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Prevalence and Correlates of Death Anxiety Among Frontline Healthcare Workers: A Cross-Sectional Study

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Abstract

Background Frontline healthcare workers face repeated exposure to death, critical illness, and patient suffering. This chronic exposure contributes to death anxiety, defined as persistent fear and dread related to dying and death. Unaddressed death anxiety affects mental health, empathy, clinical decision-making, job satisfaction, and staff retention. Despite its relevance, Indian data on death anxiety among public-sector healthcare workers remain limited, particularly after the COVID-19 pandemic. Understanding its prevalence and associated factors is essential for designing targeted mental health interventions and occupational health policies.

Objective: To estimate the prevalence of death anxiety and identify its sociodemographic and occupational correlates among frontline healthcare workers in public health facilities.

Methods: A cross-sectional study was conducted from January to August 2025 among doctors, nurses, and paramedical staff working in emergency departments, intensive care units, and inpatient wards of public health facilities in Bhopal, Madhya Pradesh. Participants with at least six months of clinical experience were recruited through consecutive sampling. A total of 50 participants were included. Data were collected using a pre-tested sociodemographic and occupational proforma and Templer's Death Anxiety Scale, Hindi/English version. The scale has 15 items scored as True=1 and False=0, with a total score range of 0–15. Scores of 11 and above were classified as high death anxiety, 7–10 as moderate, and 0–6 as low. Ethical approval was obtained from the Institutional Ethics Committee, and written informed consent was taken from all participants. Data were entered in MS Excel and analyzed using SPSS version 26. Prevalence was expressed as percentage with 95% confidence interval. Associations were tested using Chi-square test and Fisher's exact test where applicable. A p-value <0.05 was considered statistically significant.

Results: The study included 50 participants with a mean age of 32.4±6.8 years. Females comprised 60% of the sample, and males 40%. Nurses accounted for 48% of participants, followed by doctors at 34% and paramedical staff at 18%. Nearly 44% of participants were posted in ICU or emergency departments, and 56% worked in general wards. Regarding work experience, 56% had less than five years of experience, while 44% had five years or more. The prevalence of high death anxiety was 44% (22/50), moderate death anxiety was 36% (18/50), and low death anxiety was 20% (10/50). High death anxiety was more common among females, with 16 of 30 females (53.3%) scoring in the high range compared to 6 of 20 males (30.0%). This difference was statistically significant ($\chi^2=4.17$, $p=0.04$). Similarly, participants posted in ICU or emergency departments reported higher rates of high death anxiety, 12 of 22 (54.5%), compared to 10 of 28 (35.7%) in general wards, though this did not reach statistical significance ($p=0.18$). Participants with less than five years of experience had a higher prevalence of high death anxiety at 15 of 28 (53.6%) compared to 7 of 22 (31.8%) among those with five or more years of experience ($p=0.12$). No significant association was observed between age group and death anxiety levels.

Conclusion: Death anxiety is prevalent among frontline healthcare workers, affecting nearly two-fifths of the study population. It is significantly higher among female staff. The findings highlight the need for routine mental health screening, confidential counseling services, and institutional support mechanisms such as peer debriefing and workload management to address death anxiety and safeguard healthcare worker well-being.

Keyword: Death anxiety, Healthcare workers, Frontline staff, Mental health, Occupational stress, Templer's scale

Introduction

Healthcare delivery, especially in acute care settings, inherently involves exposure to suffering, critical illness, and

mortality. For frontline healthcare workers, this exposure is not occasional but routine. Over time, repeated encounters with dying patients can intensify death anxiety, a

psychological construct referring to the fear, dread, and negative emotional reactions associated with the prospect of one's own death or the death of others.

Death anxiety is not a clinical diagnosis but a measurable psychological state that influences behavior, coping, and professional functioning. Moderate levels may promote caution and patient-centered care, but high levels are associated with avoidance behavior, emotional exhaustion, depersonalization, and burnout. During and after the COVID-19 pandemic, multiple international studies reported elevated death anxiety among nurses and physicians working in high-risk units. In India, data remain sparse, with most available studies focusing on oncology nurses or medical students rather than frontline staff in public hospitals.

