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Thanatological anxiety (types of fear of death in the Covid-19 period) in a randomly selected group including medical personnel.

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Abstract
Topic: Thanatological anxiety (types of fear of death in the Covid-19 period) in a randomly selected group including medical personnel)
Aim of the study: an attempt to investigate the occurrence of thanatic anxiety in the studied population
Theoretical assumptions (J. Maxelon, 1986; Hoelter, 1978, Mesjasz, 2010) in life-threatening periods (pandemics, wars, traumatic accidents) there is fear of death in people, which determines the actions of the individual
*Study group: N = **522 people** : women (440, or 84%); men (82, or 16%).*
Methodology used: Questionnaire of Fear of Hoelter 's death in Polish adaptation (J. Maxelon, 1986)
HypothesesH $_1$: The studied group declares the presence of thanatic anxiety
H $_2$: There are correlations between age and thanatic anxiety in the study group.
H $_3$: There are correlations between sex and thanatic anxiety in the study group.
H $_4$: Medical personnel declare a certain degree of thanatic anxiety .

***Conclusion:** The studied group declares the presence of thanatic anxiety . He is most afraid of dying in fire and distorting the body. He also expresses his concern about uncertainty about what will happen after death and concern for family*
There are correlations between age and thanatic anxiety in the study group , including uncertainty and fear of the unknown.
There are correlations between gender and thanatic anxiety in the studied group. In the group of men there is a greater intensity of fear of the unknown, fear of apparent death, and fear of premature death.
Women differed from men in the greater prevalence of all types of anxiety
There is a difference in anxiety about body appearance between healthcare professionals and other respondents. Healthcare professionals are less concerned about the appearance of the body.
***Key words:** thanatology, fear of death Covid-19, medical staff*

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I. Introduction

(Approach to death)

Each death is seen as the final stage of life combined with sadness and bad events. Instinctively, man uses various defense mechanisms to reduce the best use of life. This approach was represented by Epicurus, who believed that death should not be afraid because when we exist, death does not exist, and when death does appear, we cease to exist (Zuccaro, 2004).

Epictetus also had similar approaches , saying that death is not terrible, it is only terrible to think that death can be terrible (Laertios ,1984).

Others have argued that true life is only possible when we live with the awareness of death. The use of defense mechanisms causes that a person does not perceive what is real and distorts the image of reality. Martin Heidegger was thinking in this way when he wrote about 'being to death. (Heidegger, 2011).

With the advent of the detailed sciences, mainly psychology, humans began to take a great interest in the human being and his existence. But it was only the emergence of a special branch of psychology - thanatopsychology - that the problem of death was distinguished. When it was discovered that the experience of

death translates into human development and psyche, interest in the psychology of death began to grow. People began to openly say that the most common mistake in approaching death is throwing it out of life. It is important to realize that he is approaching death all the time. Approaching death is irrelevant only to those whose life also does n't seem to make sense. Not being able to die also means being unable to live. (Heidegger, 2011).

Types of Actual Death

There are several common situations in which death occurs. The division proposed below seems to cover all possible circumstances in which a person leaves the world.

- accidental death is often called an accident, an accident. This is the most shocking type of death because there is no way to predict and prepare for an accidental death. Due to the shocking beginning and the process, he sometimes aggressively raises the question of responsibility for his own life and for the one who died unexpectedly.(Midura , 2013).

-the disease is the most common cause of death. It destroys a large part of society, especially during the pandemic (Gulka, Tucholska, 2019).

-war is understood here as an extended death penalty for a larger community, since those who declare war doom a nation and a generation to collective death. Mass death in war differs from death from an epidemic in that it is ultimately caused by humans. War "makers" disrupt the lives of individuals and societies in such a way that they ultimately kill them. So war, whether defensive or offensive, always carries with it death threats, if not real mass death. War is like eye contact with death, because every day thousands of people die not only from fighting, but also from disease or bad food (Guzowski, Krajewska-Kułak, Bejda, 2016).

- murder and suicide have different motives and serve different purposes: in the case of murder, someone's life ends, during the act or attempted suicide - an attempt on one's own life. Suicide deaths in particular are becoming an environmental problem, as well as of those who engage in such behavior. For a man trying to commit suicide, this is psychologically the best option life has to offer. Forced abandonment of life is pathological behavior.

- a religious victim. Human sacrifice in the religious theme is well known for a long time. Sacrificial death is surrounded by an emotional atmosphere. In this case, it seems right to say that the martyr is dead. Such death is the object of religious worship among the faithful.

- Execution, exile and imprisonment are forms of death strictly defined by the cultural and legal traditions of a given country. A common feature of these types of deaths is the lack of connection with basic groups such as: country, family, friends. Death in exile is a form of execution of a sentence against a person who actually or seems to threaten society. Today, exile is being replaced by internment, that is, exile without leaving the country. Death in prison occurs suddenly or slowly, from exhaustion, torture or caused by the disease(Ostrowska, 2005).

- Torture is the most common cause of death of prisoners. Psychiatrists describe torture not so much as sadism as a willingness to demonstrate its superiority. Victims are driven to extreme emotional states, depression, anxiety, memory loss, hallucinations, and the inability to concentrate.

-Aging. The importance of social roles declines in old age. Many people develop a disease that hastens natural death. It should also be emphasized that death later in life can be more problematic than accidental or dangerous disease

Several of the aforementioned death situations suggest different conditions. It is also to be expected that the subject of a person's thanatic attitude will vary depending on what problem they encounter. Will it be a death issue in the context of war, aging or a pandemic as defined above in the various death cases. Therefore, it is necessary to understand them in order to reasonably recognize the problem of the object of the attitude towards the death of Makselon , 1984.

