

*Review Article***The relationship between religiosity and spirituality with death anxiety among nurses: A systematic review**Solmaz Saeidi ^a  | Fatemeh Hamidi ^{b*} 

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Abstract

This systematic review sought to compile evidence on the connection between religiosity and spirituality and death anxiety (DA) among nurses. A comprehensive search was conducted on Scopus, PubMed, and Web of Science databases using keywords derived from Medical Subject Headings, including "Death", "Death Anxiety", "Nurses", "Spirituality", "Religiosity", and "Religion", spanning from the earliest available data to March 1, 2022. The quality of the included studies was evaluated using the Appraisal tool for Cross-Sectional Studies (AXIS tool). Two researchers independently performed data extraction and quality assessment for the included studies. In the present study, six relevant articles were included. According to the results, 37.46% of nurses identified as Catholic, and 22.70% as Protestant. Two studies explored the relationship between religiosity and DA in nurses, revealing a significant negative correlation. Four studies investigated the association between spirituality and DA among nurses, with three of them indicating a significant negative relationship. However, one study demonstrated a significant positive correlation between spirituality, spiritual care, and DA among nurses. Overall, the majority of studies suggested that religiosity and spirituality have a negative association with DA in nurses. The findings of this study contribute to a better understanding of DA and its related factors in nurses. Additionally, designing interventions that focus on religiosity and spirituality may help reduce DA in nurses, thereby improving patient care. Therefore, future researchers are encouraged to design well-structured interventions based on religion and spirituality for nurses dealing with DA.

Keywords: Death, Death Anxiety, Nurses, Spirituality, Religion.**1 | Introduction**

Death is a biological phenomenon and inevitable, which thinking about it can have adverse psychological consequences in nurses. One of these effects is anxiety and stress caused by death which is called death anxiety (DA) [1, 2]. DA is a complex concept that includes aspects such as the denial of death, fear of one's own death and the death of others, avoidance of discussions about death, and a hesitancy to engage with individuals who are nearing the end of life [3]. Therefore, DA can lead to adverse mental health outcomes such as depression, burnout, and turnover [4]. Meanwhile, nurses as an important part of health care professionals, are often associated with dying patients, which can lead to DA in them [5]. Caring for dying patients is considered to be one

of the most stressful responsibilities of nurses, whose quality of professional life decreases with increasing levels of exposure to dying patients [6]. Also, nurses with high levels of DA may not provide adequate care for dying patients [7].

Existing evidence indicates that nurses, in comparison to other healthcare professionals, often encounter elevated levels of DA due to their prolonged presence at the patient's bedside [8, 9]. A study in Israel demonstrated that nurses reported high levels of DA, with a score of 4.15 out of 7 [3]. Similarly, research in Iran revealed that 36% to 39% of intensive care nurses experience moderate to severe levels of DA [10]. However, the perceived high levels of DA among nurses can lead to adverse outcomes, including impaired communication between nurses and patients,

a decline in the quality of nursing care, and a reduction in the overall quality of life for patients [11]. Therefore, it becomes crucial to identify DA and its associated factors in nurses, considering their potential impact on patients' health outcomes. Moreover, the ability of nurses to effectively manage DA is instrumental in helping them cope with death and develop high-quality care programs for patients nearing the end of life [12].

DA may be linked to various factors, including economic, social, the death of a family member, religiosity, spirituality, the presence of a serious illness, and personality traits [13]. Religiosity and spiritual beliefs are recognized as significant factors in alleviating DA [14]. Religiosity is defined as "an evaluation of the positive, personal, and social consequences of religious practices, coupled with the belief in the existence of a supreme being" [15]. Some prior studies indicate a negative correlation between religiosity and spirituality with DA in nurses [12, 16]. However, an exception exists as one study suggests a positive relationship between religiosity, spirituality, and DA in nurses [17]. Nurses from diverse religious backgrounds, such as Islam and Christianity, may hold distinct views and attitudes toward DA. In Islam, religious beliefs present a perspective of immortality after death. Nevertheless, Islamic literature contains numerous vivid narratives depicting the experience of death and the afterlife, which can draw attention to the heightened anxiety associated with confronting mortality [18].

Numerous studies have individually explored the connection between religiosity and DA in nurses. However, as of now, there is no published study that provides a comprehensive summary of the literature on the relationship between religiosity and DA among nurses. Recognizing the significance of this matter, this systematic review aims to consolidate and present the existing evidence regarding the association between religiosity, spirituality, and DA among nurses.

2 | Methods

2.1 | Study registration and reporting

Conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist [19], this systematic review was not registered in the International Prospective Register of Systematic Reviews (PROSPERO) database.

