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Death Anxiety And Spiritual Care Needs of Women of Reproductıve Age During The COVİD-19 Pandemic: Descriptive –Cross Sectional Study

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Death anxiety, Reproductive age, Spiritual care, Women

ABSTRACT

COVİD-19 infection has become a pandemic in a short time all over the world, causing anxiety and fear of death in individuals, and increasing the need for spiritual care. This study aimed to determine the level of death anxiety and spiritual care needs of women of reproductive age during the COVİD-19 pandemic. This research was conducted as a descriptive and cross-sectional study. The research data were collected by using survey questions prepared by researchers, the Death Anxiety Scale, and the Spiritual Care Needs Inventory. The t-test, one-way analysis of variance, and correlation analysis were used as the statistical analysis. The mean the Spiritual Care Needs Inventory score of women was 62.58±22.10, and the mean The Death Anxiety Scale score of women was 7.71±1.74. In the study, it was determined that women of reproductive age felt a high level of spiritual care need during the pandemic period and experienced moderate death anxiety.

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Covid-19 Pandemisinde Üreme Çağındaki Kadınların Ölüm Kaygısı ve Spiritüel Bakım Gereksinimleri: Tanımlayıcı-Kesitsel Çalışma

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ÖZ

COVİD-19 enfeksiyonu tüm dünyada kısa sürede pandemi haline gelerek bireylerde kaygı ve ölüm korkusuna neden olurken, manevi bakım ihtiyacını da arttırmaktadır. Bu çalışma, COVİD-19 pandemisi sırasında üreme çağındaki kadınların ölüm kaygısı düzeyini ve manevi bakım ihtiyaçlarını belirlemeyi amaçlamıştır. Bu araştırma tanımlayıcı ve kesitsel bir çalışma olarak yapılmıştır. Araştırma verileri araştırmacılar tarafından hazırlanan anket soruları, Ölüm Kaygısı Ölçeği ve Manevi Bakım İhtiyaçları Envanteri kullanılarak toplanmıştır. İstatistiksel analiz olarak t-testi, tek yönlü varyans analizi ve korelasyon analizi kullanılmıştır. Kadınların Spiritüel Bakım Gereksinimleri Ölçeği puanı ortalaması 62,58±22,10, Ölüm Kaygısı Ölçeği puanı ortalaması ise 7,71±1,74 olarak saptanmıştır. Araştırmada üreme çağındaki kadınların pandemi döneminde yüksek düzeyde manevi bakım ihtiyacı hissettikleri ve orta düzeyde ölüm kaygısı yaşadıkları belirlenmiştir.

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INTRODUCTION

COVİD-19 infectious disease was recognised as a global pandemic by the World Health Organization on 11 March 2019. All across the world, over 5.11 million individuals were infected with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and approximately 333 thousand people died of the COVİD-19 disease until 22 May 2020 (1,2).

The pandemic had negative physical, social, and mental effects on people all over the world. In the relevant literature, it is stated that the women more frequently had complaints about mental health (3,4). Numerous factors such as the prolongation of stay at home, the restriction of visits, and teleworking due to isolation measures during the pandemic increased the likelihood of experiencing mental problems. The leave of absence granted by administrative authorities to working women with a child aged below 10 years, the closure of schools and the transition to distance education affected particularly the women because the women did the housework, got involved with the education of their children, and were obliged to telework. These factors negatively affected the physical, social, and mental health of women (4).

