Fear of death: everyday experience-based nurses ʾobservations in working with elderly and old patients ill with chronic cardiovascular diseases

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Summary

Fear of death occurs when elderly and old patients (EOPs) are faced with life-threatening events or extreme psychological stress. For most, anticipation of death triggers negative emotions such as the fear of losing of oneself, helplessness, and a loss of control. Fear of death is one of the most prevalent psychiatric consequences of chronic health conditions. Nurses face challenges in caring for EOPs ill with chronic cardiovascular diseases (CCVDs) snd this is related to high emotional stress and fatigue associated with constant monitoring of patients and managing their anxiety and fears. Fear of death is a common concern among EOP with CCVDs. There is relatively little research that examines the relationship between EOPs ʾCCVDs and experienced fear of death phenomena from the perspective of nurses. Research question, to which the answer was sought was ‘How do nurses describe the symptoms, signs of fear of death among EOPs ʾill with CCVDs and how they recognise the features of patients ʾfear of death?’ A total of 15 nurses had participated in the study. Data were collected by using semi-structured interviews. The manifest qualitative content analysis for data analysis were applied. Findings revealed that the related emotional/psychological, physiological and behavioural changes were observed by nurses and the characteristics for recognising the feeling of death in patients were identified. Characteristics of EOPs ill with CCVDs and experiencing fear of death are related to changes in emotions, behaviour and physical/physiological symptoms/signs that are interrelated with their emotional state. The social, spiritual and creative needs of patients are intensified while they experience fear of death.

Keywords: caring, chronic cardiovascular disease, elderly / old patient, fear of death, manifest qualitative content analysis, nurse, qualitative design, semi-structured interview.

Mirties baimė: kasdiene patirtimi pagrįsti slaugytojų stebėjimai dirbant su pagyvenusio ir seno amžiaus pacientais, sergančiais lėtinėmis širdies ir kraujagyslių ligomis

Anotacija

Mirties baimė yra viena iš labiausiai paplitusių lėtinių sveikatos sutrikimų psichikos pasekmių, atsirandanti tada, kai pagyvenusio ir seno amžiaus pacientai susiduria su gyvybei pavojingomis sveikatos būklėmis arba didžiuliu psichologiniu stresu. Daugumai pacientų mirties laukimas sukelia neigiamas emocijas – baimę prarasti save, bejėgiškumą ir kontrolės praradimą. Slaugytojai atlieka svarbų vaidmenį, padėdami pacientams įveikti mirties baimę ir kitus su liga susijusius sunkumus. Pagyvenusio ir seno amžiaus pacientams, sergantiems lėtinėmis širdies ir kraujagyslių ligomis, dažnai

būdinga mirties baimė. Nors atlikta daugybė tyrimų, nagrinėjančių mirties baimės ir lėtinių širdies ir kraujagyslių ligų koreliaciją, vis dėlto dar trūksta informacijos apie ryšį tarp šių dviejų kintamųjų iš slaugytojų praktinės patirties pozicijų. Tyrime iškeltas klausimas: „Kaip slaugytojai apibūdina pagyvenusio ir seno amžiaus pacientų, sergančių lėtinėmis širdies ir kraujagyslių ligomis, simptomus ir atpažįsta šių pacientų mirties baimės požymius.“ Tyrime dalyvavo 15 slaugytojų. Duomenys rinkti naudojant pusiau struktūruotus interviu, o analizuoti taikant manifestinę kokybinę turinio analizę. Tyrimo rezultatai atskleidė slaugytojų stebimus pagyvenusio ir seno amžiaus pacientų, sergančių lėtinėmis širdies ir kraujagyslių ligomis, mirties baimės požymius ir emocinius / psichologinius, fiziologinius, elgesio pokyčius. Sergančių lėtinėmis širdies ir kraujagyslių ligomis bei išgyvenančių mirties baimę pagyvenusio ir seno amžiaus pacientų charakteristikos susijusios su emocijų, elgesio ir fizinių / fiziologinių simptomų / požymių pokyčiais, kurie neatsiejami nuo jų emocinės būklės. Pacientų socialiniai, dvasiniai ir kūrybiniai poreikiai sustiprėja jiems išgyvenant mirties baimę.

Reikšminiai žodžiai: rūpinimasis, lėtinės širdies ir kraujagyslių ligos, pagyvenusio / seno amžiaus pacientas, mirties baimė, manifestinė kokybinė turinio analizė, slaugytojas, kokybinis dizainas, pusiau struktūruotas interviu.

