Coronavirus Fear and Life Quality Perceptions of COVID-19-Positive Patients' Spouses

COVID-19 Pozitif Hasta Eşlerinin Koronavirüs Korkusu ve Yaşam Kalitesi Algıları

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Abstract

This study was conducted to determine the fear of coronavirus and quality of life perceptions of the spouses of patients diagnosed with COVID-19 who were treated and discharged. This cross-sectional-descriptive study was conducted with the spouses of 111 patients who were diagnosed with COVID-19 in a district state hospital and were treated and discharged. Data were collected with the Patient Spouse Identification Form, the COVID-19 Fear Scale, and the WHOQOL BREF 27 Quality of Life Scale. Data were evaluated by percentage, arithmetic mean, standard deviation, t test, Mann Whitney-U test, Kruskal-Wallis test and Pearson Correlation coefficient. The mean COVID-19 Fear scale score of the participants was 16.92 ± 6.20. A statistically significant difference was found between the education level, chronic disease status, hospitalization period of the spouse, and knowledge of the new type of coronavirus and the quality of life sub-dimensions mean scores of the participants. As individuals' fear levels increase, the quality of life psychological health sub-dimension score decreases.

Keywords: COVID-19, fear, spouses, life quality.

Öz

Bu çalışma COVID-19 tanısı alan tedavisi ve taburculuğu gerçekleşen hasta eşlerinin koronavirüs korkusu ve yaşam kalitesi algılarını belirlemek amacıyla yapılmıştır. Kesitsel-tanımlayıcı türdeki bu araştırma bir ilçe devlet hastanesinde COVID-19 tanısı alan tedavisi ve taburculuğu gerçekleşen 111 hastanın eşi ile yürütülmüştür. Veriler Hasta Eşi Tanıtım Formu, Kovid-19 Korkusu Ölçeği, WHOQOL BREF 27 Yaşam Kalitesi Ölçeği ile toplanmıştır. Veriler yüzdelik, ortalama, standart sapma, t testi, Mann Whitney-U testi, Kruskal Wallis Varyans analizi ve Pearson Korelasyon katsayısı ile değerlendirilmiştir. Katılımcıların Kovid-19 Korkusu ölçek puan ortalaması 16.92 ± 6.20'dir. Katılımcıların eğitim durumu, kronik hastalık durumu, eşin hastanede yatış süresi ve yeni tip koronavirüs bilgisinin olması durumu ile yaşam kalitesi alt boyut puan ortalamaları arasında istatistiksel olarak anlamlı saptanmıştır. Bireylerin korku düzeyleri arttıkça yaşam kalitesi psikolojik sağlık alt boyut puanı azalmaktadır.

Anahtar Kelimeler: COVID-19, eşler, korku, yaşam kalitesi.

1. INTRODUCTION

Ongoing COVID-19 is a severe acute respiratory syndrome disease that has swept the world, with the first case reported in China in 2019. There have been 769.369.823 confirmed COVID-19 cases, with 6.954.336 deaths reported globally to the World Health Organization on August 9, 2023. From January 3, 2020 to August 9, 2023, 17.004.677 confirmed COVID-19 cases with 101.419 deaths were reported from Turkey (WHO, 2023). It is important to develop effective public health strategies and take the necessary measures to control the situation during pandemic periods (Alyami et al., 2021; Harper et al., 2021). Various mandatory measures have been taken in almost every country in this process. In order to prevent the spread of coronavirus in Turkey, decisions have been taken to close public places such as schools, shopping malls, entertainment centers, cinemas, and sports halls. On the other hand, people under the age of 20, over 65, and individuals with chronic diseases were asked to participate in home quarantine practices to protect themselves (Harper et al., 2021; Satici et al., 2021). Since COVID-19 is contagious and fatal, taking these measures caused significant physical and mental health problems in individuals (Aksoy et al., 2021; Ekiz et al., 2020; Satici et al., 2021). During epidemic periods, it is common to experience many negative emotions (guilt, anxiety, intense fear, panic, anger, anger, helplessness, and hopelessness). Fear is experienced in the form of losing livelihoods, not being able to work during isolation, being dismissed from work, being quarantined and socially excluded in case of diagnosis, being counted from the group that is the source of the disease, getting the disease and dying, losing loved ones due to the virus, and being separated from loved ones with quarantine practice (Ahorsu et al., 2022; Çelik and Öztürk, 2023; Gencer, 2020). People refused to take care of unaccompanied children, the elderly, or disabled people for fear of being infected, and felt helplessness, boredom, loneliness, and depression due to isolation (Belen and Yıldız, 2022; Demir and Ateş, 2023). Studies have shown that uninfected people are afraid of contact with people infected with COVID-19 (Çıbık et al., 2022).