Defense mechanisms against the thanatic fear

Freud presented defense mechanisms that are designed to guarantee the proper functioning of an individual. As self defense systems, these mechanisms perform multiple functions. They help to maintain a high level of well-being, reduce anxiety, and strengthen the sense of dignity. In psychoanalysis, defense mechanisms work almost exclusively in the context of neurotic behaviors, currently it is claimed that the unconscious defense mechanism of "I" is also a feature of a normal, relatively healthy person

(Kozielecki, 2000). Death psychologists believe that in the face of every death, a person is accompanied by defense mechanisms. These mechanisms work mainly to reduce the anxiety associated with death. Usually, it is not just one defense mechanism that works, but it is several interrelated mechanisms. There are also various factors that determine how many and how these mechanisms will appear. These factors include, but are not limited to:

- orderly age of the person who experienced the phenomenon of death,
- attitude and approach to own death,
- current physical and mental condition,
- the influence of some other variables such as: religious beliefs,
- information gained about death and dying,
- degree of emotional maturity

(Laughlin ., 1979)

Defense mechanisms work intuitively. They are methods of conflict resolution of mental disorders that are supposed to help individuals adapt by reducing the sense of fear. With regard to attitudes towards death, three defense mechanisms should be taken into account: denial, denial and rationalization, these are the most typical human reactions to the fear of death (Obuchowski, 2001)

Repression is the most famous and widespread defense mechanism. It is based on eliminating from human consciousness thoughts about situations and things that cause anxiety, guilt and fear. In order to prevent repressed content from returning, people often engage in additional activities, but repressed thoughts are hidden signposts of their actions. The desire to deny the problem of death is present in human consciousness as well as the desire to forget about things related to one's own illness or the desire to forget about passing. Psychologists say that without faith in life after death, people only have to avoid death. The phenomenon of tabooing is based on the elimination of talking about the topics related to human dying, and even hiding and manipulating them .(Baka, 2009).

The elimination of the topic of death and the fear of dying is manifested, inter alia, in in increasing activity. The need for constant occupation, the inability to be with yourself, the need to fill your free time with anything. All activities aimed at avoiding opportunities for self-reflection. Repression is a manic protection against depression and the fear of death .(Zinczuk , 2008)

According to other data describing the manifestations of denial, it is stated that after reaching middle age, when we learn more and more of the truth that our own death is inevitable, in some cases the need to defend ourselves against this fact grows sharply. On the other hand, the midlife crisis may provide an opportunity to integrate different perceptions about one's own possible death. More specifically, a midlife crisis often leads to anxiety and depression and thus miraculously protects the ego from its provocative reality. This behavior differs from adolescence, when defensive suppression of the fear of death runs parallel to occasional meetings, such as at funerals. Running away from death by denying its facts and problems brings a taste of sudden, momentary, empty joy. It is also the emotional overtone of many actions taken to protect against the thoughts and fear of death. One of the main reasons for denying death is the fear of losing a relationship with someone important. Danger of death is the same as questioning future relationships. Objections to death are not only about avoiding the dangers usually associated with its fact. From a psychological point of view, understanding of the opposition to death is more likely to be understood, in which the conscious fear of losing relationships in the first place is perceived. Often times, a person lives in an illusion that allows him to assume for some time endless possibilities of contact with people who are important to him. In interpersonal relationships, people in communication can connect with each other. This availability, especially in times of desperate need, is realized in emotional support. Reflection on one's own death and the death of others brings to mind the truth about the value of man and his integration with the social system. Understanding this by some people causes withdrawal into their own interior in order to overcome the fear of losing their life and their natural self- image (Zinczuk , 2008,) There are also reactions in which a person builds his own intimate world, different from the one that surrounds him. To remain in this attitude is an expression of denial to the phenomenon of death. Usually in such situations moderate behavior is encountered, but there may also be fits of anger. They may be the reason for the desire to express something of themselves to the world or it may also be an attempt to check whether the person closest to us is still worried about what is happening to us. Although psychologists have slightly different views on the course of the death process, all agree that the innate structure of the intimate world of an terminally ill patient often breaks down from the moment they enter the final phase. As it turns out, hospital staff, his family, and even friends can almost always notice a withdrawal from dying patients .(Musiał, 2015) A. Weisman distinguishes four levels of dynamics of death denial.

- The first is to accept the fact that the person is terminally ill,

- The second is to reject the truth about the end of life,
- The third is to analyze, activate the concept and notion that the disease can be cured with some miracle cure or situation,
- The fourth level is the change of beliefs about the general importance of one's own position in order to adapt to the correct perception of one's own conditions and possibilities (Becker , 2016).

Of course, the course and degree of denial varies, but it largely depends on the type of disorder and self-image. People with certain medical conditions develop a unique self-image. This, in turn, sometimes has a huge impact on the undertaken social function. Denying death has a social dimension not only from the point of view of the patient who is aware or at least senses the importance of social groups. The denial also applies to the dying person's social circle, primarily including the medical services and members of the immediate family.

It concludes that if a person is always fully aware of death, especially if he is completely immersed in the fear of death, life is almost impossible. It has also been found that personality disorders develop when the fear of death stops working(Łukaszewski, 2011).

Group research

The questionnaire consisted of a record and 43 questions from the Multidimensional Death Fear Scale. The respondents answered the questions online .

The study group consisted of **522 people ,** both women (440, i.e. 84%) and men (82, i.e. 16%), which is presented in Chart 1.

