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Research Article

The Relationship between Spiritual Health and Death Anxiety among Acute Respiratory Patients: A Correlational Cross-Sectional Study

Zahra Abedini [1], Mahsai Haji Mohammad Hossein [2], Ashraf Khoramira [1], Zahra Aliakbarzadeh Arani [3]*

[1] *Department of Nursing, School of Nursing and Midwifery, Qom University of Medical Sciences, Qom, Iran*
[2] *Department of Emergency Medicine, School of Paramedicine, Qom University of Medical Sciences, Qom, Iran*
[3] *Spiritual Health Research Center, Qom University of Medical Sciences, Qom, Iran & Department of Gerontology, School of Medicine, Qom University of Medical Sciences, Qom, Iran*

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Corresponding Author: *Spiritual Health Research Center, Qom University of Medical Sciences, Qom, Iran & Department of Gerontology, School of Medicine, Qom University of Medical Sciences, Qom, Iran*
Email: *zaliakbarzade@gmail.com*

ABSTRACT

Introduction: Death anxiety is a common psychological concern among COVID-19 patients admitted to the emergency department. The management of death anxiety is a priority. Previous studies have confirmed the important role of spirituality in managing death anxiety among patients.

Objectives: This cross-sectional study aimed to determine the relationship between spiritual health and death anxiety among COVID-19 patients at a respiratory care center.

Methods: Participants were 236 Muslim patients in the emergency department of a respiratory care center in Qom, Iran. Patients with COVID-19 were selected through convenience sampling. The Paloutzian and Ellison Spiritual Health Scale and Templer's Death Anxiety Scale were used to measure the variables. SPSS software version 25 was used. The data analysis was conducted using Pearson and Linear Regression tests.

Results: The mean spiritual health score was 70.14 ± 2.96, and the mean death anxiety score was 10.84 ± 1.43. A significant negative correlation was observed between spiritual health and death anxiety among COVID-19 patients ($r = -0.226$, $p < 0.05$). Male participants had a higher mean spiritual health score of 70.55 ± 3.16 and a lower mean death anxiety score of 8.04 ± 3.06. The total spiritual health score ranges from 20 to 120, and the total death anxiety score ranges from 0 to 15. A significant regression model was identified, and the independent variables explained a proportion of the variance in death anxiety. The following factors were found to predict the patient's death anxiety: Existential Health ($\beta = 0.27$; $t = -2.65$; $p < 0.001$), Religious Health ($\beta = 0.30$; $t = -2.35$; $p < 0.001$), and gender ($\beta = -0.32$; $t = -2.14$; $p < 0.05$).

Conclusions: This study indicated that spiritual health is associated with lower death anxiety among Muslim patients with COVID-19. Spiritual interventions are recommended to promote spiritual health among patients, particularly in emergency departments.

Keywords: Death Anxiety, Emergency Department, Spiritual Health, Spirituality

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1. Introduction

Healthcare systems faced the coronavirus disease 2019 (COVID-19) pandemic, and the majority of emergency wards were occupied. COVID-19 is a respiratory disease with a 2% case fatality rate. Millions of people were infected and died worldwide (1). This contagious virus spread worldwide and was declared a public health emergency. This critical situation led to the collapse of health systems and a high burden of patient care, especially in clinical settings (2). Many researchers confirmed that this disease significantly affects people's quality of life and mental health (3). The pandemic has been associated with death anxiety in the community. It is known that emotional distress, such as death anxiety, increases morbidity and susceptibility to disease (4). Ornell et al. (2020) indicated that fear of the unknown process and consequences of disease increased stress levels in patients (5). A study showed that 50.9% of the community had symptoms of anxiety during the critical situation (6). In another study, approximately 45.1% of the population experienced anxiety due to the pandemic (7). Death anxiety is a common psychological concern characterized by panic and fear of dying (8). A high level of death anxiety is problematic and can lead to decreased quality of life and a greater sense of helplessness (9). Moreover, the risk of life-threatening outcomes, such as suicide, is increased (10). Other researchers found that individuals who experience respiratory symptoms suffer from death anxiety (11). A similar study reported psychological complications among patients with infectious diseases (10). Moreover, high levels of death anxiety were associated with morbidity and mortality and were also associated with dissatisfaction, stress, decreased physical functioning, poor resilience, and weakened beliefs (12).