Due to the high morbidity and mortality of COVID-19, the fear experienced by individuals may negatively affect their quality of life (Sertdemir and Tok Özen, 2022). Quality of life includes individuals' perception of physical and mental health, their interactions with each other, health risks and conditions, functionality and social support, socioeconomic status, and resources, conditions, policies, and practices that affect the perception of health and functionality of society (CDC, 2000). Quality of life consists of many elements, such as physical diseases, mental factors, social relations, physical environment, and stigmatization, and affects life significantly (Aydıner Boylu and Paçacıoğlu, 2016). Studies have shown that quality of life is affected by age, gender, education, income, marital status, health, social support, characteristics of housing, quality of work life, and leisure time (Aydıner Boylu and Paçacıoğlu, 2016). The COVID-19 pandemic brought along situations such as uncertainties and chaos, changing and restricted daily life flow with the measures taken and bans imposed, the contagious rate of the disease, its severe course and fatal outcome, stigmatization and blaming, and exclusion, and it was observed that all of the psychological reactions expected after trauma were experienced during this epidemic period (Ekiz et al., 2020; Demir and Ateş, 2023). COVID-19 fear and quality of life have been mostly researched on healthcare professionals and patients in the literature, and it has been examined in many studies that it has important psychological consequences, increased risk of contracting COVID-19 due to close contact with infected patients, fear of transmitting the infection to family and colleagues, and fear of death due to increased COVID mortality (Stefanatou et al., 2022). However, there is no study in the literature investigating the fear of COVID-19 and the quality of life of patient relatives. During pandemic periods, it should be investigated who are the most affected people in society and how much support they need. In a Mexico-based study investigating the quality of life of patients with rheumatic diseases during the COVID-19 pandemic, it was found that factors such as depression, anxiety, age, and the economic impact of COVID-19 affected the quality of life of patients (Guaracha-Basanes et al., 2022). In the study conducted on children with disabilities during the pandemic, it was concluded that children with disabilities had a lower quality of life compared to children with normal development and that the quality of life increased by increasing physical activities (Nedim and Gürşan, 2023). Studies have found that the relationship between fear of COVID-19 and quality of life is negative (Aksoy et al., 2021; Sertdemir and Tok Özen, 2022; Taspinar et

al., 2021). This study was conducted to determine the fear of coronavirus and quality of life perceptions of the spouses of patients diagnosed with COVID-19, whose treatment and discharge were completed.

Research questions:

- What are the participants' opinions on spouse and social relationships?

-What is level of the coronavirus fear among the spouses of COVID-19 patients diagnosed, treated, and discharged?

-What are level of quality of life sub-dimensions among the spouses of COVID-19 patients diagnosed, treated, and discharged?

-What are the factors affecting the COVID-19 fear and quality of life sub-dimensions of the spouses of COVID-19 patients diagnosed, treated, and discharged?

-Is there a relationship between coronavirus fear and quality of life sub-dimensions of the spouses of COVID-19 patients diagnosed, treated, and discharged?