Public health facilities in India operate under high patient loads, limited staffing, and resource constraints. These conditions amplify occupational stress and may exacerbate death anxiety. Understanding the burden and correlates of death anxiety in this context is important for two reasons. First, healthcare worker well-being directly affects the quality and safety of patient care. Second, high attrition and absenteeism among staff threaten the functioning of already strained public health systems.

The present study was conducted to address this gap. The objectives were to estimate the prevalence of death anxiety among frontline healthcare workers in public health facilities in Bhopal and to identify sociodemographic and occupational factors associated with high death anxiety. The findings are intended to inform institutional mental health programs and policy interventions.

Methods

- Study Design and Setting:** This was a cross-sectional analytical study conducted between January and August 2025 in public health facilities under the Department of Health and Family Welfare, Government of Madhya Pradesh. The facilities included district hospitals and medical college-affiliated units in Bhopal. The study was conducted in emergency departments, intensive care units, and general medicine and surgery wards.
- Study Population and Sampling:** The study population consisted of doctors, staff nurses, and paramedical staff who had been working in clinical roles for at least six months. Participants on long leave, those with a known diagnosis of severe psychiatric illness, and those who declined consent were excluded. Consecutive sampling was used until the target sample size of 50 was reached. The sample size was calculated for a prevalence estimate, assuming a 40% prevalence of high death anxiety based on prior Indian studies, 95% confidence interval, and 15% absolute precision.

Study Tools: Data were collected using two instruments:

- Sociodemographic and Occupational Proforma: Collected age, gender, profession, department, years of experience, and night shift frequency.
- Templer's Death Anxiety Scale: A 15-item self-administered scale. Each item is scored 1 for "True" and 0 for "False." Total scores range from 0 to 15. Scores of 11–15 indicate high death anxiety, 7–10 moderate, and 0–6 low. The scale has been validated in Indian populations and translated into Hindi.

Ethical Considerations

Ethical approval was obtained from the Institutional Ethics Committee of. Written informed consent was obtained from

all participants. Confidentiality was maintained by assigning codes to participants and storing data on a password-protected computer. Participation was voluntary, and participants could withdraw at any time without penalty.

Data Analysis

Data were entered into MS Excel and analyzed using SPSS version 26. Descriptive statistics were used to summarize sociodemographic and occupational characteristics. Prevalence of high death anxiety was expressed as percentage with 95% confidence interval. Associations between categorical variables were tested using Chi-square test or Fisher's exact test where expected cell counts were <5. A p-value of less than 0.05 was considered statistically significant.

Results

Sociodemographic and Occupational Profile

A total of 50 frontline healthcare workers participated. The mean age was 32.4 years with a standard deviation of 6.8 years, ranging from 24 to 48 years. The gender distribution showed a predominance of females, with 30 participants (60.0%) and 20 participants (40.0%) being male.

In terms of professional category, 24 participants (48.0%) were staff nurses, 17 participants (34.0%) were doctors, and 9 participants (18.0%) were paramedical staff including lab technicians and pharmacists.

Work setting varied across departments. Twenty-two participants (44.0%) were posted in high-exposure areas such as intensive care units and emergency departments, while 28 participants (56.0%) worked in general medicine, surgery, and obstetrics wards.

Regarding clinical experience, 28 participants (56.0%) had less than five years of service, and 22 participants (44.0%) had five or more years of experience. Shift pattern analysis revealed that 32 participants (64.0%) worked night shifts more than eight times per month.

Prevalence of Death Anxiety

Assessment using Templer's Death Anxiety Scale showed that 22 participants (44.0%) had high death anxiety, 18 participants (36.0%) had moderate death anxiety, and 10 participants (20.0%) had low death anxiety. The mean score on the scale was 9.8 ± 3.2 .

