"BALANCING LIFE AND DEATH: UNRAVELING THE IMPACT OF WORK ENVIRONMENT ON DEATH ANXIETY, RESILIENCE, AND SPIRITUAL WELLBEING AMONG HEALTH PROFESSIONALS IN INTENSIVE CARE AND NON-INTENSIVE CARE UNITS"

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Abstract
The current study aimed to investigate the impact of work environment on healthcare professionals, particularly in intensive care and non-intensive care settings. The emotional experiences of health professionals were explored through the assessment of death anxiety, resilience, and spiritual wellbeing. Data was collected from a total of 160 healthcare professionals, including both doctors and nurses. This sample was divided into two groups: the intensive care group (n=70) and the non-intensive care group (n=90). To measure the variables, translated Urdu versions of the Death Anxiety Scale (Templer, 1970), State Trait Resilience Scale (Hiew, 1999), and Spiritual Wellness Scale (Ingersoll, 1998) were used. The collected data were then analyzed using independent sample t-tests. The results indicated significant differences between the two groups in terms of death anxiety, resilience, and spiritual wellbeing. Therefore, it was concluded that the work environment, whether in intensive care or non-intensive care, has differing effects on the emotional experiences of healthcare professionals. Furthermore, a correlational test was employed to examine the relationship between work experience and the research variables. The findings revealed a negative correlation between work experience and death anxiety (r = -.63, p< .01), suggesting that as work experience increases, death anxiety tends to decrease. On the other hand, a positive correlation was found between total work experience, resilience (r=.53, p< .01), and spiritual wellbeing (r = .43, p< .01), indicating that with more work experience, resilience and spiritual wellbeing tend to improve. Overall, the results also indicated a negative correlation between death anxiety and both resilience and spiritual wellbeing. In conclusion, the study highlights the importance of considering work environment and experience in understanding the emotional well-being of healthcare professionals, particularly in intensive care and non-intensive care settings.

Keywords: *Death anxiety, resilience, spiritual wellbeing, healthcare professionals, work experience, work setting.*

INTRODUCTION

In contemporary healthcare systems, doctors and nurses are integral members of a collaborative team. Doctors provide diagnoses and treatment plans, while nurses offer physical care and support to patients. The efficient functioning of medical facilities relies on the presence and cooperation of both doctors and nurses.

In hospitals, patients are typically categorized into different units based on the severity of their conditions. Regular units cater to less severe outpatient cases, allowing patients to leave the hospital after receiving medical advice. Conversely, intensive care units (ICUs) offer crucial medical

attention to patients experiencing severe conditions, including organ failure. The intense environment of ICUs exposes healthcare professionals to repeated encounters with traumatic situations, potentially leading to psychological issues including burnout, post-traumatic stress, anxiety, and depression. Studies have shown that nursing students often face challenges when confronted with death situations, finding them emotionally exhausting (Sadala & da Silva, 2009).

Nevertheless, certain healthcare practitioners exhibit resilience and manage to perform effectively in the demanding environment of the ICU. Various factors contribute to fostering resilience in nurses, and one significant factor is their spiritual wellbeing. This study's main aim is to investigate the relationships between death anxiety, resilience, and spiritual wellbeing among healthcare professionals, focusing particularly on doctors and nurses who work in both Intensive Care Units (ICUs) and Non-Intensive Care Units (NICUs).

Death anxiety is a state characterized by feelings of fear, worry, and uneasiness arising from real or imagined encounters with mortality (NANDAI, 2007). According to Cicirelli (2006), death anxiety encompasses both mental and spiritual aspects, representing a multidimensional construct influenced by emotional, cognitive, experiential, and motivational components. It also undergoes developmental changes and is shaped by socio-cultural influences. Increased awareness of death serves as a catalyst for the onset of death anxiety, with its characteristics often clustering within three distinct categories: i)) Encountering stressful environments,, ii diagnosis of severe illnesses with life-threatening potential, and iii) encounters associated with death and the dying process.