2. METHODS

2.1. Design and Participants

This cross-sectional descriptive study was conducted in a district center between July 15, 2020, and September 20, 2021. The population of this study consisted of the spouses of patients diagnosed with COVID-19, treated and discharged in a district state hospital. The spouses of patients over 18 years old who had no communication problems and voluntarily agreed to participate were included in the study. The "G. Power-3.1.9.2" program was used and calculated after the data collection phase to determine whether the sample size was sufficient at an 80% confidence level. Accordingly, the effect size of the study was calculated based on the explanatory power through the regression analysis model. The minimum effect size for the study was 0.146, and the power of the study was determined as 0.95. According to Cohen, the minimum value for post-hoc power analysis is 0.67 (Cohen, 2023). In the study, it was determined that a sufficient number of samples was reached with 111 participants.

2.2. Data Collection Method and Data Collection Tools

Study data were collected with a total of three forms, including "Patient's Spouse Introduction Form, Fear of COVID-19 Scale, WHOQOL BREF 27 Quality of Life Scale (WQQLS)", which included the socio-demographic characteristics of the patient's spouse, and the variables related to the experiences of the spouse after the diagnosis of COVID-19.

The researcher developed the Patient Spouse Information Form by reviewing the relevant literature (Alyami et al., 2021; Ekiz et al., 2020; Harper et al., 2021). The Patient Spouse Information Form consists of two sections and 26 questions, including ten questions about the socio-demographic characteristics of the spouses of the patients participating in the study (age, gender, income, education, professional and marital status, family type, with whom they live, chronic disease status) and 16 questions including information about the COVID-19 process (time of receiving COVID-19 diagnosis, receiving COVID-19 diagnosis in the family/neighbor, COVID-19 knowledge, economic problems). Participants' opinions on spouse and social relationships were evaluated with two closed-ended questions in this form. These are: How were your relationships affected after your spouse's COVID-19 disease? and How was your social life situation affected after your spouse's COVID-19 disease?

The Fear of COVID-19 Scale was developed by Ahorsu et al. (2022) (Ahorsu et al., 2022) as a 7-item, 5 Likert-type (1= Strongly disagree, 5= Strongly agree) unidimensional scale. The lowest score is 1, and the highest score is 5. The total score is calculated by summing each item's score (minimum, maximum points). The higher the score, the higher the fear of COVID-19 is considered. The original scale had factor loadings (.66 to .74)

and adjusted item-total correlations (.47 to .56). Cronbach's alpha was 0.82. The internal consistency and test-retest reliability of the scale are α = .82 and ICC = .72 (Ahorsu et al., 2022). The Turkish adaptation study of the Fear of COVID-19 Scale was conducted by Satici et al. (2021), and Cronbach alpha, McDonald Omega, Guttmann lambda, and composite reliability were evaluated, and the total scale reliability coefficient was found to be .84 (Satici et al., 2021). In this study, the Cronbach's alpha value of the COVID-19 Fear Scale was calculated as α=.91.

WHOQOL BREF 27 Quality of Life Scale (WQQLS) is a 26-question shortened form of the original 100-question World Health Organization Quality of Life Scale (WHOQOL) developed by WHO. The scale consists of 5-point Likert-type physical health, psychological health, social relationships, and environmental area sub-dimensions. The scale has no total score; higher scores indicate a better quality of life. The first two questions in the scale are general; the scores of these questions are not included in the sub-dimension scores but are evaluated separately. The validity and reliability of the scale were performed by Eser et al. (1999) (Eser et al., 1999), and the WHOQOL-BREF-TR 27 form was created by adding one question. In this study, the Cronbach Alpha values of WHOQOL BREF 27 Quality of Life Scale were found to be .89 for the physical health sub-dimension, .78 for the psychological health sub-dimension, .85 for the social relationships sub-dimension, and .56 for the environmental area sub-dimension.

