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Depression in healthcare workers: influence of Fear of Death, Spirituality, and Religion.

Depresión en trabajadores de la salud: influencia del Miedo a la Muerte, la Espiritualidad y la Religiosidad.

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Resumen

La pandemia de COVID-19 ha incrementado las muertes alrededor del mundo, siendo el caso de Argentina el cual registra un exceso de mortalidad por todas las causas del 10,6%, lo que ha generado una carga de trabajo considerable en el sector salud, siendo los trabajadores los más afectados. Una de las principales consecuencias a las que estuvieron expuestos ha sido el desarrollo de síntomas de depresión. Para observar cómo las variables Miedo a la muerte, Espiritualidad y Religiosidad influyen en la posibilidad de desarrollar síntomas de depresión en la población de trabajadores de la salud, se utilizó un enfoque cuantitativo, transversal y de regresión en una población de 200 trabajadores de la salud, siendo el Miedo a la muerte la variable explicativa más relevante, seguida de la Religiosidad y la Espiritualidad respectivamente para entender el modelo.

Palabras claves

Depresión; Miedo a la Muerte; Espiritualidad; Religiosidad; Personal de salud.

Abstract

The COVID-19 pandemic has increased deaths worldwide, with Argentina registering an excess of mortality from all causes of 10.6%, which has generated a considerable workload in the health sector, with workers being the most affected. One of the major consequences to which they were exposed has been the development of symptoms of depression. To observe how the variables of Fear of death, Spirituality, and

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Religiosity influence the possibility of developing symptoms of depression in the population of health workers, a quantitative, cross-sectional, and regression approach was used in a population of 200 healthcare workers, with Fear of death being the most relevant explanatory variable, followed by Religiosity and Spirituality respectively to understand the model.

Keywords

Depression; Fear of death; Spirituality; Religiosity; Health personnel.

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Depression in healthcare workers: influence of Fear of Death, Spirituality, and Religion

The COVID-19 pandemic has increased the demand for healthcare professionals, resulting in emotional and psychological outcomes, particularly for those in direct contact with COVID-19 patients. Babore (2020) found that healthcare professionals reported an increase in workload during the pandemic, which was associated with higher levels of stress and affected work engagement. Gungodan and Arpaci's research has shown that fear of COVID-19 was positively associated with depression and death anxiety, agreeing that levels of stress and reduced work engagement due to the pandemic (Gundogan & Arpaci, 2022). Additionally, their study revealed that depression mediated the relationship between fear of COVID-19 and death anxiety. These results suggest that healthcare professionals experienced high levels of stress related to the outbreak and relied on a wide range of coping strategies to manage this stress, such as seeking social support and engaging in problem-solving activities (Candelori, 2020). According to Htay (2020), stigmatization, fear of being infected, and a lack of personal protective equipment are among the factors that had the greatest negative effects on mental health. In a study conducted by Lai (2020), it was found that fatigue was the primary symptom experienced by healthcare workers, which could be attributed to factors such as excessive working hours, consecutive working days, limited space, lack of resources, and stress. The study also reported a significant prevalence of anxiety, depression, insomnia, and distress among healthcare workers, with female healthcare workers, nurses, frontline workers, those with less work experience, and those who worked longer hours being more vulnerable to these symptoms. The co-occurrence of these experiences significantly increases the risk of not getting enough rest and potentially developing emotional exhaustion and depersonalization as burnout symptoms (Navinés 2021). In addition to fatigue, the COVID-19 outbreak has also been associated with increased symptoms of depression, such as sadness, loss of interest or pleasure, low self-esteem, and recurring thoughts of death or suicide (Arrom 2015; Kaplan 2015; Lai, 2020).

The COVID-19 pandemic has been also associated with an elevated risk of suicide among healthcare workers due to their exposure to death and traumatic experiences, which increases symptoms of depression and primarily the risk of suicide by normalizing pain to reduce the fear of death (Chu, 2017). Additionally, while isolating oneself from family can reduce the risk of contagion, it can also increase the perception of loneliness and the risk of suicide (Reger, 2020). Thus, healthcare workers face a dilemma of choosing between taking care of their health or continuing to provide services at a critical moment, despite the risks they face (Reger, 2020). Healthcare workers with close contact with COVID-19 patients exhibited higher degrees of distress (Reger, 2020).