There is an essential need to identify and improve strategies to address psychological and social problems (4). Spirituality is an effective complementary approach that can help patients adapt to problems, thereby helping them cope with illness, death, distress, and pain (13). Spirituality is defined as the "dynamic and intrinsic aspect of humanity through which persons seek meaning and purpose as well as relationships to self, family, others, and community" (14). Higher levels of spiritual health are associated with greater self-control and improved health-protective practices among patients. It is crucial to pay attention to the spiritual health of patients experiencing a life-threatening disease. Furthermore, studies have shown that spiritual well-being promotes a sense of peace and healing. It is essential for managing distress and death anxiety and can reduce fear of death and dissatisfaction with life (15).

Iran has a rich social, cultural, and religious context. Limited studies have been conducted on death anxiety among Muslims death anxiety, and there is a notable gap in research on spirituality in this area. Despite evidence supporting the role of spirituality in Islamic countries and the increasing number of acutely ill patients, further research should be conducted on spiritual aspects of emergency care. Identifying the association between spiritual health and death anxiety would help nurses understand how spiritual care could reduce patients' anxiety and illness-related symptoms. Previous studies have confirmed the effectiveness of spirituality in managing anxiety and fear (16). Previous studies have reported inconsistent findings regarding the relationship between spirituality and anxiety. Some studies have focused exclusively on older adults and have not examined the influence of demographic characteristics (17). There is limited evidence on spiritual health and death anxiety in critical situations.

2. Objectives

This study aimed to determine the association between spiritual health and death anxiety among COVID-19 patients in the emergency department of a respiratory care center in Qom, Iran.

3. Methods

3.1 Study Design

This cross-sectional study used a descriptive correlational design.

3.2 Participants

A total of 236 patients with COVID-19 were included in the study. → The sample size was determined based on a similar study (14), a 95% confidence level, 90% power, and (r = 0.25). The minimum required sample size was estimated to be 157 patients. Considering the design coefficient equal to 1.5, the sample size was 236.

$$n = 4 + \left(\frac{\left(\frac{Z\alpha}{2} + ZB\right)}{0.5 - In\left(\frac{1+r}{1-r}\right)}\right)^2$$

Inclusion criteria were COVID-19 infection, residence in Qom (a holy city), being Muslim and Iranian, Persian language proficiency (to complete the Persian version of the questionnaire), age 18–65 years, and hospitalization for >1 day. Exclusion criteria were inability to answer the questions and the death of a family member.

To minimize sampling bias, COVID-19 patients were selected from various age and gender groups. All participants were native Persian speakers. To minimize

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response bias, clear and understandable questions were used. The participants had no pain or fatigue.

3.3 Scale

A sociodemographic questionnaire consisting of items on age, gender, marital status, and educational level was used. Patients who met the inclusion criteria were asked to complete the questionnaire during the COVID-19 pandemic. The instruments contained information about the main variables and study objectives. The Paloutzian and Ellison Spiritual Health Questionnaire is a valid 20-item instrument, comprising two subscales: religious health and existential health (18). The total score ranges from 20 to 120. The total score was calculated by summing the responses after reverse-scoring the negative items. Spiritual health was categorized as low (20-40), medium (41-100), and high (101-120). The high scores represent better spiritual health. The reliability of this questionnaire has been established in previous studies (19).

Death anxiety was evaluated using the Persian version of Templer's death anxiety scale. It consists of 15 items that are scored 0-1, and the total score ranges from 0 to 15. The higher scores represent greater death anxiety. It has a cutoff score of 50. This tool was validated in the Iranian population in a previous study (20).

3.4 Data Collection

The participants were 236 patients at a respiratory care center in Qom, a holy city in central Iran. They were selected through convenience sampling. They completed the questionnaires between April and May 2020, during the COVID-19 pandemic.

3.5 Data Analysis

Data were analyzed using SPSS, version 25. Demographic characteristics and levels of spiritual health and death anxiety were described using descriptive statistics. Pearson correlation and linear regression analyses were used to examine the association between death anxiety and spiritual health after controlling for independent variables. The adjusted β-value with 95% confidence intervals → was calculated using linear regression analysis of death anxiety in relation to spiritual health after adjusting for potential confounding variables.

3.6 Ethical Consideration

This study was approved by the Ethics Board of Qom University of Medical Sciences, Iran (IR, MUQ.REC.1399.055). Written informed consent was obtained from the participants. The patients' questionnaires were kept anonymous, and their responses were kept confidential.