2.3. Data Analysis

The data were analyzed in the SPSS 22.0 (Statistical Package for the Social Sciences) program. In the analysis, parametric tests were applied to the distribution whose skewness coefficient was within the limits of +, - 1. The data were analyzed at a 95% confidence interval and 0.05 statistical significance level. Data were analyzed using percentage, mean, standard deviation, t-test, Mann Whitney-U test, Kruskal-Wallis test Pearson Correlation. When Kruskal-Wallis test was significant, the post hoc the corrected Mann–Whitney U-test was used to determine the difference. The correlation relationship was interpreted as r:0.00-0.30=weak, r:0.31-0.49=medium, r:0.50-0.69=strong, r:0.70-0.10=very strong relationship (Tavşancıl, 2002).

2.3.1. Dependent and independent variables in the study

The dependent variables of the study were the fear and quality of life sub-dimensions perception scores of the spouses of patients diagnosed with COVID-19, treated, and discharged. The study's independent variables were gender, educational status, presence of chronic disease, duration of hospitalization, and knowledge about COVID-19 disease of the spouses of patients diagnosed with COVID-19, treated and discharged.

2.4. Ethical Aspects of The Study

Permission was obtained from the Ministry of Health Scientific Research Platform, a University Clinical Research Ethics Committee (20-KAEK-183), and a district state hospital administration to conduct the study. The researcher completed the data through telephone interviews with the spouses of the patients who agreed to participate in the study, whose verbal consent was obtained, and who took the time to answer the questions. It took approximately 20 minutes to answer the questions.

3. RESULTS

Demographic characteristics of the spouses of the patients who participated in the study are presented in Table 1. The mean age of the participants was 53.99±14.67 years; 53.3% were male, 38.7% were housewives, 44.1% were primary school graduates, 70.3% had income equal to expenses, 95.5% were nuclear families, 55% lived with their spouses, and 62.2% did not have any chronic disease (Table 1).

Table 1. Participants' Demographic Characteristics (n=111).

Characteristics		**X̄ ± SS**	
Age (Min=25 Max=85)		53.99±14.67	
		Number	**%**
Gender	Female	53	47.7
	Male	58	53.3
Occupation	Worker	10	9.0
	Officer	26	23.4
	Retired	23	20.7
	Housewife	43	38.7
	Other (Tradesmen, Farmer)	9	8.1
Education	Illiterate	18	16.2
	Primary education	49	44.1
	High school and equivalent	17	15.3
	University	27	24.3
Income Status	Income equal to expenditure	78	70.3
	Income less than expenditure	24	21.6
	Income more than expenditure	9	8.1
Family Type	Nuclear	106	95.5
	Extended	5	4.5
People he/she lives with	Spouse	61	55.0
	Spouse and Children	50	45.0
Presence of chronic disease	Yes	42	37.8
	No	69	62.2
	Total	**111**	**100.0**

Table 2 presents the characteristics of the participants related to COVID-19. The duration of hospitalization of 50.5% of the participants' spouses was between 1-5 days, 43.2% had a history of COVID-19 disease in their family other than their spouses, 93.7% were isolated due to COVID-19, 29.7% had a history of COVID-19 disease in their neighbors, and 84.7% had information about the new type of coronavirus. Most participants (90.1%) received information about COVID-19 from the media. It was found that 19.8% of the participants reported experiencing changes in family relationships during the process of being diagnosed with COVID-19, 63.1% reported not working during COVID-19, and 27.9% reported experiencing economic problems due to the pandemic. Among the participants, 26.1% defined the most difficult situation due to COVID-19 as longing for family. In this process, 14.4% of the participants wanted to receive information about the disease, medication, and vaccines. Among the participants, 6.3% perceived their level of anxiety about their health as "very," and 71.2% perceived their general health as "good" (Table 2).

Table 2. Participants' Characteristics Regarding COVID-19 (n=111).