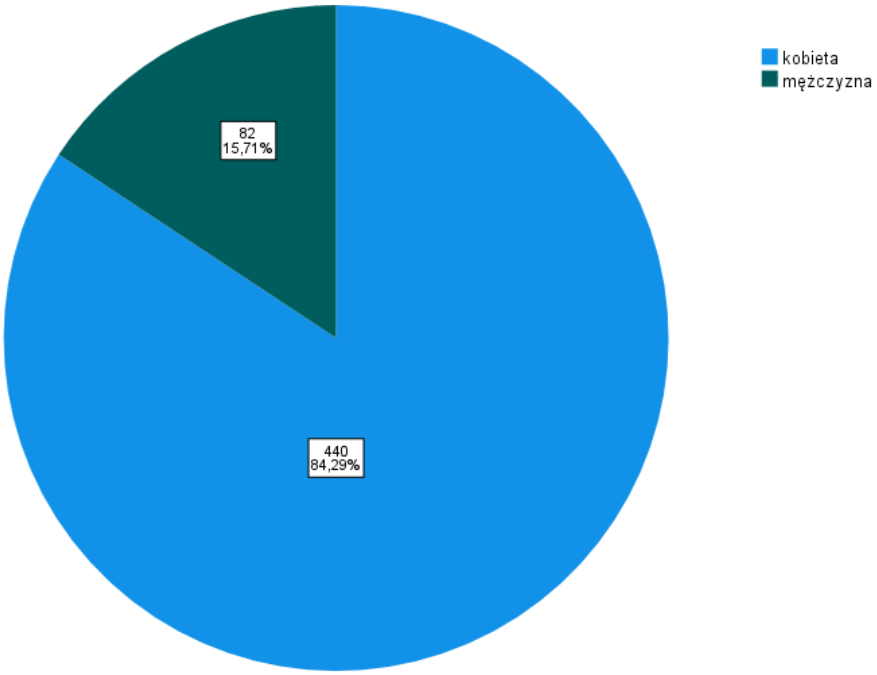

Chart 1. Gender of the respondents

Age was the only quantitative variable in the survey. Table 1 presents the basic statistics describing the age of the respondents. The youngest person was 17 years old at the time of completing the questionnaire, and the oldest was 67 years old (5 people did not provide their age). The average age of the respondents was 29.81 years.

Table 1. Basic statistics describing age

	N	Minimum	Maximum	Mean	Standard deviation
Age	517	17	67	29.81	9.361

The last question describing the studied group was a question about the work performed. Among the respondents, 118 people (23%) work in the medical service and 404 respondents (77%) are not medical personnel.

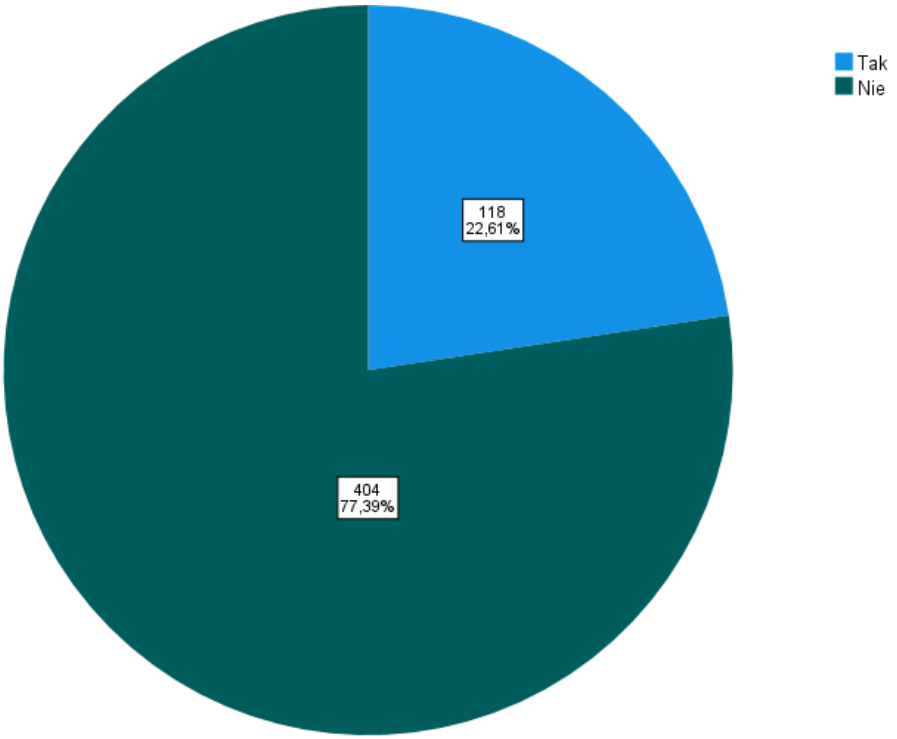

Chart 2. Responses to the statement "44. I do work related to the medical service "

The following hypotheses were made
H_1: The study group declares the presence of thanatic anxiety
H_2: There are correlations between age and thanatic anxiety in the study group.
H_3: There are correlations between sex and thanatic anxiety in the study group.
H_4: Medical personnel declare a certain degree of thanatic anxiety .

Description of the results obtained

Tables 2, 3 and 4 provide answers to the questions on the Multidimensional Death Fear Scale. Responses that were selected by the largest number of people are marked in bold. As many as 292 (56%) respondents fully agree with the **statement 13. "I'm afraid of dying in a fire** " (Table 2). On the other hand, the largest number of respondents (268, ie 51%) **completely disagreed with the statement 7. "I'm afraid that my body will be deformed after death."**

Table 2. Answers to questions 1 to 14 of the survey

	I completely disagree	I do not agree	I rather disagree	I have no opinion	rather agree	I agree	I totally agree
1. I am afraid of dying slowly	22	14	14	35	75	86	**276**
2. A visit to a funeral home scares me	**147**	84	51	69	56	36	79
3. I would like to donate my body for the development of medical knowledge	119	48	50	81	59	43	**122**
4. I am afraid of people dying in my family	39	36	23	thirty	60	84	**250**
5. I am afraid there is no eternal life	**167**	53	37	66	45	44	110
6. Probably many people were said to have died while they were still alive	61	58	66	**143**	58	48	88
7. I am afraid that my body will be distorted after death	**268**	58	37	53	26	22	58
8. I am afraid that I will die before my life goals are achieved	96	38	42	48	62	69	**167**
9. I am concerned about the thought that the body will decompose after death	**246**	63	22	46	32	23	90

