

Death and COVID-19 Anxiety in Home-Quarantined Individuals Aged 65 and Over During the Pandemic

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Abstract

Urgent measures were taken for those at the age of 65 and over who were at the risk group all over the world due to the COVID-19 pandemic. It is known that many individuals at the age of 65 and over have experienced anxiety due to the uncertainties. This study aimed to determine the anxiety and death anxiety in individuals aged 65 and over who were isolation at home due to being diagnosed with COVID-19 or being in contact during the pandemic process.

The study is descriptive and cross-sectional. It was performed with 656 home-quarantined individuals aged between 65–80 years with positive or negative real-time polymerase chain reaction (RT-PCR) test result. A form including questions about the death anxiety and the Coronavirus Anxiety Scale Short Form prepared by the researchers were administered to the individuals by phone call.

Of the participants, 49.5% were male. Median COVID-19 anxiety score was 4 (0–18). Anxiety scores of the male and female participants were similar. Participants with negative polymerase chain reaction (PCR) results and those with death anxiety had

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higher COVID anxiety scores. Death anxiety has increased by 1.661 times in male gender, 1.983 times in RT-PCR positivity and 0.146 times in the presence of symptoms. Individuals with positive COVID-19 test results or those aged 65 and over who had death anxiety and negative COVID-19 test result but who were in home-isolation due to being a contact had higher anxiety score. For this reason, those with death anxiety can be supported in line with their religious beliefs to reduce anxiety. Those with negative PCR test results in quarantine can be adequately informed about the COVID-19.

Keywords

COVID-19, elderly people, home isolation, anxiety, death anxiety

Introduction

Infectious epidemics are a condition that exists at every stage of human history and Coronavirus (COVID-19) is the latest. This epidemic has caused perhaps the biggest crisis of the last 100 years all over the world (Aslan, 2020). Due to its rapid spread in other countries and regions of the world, COVID-19 has been defined by the World Health Organization (WHO) as an “internationally alarming public health problem” (Shigemura et al., 2020).

The COVID-19 outbreak has strained healthcare capacities in many parts of the world. Lack of knowing how to deal with such a crisis in our country, as in all countries of the world, has led countries to determine the policies to be followed after the epidemic began (Turkish Medical Association, 2020). Measures were taken quickly, especially for those known to be in the risk group.

Mortality rate of COVID-19 is directly correlated with the age of the infected individuals and the highest mortality rates have been observed in the individuals over the age of 65. High mortality rate in this age group and many accompanying uncertainties have caused anxiety (Weiss & Murdoch, 2020). The individuals over the age of 65 have been accepted as the risk group and stayed in home-isolation for a long time. Many countries still do not follow the WHO’s recommendations on isolation (widespread testing, isolation of cases, contact tracing, and social isolation). In fact, by applying haphazard measures instead, some try to reduce deaths by protecting only individuals over the age of 65 and those with morbidity (The Lancet, 2020).

Looking at the current situation, globally, the group that most needed social support was individuals over the age of 65 and many elderly people had fear and trust problems due to uncertainties. In our country, individuals are organized to support vulnerable people; municipalities, businesses, non-governmental organizations, and national governments have provided support to those in need and have not hesitated to provide much support to strengthen social security and health services (Weiss & Murdoch, 2020). Although the country, region, race, and healthcare system in which there is the

pandemic differ, the bans and restrictions accompanied by the difficulties experienced during the process have caused the individuals over the age of 65 years to have anxiety and death anxiety (Khademi et al., 2020).

Death anxiety has been defined as the thoughts, fears, and emotions about the last incident of life (Karaca, 2000). Although fear of death and death anxiety are used as different concepts in literature of death anxiety, they are mostly interchangeable (Feifel & Nagy, 1981; Wink & Scott, 2005). Many variables such as age, psychological maturity, piety, a sudden loss, and fatal diseases affect the death anxiety experienced by the individuals (Chan & Yap, 2009). According to the most common religious belief in Turkey, it is believed that there is life after death and that the individuals are awarded for deaths after a disease. Smith, Nehemkins, and Charter (1983–1984) reported that the belief of being rewarded for deaths after a disease affected the death anxiety.

