The Oncologist®
Schwartz Center Rounds

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Update: Fear of Death

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Learning Objectives

After completing this course, the reader will be able to:

1. Describe the fears that patients experience regarding death and the dying process.
2. List the most successful methods caregivers can use to empathize with the dying patient.
3. Discuss the benefits to physicians who share the emotional journey with patients during end-of-life care.

CME

Abstract

Shortly before his death in 1995, Kenneth B. Schwartz, a cancer patient at Massachusetts General Hospital (MGH) founded The Kenneth B. Schwartz Center® at MGH. The Schwartz Center® is a nonprofit organization dedicated to supporting and advancing compassionate health care delivery, which provides hope to the patient and support to caregivers and encourages the healing process. The center sponsors the Schwartz Center Rounds®, a monthly multidisciplinary forum where caregivers reflect on important psychosocial issues faced by patients, their families, and their caregivers, and gain insight and support from fellow staff members.

For many, cancer is synonymous with death. Fearing death is a rational response. For too long, medicine has ignored this primeval fear. Increasingly, clinicians recognize and address end-of-life issues, facing patients' and our own emotional vulnerabilities in order to connect and explore problems and fears. Listening and learning from the patient guides us as we acknowledge much of the mystery that still surrounds the dying process. Rarely is there a simple or right answer. An empathetic response to suffering patients is the best support. Support is vital in fostering the adjustment of patients. A silent presence may prove more helpful than well-meant counsel for many patients. Through an examination of eight caregiver narratives of their patients' experiences, the role of the health care provider in the dying process, particularly in regard to challenging fear, is reviewed. *The Oncologist* 2005;10:160-169

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Case Presentations

Below, speakers present memorable cases significant for the prominent place that fear played for the patient at the end of life. A wide variety of fears are expressed even within this small group of case studies, confirming that such a strong emotion is always uniquely individual. They range from fear of the unknown in terms of what to expect in the afterlife, concerns over what was being left behind, and making peace with God. The patients' personal and clinical details have been changed to protect their anonymity.

Physician: Mr. A articulated his concern to me that he had not lived his life in a way that he felt was appropriate. He felt that he had not been a good husband or father and had not performed well at work. He was feeling both depressed and incredibly concerned about dying. He had an overwhelming sense that he was going to be punished and that death would be the time for this. However, by addressing conflicts and his regrets with respect to his relationships with family members, his fears and depression resolved.

Physician: Mrs. B was an elderly woman who expressed her anxiety to me by saying she was still too young to die. She was on anticancer therapy but had a conflict because she felt so healthy when not on chemotherapy and so sick during treatment. She wished to prolong her life but did not want to deal with negative symptoms from chemotherapy.

Nurse: Mr. C looked me in the eye one day and said, "I'm afraid, tell me how I will die." He wanted to know exactly what it would look like, what was coming, and what it would feel like in order to prepare himself to die. He was terrified, and his fear frightened me. I tried to answer his questions but was so nervous I could actually hear my own heart beating in my ears at the same time.

Nurse: Mr. D was a father and husband with a tremendous fear about what would happen to his family once he had died. He was despairing and initially could not be comforted, despite the best efforts of his family. They said things like, "Please, don't worry yourself about it, we will take care of it." He felt that something ominous and terrible would happen to his family once he died. He was also distressed that he would entirely disappear from their lives and particularly experienced fears about practical aspects of their lives without him. For example, Mr. D continually worried about how his son would get to soccer practice, and while we had all initially reassured him that it would be fine, it was not until we made an exact plan of how such events would happen, including timing and a route, that his fears were alleviated.