As death anxiety can poses dangers to the mental health of health professionals it is necessity for nurses to assess it diligently. Findings indicates that nurses experiencing heightened death anxiety are hesitant when it comes to discussing death-related matters with patients and their families as compared to nurses who have undergone training in death communication (Deffner & Bell, 2005). Stoller (1980) conducted a study on nurses' experiences and patient care which revealed that licensed practical nurses (LPNs) with more working experience reported less uneasiness when dealing with dying patients compared to those with less experience. It was suggested that LPNs develop coping strategies through their experience to address death anxiety. Additionally, experience has been identified as a contributing factor in shaping nurses' positive attitudes towards dying patients and the quality of care they deliver. The assessment of death anxiety among nurses in healthcare systems should not be under estimate and it is crucial to implement necessary interventions aimed at addressing and managing death anxiety.

During a study investigating nurse resilience and post-traumatic stress disorder (PTSD), researchers discovered that intensive care nurses face a heightened risk of experiencing psychological disorders. The study found that the demanding work settings such problems prompting some nurses to pursue less stressful job opportunities (Mealer, Jones, & Moss, 2014). However, there are ICU nurses who excel in providing exceptional care despite the challenging ICU settings. These nurses possess the capacity to withstand the effects of painful experiences and capable to deliver standard support to their clients. Resilience is the trait that enables nurses to perform effectively in ICUs.

Researchers have taken an interest in resilience due to their observations of individuals who can maintain their psychological and physiological well-being even after experiencing traumatic events. These individuals demonstrate the ability to bounce back despite facing significant distress.

Human resilience is a comprehensive concept that refers to an individual's capacity to overcome adversity, effectively handle challenges, and maintain their psychological and physical well-being when confronted with distressing situations, including trauma and life stressors (Newman, 2005). Resilience is not a fixed trait; instead, it is a dynamic quality that individuals can develop at any stage of life and under any circumstances. This dynamic nature implies that resilience is not predetermined or restricted to specific developmental phases; rather, it can be nurtured and strengthened throughout a person's entire lifespan (Thies, 2006).

In a study conducted in Iran during the recent pandemic (Rayatpisheh et al., 2023), researchers explored resilience and death anxiety among older adults. They found an inverse relationship between resilience and death anxiety. Similarly, Cao, Yang, and Wang (2020) discovered that

mothers who had lost their children exhibited higher anxiety when they had lower resilience levels. Likewise, Toledano-Toledano et al. (2019) observed an inverse connection between parents' resilience and death anxiety among parents of children suffering from cancer.

Research on resilience has highlighted the importance of spirituality as a protective factor in dealing with life's challenges and obstacles. According to Gomez and Fisher (2003), spiritual well-being is characterized by positive emotions, behaviors, and thoughts related to one's connections with oneself, others, and nature. This concept encompasses aspects like finding inner peace, engaging in positive interactions with oneself and others, and feeling connected to a broader world. Spiritual well-being empowers individuals by helping them recognize their strengths, facilitating healing, and contributing to the development of resilience. It serves as a source of hope and coping resources that assist individuals in navigating life's difficulties.

In a study focusing on older adults, Manning (2013) concluded that spirituality plays a role in fostering resilience in this population. Smith (2004) suggested in their research that individuals with higher levels of spiritual intelligence demonstrate greater tolerance, which aids them in adapting to stressful situations. Thanooja and Seena (2017) found in their study on resilience and spirituality as correlates of psychological well-being among adolescents that there was a significant positive relationship between resilience and spirituality, as well as resilience and psychological well-being.

In a study by Hatami and Shekarchizadeh (2022) on dental students, a significant association was discovered between spiritual health, resilience, and happiness. Charlotte, Shelton, Sascha, Kelly, and Phipps (2019) explored the relationships between spirituality, leader’s resilience, and life satisfaction. The results revealed positive correlation between all these variables, also individuals practicing meditation showed higher scores on resilience in comparison to those who did not meditate.