The anxiety and death anxiety experienced by individuals over the age of 65 regarding the obligation to stay at home during the epidemic may perhaps guide us about the disasters that may occur in the future. This study aimed to evaluate the death anxiety and anxiety levels of individuals over the age of 65 who had positive and negative COVID-19 real-time polymerase chain reaction (RT-PCR) test results and who were isolated at home due to their patient/contact status during the pandemic.

The Research Questions

What are the anxiety levels of the individuals over the age of 65 during the COVID-19 pandemic?

Do the individuals over the age of 65 have death anxiety during the COVID-19 pandemic?

Does home isolation cause anxiety and death anxiety during the COVID-19 pandemic?

Material and Method

Type of the Research

It is descriptive and cross-sectional.

Objective of the Research

This study aimed to evaluate the death anxiety and anxiety levels of individuals over the age of 65 who had positive and negative RT-PCR test results and who were isolated at home due to their patient/contact status during the pandemic.

The Location and Sample of the Research

The universe of the study consists of COVID-19 cases between the ages of 65 and 80 whose RT-PCR test results are positive/negative according to the records of the Kayseri Provincial Health Directorate Public Health Services. Between September 30, 2020 and January 10, 2021, individuals aged between 65 and 80 whose RT-PCR test results were positive/negative and who were isolated for this reason were called by the researcher, and 808 participants were reached. Out of these participants, 152 patients were excluded from the study due to incomplete data. The study was completed with 656 patients who were RT-PCR positive and did not need hospitalization and who were RT-PCR negative contacts.

Data Collection Tools

The research data were collected with the “Question Form” and “Corona Virus Anxiety Scale Short Form,” which include questions about the socio-demographic characteristics and death anxieties of individuals over the age of 65.

Question form; in this form, there are a total of 14 questions about the socio-demographic characteristics and death anxiety of the individuals over the age of 65. The questions were formed by the researchers through reviewing the literature (Özen et al., 2020; Tanhan, 2010).

The Questions About the Death Anxiety in the Form:

What were you most worried about during the COVID-19 process?

Do you have death anxiety?

Does postmortem make you anxious?

Are you worried about suffering in the premortem period?

Are you worried about suffering at the moment of death?

Do you feel anything when you think of the moment of death?

Coronavirus Anxiety Scale Short Form; the Turkish validity and reliability study of the scale, which was developed by Lee in 2020 (Lee et al., 2020), was conducted by Biçer et al. in 2020. The scale is a 5-point Likert-type one-dimensional scale consisting of five questions. The high score obtained from the scale indicates that the individual has high coronavirus anxiety. It is a self-assessment scale and used to determine the frequency of coronavirus anxiety symptoms experienced by individuals. The value of Cronbach’s alpha is 0.83 (Biçer et al., 2020).

Data Collection

The consents to participate in the study and the telephone numbers of individuals over the age of 65 who were taken into isolation at home due to having a positive RT-PCR test result or negative RT-PCR test result but being in contact were obtained. The

telephone numbers of those who gave consents were obtained from the Public Health Management System. The data of the study were collected by the researchers by phone calls with individuals over the age of 65 who agreed to participate in the study. Interviews were carried out by phone calls to make individuals over the age of 65 feel more comfortable and comply with the isolation rules in the fight against COVID-19. First of all, individuals over the age of 65 were met by phone, they were informed about the research, their verbal consents were obtained from the individuals who accepted the interview, and the interview was initiated by saying that the interview would be recorded. During the meeting, care was taken for the participants to make statements about their home isolation experiences in the fight against COVID-19. The interviews were recorded using a tape recorder and each interview was completed in two sessions, with 10–15 minutes for each session, in a total of approximately 20–25 minutes. “Question Form” and “Coronavirus Anxiety Scale Short Form” were applied to the patients with questions about their demographic characteristics and death anxiety. Whether they had an accompanying symptom or not was questioned during the interviews. The severity of the symptoms was graded as mild and moderate by the physician, but the type of the symptoms was not recorded.

