RESEARCH

THE EFFECT OF RELIGIOUS COPING ON GERIATRIC ANXIETY IN A GROUP OF OLDER TURKISH WOMEN DURING THE COVID-19 PANDEMIC PERIOD

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Abstract

Purpose: This study aims to determine the effect of religious coping on geriatric anxiety in a group of older Turkish women during the COVID-19 pandemic period.

Methods: Implementing a cross-sectional research design, this study was conducted on 356 women who visited the women's health clinics, for various reasons, in a hospital in Elazig, Turkey, between January and February 2021. Data were collected using a sociodemographic form, the COVID-19 Phobia Scale, the Religious Coping Scale, and the Geriatric Anxiety Inventory.

Results: The study determined that 78.4% of the women were between 60 and 70 years old, 43.0% had a basic level of literacy, 82.9% were married, 45.8% had equal income and expenditures, and 69.9% were housewives. Data showed 87.9% of the women had chronic diseases and 45.2% had difficulties accessing hospital services. The relationship between geriatric anxiety and the age and marital status of participants was significant. Women aged 71 to 81 years and single women had a higher risk of geriatric anxiety; unemployed women were found to have more geriatric anxiety. Those with geriatric anxiety perceived their health status to be moderate. The negative religious coping score was found to be statistically significantly higher in the older women who experienced geriatric anxiety.

Conclusion: These results reveal the importance of supporting older women in coping with fear and geriatric anxiety. Old age often brings loneliness and loss of income for women and those forced to remain at home due to restrictions during the COVID-19 pandemic period need to be considered holistically.

Keywords: Women; Anxiety; COVID-19.

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INTRODUCTION

The COVID-19 pandemic, which had a global impact at of the end of 2019, has produced an extraordinary situation for Turkey and other countries (1). It is documented that this pandemic has increased the risk of mental health disorders such as schizophrenia, anxiety, depression, and acute stress reactions in society (2). Researchers have further suggested that the unfavourable effects of the COVID-19 pandemic can cause extreme concern regarding disease and mortality, nervousness, high alcohol and cigarette consumption, insomnia, nightmares, divorce, and suicide (3,4,5).

The World Health Organization (WHO) has communicated that the number of individuals 60 years old and over in the world population is gradually increasing (6). Studies have reported that the progression and fatality risk of COVID-19 is three times higher in aged individuals (7). It has been proposed to isolate the most susceptible people, namely the aged, until appropriate treatment is provided. The WHO recommends strict social isolation in the geriatric community to lessen human losses in severely affected countries. It has been suggested that older people throughout the world should remain in isolation indefinitely (8).

Social isolation and loneliness are especially hard on the elderly, as they may suffer from functional constraints, insufficient economic and social resources, the loss of spouses and relations, varying family compositions, and the loss of mobility (5). Even older people with a greater social comfort level can show downstream repercussions in this kind of isolation, as they often wish to attend social activities, religious congregations, and spiritual communities for their physical and mental health. Social communication stimulates and supports brain function, but prolonged social isolation can result in detrimental effects (7). With the rise in their fear, panic, and anxiety increase in older persons and their families (3).

It is essential to comprehend the spiritual well-being of older adults during stressful and dangerous situations such as the COVID-19 pandemic. Positive religious coping was found to be associated with lower depression and anxiety scores, and one study has also found that older women, who pay more attention to spiritual activities and religious rituals, have had higher religious coping levels than men during the pandemic (9). Another study on women from South America reported a significant negative correlation between depression and religiosity that was more influential in those aged 65 and older (10). Despite the increasing number of studies on the relationship between religiosity and well-being, the explorations into this relationship are insufficient concerning aged women, especially during the pandemic. Women are reported to have three times the rate of anxiety than men during this period (11). A study also found that depression, anxiety, and health anxiety levels were higher in women (12).

The very few studies that research older women's health and supportive measures during the pandemic are limited. This study aims to determine the effect of religious coping on geriatric anxiety in a group of older Turkish women during the COVID-19 pandemic period.

MATERIALS AND METHODS

This study had a descriptive cross sectional study design and completed with 356 women who met the criteria (being a Turkish woman, being over 60 years old, being literate, and not having any communication barriers). This study was conducted in Elazig, Turkey, between January 2021 and February 2021.