10. If I had died my friends would have lived it for a long time	50	35	58	**131**	94	70	84
11. I am afraid of sudden death	97	47	31	36	53	58	**200**
12. I fear everything that is dead	**169**	80	63	63	45	32	70
13. I'm afraid of dying in fire	40	26	23	27	42	72	**292**
14. I would have no trouble touching the body	**129**	58	49	77	55	51	103

It can be noticed that most responses (389, i.e. 74.5%) "I completely agree" were marked in **statement 20** . **"If I died tomorrow, my family would be upset" (Table 3). In second place (388, or 74.3%) was the statement 15. "If people dear to me died suddenly, I would suffer long time".** On the other hand, the answer "I completely disagree" (312 people, ie 59.8%) was most often chosen with the statement 27. "Since everyone is dying, you do not have to worry too much that a friend is dying."

Table 3. Answers to questions 15 to 28 of the survey

	I completely disagree	I do not agree	I rather disagree	I have no opinion	rather agree	I agree	I totally agree
15. If people dear to me die suddenly, I would suffer for a long time	9	11	11	21	36	46	**388**
16. I am not afraid of meeting my Creator	66	14	thirty	133	45	48	**186**
17. I tremble at the thought that my body might be embalmed	**264**	70	37	83	twenty	13	35
18. I am afraid my dying will take a long time	50	33	28	84	67	59	**201**
19. Discovery of a dead body would be a terrifying experience for me	67	27	36	61	69	67	**195**
20. If I died tomorrow, my family would be upset	10	7	2	22	33	59	**389**
21. I am afraid that death ends everything	123	32	39	68	57	33	**170**
22. I am frightened at the thought that it may be difficult to identify my body after death	**180**	78	40	84	44	twenty	76
23. I am afraid that I will not live long enough to enjoy my retirement	102	44	39	72	58	53	**154**
24. I am afraid of dying from cancer	47	22	21	46	57	90	**239**
25. Walking alone through the cemetery at night would certainly be fearful	81	42	53	41	70	59	**176**
26. I would not like students to learn on my body after their death	129	48	43	79	33	twenty	**170**
27. Since everyone is dying, you don't have to worry too much that a friend is dying	**312**	91	34	thirty	23	14	18
28. I am afraid that there may not be a Supreme Being	**186**	37	38	113	37	29	82

Table 4 shows that the majority of responses (341, or 65.3%) "I completely agree" received **the statement 36. "No one can say with certainty what will happen after death." In the case of statement 34. "I do not like the thought about the possibility of burning a corpse", the most frequently marked answer was "I completely disagree** " (227, ie 43.5%).

Table 4. Answers to questions from 29 to 41 of the survey

	I completely disagree	I do not agree	I rather disagree	I have no opinion	rather agree	I agree	I totally agree
29. There should be such criteria that it can be concluded with certainty that someone is dead	23	14	5	90	51	72	**267**
30. It doesn't matter to me which coffin I am buried in	35	11	16	33	44	62	**321**

31. I don't think I will have time to experience everything I want	31	32	22	64	71	66	**236**
32. I have a fear of dying by asphyxiation or drowning	50	27	17	47	59	53	**269**
33. It would be terrifying for me to get a dead body out of the way	74	37	40	61	68	73	**169**
34. I don't like the thought of burning a corpse	**227**	67	45	73	29	25	56
35. Sometimes I get distracted when a loved one dies	22	12	22	46	59	95	**266**
36. No one can say with certainty what will happen after death	31	14	13	thirty	38	55	**341**
37. The thought that I might be aware when they put me in the grave scares me	92	35	34	36	54	56	**215**
38. I hope that more than one doctor will test me before my death is pronounced	60	26	23	87	53	62	**211**
39. I am not sure if I will see my children growing up (nieces, nephews)	77	39	32	94	60	55	**165**
40. It worries me that I will be placed in a coffin after death	**201**	40	38	69	39	thirty	105
41. Have you experienced a serious threat to your life?	**159**	72	47	50	60	40	94

Chart 3 shows that the greatest number of people (149, i.e. 28.5%) survived the death of a loved one 7 or more years ago. The answer "a year ago" was second, chosen by 143 people, which is 27.4%.