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In the initial stages of the COVID-19 outbreak in China, 72% of healthcare workers reported experiencing general discomfort associated with symptoms of depression and anxiety, with 34% reporting insomnia. Similar to this case, studies highlighted symptoms of discomfort and mental health issues all around the world, as seen in AlAteeq's research where half of the participants presented depressive and anxiety disorders (AlAteeq, 2020). In addition to this, Abeldaño Zuñiga (2021) reported a similar scenario with a sample of healthcare workers taken in Latin American countries, where Chileans had the highest frequency of post traumatic stress symptoms and death anxiety, followed by the Argentinian part of the sample. This aligns with another study conducted in the United States, where 43.1% of the respondents showed mild or higher anxiety and 31,6% reported insomnia.

Despite the challenges faced, not all healthcare workers experienced the same emotional impact, as different factors - such as fear of death, spirituality, and religion- may decrease or increase the risk of developing symptoms of depression.

Fear of death among healthcare workers

Gert (1995) defines death as the irreversible cessation of all observable functions of an organism as a whole and the loss of self-consciousness. According to Fernanda et al. (2007), fear of death could be understood as the response to the stimulus of death, the loss of one's self, pain, and uncertainty, as to what is supposed by what may or may not exist after death. Different studies have shown that people who experience a greater fear of death tend to manifest a greater risk of developing symptoms of depression. In a Turkish study, death anxiety was positively associated with depression, (Krakus & Elveren 2021). Regarding the medical field, another study has shown that medical students who reported higher levels of death anxiety also had decreased psychological health and less favorable attitudes toward palliative care (Thiemann et al., 2015).

It's important to note that, however, health professionals report having less fear of death than the general population, specifically less fear of the unknown aspects of death -such as what happens after death and the process of dying- as well as the consequences of death itself -including the fear of being separated from loved ones and the physical pain that is associated with the process of dying-. This suggests that the lower fear of death among health professionals could be attributed to the learning effect of working in the health field, as they are exposed to death and dying more frequently, which could desensitize them to the fear associated with these experiences. Additionally, health professionals are trained to manage the physical

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and emotional aspects of death and dying, which could lead to a greater sense of control and mastery over these experiences (Fuentes, 2016).

In this scenario, while health professionals express medium-low levels of fear of death and medium-high levels of resilience, an inverse relationship has been found between fear of death and spirituality, with those who report higher levels of spirituality reporting lower levels of fear of death (Quiñones, 2018). However, even though it has been observed that spirituality, religion, and mental health may serve as protective factors for mental health, studies that have addressed this topic have produced inconsistent findings (Simkin, 2017).

Spirituality, fear of death and mental health

According to Piedmont (2012), spirituality -also referred to as spiritual transcendence (Verbit 1970)- has been described as a motivation that drives human behavior, striving to build a more extensive sense of personal meaning. Numerous studies suggest that individuals who experience a fear of death may also undergo a spiritual renewal process, which may serve as a coping mechanism. Specifically, individuals who reported higher levels of death anxiety were more likely to report experiences that involved a sense of connection to an order larger than themselves. Such experiences could include feelings of connectedness to nature, other individuals, or a higher power. Additionally, different studies highlighted the potential role of existential well-being in mitigating the negative effects of fear of death on spiritual experiences (Kowalczyk, 2020). Therefore, higher levels of spirituality are frequently related to fewer symptoms of depression (Finck Barboza & Forero Forero, 2011; Gallardo-Peralta & Sánchez-Moreno, 2020). Gallardo-Peralta and Sánchez-Moreno, (2020) report significant and negative relationships between spirituality and anxiety in doctors and nurses, the latter demonstrating a better affinity for spirituality and coping with depressive symptoms. When examining other aspects of spirituality, fear of death is negatively related to spiritual thinking about life after death (Chow, 2021). Consequently, Roman (2020) suggests that health workers require creating an environment that supports patients through spiritual connection. These promote independence through spiritual care by a compassionate presence, active listening of fears, desires, and dreams, obtaining a patient's spiritual history, and attending to all spheres of their life. Tüzer's (2020) study emphasized the significance of nursing education in delivering spiritual care, and proposed that nursing students' attitudes toward death and spirituality could influence their capacity to provide spiritual care to patients. The findings of the study indicated that nursing students with more positive attitudes toward death exhibited higher levels of spirituality. However, they lacked confidence in providing spiritual care to patients.