Data Evaluation

The study’s statistical evaluation was made using the SPSS version 22.0 (IBM Corp., Armonk, NY, USA) computer package program. Descriptive statistics were given as mean, *SD*, median, minimum, and maximum. Numbers and percentages were used for categorical data. The distribution of the data was assessed using the Kolmogorov–Smirnov test. The chi-square test was used to evaluate categorical data. The student t-test was used in paired groups for the normally distributed numerical data (COVID-19 anxiety score). Mann–Whitney U test was used for the non-normally distributed numerical data. The relationship between numerical data was evaluated using the Pearson-correlation test. Factors affecting the death anxiety were evaluated using Binary logistic regression analysis. $p < .05$ was accepted as the statistically significant value.

Ethics

Institutional permission was obtained from Kayseri Provincial Health Directorate to carry out the study. Ethics committee approval was obtained from Nuh Naci Yazgan University Non-Interventional Research Ethics Committee (Decision No: 2020/12, Decision Date: September 22, 2020).

Results

This study was completed with 656 elderly individuals. During the study, the prevalence of individuals who were over the age of 65 with positive or negative RT-PCR test

result and who were taken into isolation at home due to being infected or in contact was 4.9%. Of the participants, 49.5% were male, 82.2% were PCR positive cases, and 78.4% had at least one mild and/or moderate level of symptom. The mean age was 69.9 ± 5.7 . Of the participants, 78.4% had symptoms, 42.4% had at least one chronic disease, 6.1% lived alone, and 5.6% had a disability. While 89.5% of them could meet daily life activities alone, 70% had one person helping. Of the participants, 2.6% did not follow the rules and went out of the house while in isolation while 55.3% had death anxiety during isolation. The median Coronavirus Anxiety Scale score of all participants was 4 (0–18) (Table 1). While 21.8% of the participants had hypertension, 16.9% had diabetes mellitus, 6.9% had chronic obstructive pulmonary disease (COPD), 5.8% had Coronary artery disease (CAD), 0.5% had hyperlipidemia, 1.2% had neurological diseases, 1.2% had thyroid diseases, and 0.5% had rheumatic diseases.

When the participants were asked what they were most worried about during the COVID-19 process, 20.7% said they were worried about dying, 16.9% were worried about not seeing their loved ones and being alone, and 16.3% were worried about getting sick due to coronavirus. When questioned about how they felt when they thought of death, 37.3% stated that they were worried about the postmortem and 32.6% stated that they felt nothing when they thought about death (Table 2).

Coronavirus Anxiety Scale scores of male and female participants were similar ($p < .050$). Participants with negative RT-PCR results and death anxiety had higher scores of Coronavirus Anxiety Scale ($p < .001$; $p < .001$) (Table 3).

Table 1. Characteristics of the Participants.

Characteristics	n (%)
RT-PCR positivity (+)	539 (82.2)
Age (mean \pm sd) (min–max)	69.9 \pm 5.7 (65–99)
Symptom (+)	514 (78.4)
Chronic illness (+)	278 (42.4)
Presence of thought of death (+)	363 (55.3)
Living alone (+)	40 (6.1)
Capable of daily activities (+)	587 (89.5)
Disability (+)	37 (5.6)
Assistant at home (+)	459 (70)
Going outside (+)	17 (2.6)
Helping with shopping/home needs	
Family	437 (66.6)
Neighbors	108 (16.5)
Order	63 (9.6)
Fidelity	10 (1.5)
Own	38 (5.8)
Coronavirus Anxiety Scale score [median (min–max)]	4 (0–18)

Table 2. Anxiety Characteristics of Individuals Aged 65 and Over.