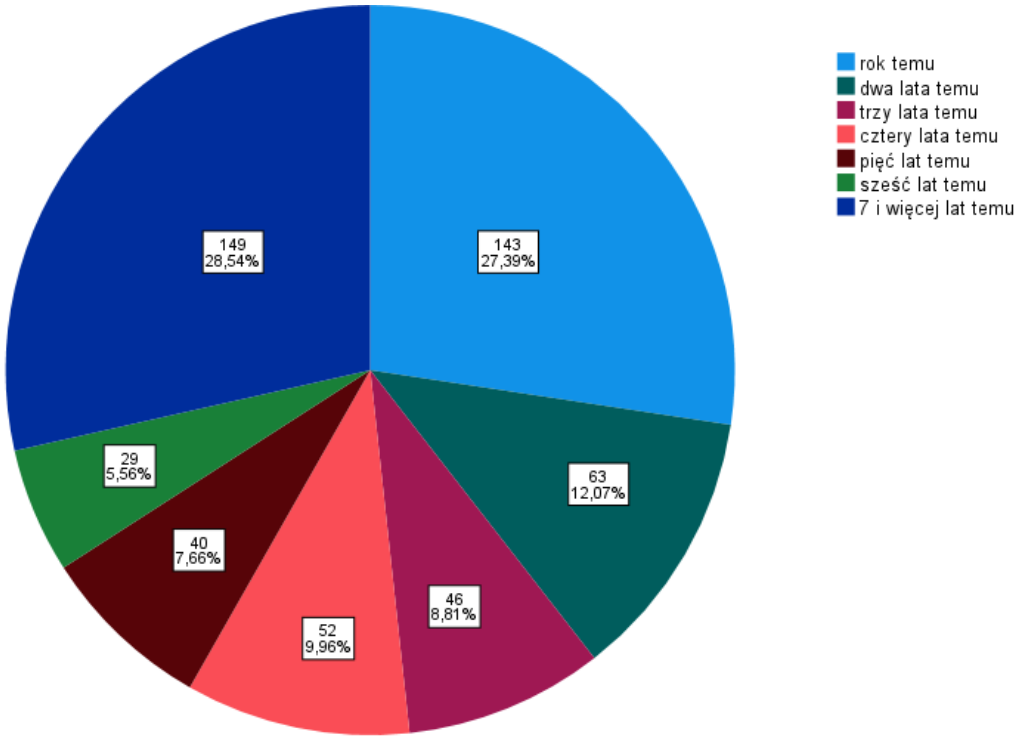

Chart 3. Responses to the statement “42. How many years ago did you experience the death of a loved one? "

Question 43 was the only open-ended question that concerned experiences and thoughts related to death (e.g. a loved one). Here there were answers such as: s mutek, regret, longing, anger, despair, helplessness, helplessness, hopelessness, anxiety, fear, fear, feeling of emptiness, pain, reflections, shock, absent-mindedness, drama, collapse of the current world, depression, seeking faith / God, trauma, suffering, relief that the deceased does not suffer, helplessness, terror, nostalgia, depression, disbelief.

3.3. Statistical method

Statistical analysis was performed using IBM SPSS Statistics software . The individual types of fears consisted of sets of questions: fear of dying (1,11,13,18,24,30), fear of the dead (12,14,19,25,32,33), fear of the destruction of the body (3, 7,9,16,34), fear of the living (4,10,20,27,39), fear of the unknown (5,21,28,35,36,40), fear of apparent death (6.29, 31,37,38), fear of body appearance (17,22,26), fear of early death (2,8,15,23)

Table 5. Results of tests of significance of the correlation coefficient rho Spearman

1. Fear of dying	Correlation coefficient	-0.036
	Significance (two-sided)	0.417
	N	517
2. Fear of the dead	Correlation coefficient	-0.005
	Significance (two-sided)	0.917
	N	517
3. Fear of the destruction of the body	Correlation coefficient	-0.076
	Significance (two-sided)	0.085
	N	517
4. Fear for the living	Correlation coefficient	-0.060
	Significance (two-sided)	0.174
	N	517
5. **Fear of the unknown**	Correlation coefficient	-0.111
	Significance (two-sided)	**0.011**
	N	517
6. Fear of apparent death	Correlation coefficient	-0.004
	Significance (two-sided)	0.926
	N	517
7. Fear about the appearance of the body	Correlation coefficient	0.032
	Significance (two-sided)	0.472
	N	517
8. Fear of early death	Correlation coefficient	-0.047
	Significance (two-sided)	0.285
	N	517

Table 5 shows that only one p-value (two-sided significance) is less than 0.05 (bold). Then it can be concluded that there is a significant relationship **between age and the fear of the unknown** . In the remaining cases, the two-sided significance is greater than 0.05, which means that there is no correlation between age and the other seven fears.

Table 6. Test results for the normality of the distribution by **gender**

		Kolmogorov-Smirnov test		
Sex		Statistics	df	Relevance
1. Fear of dying	woman	0.099	440	0,000
	man	0.121	82	0.005
2. Fear of the dead	woman	0.085	440	0,000
	man	0.114	82	0.010
3. Fear of the destruction of the body	woman	0.097	440	0,000
	man	0.175	82	0,000
4. Fear for the living	woman	0.103	440	0,000
	man	0.137	82	0.001
5 **. Fear of the**	woman	0.060	440	0.001

unknown	man	0.083	82	**0.200**
6. **Fear of apparent death**	woman	0.085	440	0,000
	man	0.075	82	**0.200**
7. Fear about the appearance of the body	woman	0.082	440	0,000
	man	0.154	82	0,000
8. **Fear of early death**	woman	0.088	440	0,000
	man	0.097	82	**0.054**

Table 6 shows the results of the Kolmogorov-Smirnov tests . It can be seen that only in **the case of men** (in three places) the significance is greater than 0.05 (bold). In these three cases, we are dealing with a normal distribution. But given that we did not obtain a normal distribution for women, nonparametric tests were then performed to investigate whether gender had an influence on tanatic anxiety .

Mann-Whitney U test results for independent groups (men and women)

	The null hypothesis	Test	Relevance	Decision
1	Schedule 1. "Fear of dying" is the same for men and women.	Mann-Whitney U test for independent samples	0,000	Discard the null hypothesis.
2	Schedule 2. "Fear of the dead" is the same for men and women.	Mann-Whitney U test for independent samples	0,000	Discard the null hypothesis.
3	Schedule 3. "Fear about the destruction of the body" is the same for women and men.	Mann-Whitney U test for independent samples	0,000	Discard the null hypothesis.
4	Schedule 4. "Fear for the living" is the same for men and women.	Mann-Whitney U test for independent samples	0.002	Discard the null hypothesis.
5	Distribution 5. "Fear of the unknown" is the same for men and women.	Mann-Whitney U test for independent samples	0.001	Discard the null hypothesis.
6	Distribution 6. "Fear of apparent death" is the same for men and women.	Mann-Whitney U test for independent samples	0,000	Discard the null hypothesis.
7	Distribution 7. "Fear about the appearance of the body" is the same for men and women.	Mann-Whitney U test for independent samples	0,000	Discard the null hypothesis.
8	Distribution 8. "Fear of early death" is the same for men and women.	Mann-Whitney U test for independent samples	0,000	Discard the null hypothesis.