During the pandemic process, the fear of being infected with the disease, the worries about infecting loved ones and the people around with the disease, and uncertainties about the disease act as sources of anxiety (4).One of these anxieties is death anxiety. Death anxiety means to have fear of death constantly, abnormally, and in panic (5). Death anxiety can lead to psychological stress, impaired ego integrity, life dissatisfaction, a decline in physical functions and religious beliefs (6). Spiritual care occupies a crucial place in coping with these negative effects of the pandemic (7). The spirituality that can be confused with concepts such as ethics, belief, and religion is a significant concept that can be utilized with various meanings and enables the individual to understand himself/herself, his/her relations with other individuals, and his/her place in the universe (8). Spirituality can be defined as the manner in which individuals seek the meaning and purpose of life and have relationships with themselves, others, nature, and the belief, which is deemed by them as sacred (9). Every individual has a spiritual dimension, and spiritual needs are satisfied by spiritual care. Spiritual care allows the individual to develop coping strategies that are likely to help to cope with life crises and illnesses, plan for the future and facilitate recovery processes, and it enhances satisfaction and reduces anxiety in individuals (10,11,12).

Identifying women's death anxie

ty levels and their spiritual care needs during the period of the pandemic is of importance to the planning of services to be provided to women and the enhancement of the quality of women's lives. After the COVID-19 outbreak, needs must first be determined through research for possible situations. Therefore, this study was conducted to examine the spiritual care needs and death anxiety levels of women of reproductive age living in Turkey during the COVİD-19 pandemic and the relationship between them.

Research questions:

- What are the levels of death anxiety and spiritual care needs of women of reproductive age during the COVİD-19 pandemic?

- What are the factors associated with death anxiety and spiritual care needs of women of reproductive age during the COVİD-19 pandemic?

- Is there a relationship between death anxiety and spiritual care needs of women of reproductive age during the COVİD-19 pandemic?

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MATERIALS AND METHODS

Design

This study is a descriptive and cross-sectional study.

Setting and Participants

This research was conducted with women of reproductive age who applied to the Department of Gynecology and Obstetrics of the Faculty of Medicine of XXX University of Türkiye from 16 October 2021 to 23 November 2021. The research was concluded with 422 women of reproductive age who met the inclusion criteria and answered the data collection forms completely. The inclusion criteria for the study were being female, being in reproductive age (15-45), being able to read and write Turkish, and volunteering to participate in the study. The exclusion criteria were having cognitive, hearing and vision problems, being diagnosed with any psychiatric illness and experiencing death anxiety due to problems related to women's health. The sample size was calculated by using G*power software, and in this respect, it was designated as 400 participants with a confidence interval of 95% and a margin of error of 5%.

Data Collection

The research data were collected with “the Personal Information Form, the Death Anxiety Scale, and the Spiritual Care Needs Inventory.” The data were collected face-to-face by the researcher with the women who volunteered to participate in the study after informing them and obtaining their consent. The women filled in the data collection forms by self-report, which took an average of 10 minutes.

The Personal Information Form

This form was prepared by researchers as per the review of the relevant literature. The form had eight questions about participants’ socio-demographic characteristics and six COVİD-19-related questions, and hence, it was comprised of 14 questions in total (11,12)

The Death Anxiety Scale (DAS)

The DAS was developed by Templer in 1970 and the validity and reliability study for the DAS was performed in Turkish in 2008 by Akca and Kose (13,14). The DAS has 15 dichotomous items, and thus, the respondents answer to DAS items as either “yes” or “no”. In the first nine DAS items, a "yes" answer is worth 1 point and a "no" answer is worth 0 points. The remaining six items are scored in the opposite way. Total scores to be obtained by a respondent from the DAS range from 0 to 15 points, and a high DAS score shows that the respondent has high-level death anxiety. While Cronbach's alpha coefficient for the DAS was 0.75 (14). It was found to be 0.70 in the present study. Accordingly, the scale appears to be valid on our study population.

The Spiritual Care Needs Inventory (SCNI)

The SCNI was developed by Wu et al. in 2016 and was adapted to Turkish by İsmailoğlu et al. in 2019 (15,16). The SCNI has 21 items. SCNI items cover patients’ potential spiritual care needs. The level of necessity of spiritual care needs that are addressed in SCNI items is rated by patients as per a five-point Likert scale. The increase in the total SCNI score indicates that the patient is more in need of spiritual care. The SCNI has two components, that is, meaning and hope (items 1-12 and 14) and caring and respect (items 13 and 15-21). While Cronbach's alpha coefficient for SCNI was 0.93 (16). İt was found to be 0.90 in the present study. Accordingly, the scale appears to be valid on our study population.