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Religion, fear of death and mental health

Religion differs from spirituality as the former results in the latter shaping through different religious organizations (Piedmont, 2012; Simkin & Piedmont, 2018). While spirituality has been identified as a potential protective factor against depression, certain religious beliefs may not effectively mitigate the fear of death. Yang's research investigated the association between religious attendance and depressive symptoms in South Korea (Yang, et al., 2021). The study reported a negative relationship between religious attendance and depressive symptoms, partially mediated by social support and a sense of belonging. However, Bassett (2021) reported that certain religious beliefs were found to be ineffective in attenuating the fear of death. Furthermore, King et al. (2013) suggested that individuals with a spiritual understanding of life exhibited worse mental health outcomes than those who were not inclined towards spirituality or religion, although attendance at religious services was not significantly associated with these outcomes. Skirbekk (2017) reported several factors were positively associated with depression among older adults. Regarding religiosity, certain aspects appear to have a positive association, while others exhibit a negative relationship; Specifically, attending religious services regularly was associated with a lower risk of depression, while highly religious individuals were more likely to experience depression (Skirbekk, 2017). Moreover, the study revealed that women reported higher levels of depressive symptoms than men. Finally, the study concluded that while spirituality might be a protective factor against depressive symptoms in older adults, religiosity may not have a significant impact. The findings suggested that social support and having a sense of purpose in life may prevent symptoms of depression (Skirbekk, 2017). Interestingly, some research has suggested that women who practice Buddhism are more likely to develop symptoms related to anxiety and depression (Lay, 2020).

Hence, since there is no consensus regarding how these variables are associated, the present study aims to explore the link between spirituality, religiosity, fear of death, and depression in health personnel in the local context.

Method

Participants

The sample consisted of 200 healthcare workers from public and private hospitals in Buenos Aires (Argentina), including 125 women (62.5%) and 75 men (37.5%). The ages of the participants ranged from 21

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to 72 years (M= 42.03; SD= 10.89). Participation was voluntary and anonymous through an online form, complying with the codes of ethical conduct established by the National Council for Scientific and Technical Research (CONICET) (Res. D No. 2857/06).

Instruments

Abbreviated Fear of Death Scale BFODS-SF (Collett-Lester, 1969)

It is a self-administered questionnaire that consists of eight items grouped in two dimensions: fear of one's death (eg, "What it will be like to be dead") and fear of the death of others (eg "The loss of a loved one"). The scale presents a Likert-type response format with five anchors ranging from 1 (Not at all) to 5 (A lot). For the present study, the version validated in the local context by Simkin and Quintero (2017) was used.

Spirituality and Religious Sentiments Assessment Scale ASPIRES-SF (Piedmont et al., 2008)

The shortform spirituality and religious sentiments assessment scale is made up of 13 items that assess two dimensions: spiritual transcendence (eg, "Although some people may be difficult, I feel an emotional bond with all of humanity.") And religious feelings (eg, "How often do you read the Bible / Torah / Gita?"). The scale presents a Likert-type response format with the anchoring of five to seven responses according to the degree of agreement of the participants. A version of the technique adapted and validated in the local context by Simkin and Piedmont (2018) was administered.

Patient Health Questionnaire CSP-9 (Kroenke et al., 2010)

It is a brief self-report measure that assesses the presence and severity of depressive symptoms, made up of 9 items (e.g. "Little interest or pleasure in doing things"). The scale presents a Likert-type response format that ranges from 0 (No, not at all) to 3 (Almost every day). In the present study, the version adapted to the local context by Matrángolo, et al. was used (2022).

Procedure

A quantitative, cross-sectional, and regression approach was used. Statistical analyzes were performed using IBM SPSS Statistics 25, the goodness of fit for the regression models considered R as an indicator of the effect size and R2 corrected as an indicator of the total variance, the assumptions of multicollinearity, homoscedasticity of the residuals, and no autocorrelation of the model to confirm its

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goodness of fit (Freiberg Hoffmann & Fernández Liporace, 2015). The Durbin-Watson statistic was used to examine non-autocorrelation, with possible values ranging from 0 to 4. Likewise, for the diagnosis of multicollinearity, the condition index and the variance inflation factor (FIV), the first below 30 and the second below 10 (Freiberg Hoffmann & Fernández Liporace, 2015).