Introduction

Relevance of the topic. Experiences of fear of death in elderly and old patients (EOPs) is an important topic being addressed by health care sector [1]. Chronic cardiovascular diseases (CCVDs), including heart diseases and stroke, account for one-third of deaths globally [2]. World Health Organisation (WHO) highlights that 17.7 million people die annually from CCVDs [3]. EOPs with CCVDs experience physical health problems as well as various forms of psychological distress including depression, anxiety, and disappointment [4]. EOPs ill with CCVDs are a high-risk group. In EOPs' with CCVDs, the feeling of fear of death is very common and can cause not only physical but also psychological stress. 70% of patients ill with CCVDs experience from moderate to severe fear of death [5].

Death as a psycho-social phenomenon can be stressful for patients, their families, and nurses [6]. Fear of death is and uneasy feeling of worry created by the awareness of an actual/imagined threat to individual's being [7]. The fear of death means the worry, fear, or discomfort that is generated after the individual is made aware of her/his own mortality [8]. Fear of death occurs when EOPs are faced with life-threatening events or extreme stress [9, 10, 11].

Nurses play an important role in helping patients overcome their fear of death. Nurses face challenges in caring for EOPs ill with CCVDs: high emotional stress and fatigue are associated with constant monitoring of patients and managing their anxiety and fears [12].

Research problem. Fear of death is a common concern among EOPs with CCVDs. Although there is a large body of research that examines fear of death experiences and CCVDs autonomously, there is relatively little research that studies the relationship between these two phenomena from the perspective of nurses.

The *research question*, to which the answer was sought in this study, was the following: 'How do nurses describe the symptoms / signs of fear of death among EOPs 'ill with CCVDs?' The *study focus* was the experience-based nurses 'observations while working with EOPs ill with CCVDs who are experiencing the fear of death. The *study aim* was to reveal and justify the experiences of EOPs ' ill with CCVDs fear of death from the perspective of nurses.

The observations of nurses based on everyday experience in the manuscript mean direct experiences of nurses in working with EOPs ill with CCVDs and observing their behaviour, emotions, physiological symptoms, the assessment of which helps nurses make decisions about specific effects on improving and stabilising the patients' condition.

Literature review

Thinking about death is a cognitive element of human activity that allows individuals to become aware of the encounter with reality. Fear of death is a complex construct with cognitive, affective,

and experiential characteristics. Here are differences between thinking about death and fearing death. Thinking about death arises from a particular reflection and detachment from the death, and fear is an emotional reflex [13]. Attitudes toward death may be a consequence of an personal philosophy of life, religion, or behavioural style related to specific culture. Death attitudes include fear of death and anxiety about death. Fear is a reaction to obvious danger, and anxiety to hidden danger. Fear refers to an emotional reaction without signs of pathology, while anxiety is perceived as an objectless, externally unconditioned reaction and it is a sign of pathology. The fear of death lies in human biological instincts and is related to the subconscious struggle of an individual for her/his life [14].

Death is one of humanity's most important existential concerns. Humans have a biological survival instinct, but they are also aware of their own mortality, which is inevitable and unpredictable. The conflict between instincts and the awareness of one's own mortality can lead to existential anxiety, in order to reduce anxiety and fear of death, people expand their cultural worldview and seek self-esteem, which is provided by compliance with relevant cultural norms, standards and values [15].

The concept of death experience is defined as the patients' perception of death. The factors that determine the perception of death and the fear of death are related to the age of person, previous experience of death in the family, maturity of the person and a strong faith that helps to overcome the fear of death [16]. A person's experience causes a her/his to consciously recognise death [17]. Death awareness creates a sense of understanding about death, and the level of understanding and appreciation of elderly patients is determined by their extensive experience of death. By becoming aware of the reality and consequences of death, patients develop the ability to survive any experience of death by accepting its existence [18]. Death awareness is determined by the following factors: number of death experiences, concept of death before and after death experiences, biological understanding of death, existential understanding of death; spiritual understanding of death; mourning habits and support system availability [19].

EOPs ill with CCVDs experience physical health problems as well as various psychological disorders such as depression, anxiety and hopelessness. Death is a psychosocial phenomenon that can be stressful for patients, their families, and health care providers. Death anxiety is defined as a vague, unpleasant feeling of anxiety or fear arising from the perception of a real or imagined threat to one's existence. Death anxiety occurs when people experience life-threatening events or extreme psychological stress [20]. For many patients, waiting to die leads to negative emotions such as fear of losing oneself, helplessness and loss of control. Death anxiety is one of the most common psychiatric consequences of chronic health conditions, and patients with cardiovascular disease experience moderate to severe death anxiety [21].