2.2 | Search strategy

An extensive search was conducted on Scopus, PubMed, and Web of Science databases via keywords extracted from Medical Subject Headings such as "Death", "Death Anxiety", "Nurses",

"Spirituality", "Religiosity", and "Religion" from the earliest to March 1, 2022. For example, the search strategy was in PubMed/MEDLINE database including (("Death Anxiety") OR ("Anxiety") OR ("Death") OR ("Fear of Death") OR ("Fear of Dying") OR ("Fear")) AND (("Religiosity") OR ("Faith") OR ("Religion") OR ("Spirituality") OR ("Spiritualism") OR ("Spiritual") OR ("Existentialism"))) AND (("Nurses") OR ("Nursing")). Keywords were integrated using Boolean operators, specifically "AND" and "OR." All search steps were independently conducted by two researchers. Gray literature, encompassing conference presentations, expert opinions, dissertations, research and committee reports, and ongoing research, was intentionally excluded from this systematic review. Gray literature refers to documents available in both print and electronic formats that have not undergone evaluation by a commercial publisher [20].

2.3 | Inclusion and exclusion criteria

Original studies published focusing on the relationship between spirituality and religiosity with DA among nurses were included in this systematic review. The information related to nurses was extracted from studies that focused on the relationship between spirituality and religiosity with DA among nurses and other healthcare professionals. In this systematic review, there were no language restrictions. Letters to the editor, case reports, conference proceedings, experiments, studies with qualitative designs, and reviews were excluded.

2.4 | Study selection

EndNote X8 software was employed for data management. The process involved the removal of duplicate articles, initially through electronic means and subsequently manually. Evaluation of the title, abstract, and full text of articles was carried out according to the inclusion/exclusion criteria. Any disagreements in the assessment of studies were resolved through the involvement of a third researcher. To prevent the loss of pertinent data, the reference list of eligible studies was thoroughly reviewed.

2.5 | Data extraction and quality assessment

Researchers gathered information, encompassing the first author's name, year of publication, location, ward, sample size, type of religion, male/female ratio, age, single/married ratio, level of education, work experience, questionnaire, and key results. The quality assessment of the included studies utilized the Appraisal tool for Cross-Sectional Studies (AXIS tool). This tool comprises 20 items rated on a two-point Likert scale, with "yes" (score of 1)

and "no" (score of 0) options. The assessment covers report quality (7 items), study design quality (7 items), and potential introduction of biases (6 items). AXIS categorizes study quality into three levels: high (70 to 100%), fair (60 to 69.9%), and low (0 to 59.9%) [21]. Both data extraction and quality assessment of included studies were independently conducted by two researchers.

3 | Results

3.1 | Study selection

In this systematic review, a total of 2,486 studies were identified through database searches. Following the elimination of duplicate studies, 1,221 articles remained. A thorough examination of the title and abstract resulted in the exclusion of 1,012 studies that did not align with the research purpose, and 165 studies were excluded due to not having a cross-sectional nature. After a meticulous assessment of the full text of thirty-nine studies, twenty-two studies were excluded due to inappropriate study design or out-

comes, and eleven studies were removed due to a lack of the desired information. Ultimately, six studies [12, 16, 17, 22-24] met the criteria for inclusion in this systematic review (Figure 1).

3.2 | Study characteristics

A total of 1,460 nurses were enrolled in six studies [12, 16, 17, 22-24]. All included studies had a cross-sectional design. Of the nurses, 87.77% were female, 42.93% were married, and 93.72% had a Bachelor of Science in Nursing (BSN) degree. Nurses' means age was 28.85 (SD=6.98). Most nurses worked in the medical-surgical unit. Also, 37.46% of nurses were catholic and 22.70% of nurses were protestant [16, 22-24]. All studies (n=6) [12, 16, 17, 22-24] used the Templer's Death Anxiety Scale (T-DAS) to assess the DA of nurses. Mean score of DA (n=4) [16, 17, 23, 24] was 5.51 (SD=1.48). Included studies were conducted in USA (n=2) [22, 24], Korea (n=2) [16, 23], Turkey (n=1) [17], and China (n=1) [12]. Details of the characteristics of included studies are shown in [Supplementary Table 1](#).