Characteristics		**n**	**%**
Duration of spouse's hospitalization	0 days (outpatient discharge)	28	25.2
	1-5 days	56	50.5
	6 days or more	27	24.3
Family history of COVID-19 disease in someone other than the spouse	Yes	48	43.2
	No	63	56.8
Isolation due to COVID-19	Yes	104	93.7
	No	7	6.3
History of COVID-19 disease in a neighbor	Yes	33	29.7
	No	78	70.3
Knowledge status about COVID-19 disease	Yes	94	84.7
	No	17	15.3
Where to get information about COVID-19 disease*	Health professional	39	35.1
	Friends, relatives, environment	54	48.6
	Media (TV, radio, newspaper)	100	90.1
	Internet	42	37.8
Changes in family relationships during the process of being diagnosed with COVID-19	Yes	22	19.8
	No	58	52.3
	Little	31	27.9
Working status in the COVID-19 process	Not working	70	63.1
	Working at home	4	3.6
	Rotational work	5	4.5
	Just like before the pandemic,	30	27.0
	Unemployment during the pandemic	2	1.8
Economic problems due to the pandemic	Yes	31	27.9
	No	80	72.1
The most difficult situation so far due to COVID-19*	Longing for family	29	26.1
	Economic distress	20	18.0
	Social withdrawal	18	16.2
	Fear of getting sick	18	16.2
	Overwhelm/psychological distress at home	17	15.3
	Dismissal/workplace closure	5	4.5
Subject for which support is requested due to COVID-19*	Getting information (disease, medicine, vaccination)	16	14.4
	Psychological support	14	12.6
	Economic support	11	9.9
Level of anxiety about his/her current health	No	39	35.1
	Little	40	36.0
	Middle	25	22.5
	Much	7	6.3
General perception of health at present	Good	79	71.2
	Middle	31	27.9
	Bad	1	0.9
	Total	111	100.0

* % is taken over n.

Table 3 presents the opinions of the participants about their spouses and social relationships after COVID-19 disease. While the rate of experiencing difficulties with their spouses in this process was (2.7%), it was reported that the most planned social activities were abandoned (86.5%), people around tried to help meet the needs (57.7%), and most of the time everything continued as before (71.2%).

Table 3. Participants' Opinions on Spouse and Social Relationships (n=111).

	Yes		No		Little	
	n	%	n	%	n	%
1. My spouse and I have become more attached to each other	49	44.1	43	38.7	19	17.1
2. We started to fight more, there was more unrest at home	-	-	108	97.3	3	2.7
3. My spouse has turned cold to me	-	-	108	97.3	3	2.7
4. I had no problems; everything continued as before	79	71.2	2	1.8	30	27.0
5. I gave up the social activities I had planned	96	86.5	12	10.8	3	2.7
6. I was afraid to tell people around me about my spouse's illness	2	1.8	108	97.3	1	0.9
7. I hid the fact that my spouse was sick from people around me	-	-	110	99.1	1	0.9
8. People around me distanced themselves from us when they learned about my spouse's illness	5	4.5	101	91.0	5	4.5
9. People around me tried to help me when I needed it	64	57.7	20	18.0	27	24.3
10. I had no problems; everything is going on as before	79	71.2	6	5.4	26	23.4

Table 4 compares the mean COVID-19 Fear and Quality of Life Sub-dimensions Scores of some descriptive and COVID-19-related characteristics of the participants. The mean score on the participants' Fear of COVID-19 scale was 16.92±6.20. The mean scores of the participants in the sub-dimensions of the WHOQOL-BREF-TR were 24.23±4.92 in the physical health, 20.45±3.20 in the psychological health, 28.63±6.05 in the environmental area and 9.26±2.81 in the social relationships (Table 4). There was no statistically significant difference between the participants' gender, educational status, chronic disease status, duration of spousal hospitalization, and knowledge of novel coronavirus and the mean score of Fear of COVID-19 ($p > 0.05$; Table 4). No statistically significant difference existed between the participants' gender status and the mean quality of life sub-dimensions scores ($p > 0.05$; Table 4). A statistically significant differences was found between the quality of life sub-dimensions mean scores and the participants' educational status, chronic disease status, duration of spouse hospitalization (except for psychological health), and knowledge of the new type of coronavirus ($p < 0.05$; Table 4).