Characteristics	n (%)
Anxiety characteristics in the isolation process	
I am worried about losing my physical and emotional abilities	14 (2.1)
I am worried about unbearable pain	57 (8.7)
I am worried about not seeing my loved ones and being alone	111 (16.9)
I am worried about not doing what I want in life	8 (1.2)
I am worried about dying	136 (20.7)
I am worried about getting sick due to the coronavirus	107 (16.3)
I am worried about financial damage and losing my job	149 (22.7)
I was not worried about anything	74 (11.3)
Death anxiety	
Yes	363 (55.3)
No	293 (44.7)
Characteristics of death anxiety	
Postmortem worries me	245 (37.3)
I am worried about suffering while dying	94 (14.3)
I am worried about suffering in the premortem period	103 (15.7)
I do not feel anything	214 (32.6)

Of the male participants, 50.5% had no death anxiety ($p: .002$). Of the participants who were isolated with positive polymerase chain reaction (PCR) result, 56% had death anxiety ($p: .253$). Of the participants with symptoms, 63.4% had the thought of death ($p < .001$). Of the participants who thought that COVID-19 disease could recur, 71.6% had the thought of death ($p < .001$). The coronavirus anxiety score of the participants with death anxiety was higher ($p < .001$) (Table 4).

There was no statistically significant relationship between age and Coronavirus Anxiety Scale score ($p: 0.125$, $r: -0.060$). Due to male gender, the death anxiety increased by 1.661 times (OR: 1.661, $p: .003$, 95% CI: 1.187 ~ 2.324), PCR positivity by 1.983 times (OR: 1.983, $p: .008$, 95% CI: 1.193 ~ 3.296) and presence of symptoms by 0.146 times (OR: 0.146, $p: .000$, 95% CI: 0.09 ~ 0.237) (Table 5).

Discussion

Determining the psychological effects such as COVID anxiety and death anxiety experienced by individuals over the age of 65 during the pandemic, evaluating these effects and attracting the attention of health professionals regarding care processes are very important in terms of elderly health. This study was aimed to evaluate the COVID anxiety and death anxiety experienced during the home isolation process due to COVID-19 in individuals aged 65 and over, where the process is severe.

Table 3. Coronavirus Anxiety Scale Score According to Some Characteristics.

Characteristics	Coronavirus Anxiety Scale Score	
	Median (min–max)	<i>p</i> -value
Male	3 (0–17)	.050
Female	4 (0–18)	
PCR (+)	3 (0–18)	<.001
PCR (–)	6 (0–17)	
Chronic illness (+)	4 (0–17)	.573
Chronic illness (–)	3 (0–18)	
Psychiatric medication (+)	2 (0–9)	.416
Psychiatric medication (–)	4 (0–18)	
Living alone (+)	3 (0–14)	.843
Living alone (–)	4 (0–18)	
Symptom (+)	4 (0–18)	.254
Symptom (–)	3 (0–12)	
Death anxiety (+)	5 (0–18)	<.001
Death anxiety (–)	2 (0–12)	

Mann–Whitney U test was applied. $\alpha = 0.05$.

Table 4. Death Anxiety According to Some Characteristics.

Death Anxiety			
Variables	Yes	No	<i>p</i> -value
Gender (M)	161 (49.5)	164 (50.5)	.002
Age	70.2 ± 5.4	69.9 ± 6	.872
RT-PCR positivity (+)	302 (56.0)	237 (44.0)	.253
Symptom (+)	326 (63.4)	188 (36.6)	<.001
Chronic illness (+)	159 (57.2)	119 (42.8)	.229
Living alone (+)	20 (50.0)	20 (50.0)	.295
Capable of daily activities (+)	324 (55.2)	263 (44.8)	.469
Disability (+)	18 (48.6)	19 (51.4)	.250
Those thinking to be infected with COVID-19 again	260 (59.1)	180 (40.9)	.004
Coronavirus Anxiety Scale score	5 (0–18)	2 (0–12)	<.000

Mann–Whitney U test was applied. $\alpha = 0.05$

In our study, the mean age was 69.9 ± 5.7 . In a study in which the effects of loneliness on the death anxiety were investigated by Guner et al., mean age was 68.28 ± 2.90 (Güner et al., 2020). In this study, 82.2% of the patients were RT-PCR positive cases isolated at home. At least one mild and/or moderate symptom was observed in

Table 5. Factors That Increase Death Anxiety.