Furthermore, the literature suggests that spiritual well-being has been linked to a reduction in death anxiety. For instance, Rasmussen and Johnson (1994) found a negative association between death anxiety and spirituality. Similarly, Ardelt (2003) suggested that spiritual beliefs are connected to increased psychological well-being and decreased death anxiety. The study conducted by Khezri, Bahreyni, Ravanipour, and Mirzaee (2015) also supports a significant negative relationship between spiritual well-being and death anxiety in patients.

Rational of study:

The current study aims to investigate the psychological well-being of healthcare professionals in the context of their work environment. By comparing health professionals in Intensive Care Units (ICUs) and Non-Intensive Care Units (NICUs), we aim to understand how the demands and stressors of these settings influence death anxiety, resilience, and spiritual wellbeing. Additionally, we will explore the relationship between work experience and these psychological factors. The study's insights can inform interventions and support systems, ultimately promoting the mental health and overall well-being of health professionals in critical care roles.

Hypothesis

1. Health care professionals working in ICU settings will show significant differences on death anxiety scale, resilience scale, and spiritual wellbeing scale as compared to those working in general wards.
2. The work experience of ICU professionals will demonstrate a significant association with their scores on death anxiety, resilience, and spiritual wellbeing.
3. House officers (HO's) working in Intensive Care Units will exhibit significantly different scores on anxiety, spiritual wellbeing, and resilience when compared to general practitioners (GPs).
4. Scores on resilience and spiritual wellbeing will exhibit a significant positive correlation with each other and a significant negative correlation with death anxiety.

Sample

A purposive sampling strategy was utilized in this study with a sample size of 160 participants. There were 67 males (41.9%) and 93 females (58.1%). 67 participants (41.8%) were between 18-24 years and remaining 93 participants (58.1%) were between 25-60 years.

The participants were divided into two groups. The first group consisted of health professionals (n=70) working in Intensive Care Units (ICUs). Due to the demanding nature of their work and limited availability of personnel for data collection, a relatively smaller sample size was allocated to the ICU units compared to general wards. The remaining participants (n=90) were health professionals working in general wards specializing in skin(n=30), eye(n=30), and psychiatry units (n=30). These specific wards were chosen because they rarely encounter situations involving death, unlike the ICUs. The general wards served as the control group, providing a similar environment to the ICUs but lacking the independent variable being studied.

Instruments

1. Demographic Sheet:

Questions included in the demographic sheet asked about the age, gender, work experience in specific ward, and ICU and non-ICU experience of health professionals..

2. Death Anxiety Scale (DAS-Urdu):

The Death Anxiety Scale (DAS) is a 20-item test originally (Templer, 1970). To make it accessible to Urdu-speaking individuals, Kausar translated it into Urdu in 2000. The DAS-Urdu uses a five-point Likert scale for respondents to rate their feelings about death. The DAS-Urdu has been proven to be psychometrically sound scale, with a reliability value of r 0.83 and 0.76. Templer (1970) also found convergent validity of the scale through correlating it (α = 0.74) with Boyar's Fear of Death Scale (BFDS).

Spiritual Wellness Scale (SWS-Urdu):

The translated Urdu version (Gohar, 2005) of the Spiritual Wellness Scale (SWS; Ingersoll (1998) was used for data collection. It consists of 60 items in 4-point Likert format; respondents rate their agreement from strongly agree to strongly disagree. The scale has demonstrated reliability and validity, with a reliability value (Cronbach's alpha) of r = 0.89. Its convergent validity was established with a value of α = 0.97 when compared with the life satisfaction scale, indicating a significant association between the two constructs. Additionally, the scale demonstrated discriminant validity with a value of α = -0.68 when compared with the aggression scale, showing a significant difference between the two constructs.