Table 4. Comparison of Participants' Some Descriptive and COVID-19-Related Characteristics with COVID-19 Fear and Quality of Life Sub-dimensions Scores

			WHOQOL-BREF-TR							
Characteristics	**COVID-19 Fear X̄±SD**	**Test**	**Physical Health X̄±SD**	**Test**	**Psychological Health X̄±SD**	**Test**	**Social Relationships X̄±SD**	**Test**	**Environmental Area X̄±SD**	**Test**
All Participants	16.92±6.20		24.23±4.92		20.45 ± 3.20		9.26 ± 2.81		28.63 ± 6.05	
Gender										
Female	17.64±6.48	t=1.177	24.15±4.29	t=-.153	20.60±3.00	t:.480	9.19±2.59	t:-.260	28.47±4.18	t:-.263
Male	16.26±5.90	p=.242	24.29±5.47	p=0.879	20.31±3.40	p:0.632	9.33±3.01	p:0.796	28.78±7.40	p:0.793
Education level										
Illiterate	15.61±4.72		21.28±3.59[a]		18.72±1.56[a]		6.83±1.47[a]		25.17±2.48[a]	
Primary-middle school	17.98±6.29	KW=3.550 p= 0.314	22.94±4.48[ab]	KW=26.661 **p=0.000**	19.08±2.89[ab]	KW=43.695 **p=0.000**	8.20±2.69[a]	KW=48.012 **p=0.000**	26.90±4.52[ab]	KW=35.931 **p=0.000**
High school and equivalent	16.71±5.28		25.65±5.37[bc]		21.18±2.88[c]		10.88±2.03[b]		29.82±3.56[bc]	
University	16.00±7.31		27.63±4.07[c]		23.63±2.20[d]		11.78±1.22[b]		33.33±8.22[c]	
Chronic disease status										
Yes	17.29±6.19	t=.485	21.93±4.47	t:-4.105	18.98±2.69	t:-4.036	7.81±2.65	t:-4.633	26.43±4.48	t:-3.106
No	16.70±6.24	p=.629	25.62±4.73	**p:0.000**	21.35±3.18	**p:0.000**	10.15±2.53	**p:0.000**	29.97±6.51	**p:0.002**
Duration of spouse's hospitalization										
0 days	16.75±6.59	KW=0.476	25.29±4.94[a]	KW= 7.660	21.32±3.04	KW= 4.696	10.82±2.33[a]	KW=12.314	30.32±4.39[a]	KW=22.171
1-5 days	17.11±6.32	p=0.788	24.75±4.89[a]	**p=0.022**	20.38±3.37	p=0.096	8.96±2.61[b]	**p=0.002**	28.57±7.24[a]	**p=0.030**
6 days and above	16.70±5.72		22.04±4.42[b]		19.70±2.89		8.26±3.06[b]		27.00±4.27[b]	
State of knowledge about COVID-19 disease										
Yes	17.01±6.41	Z=-.173	24.80±4.87	Z:-2.973	20.81±3.19	Z: -2.897	9.60±2.80	Z: -3.012	29.20±6.26	Z: -2.851
No	16.41±5.00	p=0.862	21.06±4.02	**p: 0.003**	18.47±2.53	**p: 0.004**	7.41±2.03	**p:0.003**	25.47±3.41	**p:0.004**

SD: Standard deviation, t: Student's t test, Z: Mann-Whitney U test, KW: Kruskal-Wallis assumption analysis, The common upper index indicates a significant difference.

According to the result of pearson correlation analysis performed to examine the relationship between fear of COVID-19 and Quality of Life Sub-dimensions Scores in Table 5, weak but significant inverse correlations were found between COVID-19 and only the psychological health Quality of Life Sub-dimensions Scores [r = - 0.249; p < 0.01] (Table 6).