Data were collected using a sociodemographic form, the COVID-19 Phobia Scale (C19P-S), the Religious Coping Scale, and the Geriatric Anxiety Inventory.

The sociodemographic form prepared by the researchers consists of 10 questions about the

sociodemographic characteristics of the participants. The C19P-S was developed by Arpaci et al. (2020). The C19P-S is a self-report instrument with a five-point Likert-type scale to assess the levels of COVID-19 phobia (4). Since this study was conducted during the COVID-19 pandemic period, it was deemed appropriate to use this scale. All items are rated on a five-point scale from "Strongly disagree [1]" to "Strongly agree [5]." The scale is composed of four subscales: Psychological, Psychosomatic, Economic, and Social. Scores can range between 20 and 100, with a higher score in the related subscales and total scale indicating a stronger phobia. The Cronbach's alpha value for the scale was found as 0.926 by Arpaci et al. (4). In this study, The Cronbach's alpha value was found to be 0.79.

The Religious Coping Scale was developed by Abu-Raiya et al. (13), and Eksi and Sayin adapted it to the Turkish language (14). This four-point Likert-type scale consists of ten items and two subdimensions: positive and negative religious coping. Distribution of items by subdimensions; Positive Religious Coping: 1, 2, 3, 4, 5, 6, 7; Negative Religious Coping: 8, 9, 10. In the subdimensions of positive religious coping, there are expressions such as "When faced with any problem in life, take refuge in God, ask for God's love and forgiveness, and do the best and leave the rest to God's discretion". In the subdimensions of negative religious coping, there are expressions such as "When faced with any problem in life, believing that you are punished for the sins committed, questioning yourself, thinking that God is punishing you for not being a faithful servant enough". Positive and negative religious coping scores are calculated separately. The scale does not have a cut off value. It is interpreted that as the score increases, positive or negative religious coping increases. A total Religious Coping Scale score cannot be obtained. The internal consistency coefficients for positive and negative religious coping in the current study were very good (i.e., 0.77 and 0.81, respectively) (13,14). In this study, the Cronbach's alpha internal consistency coefficient was calculated as 0.89 for the positive religious coping subscale and 0.83 for the negative religious coping subscale.

The Geriatric Anxiety Inventory was developed by Pachana et al. (15), and Karahan et al. adapted it to the Turkish language (16). The Geriatric Anxiety Inventory consists of 20 "Agree/Disagree" items designed to assess typical common anxiety symptoms. The questionnaire has "agree/disagree" response categories, and the anxiety score is obtained by adding the number of 'agree' responses, giving a total score ranging from 0 to 20. Higher scores show higher levels of anxiety. The Cronbach's alpha value for the Turkish version of the scale was reported to be 0.91 (16), and it was 0.72 in this study.

Statistical analyses were performed using the Statistical Package for the Social Sciences (SPSS) software version 22.0 (IBM Corp., Armonk, NY, USA). The data obtained from the study were expressed as the mean ± standard deviation for continuous variables and as the frequency. The Shapiro–Wilk test was performed to determine whether the data were normally distributed. Pearson's chi-square test, which is a nonparametric test, was used for categorical data that did not fit a normal distribution, and an independent sample t-test, which is a parametric test, was used for continuous data that did not fit a normal distribution. A binary logistic regression analysis was performed to determine the combination of independent variables. The accepted level of significance was 0.05.

This study was performed in line with the principles of the Declaration of Helsinki. Approval was granted by an University Non-Interventional Clinical Research Ethics Committee (Approval number: E-10840098-772.02-606). The participants were informed about the study and gave their written and verbal informed consent.

RESULTS

It was determined that 78.4% of the participants were between 60 and 70 years old, 43.0% had a basic level of literacy, 82.9% were married, 45.8% maintained equal income and expenditures, and 69.9% were housewives. It was shown that 48.8% of the participants perceived their health status at a moderate level, 87.9% had chronic illness, and 54.8% stated that they did not have any difficulties accessing hospital services during the COVID-19 pandemic (Table 1).

A statistically significant relationship was found between the age and marital status of these women and the presence or absence of geriatric anxiety. Although the difference was not statistically significant, women with a basic level of literacy were found to have more, and unemployed women were found to have the most. It was shown that those with this anxiety perceived their health status to be moderate (Table 2).