Women differed from men in all types of anxiety (Table 7). An alternative hypothesis can be accepted because the significance values are less than 0.05 (the assumed significance level). **After calculating the mean values obtained for men and women, it can be concluded that women feel more anxious than men (because the means for women were greater than the means for men for all types of anxiety).**

Table 8. The results of the tests for the normality of the distribution, taking into account whether the respondent works in the medical service

44. I perform work related to the medical service		Kolmogorov-Smirnov test		
		Statistics	df	Relevance
1. Fear of dying	Yes	0.100	118	0.006
	Not	0.109	404	0,000
2. Fear of the dead	Yes	0.090	118	0.021
	Not	0.083	404	0,000
3. Fear of the destruction of the body	Yes	0.160	118	0,000
	Not	0.097	404	0,000
4. Fear for the living	Yes	0.106	118	0.002
	Not	0.108	404	0,000
5. Fear of the unknown	Yes	0.084	118	0.042
	Not	0.064	404	0,000

6. Fear of apparent death	Yes	0.098	118	0.008
	Not	0.071	404	0,000
7. Fear about the appearance of the body	Yes	0.123	118	0,000
	Not	0.086	404	0,000
8. Fear of early death	Yes	0.091	118	0.017
	Not	0.089	404	0,000

Table 8 presents the results of the tests for the normality of the distribution. It can be seen that in all cases the values of the obtained significance are less than 0.05. This means that the examined variables do not have a normal distribution. Therefore, in order to investigate **whether the fact that the respondent works in the health service is influenced by a specific thanatic anxiety** , non-parametric tests were again carried out.

Mann-Whitney U test results for independent groups (medical and non-medical)

	The null hypothesis	Test	Relevance	Decision
1	Schedule 1. "Fear of dying" is the same for healthcare professionals and others	Mann-Whitney U test for independent samples	0.584	Take the null hypothesis.
2	Schedule 2. "Fear of the dead" is the same for healthcare professionals and others	Mann-Whitney U test for independent samples	0.141	Take the null hypothesis.
3	Schedule 3. "Fear of body destruction" is the same for medical staff and others	Mann-Whitney U test for independent samples	0.654	Take the null hypothesis.
4	Schedule 4. "Fear for the living" is the same for medical staff and others	Mann-Whitney U test for independent samples	0.620	Take the null hypothesis.
5	Schedule 5. "Fear of the unknown" is the same for healthcare professionals and others	Mann-Whitney U test for independent samples	0.492	Take the null hypothesis.
6	Schedule 6. "Fear of apparent death" is the same for healthcare professionals and others	Mann-Whitney U test for independent samples	0.664	Take the null hypothesis.
7	**Schedule 7. "Fear about the appearance of the body" is the same for healthcare professionals and others**	Mann-Whitney U test for independent samples	**0.019**	Discard the null hypothesis.
8	Schedule 8. "Fear of early death" is the same for healthcare professionals and others	Mann-Whitney U test for independent samples	0.695	Take the null hypothesis.

Table 9 shows that only one significance value is less than 0.05 (bold). In this case, we adopt an alternative hypothesis that There is a difference in the fear of body appearance between healthcare professionals and others. People working in the health service are less worried about the appearance of the body (the average number of points obtained in this set for medics was 8.86, and 9.98 for the remaining respondents). In other cases, we adopt the null hypothesis that work in the health service does not affect the types of anxiety under consideration .

II. Conclusions

The studied group declares the presence of thanatic anxiety . He is most afraid of dying in a fire and disfiguring his body , and is concerned about the uncertainty of what will happen after death and concern for his family

There are correlations between age and thanatic anxiety in the study group, this applies to uncertainty and fear of the unknown

There are correlations between gender and thanatic anxiety in the studied group. In the group of men there is a greater intensity of fear of the unknown, fear of apparent death, fear of premature death . Women differed from men in all types of anxiety.

There is a difference in anxiety about body appearance between healthcare professionals and other respondents. Healthcare professionals are less concerned about the appearance of the body

III. Discussion

Orłowska A. (2021) writes about the perception of medical personnel during the Covi-19 period. The limitations related to the epidemic, which force isolation and prevent the patient from being accompanied by the family, pose new challenges and force medical professionals to expand the scope of activities. A completely new situation, lack of procedures, chaos and a sense of anxiety make it easy to get lost in your role and its limits. If there are no relatives in the patient's environment who care about their well-being and sense of security, talk about the difficulties of their stay
The subject of death and the process of leaving has long aroused respect, the need for special care for the patient approaching the end of life, his relatives and the situation faced by the staff . It requires composure, peace. Inspires nostalgia. Sometimes it causes anxiety, not only to the patient. Some are concerned about working with critically ill, dying, or refused patients. There are also those who see a deep meaning in it, find themselves in the situation and with their work and mindfulness provide support, care for the quality of life in its last moments (Orłowska,2021).

Medical personnel towards the dying Some medical personnel believe that the sick (dying) are afraid of death, do not want to know the truth and should not be told about bad prognosis, because they may break down, lose confidence in the personnel and lose their motivation for treatment. This view is not confirmed by studies by psychologists that indicate the opposite. (Camppbell, Popescu, 2021) According to research, 75% of patients knew that they would die soon, even though no one talked to them about it. It should be remembered that the patient has the right to information about his health, and the doctor is obliged to provide it. Most doctors choose a paternalistic model of management. They "protect" the sick from information, but inform the family. Therefore, relatives are put in a special situation: either they decide to inform the patient about the incurable disease and relieve the attending physician, or they will conceal information and deceive the relatives (Kackin et al., 2020) .