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Chaplain: Mr. E asked for my help, as he wanted to improve his relationship with God. He told me, "You've got to help me improve my relationship with God. He is so confusing." I spent time with Mr. E, built trust, and discovered more about his experience of God. After several months, he did overcome his fears of being abandoned by God and of what would happen to him after he died, and understood more of what God's will was for him. After giving control of his life to God, he felt as if he could say goodbye. His testimony was, "I'm living my life as never before. I'm seeing daily perks from God, and I have so much love in my heart." One day, unexpectedly, he looked up at me and said, "I'm afraid of the end of life." Despite feeling as though we had already worked through this problem, I listened to him as he continued, "I'm so at peace with God. I want to die now, but I don't think God is going to take me yet, and I want it to end. I've stashed enough oxycodone. If I need to do myself in, you will help me, right?" I was shocked but looked at him and said, "I think we might be able to find another way." With the support of his family and caregivers, he eventually came to a peaceful death. After saying a final prayer for him the last time he was conscious, he said to me, "I have no more fears now. I'm going to a God that I know, and when I see him I'm going to put in a good

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word for you."

Nurse: Mrs. F was a woman with advanced lung cancer who had experienced both depression and anxiety. She volunteered for a program to show physicians how to teach about the end of life using a real patient. She had written very graphic, vivid descriptions of her fears in a journal, which we all found both incredible and terrifying to read. Mrs. F was obsessed with thoughts of the sensual perception of what it is like to be dead and be consumed by bugs and worms, but she worried that such thoughts were irrational. When she expressed these worries, I had to bite my tongue and say that there was nothing irrational about it. Despite my own views, I was able to normalize these fears to some extent. All around us we see what death is: the decay, people falling apart, and the disintegration that we have to accept. To normalize it to the patient was reassuring, yet it was important not to do so to the extent that I dismissed how important and painful such worries were.

We hope that, at our best moment, what we are doing is providing empathy by finding out what the patient is most afraid of and what it is that is hard for them, and allowing them to think it out loud and express their true emotions.

Nurse: Mrs. G was incredibly ill. Everyone expected her to die within 24 hours. A week later she was still holding on. She was incredibly agitated, constantly trying to get out of bed despite her frailty. One day, her daughter sat down on the bed and said, "Mom, are you afraid of dying?" Despite her delirium, the patient clearly said, "I am terrified of dying. I don't want to meet my relatives." She had had a bad experience early on in life and was really concerned that in the afterlife she would be faced with family members she did not want to reconnect with.

Psychiatrist: Mr. H was a lung cancer patient who, toward the end of life, would always hold my hand and plead with me, "Whatever you do, you can't tell me I'm dying. I'm not dying, right?" I found it hard to respond to this honestly. The patient would joke about it at times, but even then the fear was always present, and very strong. He had trouble coping. Even with his last breaths, he would still take a deep breath and say to me, "I'm not dying, right? I'm not dying?" It was terrifying for me, and I worried a lot about how best to support him and how to hold back both of our anxieties.

Dialogue

Staff Emotions

Nurse: It is sometimes really very difficult and challenging to be in a room with a dying person. It takes a lot of courage to go in and face them.

Psychiatrist: There is not a day that goes by in the life of a physician during which you do not encounter the most profound of human questions. Part of the challenge for us is to be around people who are asking these questions and not to think that we have to give an answer but to realize how privileged we are to hear and think about questions that are unfathomable and fascinating.

Oncologist: Physicians can easily increase the dose of morphine to control or relieve pain and bring comfort as they are trained to do, but to reassure someone about what it will feel like after death is something the physician is incapable of handling because they have not experienced it first hand; no one has.

Empathy

Nurse: I often worry that I will say something wrong. I think I will make things worse if I try to offer some reassurance. It is traumatic, but just showing willingness to sit and talk through important issues with a patient becomes part of healing, rather than pretending that everything will be fine.

Social Worker: There can be a sense of fear from the patient that you will find them or their thoughts so terrifying that you will abandon them and they will not be able to discuss distressing issues.

Palliative Care Physician: Often, one can only sit and listen, because there is not much else to do. Hollow reassurance will not work. Exploring the specifics and asking a patient what they find most fearful and why and finding out about their experiences will get you at least 50% of the way. When you are finally left with something so powerful and overbearing, you really need

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to be able to sit there and be honest with those piercing eyes entering you—to just be present is hard for caregivers to do. The physicians should put aside their own anxieties and remain calm, connected, and honest. After all, caregivers may be physicians, but they are also human beings who have similar questions, lack knowledge, and lack the same experiences as their patients.