The mean C19P-S economic factor score was statistically significantly higher in the women who did not experience anxiety. The negative religious coping score was found to be statistically significantly higher in the women who experienced anxiety. Although it was not statistically significant, the mean CP19-S Psychosomatic subscale score was found to be higher in women who didn't experience anxiety (Table 3).

The risk of geriatric anxiety in women aged 71 to 81 was 2.02 times (1/0.494) higher than that in women aged 60 to 70. The risk in single women was 2.32 times (1/0.431) higher than that in married women. As the C19P-S economic factor score increased, the risk decreased by 1.23 times (1/0.810). As the negative religious coping score increased, the level of geriatric anxiety increased 1.25 times (Table 4).

DISCUSSION

When the literature is examined, there are studies with different groups on religious coping and COV-

Table 1. Distribution of sociodemographic findings of the participants (N=356)

Socio-demographic Characteristics	n (%)
Age	
60-70	279 (78.4)
71-81	77 (21.6)
Educational Background	
Only Literate	153 (43.0)
Primary School	123 (34.6)
Secondary School	59 (16.6)
High School and Over	21 (5.8)
Marital Status	
Married	295 (82.9)
Single	61 (17.1)
Family Income Status	
Less than income	144 (40.4)
Income is equal to expenses	163 (45.8)
More than income	49 (13.8)
Working Status	
Yes	45 (12.6)
No	238 (66.9)
Retired	73 (20.5)
Perception of self health status	
Good	54 (15.2)
Moderate	174 (48.8)
Bad	128 (36.0)
Chronic Illness	
Yes	313 (87.9)
No	43 (12.1)
Difficulty in in accessing hospital	
Yes	161 (45.2)
No	195 (54.8)

Table 2. Comparison of the geriatric anxiety and sociodemographic findings of the participants (N=356)

Socio-demographic Characteristics	No anxiety (n=102)	Anxious (n=254)	Statistical Test* Significance
	n (%)	n (%)	
Age			
60-70	87(85.3)	192(75.6)	X^2=4.043
71-81	15(14.7)	62(24.4)	***p=0.044***
Educational background			
Only Literate	52(51.1)	101(39.8)	X^2:6.508
Primary School	33(32.4)	90(35.4)	*p=0.089*
Secondary School	10(9.8)	49(19.3)	
High School and Over	7(6.9)	14(5.5)	
Marital Status			
Married	92(90.2)	203(79.9)	X^2=5.411
Single	10(9.8)	51(20.1)	***p=0.020***
Family Income Status			
Income less than expense	44(43.1)	100(39.4)	X^2=2.106
Income is equal to expenses	41(40.2)	122(48.0)	*p=0.349*
Income more than expense	17(16.7)	32(12.6)	
Working Status			
Yes	14(13.7)	31(12.2)	X^2:0.163
No	67(65.7)	171(67.3)	*p=0.922*
Retired	21(20.6)	52(20.5)	
Perception of self health status			
Good	17(16.7)	37(14.6)	X^2=0.312
Moderate	48(47.1)	126(49.6)	*p=0.855*
Bad	37(36.2)	91(35.8)	
Chronic Illness			
Yes	90(88.2)	223(87.8)	X^2=0.013
No	12(11.8)	31(12.2)	*p=0.908*
Difficulty in in accessing hospital			
Yes	47(46.1)	114(44.9)	X^2=0.042
No	55(53.9)	140(55.1)	*p=0.838*

*Pearson chi-square test

Table 3. Examination of CP19-S and religious coping scale scores according to geriatric anxiety status

	No anxiety (N=102)	Anxious (N=254)	Statistical Test*	Significance
	Mean (SD)	Mean (SD)		
Psychological factors	24.00(2.17)	24.41(2.21)	F=0.018	p= 0.109
Psycho-somatic factors	18.01(2.40)	17.60(2.15)	F=1.458	p=0.129
Social factors	20.53(1.65)	20.54(1.87)	F=0.718	p=0.985
Economic factors	15.30(32.4)	14.59(1.91)	F=0.276	**p=0.002**
CP19-S Total	77.86(3.87)	77.15(4.32)	F=1.561	p=0.133
Positive religious coping	24.81(1.40)	24.87(1.53)	F=0.072	p=0.729
Negative religious coping	7.24(1.53)	7.66(1.41)	F=0.729	**p=0.019**