COVID-19 medical professionals who witness patients die may experience unbearable psychological pressure. (Galehdar et al., 2020) COVID-19 frontline health workers bear the burden of rapidly increasing the volume and intensity of their activities and have to cope with different types of work in the absence of orientation and training. (Kinman et al., 2020; COVID-19, 2020) An increased risk of psychological problems is associated with receiving negative information related to COVID 19. (Que et al., 2020)

Primary care providers in the environment, inconsistent procedures, and unusual exposure to trauma Primary care professionals feel anxious about their own fall Caring for patients with suspected or confirmed COVID-19 may face physical and mental integrity for fear of contamination of loved ones. unusual work environment, exposure to such a contagious virus, inexperience in newly assigned tasks, and clear control from people and the media. (Lăzăroiu , 2017).

Understanding the psychological needs of the patient, as well as - which is especially important today, during the COVID-19 pandemic - his spiritual needs, seems no less important than caring for the best treatment methods.

In the early stages of the pandemic, when COVID-19 treatment options were limited and its results were very unfavorable, spiritual support was of fundamental importance for many patients (Stefaniak, Kraszewski, 2021) as it supported them in their struggle for survival. For medical personnel - doctors, nurses, psychologists, physiotherapists, but also hospital chaplains - the first days of the pandemic, when it was not fully known whether working with patients would cost them their own health, and even cost them their own health or even their lives. (Galbadage T., Peterson BM, Wang D. et al., 2020) [25].

Activities taking into account the psychological, social and spiritual needs of patients suffering from COVID-19 are an essential element in supporting the overall therapeutic process and have had a significant impact on the well-being of patients and their relatives. The sense of meaning in life maintained in this way gave the patients additional support in their fight against the disease. Similarly, intensive activities supporting medical personnel are of great importance not only for the well-being of individuals, but also have a positive effect on the involvement and effectiveness of personnel activities. Nevertheless, they are consistent with publications from around the world that confirm the desirability of psychological and spiritual support for patients and their relatives (Ribeiro MRC, Damiano RF, Marujo R. et al., 2020) [26].

An Iranian study (Dymecka, 2021) has shown that COVID-19 patients and medical students who have been caring for COVID-19 patients show the highest levels of stress. Higher levels of stress in medical students may be associated with physical and emotional exhaustion due to the heavy burden on the healthcare system and rapid changes in medical information and procedures, as well as the perception of contagion risk, lifestyle changes due to epidemics, fear of inadequate protection due to lack of equipment such as masks, gloves and coveralls, and personal sensitivity due to little experience compared to fully qualified personnel The higher levels of stress in COVID-19 patients may be associated with fear of the serious consequences of disease and infection, isolation during treatment, loss of confidence in health services, and fear of death. experience

loneliness, denial, anxiety, depression, insomnia and despair, which may have a negative impact on the effectiveness of treatment (Vahedian-Azimi et al . 2020).

In the Spanish studies, no significant differences were observed between healthcare professionals and the general population. On the other hand, in Polish studies, a particularly high level of stress was noted among health care workers, primarily nurses, who have direct contact with sick patients, stay with them for the longest time and are most exposed to infection and transmission to their relatives. Among Polish nurses, the perception of the risk of infection was a predictor of perceived stress (Dymecka et al . 2021).During the SARS epidemic, pandemics have also been shown to cause significantly greater levels of stress in nurses compared to physicians (Wong et al . 2005)

Research (Ponińska, B. ChojnackaA-Kowalewska, G. (2020) shows that : gender does not differentiate nurses' attitudes towards dying and death of a patient. Age differentiates attitudes towards dying and death of a patient. They care for a dying patient, the older people, the more often they declare that it is not a problem for them. It is also a significant variable that differentiates the level of stress experienced by nurses after the patient's death. The older people, the better coping with the loss. a factor significantly influencing the change in the hierarchy of values after the patient's death in ro d of medical personnel. Such a change occurred more often with the increase of the age of the respondents. Marital status did not match the difficulties of nurses' work in the form of caring for a dying person and informing relatives about the patient's death. Education did not differentiate the difficulties of nurses' work in the form of caring for the dying person and informing the relatives of the patient's death. The length of service did not differentiate the difficulties of nurses' work in the form of caring for a dying person and informing relatives about the patient's death. However, it had a positive effect on the stress level of nurses after the patient's death. The older the people were, the more stress they felt. Moreover, seniority led to a change in the hierarchy of values after the patient's death. The longer the length of service, the more often the loss of a patient caused changes in the values of the respondents(Trylinska-Tekielska,2016;Trylinska-Tekielska2015)

References

[1]. Baka Ł.(2009). The fear of death and the worldview of young people: the perspective of the theory of controlling fear, Wydawnictwo im. Stanisław Podobieński Academy of Jana Długosza, Warsaw. p. 94

[2]. Becker E. (2016). Denied Death , Wydawnictwo Nomos , Warsaw, p. 39

[3]. Campbell P., Popescu G.H. (2021). Psychological Distress , Moral Trauma, and Burnout Syndrome among COVID-19 Frontline Medical Personnel Psychosociological Issues in Human Resource Management 9 (2), pp. 63–76, ISSN 2332-399X, eISSN 2377-0716

[4]. Dymecka J. (2021). The Psychosocial Effects of the COVID-19 Psychosocial Pandemic effects of the COVID-19 pandemic , Neuropsychiatria i Neuropsychologia; 16,1-2: 1-10

[5]. Galbadage T., Peterson B.M., Wang, D.C et al.(2020). Biopsychosocial and spiritual implications of patients with COVID-19 dying in isolation . Front. Psychol., 11: 588 623; doi: 10.3389 / fpsyg.2020.588 623

[6]. Galehdar N., Toulabi T., Kamran A., and Heydari H. (2020). " Exploring Nurses ' Perception of Taking Care of Patients with Coronavirus Disease (COVID - 19): A Qualitative Study , " Nursing Open 8: 171–179. doi: 10.1002 / nop2.616.