Psychiatrist: It is helpful to be clear about reassurance, sympathy, and empathy when you are talking to a patient. Reassurance is when you tell someone not to worry, which really means, "Worry alone because I don't want to hear it." Sometimes people ask us for that, and what they are saying is, "Please reassure me so that I don't have to feel it either and we'll jolly each other up." Sympathy is when you say, "If this were me, this is how I would feel." Empathy asks, "What does this feel like for you?" We hope that, at our best moment, what we are doing is providing empathy by finding out what the patient is most afraid of and what it is that is hard for them, and allowing them to think it out loud and express their true emotions.

Such discussions are especially challenging, as physicians are often not trained in the area of providing reassurance. But we can sit and listen and even if we have no answers to a patient's questions, we can still provide comfort, which is healing.

Nurse: With Mr. D, we could not relieve his fears by simply telling him that everything would be fine. In the end, we had to make an exact plan for how his family would cope without him in specific situations. There was such an overwhelming sadness for this dying father that I think it was easy to overlook his particular fears on any one day. For me, the real challenge is knowing what to say when I haven't experienced death myself.

Palliative Care Physician: Many patients fear the process of dying more than death. Mr. E felt his disease was punishing him. Some people at the end of life say, "I don't worry about being dead." Like the patient who said, "What I worry about is what's going to happen on the road to death." One of the things I've really worked on is to keep my mouth shut and look and be interested. I stop myself from running out of the room and just sit there. It may be a white-knuckle ride, but I try not to show it! Being there to allow the person to express those fears has made some patients say "Gee, that's the first time anybody sat with me and allowed me to talk about what I was afraid of."

Nurse: My final gift to the patient is to say, "I can take away some of the pain, I'll witness the struggle, I'll sit here with you, and I truly don't know what it's going to be like but I will be honest with you."

Social Worker: People come to clinicians expecting our strength, mastery, and power to help them, and when they ask you near the end what to do, they are asking you to still have that power. They are asking you because you have stood by them and you are a person who has watched other people die. They do not want to be alone with these feelings and they trust you, asking you to listen to them and to give them the best answer you can.

Psychiatrist: I will often say that I do not know how the disease is going to play out and the only guarantee I can provide is that I will be there with them even though I do not have all the answers.

Nurse: I still hate these questions that come from patients. I always will. I feel privileged to be asked but, at the same time, I never like them.

Oncologist: Such discussions are especially challenging, as physicians are often not trained in the area of providing reassurance. But we can sit and listen and even if we have no answers to a patient's questions, we can still provide comfort, which is healing.

Palliative Care Physician: In order for patients to really talk about these issues, they have to feel that they are in a safe place. Our struggle with patient fears reminds me of one of my favorite quotes: "A hero is a person who creates a safe place for others." One really needs to work to create that safe place.

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Children

Social Worker: I have found children to be very honest about death. Once you have done it a few times with kids, the part with grown-ups does not seem so bad, as they understand that I am going to take care of them. I have often thought that what would be the most frightening thing possible would be to have one of my kids die, but almost as bad, when they were little, was the idea that I would die and leave them and not do my job of taking care of them. I actually have seen people love their kids well through their very short lives, but a parent is never the same again after their child dies.

Psychiatrist: Many children don't reach a stage where they can discuss their death directly, but when they do it can be poignant. I had a 16-year-old patient who had recently received his driving license and discussed very specific things he wanted to own, such as a car. We talked about getting him a used car but he said he wanted "not just one car, but car after car after car." Another incident that comes to mind is a little girl who talked to me about how she had visited Disney and been on the Make a Wish holiday, but she wanted to be able to go back when she would be tall enough to go on every ride. Things like that can be difficult when someone has had such a short life and you have to grieve for what will never be. The same girl asked if heaven would be like the Garfield Christmas Special, where they put a hat on your head and whatever you wish for appears. I have never heard a child say that they are not looking forward to seeing a person on the other side, as they know they cannot manage alone when they have always been taken care of. Often, their biggest worry is that they won't be recognized.