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STATISTICAL ANALYSİS

The research data were analyzed by using the IBM Statistical Package for Social Science (SPSS) 21.0. The descriptive analysis was utilized to evaluate participants' socio-demographic characteristics. The suitability of the data for normal distribution was determined by Kolmogorov-Smirnov test. Since the data were normally distributed, parametric tests were used. The data were evaluated with independent sample t-test, one-way analysis of variance, and simple pearson correlation analysis, which are parametric tests. Croncbach's alpha coefficient was calculated in the reliability analysis of the scale. The research results were evaluated at the significance level of 5% and the confidence interval of 95%.

ETHICS

Prior to the research, ethical approval was obtained from the Social and Human Sciences Ethics Committee of XXX University (Date: 27 August 2021, No: 2021/645). Besides, the written permission to conduct the research was received from the Office of the Chief Physician of XXX University Hospital (Date: 15 October 2021, No: 98430). All women volunteering to participate in the research were informed about the research aim, and next, they were required to express that they consented to participate in the research. Every step of the research was carried out in accordance with the Principles of the Declaration of Helsinki. For participants under the age of 18, parental permission was obtained.

RESULT

Of all participant women, 29.6% had a paid job, 75.6% held a bachelor's degree, 13.7% had a chronic disease, and 23.5% had a child. Table 1 displayed participant women's socio-demographic characteristics.

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Table 1. Breakdown of Participant Women's Socio-Demographic Characteristics (n=422)

Characteristics		**X ± SD**	**Min-Max**
Age (year)		25.7±8.3	15-45
		n (422)	**%**
Marital status	Married	305	72.3
	Single	117	27.7
Employment status	Having a paid job	125	29.6
	Having no paid job	297	70.4
Education level	High school or below	46	10.9
	Bachelor's degree program	319	75.6
	Master's degree program	57	13.5
Place of residence	Province center	300	71.1
	District	86	20.4
	Town/Village	36	8.5
Spouse's employment status*	Having a paid job	106	90.6
	Having no paid job	11	9.4
Having any child	Yes	99	23.5
	No	323	76.5
Having any chronic disease	Yes	58	13.7
	No	364	86.3

*Single women were not included in the analysis.

Among all participating women, 29.6% had COVİD-19 infection, 88.6% had family members/relatives with COVİD-19 infection and 35.8% had lost a relative due to COVİD-19 . A large majority of participant women think that they had adequate information about the COVİD-19 pandemic. Upon the review of participant women's sources of information on the COVİD-19 pandemic, it is discerned that 74.9% of participant women obtained information from social media, and accordingly, social media was at the top as the source of information. Besides, 5.2% of participant women stated that they obtained information from scientific publications. Table 2 indicated participant women's COVİD-19-related characteristics.

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Table 2. Participant Women's COVİD-19-Related Characteristics

Characteristics		n (422)	%
Having had the COVİD-19 infection	Yes	125	29.6
	No	297	70.4
Having any family member/relative who had had the COVİD-19 infection	Yes	374	88.6
	No	48	11.4
Having any relative who died of the COVİD-19 infection	Yes	151	35.8
	No	271	64.2
Getting the COVİD-19 vaccine	Yes	381	90.3
	No	41	9.7
Having adequate information about the COVİD-19 pandemic	Yes	404	95.7
	No	18	4.3
Sources of information on the COVİD-19 pandemic*	Social media	316	74.9
	Friends/social environment	163	38.6
	Doctor	145	34.4
	Nurse/Midwife	132	31.1
	Spouse/Family	112	26.5
	Scientific publications	22	5.2

*Participant women obtained information on the COVİD-19 pandemic from multiple sources.