Talking about death is especially difficult because it is usually avoided in human dialogue; usually the majority of the population pushes the fear of death aside or even avoids it, so the topic of death becomes a taboo [22]. The perception of death is a process that is intensively studied from various perspectives (religious, psychological, biometric, philosophical, biological and medical), it is a universal experience that each person feels, experiences and encounters individually and personally, in a shared context characterised by various past experiences, together with religious beliefs, cultural or philosophical background. The fear of death is defined as the constant threat of suffering caused by the finitude of individual’s existence. An individual must be aware of his finitude because it is the essence of being a human [23].

EOPs ill with CCVDs experience concern and discomfort in daily life, associated with severe fatigue, shortness of breath and progressive deterioration of health, which disrupts the normal course of life, causing feelings of frustration, loss, depression and loneliness. A progressive disease also causes changes in the areas of personal life, the perception of personal identity changes, there is a noticeable effect on relationships with family members and social roles, spiritual experiences are caused, among which the need for hope and thoughts about death stand out. The poor prognosis of the course of the disease and the threat that patients feel to their lives when they experience an exacerbation of symptoms undoubtedly lead to thoughts of death and fear of death [24].

Symptoms of fear of death are physical manifestations that appear suddenly. These include: tremors throughout the body; palpitations - a feeling when the heart seems to jump out of the chest; lack of air; increased sweating; chills or profuse sweating; sharp pain and heaviness in the chest; numbness of the limbs; dizziness; darkening of the eyes. All these manifestations appear simultaneously, without an obvious external cause. These consequences are frightening for the patient. Often, such attacks are false, because the patient does not even realise that it is a fear attack, but thinks that it is a manifestation of a fatal disease. A person experiencing this feeling for the first time may think that he may die at any moment. This fear binds all his thoughts, which negatively affects the health of the patient [25]. The less fear of death, the better the quality of life. Men experience the fear of death and fear the process of death more than women. Regarding the quality of life, women and persons without a marriage partner had a worse quality of life in terms of psychological and social aspects. Also, a greater fear of death, dissatisfaction with their quality of life was indicated by persons who were hospitalised in the last six months due to a worsened health condition [26].

The symptoms of fear of death are so unpleasant that they can prevent patients from living. Often, the fear of death is related to the feeling of the unknown, loss of control, pain, diseases and other frightening things that are natural and understandable [27, 28]. In addition, symptoms of fear of death can affect a person's health and well-being. Health is the power of a person's life and being, which allows her/him to create life, feel, think and act. Symptoms of fear of death can cause a constant feeling of anxiety and disrupt normal life, and can have a negative effect on physical health [29]. Studying the fear of death component is particularly important, as fear is considered to be one of the most common responses of humans to death [30].

Research methodology

Research design

In research was applied the qualitative design. Qualitative research generates information that can help nurses by informing clinical decisions. Qualitative nursing research-based design focuses on patients and/or health professionals' experiences [31].

Qualitative research was applied because the exploratory approach was required on a topic that is not well known, the phenomenon of nurses working with EOPs ill with CCVDs was not possible to explain fully with quantitative research.

This qualitative research was conducted in the following order: i) selection of a research topic and question, ii) selection of a theoretical framework and methods, iii) literature analysis, iv) selection of the research participants and data collection methods, v) data analysis and description of findings, and vi) research validation [32].

Sampling and sample

Nurses working with EOPs ill with CCVDs in multi-specialty hospitals in five major cities of Lithuania participated in the study. Convenient, purposeful and criterion-based sampling was used to select the research participants.

Convenience sampling is often used in qualitative and medical research studies. In medical research, convenience sampling often involves selecting clinical cases or participants that are available around a particular location (such as a hospital) or a medical records database [33].

Purposive sampling refers to a group of non-probability sampling techniques in which units are selected because they have characteristics that the researcher needs in her/his sample. In other words, units are selected *on purpose* in purposive sampling [34]. Criterion-based sampling involves selecting cases that meet some predetermined criterion of importance [35].

The criteria for selecting research participants - nurse practitioners were as follows: the nurse's work experience with EOPs ill with CCVDs at least 10 years; work experience in a health care institution for at least 10 years; completed Bachelor's and/or Master's studies at a higher education institution in the field of nursing science.

A total of 15 nurses, all women, had participated in the study. Eight research participants are graduated with Bachelor level in Nursing, seven - with Master degree in Nursing (see Table 1).