Our struggle with patient fears reminds me of one of my favorite quotes: "A hero is a person who creates a safe place for others." One really needs to work to create that safe place.

Spiritual

Chaplain: What we need to address is whether people are experiencing fears about being dead or fears about the process of dying.

Nurse: Mrs. G was afraid to meet her relatives who were dead and who had caused her trouble in the past. One way to deal with this was to ask, "Do you believe there is any possibility that a relative might change after they die?" Usually they have some knowledge of the Bible or their particular belief and will say, "I've always thought about that." This causes them to think in another way and the afterlife can become less frightening.

Psychiatrist: Having a religious or spiritual background can make it easier for people, as most people who are spiritual, or religious, view humans as having mind and body dualism. In this kind of situation, you are lucky to view yourself in this way, because death is a separation between the spirit and physical being. Scientifically, it seems that way too, because when you watch somebody die the body is still there. It just helps if you have that view that the physical is going to be separated from your spirit so it does not matter if you are buried because there is a separation at that point.

Nurse: I do not think that having a spiritual tradition necessarily gives you an easy ride into the great beyond. For those patients, like Mr. A, who feel that they have not lived their lives well, their concept of God may emphasize a God of judgment rather than the God of love. The image of who that powerful other is very much frames their perspective of life after death, whether it is the warm embrace of the good shepherd or the place where they will get rid of all the bad apples. I think people struggle with that.

Chaplain: Sometimes the person does not believe that there is an afterlife and believes that when they die it is the end. The important thing is to find out what the patient believes in and then find out what his fears are, and see if there is anything that can be done in talking about it to explore the issues and ease the pain a little bit.

Discussion

" 'And Death shall be no more; Death, thou shalt die!' [In] the Westmoreland source of 1619…it reads 'And death shall be no more, death thou shalt die.' Nothing but a breath, a comma, separates life from life everlasting… With the original punctuation restored, death is no longer something to act out on stage with an exclamation mark.

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It is a comma, a pause. This way—the uncompromising way—one learns something from the poem wouldn't you say? Life, death, soul, God, past, present. Not insuperable barriers, not semicolons, just a comma [1]."

So soliloquizes the young Professor Bearing's mentor, Professor E.M. Ashford, in the Pulitzer Prize winning play *W;t*. The confident abandon standing in stark contrast to the play's portrayal of the tormented life and medicalized death of Vivian Bearing. For many postmodern souls, death is no comma, it is a terrifying wrench.

Dying

The clinical course of cancer has been characterized as a "living dying" experience where the individual and family attempt to maintain control and "normalize" everyday activities in the face of impending loss [2]. At the end, dying is an event beyond our comprehension and an experience that can only be imagined, fueling the fear of death and the dying process [3]. Whether a marine in Afghanistan or a patient wrestling with cancer, denial is the standard first line of defense. While hospice provides an environment where death and dying are dealt with in an open manner, many patients still limit explicit acknowledgment of the full implications of the threat. For both soldier and patient, heroes are cowards running forward. There is little evidence-based literature on dying, however, thanatology, the study of the dying process, examines the social and psychological aspects of death [4]. While this can be a season of life review, an opportunity to prepare for the end of life, to close old conflicts, to say goodbye, seek forgiveness, and fulfill life goals, it can still be a period of overwhelming distress. McGrath examined this in a recent study of hematological cancer survivors [5]. The patients, realizing that they may soon die, appreciated the opportunity to explore their lives, enhancing awareness about the fragility of life and their own mortality. They generally found that a spiritual framework for their illness was helpful and provided a way of viewing the experience as a new phase of life. Patients "mak[e] sense of living under the shadow of death," by letting go of losses and reassessing important values [6].

Kubler-Ross developed the Five Stage Model of Dying, which describes the psychological response to dying, while observing the dying in New York City and Chicago [7]. According to this theory, the dying person initially reacts to the news of an incurable disease by refusing to believe it and denying the reality of the situation. This is followed by the anger and bargaining stages, in which the person makes promises to themselves or God in exchange for more time to live. Next is depression and finally acceptance, if the individual is given enough time to work through his grief and sense of loss. This theory rapidly gained popular acceptance largely because it filled a void in health care theory. However, patients commonly oscillate among periods of calm, fear, hope, depression, anger, sadness, and withdrawal and can repeatedly block at transitions [8].