* Independent Sample T-Test

Table 4. Binary logistic regression analysis of factors affecting geriatric anxiety

a.Variables entered on step1: Age, Marital Status

		B	Wald	p	Exp(B)	95% C.I.for EXP(B) Lower-Upper
Step 1[a]	**Age**					
	60-70	--	--	**--**	--	--
	71-81	-0.706	4.767	**0.029**	0.494	0.262-0.930
	Marital Status					
	Married	--	--	**--**	--	--
	Single	-0.841	4.963	**0.026**	0.431	0.206-0.904
	CP19-S Economic factors	-0.211	10.601	**0.001**	0.810	0.713-0.919
	Negative religious coping	0.230	7.275	**0.007**	1.259	1.065-1.488
	Constant	3.367	9.051	**0.003**	37.992	--

ID-19 related fear, stress, and depression (17,18); however, no study has been found on the anxiety, and religious coping levels experienced by older women. These factors are important for women's health and it is clear that this study is needed at this time. The present study provides information to determine the effect of religious coping on geriatric anxiety in a group of older Turkish women during the COVID-19 pandemic period.

It was determined that 87.9% of the women participating in this study had chronic diseases and 45.2% had difficulties in accessing hospital services. Individuals with chronic diseases during the pandemic period could not receive the necessary medical support and did not want to go to their routine examinations for fear of contracting the virus (7). In

addition, the constraints of curfews and the need to use public transportation made it difficult to reach the hospital. In this situation, home care and telephone health services became prominent.

Over the pandemic period, women over the age of 60 felt lonelier and more anxious than men (15, 16, 19). One study has emphasized that during this time women have been more affected than men: their loneliness level has increased and their spiritual well-being level has decreased. When women faced stress factors, they needed more social support. Their anxiety level increased with the feeling of loneliness that came with social isolation (20). The current study determined that single women were more anxious than married women.

This study also determined that women with anxiety had more negative religious coping tendencies. Studies have shown that religion is a significant coping method for older adults at troubling moments in life. Religion may promote healthy attitudes among older women. Negative religious coping has been associated with lower psychological health levels (21). A study established that there was a positive correlation between negative religious coping behaviour, anxiety, and depression (22). In this study the negative religious coping score was found to higher in the women who experienced anxiety. In the literature, it is suggested that supporting the religious coping of older women was significant for their mental health during the pandemic period (3,5,9). In another study based on the subjective health perceptions of older adults, the negative religious coping of those who rated their health status as moderate was found to be higher than that of those who assessed their health status as good. Those who considered their health to be satisfactory used negative religious coping strategies less (23).

It has been determined that the C19P-S economic factor subdimension values were high in those without geriatric anxiety. This scale includes expressions of fear for the reduction in food, cleaning, and household supplies. Concerns about not being able to obtain such necessities due to scarcity have reached a phobic level. The rapid spread of the disease, its ensuing mortalities, and increased health concerns has led to more precautions regarding hygiene and physical contact (24).

Study Limitations

This study has limitations: the research was conducted solely on women over 60 years old admitted to the hospital for treatment. It should be considered that if older women who were not able to come to the hospital due to pandemic restraints had been included in the study, the results might be different; conducting the research in only one province in central Turkey constitutes another limitation of the study in terms of the generalizability of the findings.

CONCLUSION

A significant relationship was determined between geriatric anxiety and the age and marital status of women who participated in this study. Women aged 71 to 81 and single women were found to be at higher risk of developing geriatric anxiety. Those with negative religious coping behaviours were found to have higher geriatric anxiety levels. It has been ascertained that older women need support to cope with anxiety. We know many women experience loneliness and loss of income in old age. It is a time when health care is needed most, although it is often not as prioritised as it should be. Policies to create social systems, including care services and treatments, need to be put in place. It is essential to strengthen in-home nursing care services to assess these women's physical, religious coping, and mental health conditions, their capacity to deal with anxiety and fears, and to support them in their time of need.

Conflict of interest: The authors have no conflicts of interest.

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