Table 1

Demographic characteristics of research participants

ode	Gen-der	Age	Education	Work experience in a specific health care institution	Work experience with EOPs ill with CCVDs
1	Woman	57 years old	Bachelor of Nursing	35 years	18 years
2	Woman	44 years old	Master of Nursing	22 years	20 years
3	Woman	47 years old	Master of Nursing	25 years	25 years
4	Woman	42 years old	Master of Nursing	20 years	15 years
5	Woman	49 years old	Bachelor of Nursing	28 years	21 years
6	Woman	52 years old	Bachelor of Nursing	30 years	30 years
7	Woman	56 years old	Master of Nursing	35 years	24 years
8	Woman	43 years old	Master of Nursing	20 years	14 years
9	Woman	42 years old	Master of Nursing	20 years	17 years
10	Woman	52 years old	Bachelor of Nursing	30 years	18 years
11	Woman	42 years old	Bachelor of Nursing	20 years	20 years
12	Woman	44 years old	Master of Nursing	22 years	22 years
13	Woman	49 years old	Bachelor of Nursing	28 years	14 years
14	Woman	53 years old	Bachelor of Nursing	30 years	21 years
15	Woman	47 years old	Bachelor of Nursing	25 years	25 years

The average/mean length of service of nurses in nursing practice is 26 years. The average/mean of nurses working with EOPs ill with CCVDs were 20,3 years. The average age of the interviewed nurses were 47,93 years old.

Methods

Data collection

Data were collected in February-August, 2023. Research data were collected during individual semi-structured interviews with nurses practitioners.

Conducting semi-structured interviews is one of the most common ways of collecting data in qualitative nursing research. In particular, interviews are associated with qualitative research, where researchers seek to understand participants' experiences through their own words and perspectives [36].

The basis of the performed qualitative, semi-structured interviews was open-ended questions with the hope of obtaining as broad, detailed and open answers as possible, formulated and provided by the research participant her/himself, reflecting her/his perspective [37].

Interviews with nurses took place outside of working hours, so a comfortable and open environment was created to encourage open communication. Before conducting the interview, the purpose, the use of research data, and the contribution of the ongoing research to nursing practice and science were explained to each nurse individually. The interview with each informant lasted no less than 50 minutes. The shortest interview was 50 minutes. The longest - 182 min. The average duration of the total amount of interviews was 112 minutes.

Research tool

An original semi-structured interview questionnaire, divided into two blocks, was used to collect the data. In total, the interview questionnaire consisted of eight questions. The semi-structured interview questionnaire consisted of two blocks - demographic and content. There were four demographic questions - age of the nurse, length of service in a specific health care institution and working with EOPs ill with CCVDs, and level of the acquired nursing education.

Semi-structured interview questionnaire consisted of four questions:

1. What emotions were experienced by patients who feel the fear of death? [20, 21, 24, 38]. Tell about your experience.
2. How did your patients behave when they felt the tension of the fear of death? What kind of behaviour signals were to you that the patient is experiencing the fear of death? [14, 22]. Share your observations.
3. What were the physical, physiological changes in patients when they experienced the fear of death? [24, 38, 39]. Narrate, please.
4. How did you recognise that a patient have experienced a fear of death? [40, 41, 42].

Data analysis

In the study the manifest qualitative content analysis were applied for data analysis. Manifest content analysis is a method used in qualitative research to systematically examine the content of experiences [43]. Manifest content analysis focuses strictly on the tangible, explicitly stated components of a text. This method is particularly useful in scenarios where researchers seek to document and analyse the visible, straightforward elements of texts, images, or any other communicative media. The primary objective of manifest content analysis is to identify, enumerate, and record the occurrence of specific words, phrases, objects, or situations as they appear [44-46]. A manifest qualitative content analysis is particularly well-suited for this study where the aim is to document and understand the concrete elements of content without inferring any underlying meanings [47].

The initial step was to read and re-read the interviews to get a sense of the whole, i.e., to gain a general understanding of what participants were talking about. At this point researchers already started to get ideas of what the main points or ideas were that participants were expressing [48, 49]. Then researchers started dividing up the text into smaller parts, namely, into meaning units. Then these meaning units were united further. While doing this, researchers needed to ensure that the core meaning is still retained. The next step was to label condensed meaning units by formulating subcategories and then grouping these subcategories into categories [50].

Research ethics

Permission to conduct the study was obtained at the meeting of the Ethics Committee of the Faculty of Health Sciences of Klaipėda State College on 11/16/2022, meeting protocol no. 7.

Informed consent is one of the most important qualitative research ethics to consider in qualitative research. Informed consent in this study meant that participants were fully informed about the purpose and nature of the research, the procedures involved, any potential risks or benefits, and how their data will be used. Participants had the right to refuse to participate or to withdraw from the study at any time [51, 52].