4. Results

A total of 236 adult patients with COVID-19 were included in a respiratory care center in Iran. Most participants were male (56.4%) and married (59.7%). The mean age was 46.23 ± 14.22 years, with an age range of 18–65 years. Additionally, 62% of patients had a primary education level. The mean spiritual health score was 70.14 ± 2.96. Demographic characteristics of the patients are outlined in Table 1.

Table 1: Demographic characteristics of COVID-19 patients

Demographic characteristics		n	%
Gender	Male	133	56.4%
	Female	103	43.6%
Marital status	Single	96	40.3%
	Married	140	59.7%
Age	< 30	61	25.6%
	30-65	102	43.3%
	>60	73	31.1%
Education	Illiterate	17	7.3%
	Primary	146	62%
	Academic	73	30.7%

→ The mean scores for religious health and existential health were 34.62 ± 2.22 and 35.54 ± 1.88, respectively. The mean death anxiety score was 10.84 ± 2.96. Most participants had moderate spiritual health scores and low death anxiety scores (Table 2).

Table 2: Relationship between demographic characteristics and main variables

Demographic characteristics		Spiritual health Mean±SD	Death anxiety Mean±SD
Age	< 30	68.50±1.08	8.80 ± 4.06
	30-60	74.02±3.00	9.67 ±2.10
	>60	69.21±2.98	11.14±1.14
		p =0.08[a]	p =1.19[a]
Gender	Male	70.55 ± 3.16	8.04± 3.06
	Female	68.83 ± 2.76	10.72± 2.41
		P=0.04[a]	P=0.02[a]
Marital status	Single	73.10 ± 2.98	8.19 ± 4.16
	Married	68.35± 4.05	9.44 ± 2.30
		p =0.09[a]	p =0.11[a]
Education	Illiterate	69.08 ± 5.28	7.39 ± 3.06
	Primary	70.28 ± 3.08	8.16 ± 2.14
	Academic	68.87 ± 3.08	6.71± 5.91
		p =0.15[a]	p =0.32[a]

[a] Pearson correlation

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The results of the Pearson correlation analysis (Table 3) indicated a significant negative correlation between spiritual health and death anxiety among patients (r = -0.226, p< 0.05). Male participants had a higher mean spiritual health score than women (70.55 ± 3.16 vs. 68.83 ± 2.76; p < 0.05) and a lower mean death anxiety score (8.04 ± 3.06 vs. 10.72 ± 2.41; p < 0.05). Death anxiety was not significantly correlated with age, marital status, or educational level (p>0.05).

Table 3: Relationship between Spiritual Health, Religious Health and Existential Health with Death Anxiety

Variables	Religious health	Existential health	Spiritual Health	Death Anxiety
Religious Health	1	0.044[a]	0.778**[a]	-0.158*[a]
Existential Health	0.044[a]	1	0.662**[a]	-0.172**[a]
Spiritual Health	0.778**	0.662**	1	-0.226**
Death Anxiety	-0.158*[a]	-0.172**[a]	-0.226**[a]	1

*Correlation is significant at the 0.05 level (2-tailed).
**Correlation is significant at the 0.01 level (2-tailed).
[a] Pearson correlation

A standard regression analysis was performed to predict death anxiety. Based on the findings, the beta coefficient was 0.32. A significant regression model was found (p < 0.001), with 21% of the variance in death anxiety (R^2 = 0.21) explained by the independent variables. The following factors were found to predict patients' death anxiety: Existential Health (β = 0.27; t = -2.65; p < 0.001), Religious Health (β = 0.30; t = -2.35; p < 0.001), and gender (β =-0.32; t =-2.14; p < 0.05). (Table 4).

Table4: Regression analysis with predictors of death anxiety

Predictors	B	SE	*β*	T_{236}	*p*
Existential Health	-0.23	0.18	-0.27	-2.65	>0.001
Religious Health	-0.36	0.12	-0.30	-2.35	>0.001
Gender	-0.31	0.30	-0.32	-2.14	0.02
R2 = 0.21, R= 0.26, F= 5.83					