State Trait Resilience Inventory (STRI-Urdu):

An Urdu version of STRI (STRI-Urdu; Sarwar, 2005) originally devised by Hiew (1999) was used in the present study. This inventory consists of two subscales in Likert format : the State Resilience Scale (SRC, 15 items) and the Trait Resilience Scale (TRC, 18 items). Contrary to SRC which focuses on the present, respondents rate themselves based on experiences "since childhood in TRC. "The STRI-Urdu shows .81 alpha coefficient yielding the scale as reliable. To assess the concurrent validity of the TRC, it was compared with the Perceived Stress Scale, via two aspects: *Stress Intensity* and *Stress Control*. The results revealed notable correlations between the State Resilience Scale (SRC) and stress intensity (correlation coefficient of +0.54, $p < 0.0001$) and stress control (correlation coefficient of -0.40, $p < 0.0001$).

Procedure

For the purpose of the study the participants were categorized into two groups: healthcare professionals working in ICUs and those working in other wards. Doctors and nurses from both ICU and general wards were approached for data collection. Collection of data from ICU professionals is more challenging as compared to NICU due to several factors that are inherent to ICU environment that includes: time constrains and workload, interdisciplinary teamwork, shift work, fatigue, emotional exhaustion and stress. The emotional toll may reduce the willingness and capacity of ICU professionals to engage in non-essential tasks like research data collection. Keeping in view the above factors ICU professionals were approached individually for the purpose of data collection. Gathering data from ICU professionals can be a slow and time-consuming process, often taking months to complete. After providing a brief explanation of the research's purpose and obtaining informed consent from each participant, three questionnaires were distributed to them individually with instructions to complete them at their convenience.

RESULTS

Table 1 *Number of items, mean, standard deviation, range and coefficient alpha of Death Anxiety Scale. State-Trait Resilience Scale and Spiritual Wellbeing Scale*

Scales	*No. of items*	***M***	***SD***	***Range***	***a***
DAS	20	61.0	18.4	20-100	.93
STRI	33	121.1	25.6	33-165	.95
SWS	60	137.6	14.5	60-240	.76

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Table 1 demonstrates high reliability for all scales as the coefficient alpha is greater than .70 of all the scales

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Table 2 *Comparison of ICU and non-ICU health professionals via t-test on scores of Death anxiety, resilience, and spiritual wellbeing*

Variable	ICU		NICU		***t(158)***	*p*	***Cohen's d***
	M	***SD***	***M***	***SD***			
DAS	68.6	20.3	55.1	14.4	4.890	.000	0.76
STRI	106.6	29.4	132.4	14.4	-7.25	.000	-1.11
SWS	131.92	14.70	142.15	12.73	-4.62	.000	-0.743

Note: DAS =Death anxiety scale, STRI = State-Trait resilience scale; SWS =Spiritual Wellness Scale,

Table number 2 displays mean differences between ICU health care professionals (n=70) and NICU health professionals (n=90). The results indicate significant differences on death anxiety scale, state-trait resilience scale, and spiritual wellbeing scale. Specifically, ICU professionals scored higher on the death anxiety variable, while NICU professionals scored higher on both resilience and spiritual wellbeing. Cohen's d values indicate a large effect size for these differences.

Table 3 *Inter-scale correlations between Death Anxiety, Resilience and Spiritual wellbeing with Total work experience of health professionals*

Variables	1	2	3	4
1. Death Anxiety	1			
2. Resilience	- .52**	1		
3. Spiritual Wellbeing	- .64**	.47**	1	
4. Total Work experience	-.63**	.53**	.43**	1

***P<0.01*P<0.05*

the above table indicate that death anxiety has significant inverse correlation with both Resilience ($r = -0.52$, $p < 0.01$) and Spiritual wellbeing ($r = -0.64$, $p < 0.01$). Furthermore, there is a significant positive correlation between resilience and SWB ($r = 0.47$, $p < 0.01$). The table also shows a strong ($p<0.01$) positive correlation work experience with resilience ($r = 0.53$) and spiritual wellbeing ($r = 0.43$). Conversely, an inverse correlation ($r = -0.63$) of work experience with death anxiety is found ($p < 0.01$).