Correlates of High Death Anxiety

When stratified by gender, high death anxiety was reported in 16 of 30 females (53.3%) compared to 6 of 20 males (30.0%). The association between gender and high death anxiety was statistically significant ($\chi^2=4.17$, $p=0.04$).

Among participants posted in ICU and emergency departments, 12 of 22 (54.5%) had high death anxiety compared to 10 of 28 (35.7%) in other departments. This difference was not statistically significant ($p=0.18$).

Work experience also influenced death anxiety levels. Among those with less than five years of experience, 15 of 28 (53.6%) had high death anxiety, whereas 7 of 22 (31.8%) with five or more years of experience fell in the high category ($p=0.12$).

Participants working more than eight-night shifts per month reported higher rates of high death anxiety at 16 of 32 (50.0%) compared to 6 of 18 (33.3%) among those with fewer night shifts, but this was not statistically significant ($p=0.24$). No significant association was found between age group and death anxiety levels. Participants aged 25–35 years had a high death anxiety prevalence of 46.2%, while those aged 36–48 years had a prevalence of 40.0% ($p=0.68$).

Table 1: Death Anxiety Levels by Sociodemographic and Occupational Characteristics (n=50)

Characteristic	Category	Total, n (%)	High Death Anxiety, n (%)	p-value
Gender	Female	30 (60.0)	16 (53.3)	0.04*
	Male	20 (40.0)	6 (30.0)	
Department	ICU/Emergency	22 (44.0)	12 (54.5)	0.18
	General Ward	28 (56.0)	10 (35.7)	
Experience	<5 years	28 (56.0)	15 (53.6)	0.12
	≥5 years	22 (44.0)	7 (31.8)	
Night Shifts/month	>8	32 (64.0)	16 (50.0)	0.24
	≤8	18 (36.0)	6 (33.3)	

Discussion

This study found that 44% of frontline healthcare workers in public health facilities in Bhopal had high levels of death anxiety. This prevalence is comparable to findings from studies conducted during the COVID-19 pandemic in India and other low- and middle-income countries, where rates ranged from 35% to 52% among nurses and physicians in acute care settings.

The significantly higher prevalence among females is consistent with a large body of literature suggesting that women report higher levels of death anxiety than men. Proposed explanations include differences in emotional expressivity, socialization patterns, and coping strategies. In the Indian context, female healthcare workers often juggle professional responsibilities with caregiving roles at home, which may amplify psychological distress.

The observed higher rates of high death anxiety among staff posted in ICU and emergency departments, and among those with less than five years of experience, did not reach statistical significance, likely due to the limited sample size. However, the trend aligns with the hypothesis that repeated exposure to acute mortality and limited coping experience increase vulnerability to death anxiety. Night shift work showed a similar non-significant trend, supporting evidence that disrupted circadian rhythms and sleep deprivation can worsen psychological outcomes.

These findings have practical implications. First, death anxiety is common and should be recognized as an occupational health issue. Second, gender-specific interventions may be warranted. Third, early-career staff and those working in high-acuity areas may benefit from targeted support.

Limitations

The study has several limitations. The sample size was small and restricted to one city, limiting generalizability. The cross-sectional design precludes causal inference. Self-report measures are subject to social desirability bias. Future multicentric studies with larger samples and longitudinal designs are needed.

Conclusion

Death anxiety is prevalent among frontline healthcare workers, affecting nearly two-fifths of the study population. It is significantly higher among female staff. Based on these findings, the following recommendations are made:

- Integrate mental health screening for death anxiety into routine occupational health check-ups for healthcare workers.
- Establish confidential counseling and peer support programs within public health facilities.
- Implement workload management and structured debriefing sessions for staff in ICU and emergency departments.
- Provide training on coping strategies and resilience for early-career healthcare workers.

- Addressing death anxiety is not only a matter of staff welfare but also a step toward improving patient care quality and health system resilience.

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