Physiology of Fear

Fear is a defense behavior basic to survival [9]. It is the body's autonomic response that prepares the body for "fight" or "flight" from a real or perceived threat. The response is coordinated by the hypothalamus and involves both neural networks and hormones, such as epinephrine and cortisol, in a classical sympathetic drive. Acutely, this may save a life, but it is thought that it is maladaptive when chronic or exhausted by repeated activation, as in a patient dying of cancer [10]. Specific fears may include: fear of extinction, the moment of death itself, the process of dying, pain, physical suffering, isolation, loss of control, disfigurement or becoming physically repulsive, being a burden, or facing the unknown [11, 12]. One study cited the most common anticipated fears as: pain, shortness of breath, and isolation [13]. Another study identified being pain free, being at peace, having their family present, being informed, and being mentally aware as most important [14].

The important thing is to find out what the patient believes in and then find out what his fears are, and see if there is anything that can be done in talking about it to explore the issues and ease the pain a little bit.

Fear of Death in Children

Children with terminal cancer often have a greater understanding of their situation than adults realize, with knowledge advancing with age and fears being specific to the phases of conceptual development. Patients up to the ages of 4–5 years often experience separation anxiety from their parents. This means that minimizing the death threat for them requires maintaining contact with parents and reassuring the child about the return of a parent who

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must leave for short periods [15]. From ages 6–10 years, the child develops fears of bodily injury and mutilation. The use of dolls to describe surgical procedures can neutralize some of these fears. Within this age range, parental discipline also becomes formalized in the child's primitive conscience. The child realizes that "good" is rewarded and "bad" deserves punishment. This may compound a feeling of guilt and the belief that the illness and death are punishment. It is important to explicitly remind the child that this is not the case. Terminally ill children 10 years of age and older may experience profound loneliness, much like an adult. The child may wonder what their own death will be like, if it will be painful, and if they will be left to face it alone. Children need encouragement to express and discuss specific fears [16–20].

Spiritual and Existential Issues

The effect of one's belief system on fear of death has been largely neglected in the thanatology literature [21]. Many patients with terminal diseases and their families have spiritual needs and belief systems that frame their perspective on death and dying. Knowledge of these issues is vital to comprehensive care [22]. People's religious beliefs give meaning and can, therefore, provide a larger framework than the immediate fear or crisis. This was illustrated in an examination of faith among 20 patients aged 37–74 years of age suffering from advanced cancer and receiving only palliative care [23]. The study used an interview with an open question about faith and was continued only if the patient signaled a clear wish to talk, 90% of whom did. Results showed that 85% believed in God and 75% reported that they prayed. None of the patients were observed to have raised levels of anxiety after the conversation and six requested meetings with religious leaders. The authors concluded that the sensitive encouragement of questions about faith during the treatment of patients with advanced disease was both safe and important. Block and Billings reviewed questions that can be asked of a dying patient [24]. These include asking the patient if he has a spiritual practice or belief and what role it plays in his life. Enquiring about connections to a particular religion or community, church or congregation, minister or priest, may also prove useful. Other pertinent lines of inquiry are an examination of whether religious or spiritual beliefs have influenced patients at this time or in their past, whether they believe in God or a supreme being, if they pray, and the nature of their beliefs regarding death and the afterlife. Such questions encourage patients to provide specific information about their fears and their expectations about end-of-life care. Religious and spiritual beliefs have generally been thought to be helpful when examined within theoretical models of stress and coping, suggesting that having strong religious and spiritual beliefs may decrease the likelihood of suffering from stress [25]. A specific examination of the role of spirituality in psychological adjustment to cancer suggests that spirituality is related to emotional well-being and quality of life and is associated with a reduced level of distress [26].

At the end, dying is an event beyond our comprehension and an experience that can only be imagined, fueling the fear of death and the dying process.