Table 5. Pearson correlation coefficients between COVID-19 Fear and Quality of Life Sub-dimensions Scores of participants

		COVID-19 Fear	**Physical Health**	**Psychological Health**	**Social Relationships**	**Environmental Area**
COVID-19 Fear	p	1	-.160	**-.249***	-.068	-.166
	p		.092	**.008**	.479	.081
	n	111	111	111	111	111

*p < 0.01 p: Sig. (2-tailed) r: Pearson Correlation

4. DISCUSSION

The COVID-19 pandemic is a chaotic process that involves uncertainty, anxiety, fear, and stress for the patient, his/her family, and his/her environment, with many changes in the physical, mental, and economic context (Alyami et al., 2021; Demir and Ateş, 2023; Gencer, 2020). In this process, family members faced the risk of illness, the possibility of losing the patient, and the burden of loss (Ayakdaş Dağlı et al., 2020; Ekiz et al., 2020). Considering the importance of this process in which families need multidimensional care, this study was conducted to determine the fear of coronavirus and quality of life perceptions of the spouses of patients diagnosed with COVID-19, treated and discharged.

In the study, the participants experienced low rates of distress (withdrawal from their spouses, restlessness, etc.) with their spouses after the COVID-19 disease. Among the measures taken to control the outbreak during the pandemic period are decisions such as closing schools, shopping malls, cinemas, and sports halls (Satici et al., 2021). In this direction, in our study, it was found that the participants largely gave up their plans for their social lives. Similarly, studies have been conducted in which it was concluded that most participants preferred not to leave the house much, communication with people in their social environment was negatively affected, and social activity decreased (Basgun and Dogan, 2024; Li et al., 2023). When an unpredictable situation such as an epidemic occurs, people's sense of fear and panic, protection, and avoidance behaviors are considered natural reactions (Alyami et al., 2021; Gencer, 2020). The COVID-19 pandemic surrounding the world can be considered as a factor affecting social change.

Looking at the findings of COVID-19 fear in this study, it was determined that the participants experienced moderate fear of coronavirus. Similar findings are found in previous studies. In a study examining individuals' fear of coronavirus, fear of COVID-19 was found to be moderate (Aksoy et al., 2021; Çelik and Öztürk, 2023; Gencer, 2020). It has been determined that society's anxiety levels are high and the quality of life is low due to the new coronavirus (Şanlıtürk and Ardıç, 2022). There was no statistical significance between the participants' gender, educational status, chronic disease status, duration of hospitalization of the spouse, and lack of knowledge of the new type of coronavirus and the mean score of fear of COVID-19 in this study. When evaluated in terms of total score, it was found that the fear of COVID-19 was high in women, and there are findings supporting these results in the national and international literature, as well as studies in which a significant difference was found between gender, education level and presence of chronic disease and fear of COVID-19 (Aksoy et al., 2021; Alothman et al., 2021; Gencer, 2020; Şavkın et al., 2022; Tavşancıl, 2002). It has been determined that demographic characteristics such as age, gender and profession have an impact on anxiety and quality of life coronavirus (Şanlıtürk and Ardıç, 2022). These conflicting results can be explained by the differences in the study groups and cultural characteristics and the lack of sufficient data on the new medical phenomenon of coronavirus.