Table 4 *Comparison of House Officers(n=11) and General Practitioners(n=14) working in ICU through Mann Whitney U test comparing death anxiety, resilience, and spiritual wellbeing between them*

Measures	***M(SD)***		**Mann Whitney U Test**	
	HO	**GP**	***Z***	***p***
Death Anxiety Scale	77.1(11.6)	38.6(10.6)	- 4.1	.000
State-Trait Resilience Scale	123.3(14.5)	137.6(11.8)	- 2.4	.016
Spiritual Wellbeing	124.6(7.2)	160.4(15.0)	-3.7	.000

Note. HO=House Officers; GP= General Practitioner

Based on the test results, it was found that House officers have significantly greater death anxiety compared to General practitioners. Additionally, General practitioners scored higher on both resilience and Spiritual wellbeing compared to House officers, as shown in the table.

DISCUSSION

Healthcare professionals work in diverse environments, providing care to patients in various categories. Regular units handle less severe cases, while intensive care units (ICUs) cater to individuals with life-threatening conditions. This study aims to explore how healthcare professionals' psychological well-being is affected by different settings, specifically comparing ICUs and NICUs. The study focuses on comparing the two groups in terms of death anxiety, resilience, and spiritual well-being.

The first hypothesis proposed significant difference in Death Anxiety, Resilience, and Spiritual well-being between health professionals in ICUs than those working in general wards. Due to the complexity of the relationship between the independent variable (ICU setting) and the study variables (death anxiety, resilience, and spiritual well-being), a bidirectional hypothesis was formulated. Two-tailed tests were employed to assess the bidirectional hypothesis. The scores from the compared groups on all scales indicated significant differences between the two groups.

The results show that professionals working in ICUs have higher levels of death anxiety (see table 2) compared to non-ICU health care professionals. This may be attributed to the frequent exposure to misery, agony, and casualty in their clinical practice. On the other hand, non-ICU professionals, who are less frequently face such happenings, display lower death anxiety. As suggested by Cicirelli (2006), death anxiety encompasses emotional, cognitive, experiential, and motivational components. Increased awareness of death may serve as an impetus for death anxiety due to exposure to stressful environments. Similarly, Mealer, Jones, and Moss (2014) concluded that the demanding work environment prompts some nurses to pursue less stressful job opportunities.

Additionally, Toledano-Toledano et al. (2019) found high death anxiety among the parents of children suffering from cancer.

Regarding resilience, NICU professionals exhibited higher levels compared to ICU professionals (see table 2). The emotionally charged work settings of ICUs, where death experiences are more frequent, may hinder the development of resilience among professionals. Emotional responses such as crying, prevalent among healthcare professionals dealing with dying patients, further support the notion that intensive care settings have a greater impact on professionals' resilience. However, there are also studies highlighting factors that promote resilience even in response to negative events. These studies emphasize the believe in one's self, help from religion, and existential thinking in fostering resilience in the aftermath of death anxiety (Hoelterhoff & Chung, 2017). Spirituality is also identified as a means of promoting coping mechanisms and providing individuals with faith and hope to overcome negative circumstances.

The findings also suggest that spiritual well-being is higher among NICU professionals compared to ICU professionals (see table 2). The emotional suffering and unpleasant feelings associated with frequent exposure to death in intensive care settings can negatively affect the spiritual well-being of professionals and may result in burnout. In a study of burnout and spiritual well-being among 226 Saudi nurses working in ICU units in Riyadh, Al-Osaim et al. (2023) found a inverse relation of spiritual well-being with total burnout. Mallett, Price, Jurs, and Slenker (1991), studied hospice and critical care nurses, and concluded that positive association existed between burnout and death anxiety, whereas, burnout was inversely related with social support. Studies have shown that higher spiritual intelligence and spirituality scores are associated with better stress management and tolerance (Smith, 2004).