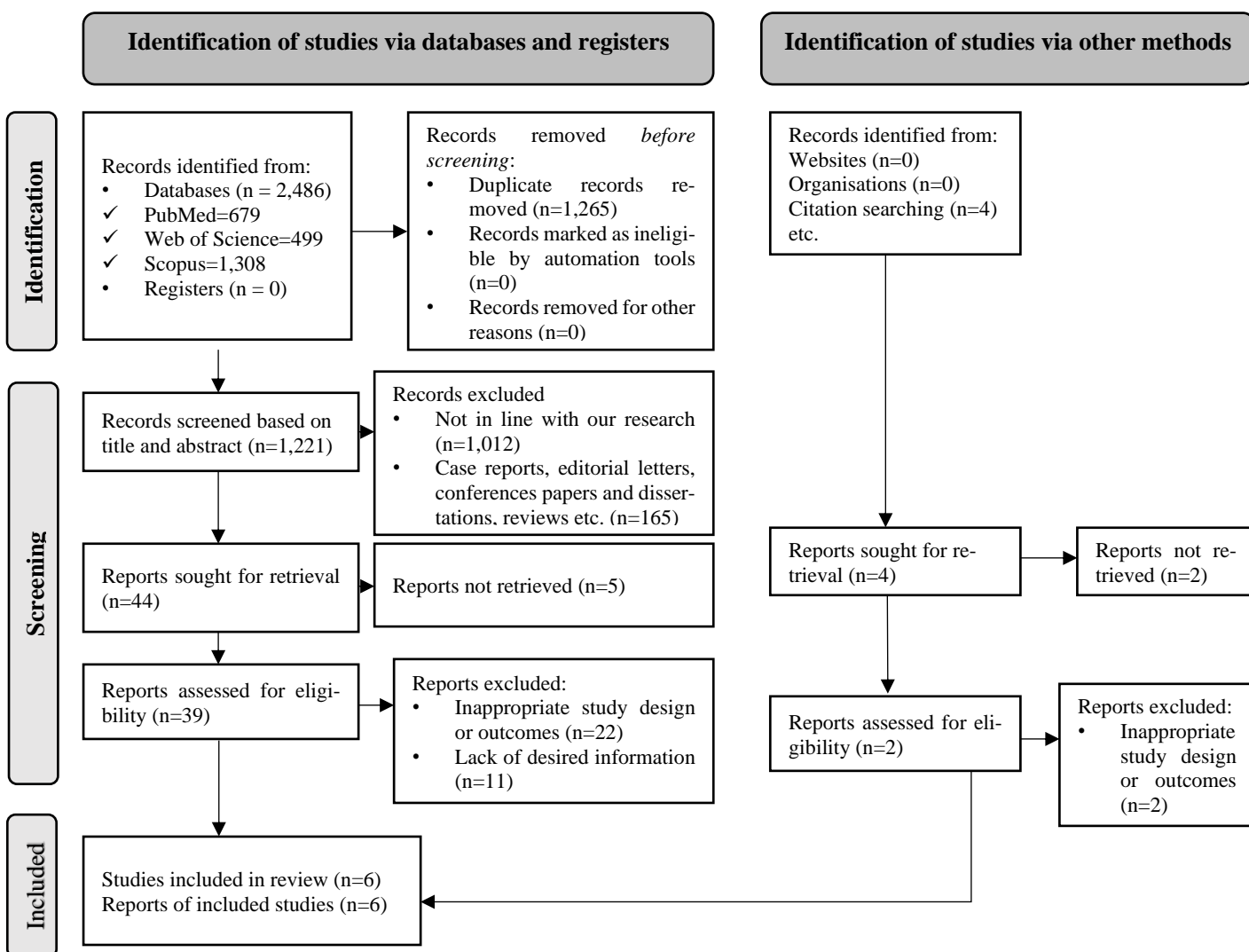


Figure 1. Flow diagram of literature selection process.

		Alvarado <i>et al.</i> , 1995	Sherman, 1997	Kim & Choi, 2010	Kim, 2013	Rahman <i>et al.</i> , 2020	Zheng <i>et al.</i> , 2021
Introduction	Clear aims	*	*	*	*	*	*
	Appropriate design	*	*	*	*	*	*
Methods	Sample size justified	*	*	*	*	*	*
	Population defined	*	*	*	*	*	*
	Sample representative of population	*	*	*	*	*	*
	Selection process representative	-	-	*	*	*	*
	Measures to address non-responders	-	-	-	-	-	-
	Appropriate outcome variables	*	*	*	*	*	*
	Valid measures	*	*	*	*	*	*
	Defined statistical significance	*	*	*	*	*	*
	Methods described	*	*	*	*	*	*
	Results data described	*	*	*	*	*	*
Results	Concerns about non-response bias	-	-	-	-	-	-
	Non-responder information described	-	-	-	-	-	-
	Results internally consistent	*	*	*	*	*	*
	Results presented for analyses	*	*	*	*	*	*
Discussion	Conclusions justified	*	*	*	*	*	*
	Limitations identified	-	-	-	-	-	*
Others	Funding sources or conflicts of interests	-	-	-	-	*	*
	Ethical approval/consent attained	-	-	*	*	*	*

Figure 2. Quality assessment of the included articles.

3.3 | Methodological quality of included study

According to the AXIS tool, the quality scores of the included studies ranged from 65% to 85%. Four studies [12, 16, 17, 23] were categorized as high quality, while two studies [22, 24] were deemed to have fair quality (Figure 2).

