejection (α=.917) lie in the excellent reliability and death anxiety scale (α=.775) lie in good reliability.

Table 4
Independent Samples t-test (N =300)

Variable	Type 1(n=150)		Type 2 (n=150)			
	M	SD	M	SD	t	p
Quality of Life	86.56	14.34	87.18	13.94	-.379	0.705
PH	13.45	2.73	13.64	2.58	-0.94	0.34
PSY	13.177	2.54	13.23	1.88	-0.68	0.49
SR	14.13	2.78	13.88	2.78	0.54	0.58
EN	12.77	2.46	12.95	2.95	-0.96	0.33
Interpersonal Rej	27.73	7.84	24.73	6.97	4.15	<.001*
Death Anxiety	48.36	7.26	41.57	8.18	7.41	<.001*

Notes. PH=Physical Health, PSY= Psychological, SR=Social Relationship, EN= Environmental.

The above table 4 shows the independent samples t-test The results indicate a statistically significant difference in death anxiety between the two groups, $t(7.604) = 0.000$, $p < 0.05$. This suggests that individuals with Type 1 diabetes reported significantly higher levels of death anxiety compared to those with Type 2 diabetes, with a mean difference of 6.79. The results also indicate a statistically significant difference in interpersonal rejection sensitivity between the two groups, $t(4.115) = 0.000$, $p < 0.05$. Type 1 diabetics reported interpersonal rejection sensitivity, with a mean difference of 3.53, suggesting greater variability and interpersonal rejection sensitivity compared to Type 2 diabetics. Furthermore the difference between the two groups was insignificant ($p = .705$), indicating no meaningful variation in the overall quality of life scores between Type 1 and Type 2 diabetics.

Table 5
Correlational Analysis between Interpersonal Rejection Sensitivity, Death Anxiety and Quality of life

Variable	1	2	3	4	5	6
1.Interpersonal rejection sensitivity scale	-	-	.38**	.45**	.43**	.28**
2. Death anxiety scale	-	-	-.23**	-0.06**	-0.08**	-.13**
3. QOL Physical health			-	.69**	.65**	.57**
4. QOL Psychological				-	.67**	.64**
5. QOL Social Relationship					-	.50**
6. QOL Physical health						-

The above-mentioned correlation table shows that there is a significant positive and moderate correlation between Interpersonal Rejection Sensitivity and Death Anxiety ($r = .38$. Additionally, there is a significant positive but weak correlation between Interpersonal Rejection Sensitivity and QOL Physical Health ($r = .28$), Psychological Health ($r = .45$), and Social Relationships ($r = .43$. Death Anxiety, on the other hand, shows a significant negative but weak correlation with QOL Physical Health ($r = -.23$. There is also a very weak negative correlation between Death Anxiety and QOL Social Relationships ($r = -.08$) and Psychological Health ($r = -.06$).Furthermore, QOL Physical Health is significantly positively correlated with QOL Psychological Health ($r = .69$), Social Relationships ($r = .65$), and Physical Health ($r = .57$). Similarly, QOL Psychological Health has a strong positive correlation with QOL Social Relationships ($r = .67$) and Physical Health ($r = .640$.Lastly, QOL Social Relationships show a moderate positive correlation with Physical Health ($r = .50$).

Discussion

The results supported the hypothesis that people with Type 1 and Type 2 diabetes had significantly different degrees of interpersonal rejection sensitivity. Individuals with Type 1 diabetes report interpersonal rejection sensitivity at far higher levels than people with Type 2 diabetes. This result is consistent with earlier studies that highlight the psychological toll that Type 1 diabetes takes, especially because it manifests early during crucial developmental phases like adolescence (Helgeson et al., 2007). The statistics indicate that the demands of continuous disease management and the visibility of their condition

exacerbate the psychosocial challenges in this demographic. Social anxiety, feelings of rejection, and exclusion may all be exacerbated by these stressors (Sparapani et al., 2016; Tilden et al., 2012).

Silverstein et al. (2005) indicated that type 1 diabetes is typically uncovered at an early age when individuals are more sensitive to social dynamics and peer acceptability . Insulin treatment and blood glucose checking are everyday rituals that often occur at social or public places and this makes the condition very obvious and people may feel extremely different than normal among peers (Helgeson et al., 2007). Beverly et al. (2008) reveal that these feelings of otherness can grow to become social disengagement or a sense of rejection especially when peers respond with misunderstanding or exclusion. Sparapani et al. (2016) also state that adolescents with Type 1 diabetes have complained of being socially isolated due to their illness, which may cause emotional distress and elevated rejection sensitivity.

The social awareness of self as a result of the chronic nature of the management of Type 1 diabetes (i.e., frequent checks, dietary limitations, and injections) can exacerbate social self-consciousness and lead to anxiety in interpersonal relationships. Such experiences agree with the general psychological findings which have correlated chronic illness with elevated rejection sensitivity and adverse psychological consequences (Downey & Feldman, 1996). Further, high rejection sensitivity can disrupt self-care routine adherence, which affects physical health (Hagger & Orbell, 2003).

These findings can be contextualized by using the theory of stigma proposed by Goffman (1963). Within this framework, persons who have visible or otherwise socially devalued characteristics, including persons who are coping with a chronic, observable illness, are at risk of being socially marginalized. The visibleness of Type 1 diabetes can therefore serve as a stigmatizing attribute that results in the perception of being judged or rejected. Conversely, Type 2 diabetes can be diagnosed at the adult stage and is less noticeable, which can protect individuals against such levels of stigma and psychosocial distress (Browne et al., 2016). Collectively, the findings of this research highlight the distinct psychosocial burden experienced by people with Type 1 diabetes. The condition is visible, the lifelong medical care is demanding, and the developmental timing of the onset of the condition all play a role in increasing rejection sensitivity.