Hypothesis number two explored the interrelationship of work experience with death anxiety, resilience, and spiritual well-being. The results, presented in table 3, proved work experience and death anxiety as negatively associated, while a positive correlation existed of work experience was found with resilience and spiritual well-being. The inverse relation of work experience with death anxiety can be attributed to healthcare professionals becoming accustomed to the demands of their job over time and developing effective coping mechanisms for stressful situations. A study by Abdel-Khalek (1998) on Kuwaiti college undergraduates during the Iraqi invasion of Kuwait (1988-2002) observed that death anxiety scores significantly increased following the invasion but decreased over time due to long-term adaptation to a distressing and insecure environment. The development of resilience over time, spirituality and relatedness also played a significant role. Heolterhoff and Chung (2017) found that coping techniques enabled individuals to strengthen their resistance and become more resilient against the impacts of death anxiety, reducing its detrimental effects on mental health. Similar findings were observed in a study by Roman, Sorribes, and Ezquerro (2001) on older nurses, indicating that more experienced nurses exhibited more positive attitudes when caring for dying patients compared to their less experienced counterparts.

Overall, the current study's findings align with the notion that experience contributes to nurses' positive attitudes towards dying patients and the quality of care they provide. The study indicates that nurses' positive attitudes towards dying patients and the quality of care they offer are influenced by total work experience, resilience, and spiritual well-being, with work experience negatively correlated death anxiety. Peters et al. (2013), highlighted the positive impact of worksite death education which reduces death anxiety and improves the standard of patient care that is needed at the terminal stage of their life. In conclusion, the present study suggests that experience plays a significant role in shaping nurses' positive attitudes towards dying patients and the overall quality of care they deliver.

The third hypothesis of the study investigated the influence of work setting of intensive care units (ICUs) on House officers (HOs) and General practitioners (GPs). A bidirectional hypothesis was formulated to study the impact of ICU setting on death anxiety, resilience, and spiritual wellbeing among doctors working in ICU setting. Considering the shortage of data from ICU doctors due to their challenging duties and responsibilities a two-tailed Mann Whitney U test was used,. The analysis of results (refer to table 4) supported significant differences between TMOs and GPs on all

the three study variables. Specifically, house officers scored higher on death anxiety compared to general practitioners. House officers refer to qualified doctors practicing under senior doctor supervision after completing their degree, while general practitioners are medical professionals who have completed their degree and mandatory residency period, now working independently in and outside hospital settings. Moreover, the results indicate that general practitioners scored higher on resilience (mean=137.6, sd=11.8) and spiritual wellbeing (mean=160.4, sd=15.0) compared to house officers. The Mann Whitney U test demonstrates significant differences between the two groups in terms of death anxiety ($Z=-4.1$, $p<.01$), resilience ($Z=-2.4$, $p<.05$), and spiritual wellbeing ($Z=-3.7$, $p<.01$).The difference observed between the two groups can be attributed to their differing levels of work experience. General practitioners typically possess more extensive work experience and practice in comparison to house officers, who are in the early stages of their medical careers. As depicted in table 3, work experience has been associated with reduced death anxiety and increased levels of resilience and spiritual wellbeing. Therefore, it is reasonable to deduce that total work experience significantly contributes to explaining the variations observed between the two groups in terms of death anxiety, resilience, and spiritual wellbeing. The additional experience gained by general practitioners over time likely contributes to their enhanced coping abilities and greater spiritual wellbeing compared to house officers.