Quality of life is a concept that has been in our lives for a long time. With the developments in human rights, quality of life has become an important indicator and a universal goal that societies aim to achieve. We can define quality of life as income, education, occupation, health, the condition of the dwelling where one lives, and satisfaction with the opportunities one has. In this study, relationships with other people, social support and sexual life were examined and the score of the social health sub-dimension of quality of life was found to be lower than the results of other studies, while other sub-dimensions were found to be higher (Aksoy et al., 2021; Ciddi and Yazgan, 2020). Individuals' spouse and family relationships and the support of their social environment outside the family are important in terms of quality of life. In our study, the social sub-dimension of quality of life can be considered moderate. The study found a statistically significant difference between the mean quality of life sub-dimensions scores and the participants' educational status, chronic disease status, duration of hospitalization of the spouse (except for psychological health), and knowledge of the new type of coronavirus. As a result of further analysis, the mean quality of life scores of illiterates, those with chronic diseases, those with a spouse hospitalized for six days or more, and those without knowledge of the new coronavirus were lower, and the difference between them was statistically significant. A study conducted in Estonia found that the higher the level of education, the higher the quality of life (Tamson et al., 2022). Considering that individuals with low education levels have low health literacy, it is not possible for them to access accurate information about the virus. It has been shown that the quality of life of patients with chronic diseases is affected in the COVID-19 epidemic. Those with chronic health problems are among the vulnerable groups with lower quality of life during the pandemic (Algahtani et al., 2021; Samlani et al., 2020). However, the extraordinary intensity of health institutions has significantly neglected this vulnerable/fragile/disadvantaged group. In addition to these reasons, the severe clinical course of COVID-19 in patients with chronic diseases is thought to be the explanatory result of the finding of low quality of life in patients with chronic diseases in our study. The results of previous studies align with the study findings (Algahtani et al., 2021; Guaracha-Basáñez et al., 2022; Qiu et al., 2020). In a study, it was found that hospitalization and length of hospitalization were independent of gender and that individuals with chronic diseases, smokers, and individuals with weak immune systems had longer hospitalization periods (Guven et al., 2023). Our study found that the mean quality of life sub-dimensions scores of those who had no knowledge of the novel coronavirus was lower. When the literature is examined, parallel results are seen between quality of life and the level of knowledge of the new type of coronavirus (Pribadi et al., 2021). In a study, nurses diagnosed many of the inpatient COVID-19 patients as lacking knowledge. Individuals experience anxiety and fear due to a lack of information (Ünsal and Saatçi, 2023). Fear and anxiety about COVID-19 are due to lack of information. It can be thought that it happened because of this. Therefore, it is important for nurses to use their educator and consultant roles in epidemic situations such as this.

Uncertainties cause anxiety in individuals. We can say that the ability of individuals experiencing stress, anxiety, and fear to cope with crises decreases. This can directly lead to a decrease in quality of life. In this study, the change in the participants' quality of life can explained by their fear of COVID-19 disease. As the fear levels of individuals increase, their quality of life psychological health levels decrease. Previous studies found that quality of life was negatively affected as the fear of COVID-19 increased (Aksoy et al., 2021; Sertdemir and Tok Özen, 2022; Taspinar et al., 2021). In a study, it was found that those who experienced high levels of anxiety had low quality of life and negatively affected their physical and mental health (Şanlıtürk and Ardıç, 2022). Social relationships items assessing the impact of the pandemic on maintaining relationships with friends and family were found to explain more than a quarter of the variability in the overall quality of life score (Algahtani et al., 2021). Aksoy et al., (2021) in their study, determined that the quality of life was low in those in close contact with COVID-19 and there was an inverse relationship between the level of fear due to COVID-19 and quality of life (physical and psychological health). We think that informing patients about COVID-19 and providing accurate information, especially with the effective use of media communication tools, will positively affect individuals' physical and psychological health. This finding may indicate the importance of providing social support in times of crisis. Since the research was conducted using a telephone interview method, which is one of the best data collection methods during the COVID-19 outbreak

due to quarantine measures, the findings should be interpreted considering this limitation.

5. CONCLUSION

In conclusion, in this study we conducted with the spouses of patients diagnosed with COVID-19, the mean quality of life scores of illiterate individuals, those with chronic diseases, those whose spouses were hospitalized for six days or more, and those who had no knowledge of the new type of coronavirus were lower. As individuals' fear level increases, their psychological health levels in the quality of life sub-dimension decrease. Considering how intense, strenuous, and exhausting the process is for patients and family members, it is inevitable that protective psychosocial programs should be developed urgently for patients and family members in order to prevent possible problems that may develop. It is important to continue informing about COVID-19 and plan interventions to improve the quality of life of family members of individuals with chronic diseases.

Limitations

Since the research was conducted using a telephone interview method, which is one of the best data collection methods during the COVID-19 outbreak due to quarantine measures, the findings should be interpreted considering this limitation.

AUTHOR CONTRIBUTION STATEMENT

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CONFLICT OF INTEREST STATEMENT

There is no conflict of interest in this study.

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