The second research hypothesis of the present study stated that there was a marked difference in the death anxiety level of Type I diabetes and Type II diabetes. This was supported by the findings which revealed that persons having Type 1 diabetes were found to have significantly higher death anxiety. It may be explained by such factors as early onset of the disease, management of it throughout the lifetime, and the incessant risk of acute complications, such as diabetic ketoacidosis and hypoglycemia (Anderbro et al., 2015).

Such findings are consistent with the study done earlier indicating that chronic illnesses onset in adolescence have been observed to increase the existential distress because of their visibility and the constant vigilance required (Snoek et al., 2004; Mathew et al., 2012). Type 2 diabetics, on the other hand, typically develop the condition at an older age and are normally considered easier to manage, and those that are more correlated to age or lifestyle factors. This could reduce the fear of death (Abdel-Khalek, 2011). Terror Management Theory (TMT) can be used to interpret these results because it proposes that heightened awareness of mortality particularly in a chronic illness poses a risk of instigating existential anxiety (Greenberg et al., 1997). In individuals with Type 1 diabetes, death anxiety is elevated due to a lack of stable worldview formation because of frequent healthcare visits and continual health threats in their lives (Iverach et al., 2014).

Type 1 diabetes is more profound in young individuals because they can internalize mortality fears at an early age. Research has established that these people tend to frame a psychological strain that revolves around future health concerns such as damage of organs

or abrupt ill-health reservations (Williams et al., 2011; Menzies et al., 2008). On the contrary, patients with Type 2 diabetes can be endowed with well-developed coping strategies, and a less intensive treatment to minimize their death anxiety (Abdel-Khalek, 2011; Nelson & Cox, 2016). The findings by the Terror Management Theory and developmental psychology indicate that interventions to improve the mental health of people with Type 1 diabetes should particularly focus on the mortality-related fear and introduce effective approaches to the potential coping with existential distress.

The increased psychological burden of Type 1 diabetes in terms of the high psychological stress of managing the disease and the higher health risks explain the higher level of death anxiety. Type 2 diabetes is a serious condition but, in most cases, it is less demanding and does not evoke the sense of immediate threat. This tendency is backed by literature on chronic illness, which also points out that illnesses that are unpredictable, visible, and severe raise the level of mortality awareness particularly among young generations (Cohen & Lazarus, 2005; Kastenbaum, 2000).

In conclusion, the results of the study support the idea of the individual psychological experience of people with Type 1 diabetes. Their strong measures of death anxiety indicate not judgement of how clinically severe the condition is but they rather show how noticeable the condition is, the early years of on set and how it continually needs to be managed. A combination of these factors enhances the knowledge on the subject of mortality and maybe needs stronger psychological assisting in the long bright future. Evidence put forward by the Terror Management Theory and developmental psychology implies that the particular implementation of mental health approaches on helping people with Type 1 diabetes must aim to alleviate the existential concerns in connection with death and lead to the implementation of adaptive responses to overcome existential distress.

Though the differences in rejection sensitivity and death anxiety were found to be significant between Type 1 and Type 2 diabetes patients in this study, no significant difference could be detected in the overall quality of their lives (QoL). This implies that QoL is not only determined by psychological distress. Such factors as appropriate medical treatment, a well-developed social support system, personal access to technology, and their coping strategies are important to QoL (Skovlund et al., 2014). Social support also provides a level of protection, as it enables people to cope with their emotional complications and be resilient (Sherifali et al., 2016). Family, friends, and healthcare providers can mitigate adverse consequences of psychological stress, which is why the QoL indicators of patients with diabetic type 1 and type 2 are not different (Fisher et al., 2018). In addition to technological inventions, such as insulin pumps, CGM, and digital health tools, help foster better self-care and emotional well-being that enhance the feeling of autonomy and control (Fogelholm et al., 2021; Lloyd et al., 2017). This may be the reason why the impact of such resources on the two groups does not vary in terms of QoL.

Also, the elements of adaptive coping, e.g. problem-solving, CBT, and mindfulness, foster the emotional adaptation and management of stress that is equally beneficial to both groups (Schmidt et al., 2018; Trief et al., 2003). In the long term, persons usually build self-efficacy enhancing their beliefs in their ability to cope with their condition and the ensuing QoL no matter the type of diabetes. Overall, although the total psychological burden is higher in individuals with Type 1 diabetes, such factors as social support, medical technology, and coping skills keep QoL comparable in both the groups. This is testimony to the fact that physical as well as psychosocial requirements need attention in the management of diabetes.

Conclusion

The findings shed Important light on the particular psychological difficulties that people with Type 1 and Type 2 diabetes encounter. Although mortality fear and

interpersonal rejection sensitivity are higher in Type 1 diabetes, QOL is similar in both groups. These results highlight the significance of psychological interventions that are specifically designed to meet the needs of each group. Healthcare professionals can enhance the general wellbeing of diabetic patients by emphasizing social integration, emotional resilience, and fear reduction. Future research should explore longitudinal trajectories of these psychological factors to develop more effective support systems.

Recommendations

The sample size may have been Insufficient to generalize findings across diverse populations. Limited diversity in demographics such as age, ethnicity, and socioeconomic status could restrict the applicability of results. Futhermore While the study highlighted differences between Type 1 and Type 2 diabetics, it may have overlooked within-group differences, such as the influence of age, duration of diagnosis, or coexisting conditions. Additionally Advancements in diabetes care were not analyzed in depth. Variations in access to technologies like insulin pumps and continuous glucose monitors may have impacted QOL outcomes. Future research should address these limitations through longitudinal designs, larger and more diverse samples, and a broader analysis of psychosocial and technological factors influencing the psychological well-being of diabetics.

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