3.4 | The relationship between religiosity and spirituality with DA among nurses

Two studies assessed the relationship between religiosity and DA in nurses [12, 22] which had a significant negative correlation. Four studies evaluated the association of spirituality and DA among nurses [16, 17, 23, 24] which three studies had a significant negative relationship [16, 23, 24]. However, one study in Turkey showed that there was a significant positive correlation between spirituality and spiritual care and DA among nurses [17]. This difference could be due to the difference in the type of understanding of DA caused by cultures, religion, and different work environments of nurses in different studies [16, 17, 23, 24].

4 | Discussion

This systematic review, encompassing six studies involving 1,460 nurses, sought to consolidate evidence on the association between religiosity and DA among nurses. The findings revealed a significant negative correlation between religiosity and spirituality with the DA of nurses, as indicated in five out of the six studies.

Death is an unavoidable reality that individuals confront in the course of their lives. Human perspectives on death are shaped by various factors, including the loss of family members, religious beliefs, and cultural influences [13]. While spirituality and religion are frequently used interchangeably, they encompass distinct concepts. Religion is typically characterized as a set of beliefs, incorporating sacred and metaphysical values that adherents are expected to follow in religious doctrines. Conversely, spirituality is more encompassing than religion, even though it may involve religious practices. Importantly, everyone possesses a spiritual dimension, irrespective of their formal adherence to religious rituals [25].

Conversely, DA is linked to unfavorable health consequences, encompassing diminished physical performance, psychological stress, a decline in religious beliefs, life dissatisfaction, and diminished resilience [25]. Moreover, DA is correlated with exposure to life-threatening situations [26]. An instance of this is evident in a Jordanian study [27] which highlighted a substantial relationship between DA, spiritual well-being, and religious coping among the elderly amid the COVID-19 pandemic. Nevertheless, existing evidence concerning the connection between religion and DA in nurses remains limited.

As one of the primary caregivers during a patient's end-of-life phase, nurses hold a crucial role and should possess the capacity to handle their own DA. Nurses who acknowledge death as an inevitable occurrence tend to exhibit a more favorable attitude when providing care to patients in their final moments [12].

Findings from a systematic review and meta-analysis indicated substantial heterogeneity and a weak negative correlation between religiosity and DA [28]. In contrast, the majority of the results in the present review demonstrated a notable and negative association between religiosity, spirituality, and DA in nurses. Consequently, it is recommended that future research concentrate on interventions aimed at diminishing DA levels, particularly emphasizing religiosity and spirituality among nurses. The development of intervention strategies grounded in religiosity and spirituality could play a pivotal role in mitigating DA among nurses.

4.1 | Limitations

In this systematic review, the presence of substantial instrumental and methodological variations precluded the execution of a meta-analysis. The absence of a meta-analysis might contribute to increased result heterogeneity, potentially diminishing the precision of the findings. However, despite this limitation, the present review-maintained robustness in terms of a systematic approach, encompassing rigorous data collection, classification, and analysis. It is acknowledged that, despite extensive searches across various databases, some studies in this field may not have been identified.

4.2 | Implications for nursing managers and policy-makers

DA among nurses can impede their capacity to deliver optimal nursing care to patients. Based on our current understanding, nurses often encounter heightened levels of DA, given their prolonged presence and caregiving responsibilities at the patient's bedside until death. Consequently, policymakers and healthcare managers can mitigate DA in nurses by devising appropriate policies informed by factors associated with DA in this professional

group. Notably, religiosity and spirituality emerge as influential factors in nurses' DA. Implementing religious and spiritual interventions for nurses could prove effective in diminishing their DA. These strategic interventions, in turn, hold the potential to reduce DA levels among nurses and enhance the overall quality of patient care.

4.3 | Recommendations for future research

Investigate the influence of cultural factors on the relationship between religiosity, spirituality, and DA. Different cultural backgrounds may shape the perception of death and the role of religious and spiritual beliefs among nurses. Explore the impact of the work environment on the relationship between religiosity, spirituality, and DA. Factors such as patient demographics, types of care provided, and levels of support from colleagues and supervisors may play a significant role.

5 | Conclusions

Overall, most studies show that religiosity and spirituality have a negative relationship with DA in nurses. The results of the present study can help to better understand DA and its related factors in nurses. Also, designing interventions focusing on religiosity and spirituality can reduce DA in nurses and improve the process of caring for patients. Therefore, it is recommended that future researchers design well-designed interventions based on religion and spirituality for DA nurses.

Supplementary files

[Supplementary Table 1.](#)

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Authors' contributions

Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work: SS, FH; Drafting the work or revising it critically for important intellectual content: SS, FH; Final approval of the version to be published: SS, FH; Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved: SS, FH.

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Competing interests

We do not have potential conflicts of interest with respect to the research, authorship, and publication of this article.

Availability of data and materials

The datasets used during the current study are available from the corresponding author on request.

Using artificial intelligent chatbots

None.

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