Confidentiality and privacy are essential qualitative research ethics to consider and are often protected by the law. Participants' personal information and responses were kept confidential and private. Researchers took steps to protect the confidentiality of their participants by using pseudonyms and storing data securely. Researches ensured that their research does not invade the privacy of participants by respecting their right to refuse to answer certain survey questions or to have certain information shared [53, 54].

Respect for participants is important ethical consideration in qualitative research. Researchers were sensitive to the needs, values, and beliefs of their participants, and always treated them with dignity and respect. This means that researchers were aware of their own biases and assumptions to avoid imposing their own beliefs on research participants [55, 56]. Researchers were sensitive to cultural and linguistic differences to find ways to communicate effectively with participants who had different backgrounds or experiences. Researchers were mindful of the power dynamics involved in research. Participants did not feel pressure to answer more positively or to provide the answers they think researchers wanted to hear. Researchers were careful to ensure that the study was conducted in a manner that is fair and respectful [57, 58].

The important ethical consideration in qualitative research is the use of findings. Researchers used findings in a responsible and respectful manner to ensure that they are not used to harm or stigmatise research participants and / or professional community of nurses and patients. Researchers were transparent about the limitations of their findings and avoided making sweeping generalisations that were not supported by the findings [59].

Conducting ethical qualitative research required a thoughtful and reflective approach that valued the perspectives and experiences of participants, and produced findings that are meaningful and impactful to nursing practice [60].

Findings

The results of interviews revealed the experiences of nurses towards fear of death which is experienced by EOPs ill with CCVDs. The related emotional/psychological, physiological and behavioural changes were observed by nurses and the characteristics for recognising the experiencing of feeling of death in patients were also described by nurses.

Nurses found that patients EOPs ill with CCVDs who were experiencing a fear of death began to take care of their physical health, such as exercising more and following the physician's orders. However, negative emotions such as irritation, dissatisfaction, aggression and anger were also observed (see Table 2). EOPs' emotional reactions related to the fear of death include anxiety, sadness, anger, dissatisfaction, and fear. Nurses stated that patients who feel the fear of death, experience anxiety and avoid communication: "patients feel anxiety, shut themselves in and do not communicate" (S4). Patients experienced anxiety for their own death because they were worried about the fate of their families: "they worry about what will happen to their loved ones after they die" (S8), and "therefore experiencing guilt" (S15). Because of their health condition, patients "are often angry with themselves, relatives, physicians, and nurses" (S8) (see Table 2).

Table 2

Changes in EOPs ʾill with CCVDs emotional reactions: category and subcategories

Category	Subcategories	Interview statements
Changes in EOPs' emotional reactions	Anxiety	*Patients experience anxiety and agitation.* (S2) *Anxiety appears, patients become withdraw … they do not speak, do not communicate.* (S4) *Anxiety and fear are often observed.* (S8) *Patients are anxious and afraid of the future.* (S11)
	Sadness	*There is a change in mood … the patient is upset and sad* often. (S5) *The common emotion observed is sadness.* (S7) *Patients feel anxious and hopeless.* (S9)
	Anger	*Patients are characterised by anger and accompanying aggressive behaviour.* (S1) *Patients are angry with everyone, themselves, doctors and relatives.* (S8) *Patients are irritated, angry, blame everyone around them, even themselves.* (S12)
	Dissatisfaction	*Patients are dissatisfied with their emotional state, express dissatisfaction.* (S4) *It is typical the dissatisfaction with one's health status, surrounding environment.* (S7)
	Get scared	*The patient feels fright and fear, cares about the future of loved ones.* (S8) *Fear, self-loathing and guilt are felt.* (S15)

The behaviour of EOPs' ill with CCVDs change - patients "start to avoid communicating with relatives and immerse themselves more in their feelings" (S11), they "refuse to communicate with the staff of a health care institution" (S14) and/or "constantly talk about death, because they feel the fear of death" (S3). The fear of death is reflected in patients' negative emotions when they refuse to eat (S5): "sink into apathy, are not interested in anything, are dissatisfied" (S8).

Support is important to patients, so they "seek support in various support groups" (S7, S15) and "are happy to establish new relationships with other patients who also face the fear of death" (S15), "want to renew relationships with loved ones to receive support and encouragement' (S12). Patients express their spiritual/existential needs through visiting religious or spiritual groups, looking for a spiritual guide or starting practicing meditation or prayer (S14), seeking meaning in life through spiritual conversion (S5), being interested in creativity and art (S13). Therefore, "patients need a spiritual guide to help them understand the meaning of life" (S14) (see Table 3).