The last assumption of the current research hypothesized a negative correlation of resilience and spiritual wellbeing with death anxiety, while positive association between resilience and spiritual wellbeing. The results supported the assumption with a significant negative correlation between death anxiety and resilience. This means that as resilience scores increase, death anxiety tends to decrease. Death anxiety encompasses thoughts, fears, and emotions linked to the process of dying, and it represents a multifaceted concept often accompanied by diverse psychological and physical symptoms of distress. In a study of resilience and death anxiety among older adults during the COVID-19 pandemic (Rayatpisheh et al, 2023) in 11 municipal districts of Iran, it was found that a significant negative relationship exists between death anxiety and resilience. On the other hand, resilience is a multidimensional construct and a personal attribute that empowers an individual to flourish despite encountering adversity. Furthermore, research has shown that spiritual wellbeing is associated with a decrease in death anxiety. The present study's findings support this idea, as they reveal a significant negative correlation ($\alpha= -.64$, $p<.01$) between spiritual wellbeing and death anxiety. The negative relationship between these variables can be attributed to the opposing nature of life and death instincts, which places them in contrasting positions.

Rababa, Hayajneh, & Bani-Iss, (2020) found low levels of religious coping and spiritual wellbeing, and high levels of death anxiety among the elderly while 2019 corona virus spread. In the study conducted by Ankita and Punam (2017), involving 200 elderly participants, a negative correlation was discovered between spirituality and death anxiety indicating that spirituality may possess healing powers and serve as a beneficial factor in reducing death anxiety in older adults.

Our findings indicate that higher spiritual wellbeing is associated with high scores on resilience scale (see table 2). As spirituality is an inherent bond with the universe, it impels humans to explore and understand their surroundings (Jenkins, 2000), consequently enabling individuals to search for meaning in life. Researches on nursing, gives importance to the role of spirituality as a coping mechanism to reduce the negative impact of traumatic stress on mental health. Similarly, resilience studies have also explored the protective aspect of religion and spirituality when individuals face life's difficulties and challenges. For instance, George (2017) study revealed positive correlation between spirituality and resilience. In the present study, we also observed a significant positive correlation between resilience and spiritual well-being. These results support the notion that spiritual well-being may play a role in fostering resilience among individuals. Charlotte, Shelton, Sascha, and Kelly (2019) conducted a study to investigate the connections between spirituality, leader’s resilience, and life satisfaction. The findings revealed positive associations between spirituality, resilience, and overall life satisfaction. Notably, participants who practiced meditation had notably higher resilience scores compared to those who did not engage in such practices. Similarly, in a recent study (Howard, Roberts, Mitchell, & Wilky, 2023) the link

between spirituality, resilience, and well-being was studied which showed positive connection between spirituality and satisfaction with life, better mental and physical functioning, and high resilience.

Conclusion

Based on the aforementioned findings, it can be inferred that the well-being of health professionals is influenced differently by various work settings and levels of work experience. While the concept of death anxiety has been explored in nursing literature, there is a need for more focused attention on this topic, especially in intensive care settings where active treatment is administered. Despite their expertise, healthcare professionals are still human and may have their own fears and concerns related to death.

Healthcare facilities, primarily hospitals, should take the initiative to establish support networks and groups where doctors and nurses have the opportunity to engage and share their experiences with dying and death in the critical care unit. Providing healthcare personnel with the necessary support systems and in-hospital counseling is critical to help them cope with the obstacles they face and, ultimately, improve their performance in the future. By acknowledging and addressing the emotional needs of healthcare professionals, we can foster a healthier and more resilient workforce that can provide better care to patients in critical settings.

Limitation and Suggestion

The study did not consider the sociocultural and socioeconomic characteristics of the participants, which limits the assessment of stressors beyond the workplace. To explore this further, researchers can broaden their investigations to include factors like socioeconomic position, family structure, culture, and working hours.

Additionally, the study solely focused on death anxiety, overlooking other emotional reactions that may arise from experiences with death and dying, such as post-traumatic stress, compassion fatigue, depression, and generalized anxiety. Future researchers interested in this topic can integrate these aspects into their studies.

Based on the study's findings, there is a need for targeted programs to assist newly recruited professionals in effectively coping with emotionally challenging work environments. Implementing organized programs or support groups, with administrative backing, is essential for improving the well-being of professionals, enhancing their self-competence and efficiency in ICU settings, and ultimately elevating the quality of patient care.

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