Rabbi Harold Kushner read from Isaiah at President Reagan's funeral. Well known for his book *When Bad Things Happen to Good People*, he is an able commentator on finding meaning in disaster and loss. His most recent book, *The Lord is My Shepherd, Healing Wisdom of the Twenty-Third Psalm*, was prompted by the events of September 11, 2001 [27]. In the days following the attacks on New York and Washington, everyone was asking, "Where was God that Tuesday?" "How could God allow that to happen?" The answer he gives is that God's promise was never that life would be fair, that a "me"-obsessed idol would charm our lives. God's promise was that when it is our turn to confront the unfairness of life, we will be able to handle it because he will be on our side; quoting psalm 23 verse 4, "Even though I walk through the valley of the shadow of death, I will fear no evil for thou art with me." The fear of death and our very reasonable self-pity can only be trumped by a greater love, or a greater fear. Helen Rosevere took this challenge further in her book *Living Sacrifice* [28]. Dr. Rosevere, a missionary in Congo, wrote, after being beaten and raped, "God asks that you trust him with this experience, even when you're not told why." Many of us will not face her experience, but all of us will face the experience of death. Lydia Kang, M.D., beautifully describes her attempts to connect with and console a devastated man making the transition to hospice who "simply won't stop crying." Beyond any words just trying to help, just sitting there, just being there, and bearing witness to the suffering, ensure that the man is no longer alone [29].

Freud and Lewis

Dr. Armand Nicholi compared the views of Sigmund Freud, an atheist throughout his life, with those of C.S. Lewis, who converted from atheism to Christianity halfway through his

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life, in the book *The Question of God* [30]. Both suffered great losses during their lives. For Freud, this was in the form of the death of his nanny who had acted as surrogate mother when he was a little boy, an experience that haunted his dreams into adulthood. He later lost, through death, a favorite daughter and a grandson. His own extreme fear of death was also exacerbated by his experiences with cancer of the palate for the last 16 years of his life. In his writing, he expresses the view that, in the deepest recesses of our minds, "Each one of us is convinced of his own immortality" and that "if you want to enjoy life, prepare yourself for death." However, Freud became obsessed with death and suffered repeated attacks of "Todenangst," the dread of death, which his doctor suggested was to an obsessive degree. Perhaps in a final attempt to control death and perhaps to reduce his fear of it, Freud requested that a physician friend euthanize him by injection in 1939.

C.S. Lewis lost his mother to cancer when he was just 9 years of age and was almost immediately sent abroad to boarding school by his father who could not deal with the grief. Lewis further encountered death during the war, when he noted that a positive aspect of such an experience was that it makes people more aware of their own mortality. The loss of his beloved wife to cancer seriously shook Lewis' faith, although he later gained a greater confidence to face death. A fellow faculty member commented close to Lewis' death, "Never has a man been better prepared." Dr. Nicholi suggests in his analysis that the views of Freud and Lewis represent conflicting aspects of everyone: the private self that yearns for a relationship with a source of love, joy, hope and happiness and another part that raises its fist in defiance and rebelliousness and says, "I will not surrender" [30].

Physician participation in the dying process challenges emotional resources and medical skills, but professional satisfaction can be gained in helping orchestrate a "good death" by relieving suffering, a vital component of good medicine.

Terror Management Theory

Freud's psychodynamic model and "Griefwork" emphasizes confronting the grief in order to accept the reality of the loss on both an emotional and an intellectual level and "letting go" of human attachments, a process viewed as facilitating change and reintegration into society [31]. Failure to let go is thought to result in longer-term misery and dysfunction. Building on this theory, Bowlby examined the effect of grief on personal attachments [32]. Bowlby interpreted grief as a result of our biological need for security in the face of danger, and when anticipating loss, we most effectively let go of attachments through repeated engagements with those we love [33].