Table 3

Changes in EOPs' ill with CCVDs behaviour and expression of their spiritual/existential needs: categories and subcategories

Category	Subcategories	Interview statements
Changes in EOPs' behaviour	Refusing to contact / interact	*The patient constantly talks about death because s/he feels the fear of death.* (S3) *The patient begins to ask about the causes of death, the impact of death on relatives.* (S7) *The patient begins to avoid communicating with loved ones and becomes more immersed in her/his feelings.* (S11) *Sometimes patients refuse to communicate with healthcare staff.* (S14)"
	Need for support / maintenance	*The patient begins to take more care of her/his health, so support and support are important* (S4) *The patient is looking for support, understanding of her/his anxiety and fear of death* (S7) *It happens that patients want to renew their relationships with loved ones in order to get support and support.* (S12) *Patients seek support in various support groups, communicate with other patients.* (S15)
Expression of EOPs' spiritual / existential needs	Denial	*Various negative reactions, refusal to eat, denial.* (S5) *The patient sinks into apathy and is not interested in anything s/he is dissatisfied.* (S8)
	The search for meaning of life	*The patient may seek spiritual conversion in order to understand the meaning of her/his life.* (S2) *Patients show creativity and are interested in art.* (S13) *Patients need a spiritual guide to help them to discover the meaning of life.* (S14)

Eating disorders are characteristic of EOPs' ill with CCVDs experiencing the fear of death. Due to frequent nausea and vomiting, patients experience indigestion, which leads to changes in eating habits, disruption of the diet (S7), and rapid weight loss. EOPs with CCVDs become less physically active because of a sudden decrease in energy, resulting in more difficult and slower movement and fatigue (S12). There is also "lower resistance to infections due to weakened immunity" (S8) and due to less appetite and anorexia.

Due to the deteriorating state of health and constant tension and stress, EOPs ill with CCVDs are characterised by general weakness and fatigue (S14). They complain of pain in the area of the heart (S1), experience changes in blood pressure ("sudden rises and falls in blood pressure" (S5)) and in heart rhythm ("heart rhythm changes from normal to very fast or very slow" (S5)). They experience headache or loss of consciousness (S13), breathing disorders, and "hair loss due to physical and emotional stress and various hormonal changes in the body in response to stress" (S12) (see Table 4).

Table 4

EOPs' ill with CCVDs physical/physiological health changes: categories and subcategories

Category	Subcategories	Interview statements
EOPs' ill with CCVDs physical/physiological health changes	Eating disorders	*Patient-specific gastrointestinal disorders affecting her/his nutrition.* (S5) *Because of nausea and vomiting, the diet is disrupted and eating habits change.* (S7) *Rapid weight loss due to indigestion and changes in the diet.* (S10)
	Decreasing physical activity	*Due to low activity, patients have a weak immunity, they get sick more often.* (S8) *A sudden drop in energy is noticed, it's harder to move, you get tired more quickly.* (S12) *Increased general weakness and fatigue.* (S14)

	Respiratory and cardiac disorders	*Characterised by hypoxia - lack of oxygen, pain in the heart.* (S1) *Heart rate changes, from normal to very fast or very slow.* (S5) *During the night, unconscious, not controlled movements and changes in body temperature may occur. (S9)* *Dizziness, headache, nausea and even loss of consciousness.* (S13)

Nurses narrate how they recognise that EOPs ill with CCVDs are experiencing the fear of death. In such cases, patients experience psychological/emotional and physiological/physical changes.

Psychological/emotional changes manifest severe anxiety (S2), feelings of hopelessness, depression, sadness (S7), panic attacks, fright, anger (S11), aggressiveness (S12). EOPs ill with CCVDs talk about death and ask questions (S8) about it. The origin of such emotions is EOPs' disappointment, uncertainty, because they cannot change the situation (S8) (see Table 5).

Table 5

Characteristics of recognition of the fear of death experienced by EOPs ill with CCVDs: category and subcategories

Category	Subcategories	Interview statements
Characteristics of recognizing the EOPs 'experiencing the fear of death	Psychological / emotional changes	*The patient is restless, often has severe anxiety.* (S2) *Patients experience a feeling of hopelessness, depression, sadness.* (S7) *Negative thoughts, depression, hopelessness and anxiety disorders occur.* (S9) *Panic attacks, severe anxiety, fear and anger are also observed.* (S11) *Patients often talk about their death, ask questions more often than in a normal situation.* (S3) *Since a person cannot change her/his fate, s/he begins to ask questions, to be interested in the topic of death.* (S8) *The patient becomes aggressive and frustrated because s/he is tormented by the unknown, it is not clear what to expect.* (S12)
	Physiological / physical changes	*Sleep disorders occur, the person's daily rhythm changes.* (S1) *The person suffers from nausea, weight loss due to poor nutrition.* (S5) *Dietary disturbances, noticeable weight loss.* (S7) *Noticeable breathing problems, increased heart rate.* (S2) *Patients are characterised by sweating, dizziness, increased heart rate.* (S6) *Frequent headache, stress causes nausea, heart rhythm disturbances.* (S10) *The patient is characterised by tremors, heart rhythm disorders.* (S14)

Physiological/physical changes include sleep disturbances (S1), nausea (S5, S7, S10), poor nutrition, weight loss (S5, S7), respiratory disturbances, palpitations (S6, S10, S14), headache and tremors (S14).