Table 3 showed the breakdown of participant women's mean SCNI and DAS scores. The mean of participant women's SCNI scores was 62.58±22.10 points, and thus, the participant women had a high mean SCNI score. Besides, the mean of participant women's DAS scores was 7.71±1.74 points, and hence, the participant women had a medium-level mean DAS score.

Table 3. Breakdown of Participant Women's Mean SCNI and DAS Scores

Measures	Mean ± SD	Min-Max
SCNI	62.58 ± 22.10	21-105
DAS	7.71 ± 1.74	2-14

Table 4 displayed participant women's mean SCNI and DAS scores as per some of their socio-demographic characteristics. The mean of married women's SCNI scores was 54.73±20.86 points whilst the mean of single women's SCNI scores was 65.53±21.93 points, and this difference

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between married and single women's mean SCNI scores was statistically significant ($p<0.05$). It was found that the women that had no paid job, had no child, had no chronic disease, had no family member/relative who had had the COVİD-19 infection, and had relatives who died of the COVİD-19 infection had higher mean SCNI scores. However, there was no statistically significant difference in participant women's mean SCNI scores as per the education level, the state of having had the COVİD-19 infection, and the state of having adequate information on the COVİD-19 pandemic. The mean of DAS scores of women who were high school graduates was 8.17±1.81 points whilst the mean of DAS scores of women who held master's degrees was 7.40±1.94 points, and this difference between mean DAS scores of women who were high school graduates and women who held master's degrees was statistically significant ($p<0.05$). Becides, there was no statistically significant difference in participant women's mean DAS scores as per the marital status, the state of having a paid job, the state of having any child, and the state of having any chronic disease.

Table 4. Breakdown of Participant Women's Mean SCNI And DAS Scores As Per Some of Their Characteristics

Characteristics	SCNI Mean±SD	DAS Mean±SD
Marital status		
Married	54.73±20.86	7.75±1.26
Single	65.53±21.93	7.69±1.74
t and p value	*t*=4.587 ***p*=0.001**	*t*=-0.282 *p*=0.778
Employment status		
Yes	58.37±22.45	7.57±1.67
No	64.28±21.82	7.77±1.78
t and p value	*t*=-2.520 ***p*=0.012**	*t*=-1.046 *p*=0.296
Education level		
High school or below	59.95±20.51	8.17±1.81[a]
Bachelor's degree program	62.82±22.38	7.70±1.69
Master's degree program	63.00±22.35	7.40±1.94[b]
F and p value	*F*=0.351 *p*=0.704	*F*=2.513 ***p*=0.044** **b<a**
Having any child		
Yes	53.19±21.36	7.72±1.67
No	65.40±21.46	7.70±1.77
t and p value	*t*=-4.929 ***p*=0.001**	*t*=0.091 *p*=0.928
Having any chronic disease		
Yes	57.15±23.34	7.46±1.55

No	63.39±23.39	7.75±1.77
t and p value	*t*=-2.000 ***p*=0.046**	*t*=-1.162 *p*=0.246
Having had the COVİD-19 infection		
Yes	62.45±22.87	7.77±1.64
No	62.57±22.30	7.68±1.79
t and p value	*t*=-0.049 *p*=0.961	*t*=0.477 *p*=0.633
Having any family member/relative who had had the COVİD-19 infection		
Yes	63.72±22.07	7.69±1.74
No	53.31±20.74	7.83±1.77
t and p value	*t*=3.096 ***p*=0.002**	*t*=-0.505 *p*=0.614
Having any relative who died of the COVİD-19 infection		
Yes	65.41±21.59	7.73±1.76
No	61.00±22.27	7.70±1.74
t and p value	*t*=1.973 ***p*=0.049**	*t*=0.191 *p*=0.849
Having adequate information on the COVİD-19 pandemic		
Yes	62.44±22.12	7.73±1.72
No	65.72±22.13	7.33±2.32
t and p value	*t*=-0.615 *p*=0.539	*t*=0.942 *p*=0.347

t: independent sample t-test, *F*: one-way analysis of variance

Table 5 indicated the results of the analysis of the correlation between participant women's mean SCNI and DAS scores. It was discerned that there was a statistically significant very weak positive relationship between participant women's SCNI and DAS scores.