Terror management theory (TMT) is based on Becker's premise that all humans are driven toward survival while simultaneously being aware of their inevitable mortality [34]. TMT asserts that socialization into a cultural worldview that lends rationality and predictability in the face of an adversarial universe provides protection against fear of death by the creation of standards and values for a meaningful life and ways to transcend death. By meeting these expectations, an individual attains greater self-esteem through feelings of increased self-worth and the promise of immortality [35]. Literal immortality is thought of as a noncorporeal aspect of the individual living on indefinitely in some way, in line with religious beliefs concerned with the afterlife. Metaphorical immortality, as suggested by TMT, is that the loved one, or the valued ideal, lives on in our hearts or with some posthumous epitaph. TMT suggests that the commonest defense mechanisms are distraction, distancing, and denying vulnerability [36, 37]. TMT investigators have reported a greater degree of fear of death among college students with low self-esteem, AIDS patients with less family support, and individuals with poorer physical and mental health [38, 39]. Patients with cancer may find it easier to cope given a "roadmap" of common anxieties: the fear of pain and suffering, loneliness, and the unknown [40]; or emotional responses to significant threats: anxiety, fear, depression, and anger [41].

Psychiatric Issues

Social anxiety disorder (SAD) is a social phobia that takes the form of a chronic anxiety disorder. Sufferers avoid specific social situations, such as eating and speaking in public, or more commonly, a variety of social situations, because of fear of negative social evaluation [42]. SAD typically operates in a "phobic cycle" that becomes increasingly distressing and debilitating over time, which can manifest itself in physical symptoms such as blushing,

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sweating, and palpitations. Selective avoidance of social situations, such as discussing problems with a physician, may reduce some distress but leaves underlying fears latent [43]. One form of anxiety that may cause extreme distress is panic disorder. It manifests itself in numerous ways, beginning with discreet episodes of intense fear termed "panic attacks," which can involve a variety of symptoms including cardiopulmonary (chest pain, palpitations), autonomic (sweating, chills), neurological (feeling dizzy, parasthesias), or psychiatric (depersonalization, fear of losing control or fear of death) symptoms [44]. Panic disorder is treated with pharmacologic treatment or cognitive behavioral therapy, the latter involving the gradual extinction of the response to increasing exposure to the threat.

Becker's work on dying suggested that the terror of death is so overwhelming to us that we understandably try to keep it in our unconscious [34]. He believes that we borrow ideals from those we look up to (such as child to father) and create a personality by internalizing the qualities we perceive as positive and use this "character armor" as a defense mechanism to pretend the world is manageable.

Caregiver Emotions

Physician participation in the dying process challenges emotional resources and medical skills, but professional satisfaction can be gained in helping orchestrate a "good death" by relieving suffering, a vital component of good medicine [45]. Despite this, clinicians may avoid the distressing experiences of helping the dying and deprive the patient of the best possible care [46]. Doctors still often feel that a patient's death is a personal failure, which can cause the physician to withdraw. These Schwartz Rounds are one forum in which caregivers are encouraged to appreciate the satisfying opportunity they have to provide patients with comfort and support and realize that they can learn a great deal about both the clinical and human aspects of medicine from dying patients [47]. Caring physicians have been said to exhibit two primary attributes—receptivity and responsibility—which they translate into excellent clinical practice. Some exude a professional "detached concern" [48]. Whatever the style, active listening is therapy for the patient, while, for the clinician, it is a remarkable opportunity to learn how people make sense of their lives and the crisis of approaching death [46].

Conclusion

For a physician to provide exemplary care to patients experiencing fear of death, they must learn how to sit and support someone who is terrified of what lies before them. This involves emotional investment in a relationship despite one's own distress and doing everything possible to alleviate distress or pain. With this connection, structured support can be provided and the individual can be allowed to grieve for those they will miss, helping them to bear their suffering. Empathy and taking the time to be present and listen to the patient are some of the most important aspects of caring for the dying patient and provide a fulfilling role for the team who share the journey.

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The fear of death is a common cause and effect of anxiety, and even those without anxiety often experience this fear in some ways. This article will examine the fear of dying as it relates to anxiety and find solutions for managing it. Death is a Natural Fear. It should be noted that death is more of a universal fear. You can have a fear of death without having an anxiety disorder since death is something that most people are naturally programmed to fear for the sake of evolution and the survival of the human race.