Discussion

The research revealed the experiences of nurses based on daily practice working with EOPs ill with CCVDs when they experience the fear of death.

The conducted research revealed that EOPs ill with CCVDs while experiencing fear of death express anxiety, sadness, anger, dissatisfaction and are scared. International scientific studies emphasise that the symptoms of fear of death are so unpleasant that they can prevent patients from living. Often, the fear of death is related to the feeling of the unknown, loss of control, pain, diseases and other frightening things that are natural and understandable [28]. Patients with CCVDs experience physical health problems, various psychological disorders such as depression, anxiety and frustration [20]. Many EOPs ill with CCVDs experience negative emotions such as fear of losing oneself, helplessness and loss of control (21). EOPs ill with CCVDs experience concern and discomfort in their daily life, related to severe fatigue, shortness of breath and progressive deterioration of health, which disrupts the normal course of life, causes feelings of frustration, loss, depression and loneliness [24]. Fear of death by EOPs 'ill with CCVDs may cause intense feelings of panic, fear, dread or depression. It's not uncommon for EOPs living with fear of death [61, 62].

The study revealed that EOPs ill with CCVDs refuse to interact with health care personnel. EOPs' refusal to medication non-adherence and refusal to contact with health care staff is common [63, 64]. Cases of EOPs ill with CCVDs refusing contact with healthcare personnel are not covered, but research on EOPs refusing to take medication, contact states that patients are reluctant to trust treatment provided by healthcare personnel [65-67).

Research findings showed that EOPs ill with CCVDs experience denial, but searching for the meaning of life. Lack of meaning and emptiness evokes existential anxiety or threat of "non-being" [64]. Meaning-making can be an antidote for the pain of immortality [68, 69]. The three main parts of meaning in life are coherency (understanding), goal, and importance/existential significance [70-72]. Meaning plays an instrumental role in protecting mental health [73, 74]. Perceiving life as meaningful depends on the availability of cues to coherence (comprehensibility and predictability) [75, 76], purpose (aims and aspirations), and significance (value beyond the elusive and momentary) [77, 78]. Research findings of a current study reveal that cases of EOPs ill with CCVDs are specific, because EOPs who suffer from incurable chronic diseases, having lived most of their lives and achieved their goals, find it difficult to find life's stimuli. Perhaps the most important stimulus remains the family, because of which they survive thinking that their leaving will cause a lot of negative and difficult experiences for the family. From research findings is clear that EOPs want to talk about end-of-life and death.

Conversations about end-of-life care preferences are associated with greater likelihood of an individual receiving treatment that is consistent with her/his wishes, earlier referral to hospice, and overall better quality of life near death [79]. The creation of public policies and training and education to support and encourage advance care planning discussions with healthcare providers is necessary for a growing aging population, but these must occur alongside discussions between individuals and their families about serious illness, end-of-life care scenarios, and treatment preferences [80].

EOPs turn to their spiritual and creative/artistic needs. understanding the nature of the spiritual seems to be the key to grasp the concepts of health, well-being, and the quality of life [81]. Spiritual care is needed in a clinical setting to improve the patients ʾquality of life. Deep connection with another person and delight with the beauty of nature or art and (in some cases) with God are all transcendental experiences. They may enable patients to ascribe meaning to their life with a chronic illness, find hope and well-being despite burdening symptoms [82]. Existential and spiritual issues are on the verge of new clinical and research interest in medicine and nursing, especially in gerontology, oncology, and palliative care. Clinicians focus not only on symptom control but also on spiritual and existential issues such as spirituality, hope, and meaning [83].

The influences on fear of death are varied including religiosity, gender, psychological state, and age. It is assumed by the children of the elderly that the fear of death is prevalent in their parents. Daily the health care staff encounters the presence of death anxiety: from family members or the staff itself. In order to understand this phenomenon, a three-tier study was conducted on non-terminal elderly inpatients in an acute geriatric care ward [84]. In this study, there were a new component that has not yet been discussed in research on the fear of death internationally - the patient's physiological changes while experiencing the fear of death.