Results

Backward stepwise regression analysis was used to address the research question. A model was obtained in which Depression was predicted by Fear of Death, Religiosity, and Spirituality, obtaining a significance of .004 for the total model. As can be seen in Tables 1 and 2, the model's goodness of fit has been verified. (table 1) (table 2)

Results show that, while analyzing the effects on Depression, Fear of Death appears as the most relevant explanatory variable, followed by Religiosity and Spirituality respectively to understand the model (Table 3).

Discussion

The present study aimed to explore whether fear of death, religiosity, and spirituality impact depression among health personnel working in public and private hospitals in Buenos Aires, Argentina, within the context of the COVID-19 outbreak.

Results show that fear of death explains to a greater extent the risk of developing symptoms of depression, as the exposure to death, pain, illness, and the normalization of the same on a day-to-day basis serves as triggering factors that increase mental stress. This finding is in line with the research conducted by Chu (2017) which supports the idea that exposure to death and illness can lead to mental health challenges such as depression. Moreover, as Reger (2020) observed, healthcare workers undergo a complex situation: those who are patients at risk could either expose themselves to contagion and, consequently, experience greater fear of death, or, instead, face isolation reducing contagion, but also increasing the feeling of loneliness and depressive symptoms. Therefore, fear of death increases the risk of experiencing COVID-19 disease, feelings of hopelessness, loneliness, frustration, stress, and depression in healthcare workers (Sakib 2021).

Secondly, the model is also negatively explained by religiosity, which leads to the conclusion that religious beliefs could serve as a coping mechanism, which is consistent with previous research. On one hand,

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a study indicated that a higher level of spirituality/religiosity was associated with lower levels of anxiety and depression specifically in breast cancer patients, suggesting that spirituality and religiosity may play a protective role in mental health (Finck Barboza & Forero Forero, 2011). On the other hand, another study indicated that a higher level of spirituality was associated with lower levels of depressive symptoms in older adults. As explained by the authors, the findings were suggested to be due to the different ways in which spirituality and religiosity are experienced by individuals, as spirituality may be more personal and subjective while religiosity may involve external factors such as sociocultural norms (Gallardo-Peralta & Sánchez-Moreno, 2020). Overall, both of these studies suggest that religious beliefs can help individuals cope with stress and adversity. This is consistent with another study that found a significant negative relationship between spirituality and depressive symptoms, indicating that individuals with higher levels of spirituality and religious attendance may have a protective effect against depressive symptoms (Yang et al. 2021).

Additionally, results show that spirituality also impacted negatively on depression, consistent with the literature (Chow, 2021), and supporting those findings that report that those who experience fear of death also undergo spiritual renewal, which could imply greater confidence in dealing with adversity (Kowalczyk, 2020).

In summary, this study suggests religious and spiritual attitudes are relevant in dealing with adversities and overcoming depressive symptoms (Cunha, 2020). Therefore, following Roman (2020), health workers could benefit from creating an environment that supports both patients and themselves through spiritual connection.

Nevertheless, as a strong body of literature also reports religion and spirituality are related to lower mental health, suggesting that religious affiliation and spiritual beliefs are associated with a lower likelihood of having a common mental disorder (King et al., 2013), further research needs to explore those certain religious or spiritual beliefs that are ineffective at the time of attenuating the fear of death (Bassett 2021). Therefore, more research is needed to establish a causal relationship between religious attendance and mental health to explore the potential mechanisms through which the relationship operates (Yang, 2021).

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Table 1

The goodness of fit for the regression model

R	***R^2***	***R2 adjusted***	***Durbin-Watson***
0.254	0.065	0.050	2.102

Table 2

Multicollinearity Index

	Condition index	***VIF***
REL	3.958	1.415
FOD	9.806	1.163
SPI	15.119	1.482

REL= Religiosity; FOD= Fear of death; SPI= Spirituality

Table 3

Regression Coefficients of the model

	B	***IC 95%***	***SE***	***Beta***	***t***	***Sig.***
REL	-.188	[-.506; .131]	.162	-.095	-1.161	.247
FOD	.269	[.088; .450]	.092	218	2.931	.004
SPI	-.093	[-.351; .165]	.131	-0.60	-.712	.477

REL= Religiosity; FOD= Fear of death; SPI= Spirituality