5. Discussion

Participants in this study had a low mean score of death anxiety and a moderate mean score of spiritual health. This study confirmed the association between spiritual health, religious health, and existential health and death anxiety among patients in a respiratory care center. Previous studies have shown that religious health and strong faith are associated with positive emotions and can be beneficial resources for promoting health and reducing mental health symptoms such as anxiety, depression, suicide, and sleep disorders (4). Previous research indicated that, because of the acute, progressive nature and high fatality of respiratory infectious diseases, patients experienced anxiety and fear of death. Researchers reported negative feelings about the meaning of life and dissatisfaction during the pandemic, whereas spiritual support promotes health (21). Spiritual health promotes a positive outlook and helps patients manage psychological stress and negative emotions (22). This study was conducted among Muslims in Iran to evaluate death anxiety and spiritual health in COVID-19 patients. The setting was a holy city, and patients had favorable levels of spiritual health, which may have contributed to the low levels of death anxiety. Therefore, spirituality and religious involvement were associated with lower death anxiety among Muslim participants. Most patients in the current study reported good levels of religious health. This was in agreement with a previous study (23). Patients who are actively involved in spiritual and religious communities may be at lower risk of negative emotions because they place importance on their beliefs and faith. Religious involvement and faith play a significant role in helping patients cope with the consequences of complex diseases and the pressures of life (24). In this study, religious health and existential health were found to be predictors of death anxiety in Covid-19 patients. Our results are consistent with a similar study (25). Religious health can protect patients from distress associated with mortality (26). Thus, spiritual care is recommended to promote patients' spiritual health, and spiritual training for the community is essential. It has been suggested that chaplains should be available in hospitals for COVID-19 patients. It is recommended that nurses should encourage spiritual care during the pandemic.

Our findings showed that death anxiety was not significantly correlated with age. This finding is consistent with similar studies. Researchers indicated that both older and younger patients have lower levels of death anxiety (26), although a study reported high levels of death anxiety in older patients (17). Lower death anxiety among older adults may be associated with disability, impaired self-esteem, pain, and other problems (14). Our study population included participants from different age groups. The current study found that spiritual health and death anxiety

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varied by gender, with gender identified as a predictor of death anxiety. In this study, men had a higher level of spiritual health. A similar study also reported a high level of spirituality and religious health, and coping in men (27). Recent research has indicated that gender may influence spirituality (26). Additionally, several studies have explained high levels of death anxiety in women (28). This study indicated that men had a lower mean death anxiety score than women. Other researchers have also reported significant associations between death anxiety, spiritual health, and some demographic characteristics among COVID-19 patients (17). These findings were similar to those of previous studies conducted during other pandemics (29). Researchers found that the death of a family member can also affect spiritual health, leading to despair and religious doubt (23). Therefore, supportive religious services may be valuable for reducing death anxiety among women. However, these results may be attributed to coping strategies, social activities, and social roles. This difference may be explained by restrictions on attending religious rituals, such as prayer at the mosque, during the pandemic. It is evident that our patients participated in fewer religious rituals than outpatients. Some researchers reported that acutely ill patients had lower levels of religious activity (24). Therefore, spiritual interventions, such as providing supportive and religious resources, empathy, communication, and referral to clergy, are suggested to improve the well-being of COVID-19 patients (17). Therefore, understanding the importance of spiritual care and religious interventions is crucial for nurses

5. 1 Limitation

This study had some limitations. It was a single-center study, and the patients were selected from a respiratory care center in an Iranian holy city. Data were collected using self-reported questionnaires. Outpatients were not assessed. A nonrandom sampling technique was used, which may limit the generalizability of the findings. Difficulties may have occurred during data collection because of the patients' morbidity. Future research should examine other potential variables, such as social support and religious coping, as well as factors contributing to death anxiety among patients in respiratory care centers.

5.2 Conclusion

The findings of this study confirmed the association between spiritual health, religious health, and existential health and death anxiety among COVID-19 patients in a respiratory care center. Existential health, religious health, and gender were identified as the most important factors associated with death anxiety. This research revealed that men have lower levels of death anxiety than women, and supportive religious services may be useful for reducing death anxiety. This study indicated that spiritual health is associated with lower death anxiety among Muslim patients with COVID-19. Spiritual interventions are recommended to promote spiritual health among acutely ill patients, particularly women. Therefore, there is an essential need for research evaluating spiritual and religious interventions to help control patients' death anxiety during critical situations.

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Statements

AI Use: The researchers used AI for language editing. All data collection and analyses were performed by the authors without the use of AI.

Authors' Contribution: All authors contributed substantially to data collection, data analysis, and manuscript revision.

***Conflict of Interests*:** The authors declare no conflict of interest.

Data Availability: The datasets are available from the authors.

Ethical Approval: This study was approved by the Ethics Board of Qom University of Medical Sciences, Iran (IR, MUQ.REC.1399.055).

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Informed Consent: Written consent was obtained from the participants. The patients were informed that they could withdraw at any time.

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