[7]. Gulka B. Tucholska K.(2019). Psychology of time in the context of health and disease, UJ Kraków, , p. 73

[8]. Guzowski A. Krajewska-Kułak E. Bejda G.(2016) Kultura Śmierci. Kultura Dyrania, UM in Białystok, Białystok, p. 47

[9]. Heidegger M.(2011). The concept of "being to death" and the evolution of the concept of nothingness in the philosophy of Martin Heidegerr , Studia Philosophica Wartislaviensia , Jagiellonian University , p. 11

[10]. Kackin O., Ciydem E., Aci O.S, and Kutlu, F.Y. (2020). " Experiences and Psychosocial Problems of Nurses Caring for Patients Diagnosed with COVID-19 in Turkey: A Qualitative Study , "International Journal of Social Psychiatry. doi: 10.1177 / 0020764020942788

[11]. Kinman G., Teoh K., and Harriss A. (2020). " Supporting the Well-Being of Healthcare Workers during and after COVID-19, " Occupational Medicine 70 (5): 294–296. doi: 10.1093 / occmed / kqaa096

[12]. Kozielecki J. Psychological concepts of man, Wydawnictwo Akademickie Żak 2000, p. 14

[13]. Laertios D.(1984). Lives and Views of Famous Philosophers , PWN, Warsaw, pp. 122-135

[14]. Laughlin H.P.(1979) . The Ego and Its Defenses , New York, 1979, p. 16

[15]. Lăzăroiu G., Pera, A., Ştefănescu-Mihăilă RO, Mircică N., and Neguriță O. (2017). " Can Neuroscience Assist Us in Constructing Better Patterns of Economic Decision-Making ?, " Frontiers in Behavioral Neuroscience 11: 188. doi: 10.3389 / fnbeh.2017.00188

[16]. Łukaszewski W.(2011). The Torment of Life. How people cope with the fear of death , Wydawnictwo Smakorii, Warszawa, p. 146

[17]. Makselon J. (1984). The subject aspect of attitudes towards death, Analecta Cracoviensia XVI, p. 13

[18]. Midura M.(2013). The randomness of death. Selected Aspects, Rational, 2013, p. 22

[19]. Musiał,M (2015). Intimacy and its contemporary transformations: a study of the philosophy of culture, UNIVERSITAS Society of Authors and Publishers of Scientific Papers, Warsaw. p. 101

[20]. Obuchowski K.(2001). In Search of Human Properties, Oficyna Wydawnicza Garmond p. 39

[21]. Orłowska A.(2019). Who are the medics and how are they perceived during Covid-19 Puckie Hospice of St. Father Pio https://hospitium.org/ostatnie-chwile-zycia-spedzone-z-ochrona-zdrowia-czyli -kim-sa-i-as-sa-perceived-medics-in-time-covid-19

[22]. Ostrowska A.,(2005). Death in the experience of an individual and society, Publishing House of the Institute of Philosophy and Sociology of the Polish Academy of Sciences, Warsaw.

[23]. Ponińska B. ChojnackaA-Kowalewska G. (2020) Nurses' attitudes towards dying and death of patients Nurses , attitude towards patient dying Death ; State Vocational University in Włocławek DOI: http : //dx.doi.org/10.21784/IwP.2020.003 ISSN: 2451-1846

[24]. Prazeres F., Passos L., Simoes JA et al.(2020). COVID-19-related fear and anxiety : spiritual-religious coping in healthcare workers in Portugal. Int . J. Environ . Res . Public Health, 2020; 18: 220; doi: 10.3390 / ijerph18 010 220

[25]. Que J., Shi L., Deng J., Liu J., Zhang L., Wu S., et al. (2020). " Psychological Impact of the COVID-19 Pandemic on Healthcare Workers : A Cross-Sectional 3076 Study in China, "General Psychiatry 33: e100259. doi: 10.1136 / gpsych-2020- 100259

[26]. Ribeiro, MRC, Damiano, RF, Marujo R. et al.(2020). The role of spirituality in the COVID-19 pandemic : a spiritual hot Line project . J. Public Health (Oxf .), 42: 855–856
[27]. Stefaniak T., Kraszewski J.(2021). Spiritual and psychological care in covid wards . Med. Prakt ., 5: 152–153, 156 .
[28]. Sylvester A.M: COVID - a caring reflection . J. Pastoral Care Counsel ., 2020; 74: 141; doi: 10.1177 / 1 542 305 020 921 771
[29]. Trylińska –Tekielska ,E.(2019). Praca w hospicjum Predyktory podjęcia pracy w hospicjum oraz ich konsekwencje w grupie pracowników zawodowych i wolontariuszy hospicyjnych oraz wolontariuszy zwykłych-Psychologiczny Model Zespołu pracującego w warunkach ekspozycji. Poznań Silva Rerum
[30]. Trylinska-Tekielska E.(2015) Psycholog w Hospicjum Warszawa Scholar
[31]. Vahedian-Azimi A. Moayeh M.S. Rahimibashar F. et al.(2020) . Comparison of the severity of psychological distress among four groups of an Iranian population regarding COVID-19 pandemic . BMC Psychiatry, 20: 402.
[32]. Wong T.W, Yau J.K, Chan C.L et al .(2005). The psychological impact of severe acute respiratory syndrome outbreak on healthcare workers in emergency departments and how they cope . Eur J Emerg Med 12: 13-18.
[33]. Zinczuk J.(2008). Coherence of emotional reaction components and coping styles with both threatening stimuli - research report. Psychologia-Etologia-Genetyka , Warsaw, pp. 58-88
[34]. Zuccaro C.(2004). Theology of Death, WAM, Krakow, p. 22

Trylińska -Tekielska E, et. al. "Thanatological anxiety (types of fear of death in the Covid-19 period) in a randomly selected group including medical personnel." *IOSR Journal of Nursing and Health Science (IOSR-JNHS)*, 11(5), 2022, pp. 19-31.