Table 5. Analysis Of The Correlation Between Participant Women's SCNI And DAS Scores

Measures	N	Mean±SD	r *	p
SCNI	422	62.58±22.10	0.122	**0.012**
DAS	422	7.71±1.74		

* Pearson correlation analysis (correlation coefficient r=0.00-0.25 very weak, r=0.26-0.49 weak, r=0.50-0.69 moderate, r=0.70-0.89 high, r=0.90-1.00 very high)

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DISCUSSION

In this study, it was aimed to examine the spiritual care needs and death anxiety levels of women of reproductive age and the relationship between them. Questions with no clear answers about the COVİD-19 pandemic such as "When will the pandemic come to end?" and "Which methods will be used in the treatment?", the exposure to a constant flow of information about the pandemic and its effects, the decrease in social relations due to the pandemic, and recommendations or restrictions such as the one requiring individuals to stay at home can affect the individual's mental health negatively and can remind individuals of the reality of death more often. In the relevant literature, it is put forward that sleep problems, fear, stress, and anxiety were more frequently experienced during the pandemic (17,18). There are differences in levels of these symptoms as per the gender, and the women exhibit symptoms such as fear and anxiety more frequently than the men do (19,20).

In the current research, it was discerned that the mean of participant women's DAS scores was 7.71±1.74 points, and thus, participant women had a medium-level mean DAS score. In the study performed in Turkey by Kavaklı et al., it was identified that the women had high-level death anxiety during the COVİD-19 pandemic (21). It is known that death anxiety created unpleasant emotions and thoughts about the end of life. Considering that death is prevalent due to the SARS-CoV-2, it is likely that the individuals' death anxiety levels will increase. Also, as all human beings are not psychologically affected by the SARS-CoV-2 evenly, they can naturally have different levels of death anxiety (21,22). This difference can be explained by personality characteristics and cultural differences. In the relevant literature, it is asserted that the education level could be associated with COVİD-19-related fear, worry, and obsessive thoughts (18, 23). In parallel to the relevant literature, the current research also identified that there was a relationship between women's death anxiety and education levels. In the present study, the mean DAS score of women who graduated from high school was 8.17±1.81 points whilst the mean of DAS scores of women who held master's degrees was 7.40±1.94 points, and the difference between mean DAS scores of women who were high school graduates and women who held master's degrees was statistically significant ($p<0.05$). This difference might have stemmed from the fact that the women with higher levels of education were likely to have higher levels of health literacy about the COVİD-19 pandemic. In a similar vein to the finding of the current research, the study by Şavkın et al. found that having high-level education decreased COVİD-19-related fear and anxiety (24). The result of our study is consistent with the literature.

In the current research, it was identified that death anxiety levels of participant women during the COVİD-19 pandemic had no statistically significant relationship with the marital status, the state of having a paid job, the state of having any child, and the state of having any chronic disease. This situation may have been associated with participant women's personal characteristics. In the same vein, in the current research, it was discerned that death anxiety levels of participant women during the COVİD-19 pandemic had no statistically significant relationship with the state of having had the COVİD-19 infection, the state of having any family member/relative who had had the COVİD-19 infection, the state of having a relative who died of the COVİD-19 infection, and the state of having adequate information on the COVİD-19 pandemic. In the study by Şavkın et al., it was identified that the individuals who had a relative dying of the COVİD-19 infection had higher anxiety levels (24). In the study by Özdin et al., it was found that the women who had friends or relatives who had the COVİD-19 infection had higher anxiety levels (18).This difference may have been due to the fact that the mental effects of the COVİD-19 pandemic were not felt by every individual at the same level.