However, physiological changes, such as nutritional disorders, decreased physical activity, and respiratory and cardiac disorders that are associated with the EOPs' fear of death for the first time within the international and national research context on EOPs ill with CCVDs. This comes from our research study. On the one hand, it could be 'nothing new' when we talk about EOPs ill with CCVDs, because the mentioned symptoms are not unusual or new in the mentioned patients ʾpopulation [85]. On the other hand - these are new evidences that are related to physiological changes in the context of the patient's fear of death and these symptoms should not be ignored. And even more so, they should not be taken for granted. It is meaningful to conduct research with a focus on physiological changes in patients living in fear of death in different age groups of patients and in different cases of chronic or incurable diseases [86], inviting practicing nurses to participate in the research and share their experiences and opinions related to working with the EOPa' population.

Everyone's experience of the death of death is different and it can be difficult to know when a person is reaching the last few days of their life. Timely recognition that a person may be imminently dying and clear communication of that possibility enables the person to receive the best possible care, and those around them to be prepared and supported. If a person dies peacefully without needless suffering, the family and health carers have the best opportunity to see the death as a good death [83-86]. Research findings revealed that EOPs ill with CCVDs experience psychological (anxiety, sadness, hopelessness, being aggressive, being frustrated) and physiological (nausea, weight loss changes, cardiac rhythm abnormalities) changes. The mentioned characteristics or symptoms mostly are not the same as it is in the terminal phase of life, when the person experiences deteriorating day by day or hour by hour, becoming bed-bound for most of the day, complains about extreme tiredness and weakness, being less responsive and less able to communicate, needing help with all personal care, difficulty swallowing food, fluids and oral medication, reduced urine output, new urinary or faecal incontinence, changes in her/his normal breathing pattern, noisy chest secretions, mottled skin and cold skin particularly hands and feet delirium, the person telling the nurse s/he feels like s/he is dying [75-78]. The only symptom of EOPs' ill with CCVDs that is similar to terminal phase of life is little interest in food or drink.

However, the difference in the mentioned two situations of this symptom - the disease and the terminal phase - is related to the patient's awareness: EOPs ill with CCVDs experience an emotion that influences psychological and physiological symptoms/signs, while in the terminal phase of life there are physiological sharp changes. Then the refusal to eat is not related to the emotion in terminal phase. In the first case there is the fear of death, in the second - the process of dying. These are different phenomena.

Research limitations. The research results are based on the experiences of nurse practitioners, which are important, but it is also relevant to study the authentic experiences of EOPs' ill with CCVDs themselves about their fear of death. Such a study will create opportunities to more objectively describe the notion of ‘fear of death’, and to specify the signs of fear of death more precisely. Such information has a meaning for the training of nurses and clinical nursing practice by expanding the concepts of phenomena relevant to nursing, developing emotional intelligence relevant to the nursing profession, contributing to the education and training of nurses, and strengthening of clinical nursing practice.

Impact to nursing education and nursing practice. A study was carried out in the specification of care for the development of clinical nursing and in refining the understanding of the fear of death experienced by EOPs' ill with CCVDs: the fear of death is not the same as the death anxiety or the dying process that occurs in the last stage of life. This clarification is relevant for nursing practice, because if properly understood, nurses can organise targeted help and support for the patient, and in such cases, medicinal effects are not necessarily required. The knowledge obtained in the study is also important for the education and training of nurses in specifying three relevant terms/notions such as ‘fear of death’, ‘death anxiety’ and ‘dying' related to the end-of-life. These notions could be relevant for all patients, regardless of age, disease, gender, social status and other demographic characteristics. Such specific knowledge contributes to the development, expansion and improvement of the clinical thinking of nursing students and nurses practitioners, and is related to the quality of nursing education and nursing practice.

Conclusions

Characteristics of EOPs’ ill with CCVDs and experiencing fear of death are related to changes in their emotions, behaviour and physical/physiological symptoms/signs that are interrelated with

their emotional state. The social, spiritual and creative needs of patients are intensified while EOPs experience fear of death.

Fear of death is not the same as death anxiety or the end-of-life states / conditions. Fear of death is the response to a perceived threat regarding health condition, while death anxiety involves worry about a threat that has not yet, or may never, happen. Fear of death and terminal phase of life differs regarding EOPs ʾdue to the patients ʾawareness. In the case of fear of death, the patient consciously expresses emotions that influence a change in their behaviour directly related to several physiological changes that are not constant and their dynamics are changing. Thus, in the terminal phase of life, the EOPs ʾemotions are not the main focus and the underlying influencing factor of physiological reactions, changes and symptoms.

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