The COVID-19 pandemic raised our awareness of the need and requirement for spiritual support for patients in hospital setting. It was revealed that the stress induced by the pandemic led to people seeking support through spiritual and religious means (25). In the current research, it

was discerned that the mean of participant women's SCNI scores was 62.58±22.10 points, and hence, the participant women had a high mean SCNI score. This situation may have stemmed from the fact that the COVİD-19 pandemic affected not only health but also social life. In addition to health concerns, many factors that make life difficult and have the potential to negatively affect quality of life, such as difficulties and risks in accessing health services and limitations in social life, may have increased women's need for spiritual care. Moreover, in the current research, the mean of married women's SCNI scores was 54.73±20.86 points while the mean of single women's SCNI scores was 65.53±21.93 points, and the difference between married and single women's mean SCNI scores was statistically significant ($p<0.05$). This situation may have been due to the fact that the social support extended to married women by their spouses and, if available, by their children contributed positively to their spiritual well-being. When the literature is examined, in parallel with our finding, there are studies indicating that married women have more spiritual power and spiritual care competence in the COVİD-19 process (26,27).

In the current research, it was found that the women that had no paid job, had no child, and had no chronic disease had higher mean SCNI scores. Our study result may be due to individual and social differences. In the relevant literature, it is stated that socioeconomic status affected the reactions toward disasters such as the COVİD-19 pandemic (28,29). In the pandemic, it is stated that spiritual care needs should be addressed in a multidimensional manner specific to the individual, and that a healing health system in which the individual and family are active participants is needed (30)

In the current research, it was found that the women that had family member/relative who had had the COVİD-19 infection, and had relatives who died of the COVİD-19 infection had higher mean SCNI scores. Accordingly, it is thought that witnessing the disease course and lethal effect of COVİD-19 infection in relatives may affect the spiritual status of women and increase the need for care. Isasi et al. also emphasized the importance of protecting mental health by addressing the needs of the individual together with familial factors in a long-term process such as the COVİD-19 pandemic (30).

In our study, it was found that as the death anxiety of women of reproductive age increased during the COVİD- 19 pandemic, their need for spiritual care increased. In Aslan and Çetinkaya's study, it was found that as the perception of spirituality and spiritual care of oncology patients increased during the COVİD-19 pandemic, death anxiety decreased (31). In the study by Durmuş et al., it was determined that as the fear of COVİD-19 increased in pregnant women, their spiritual well-being levels decreased (32). In another study, it was mentioned that patients diagnosed with COVİD-19 have high death anxiety and spiritual care needs, these factors should be evaluated together and may trigger each other (31). Our results are consistent with the literature. These results suggest that spiritual health is affected during the pandemic period, spiritual care is needed, and for this, the fear of death should be reduced.

CONCLUSION AND RECOMMEDATİONS

In the research, it was identified that the women had medium-level death anxiety and high-level spiritual care needs during the COVİD-19 pandemic. It was also found that as the death anxiety of women of reproductive age increased during the COVİD-19 pandemic, their need for spiritual care increased. Considering the results of this research, the programs that are likely to enhance spiritual and mental well-being can be organized to reduce the COVİD-19-related death anxiety. Especially nurses and other health professionals should individually determine women's death anxiety and spiritual care needs during the COVİD-19 epidemic and similar epidemic processes and make improvements by taking into account the factors affecting these.Studies and research can be conducted online through technological tools to reduce the fear of death and meet spiritual care needs.

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Identifying and reducing the fear of death and spiritual care needs of women of reproductive age during the pandemic may protect their physical and psychosocial health and contribute to family and community health. In addition, reducing the need for spiritual care caused by the fear of death caused by the epidemic may reduce hospital admission, drug use and various disease burdens.

LIMITATION

The limitation of the study is that the results cannot be generalized to women in different demographic groups and geographical regions.

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