Presence of Death Anxiety	95% CI for EXP(B)			
	<i>p</i> -value	Exp (B)	Lower	Upper
Gender (M)	0.003	1.661	1.187	2.324
PCR (+)	0.008	1.983	1.193	3.296
Symptom (+)	<0.001	0.146	0.09	0.237

Binary logistic regression analysis was applied.

78.4% of the participants. In a study conducted by the Epidemiology Study Group of the Chinese Center for Disease Control and Prevention, 81% of the patients showed mild symptoms. This result is similar to the results of our study. In this study, 55.3% of the patients had an obvious thought of death. In an article trying to explain the reactions of people in the COVID-19 epidemic to death in the context of the terror management theory, it was stated that as the frequency of situations that would remind people of the thought of death increased self-esteem decreased and adherence to cultural values or religious beliefs increased as well. The COVID-19 outbreak reminds people of the thought of death every day with the effect of the media (Menzies & Menzies, 2020). The restrictions in our country for the individuals over the age of 65 before isolation and the application of isolation after the disease, dependence on someone else during the disease process, social limitations, and the intensification of the thought of death causing the feeling of proximity to cultural and religious activities were the factors that increased the level of anxiety. However, these requests are at a limited level due to the isolation, which increases the anxiety level of the patients. It is known that the COVID-19 outbreak causes an increase in anxiety worldwide (Menzies & Menzies, 2020). In this study, the Coronavirus Anxiety Scale score was low compared with the findings in literature. This may be because they think that the disease is sent by the Creator and that this can be an ordeal process of the disease.

The loneliness experienced by the elderly increases the death anxiety (Güner et al., 2020). In this study, the participants stated that they were most worried about dying (20.7%), not being able to see their loved ones and being alone (16.6%) during the COVID-19 process. The disease is defined as a life event and an inhibition that creates a threat and stress for all the facts that balance the life of the individual until that day. Both of these anxieties may have developed in response to the disappearance of COVID-19 disease, especially due to the high mortality rates in individuals over the age of 65 (Okuyuz, 1995). COVID-19 is a disease that occurs with symptoms similar to the symptoms of the seasonal flu and rarely causes death in those with mild and moderate symptoms (Karaca, 2020). Also, the possibility of not getting sick is high with individual precautions to be taken. However, considering the reactions to COVID-19 disease, the response of individuals is similar to the reaction of the individual who has a fatal disease. It is thought that especially the videos reflected on social media and

featuring the last moments of the patients who died and the death of hundreds of thousands of people from this disease increase the death anxiety and anxiety level in this disease (Kandemir, 2020; Okyayuz, 1995).

The most important issue that the participants felt when they thought about death was determined as anxiety for the postmortem and fear of suffering in the premortem period. Birth and death are the two most important realities that all living things necessarily experience. Each belief or culture attributes different meanings to birth and death. While some see death as the end, others see it as the beginning of another life or eternal life. This perspective on death significantly affects people's response to illnesses and their anxiety levels. Death anxiety, on the other hand, is an emotion that has existed since birth in the face of death, continues throughout life, and develops after the awareness that the human will no longer exist and that it can be nothing. The dependence, pain, and hurt caused by the illness in the individual as well as the meaning given to death determine the level and form of the reaction given (Bassett & Bussard, 2018; Erdođdu & Ozkan, 2007; Kandemir, 2020). High death anxiety causes general tension and an increase in some mental symptoms. All participants in the study were individuals belonging to the Muslim religious community in Turkey where there is a belief that there is life after death due to the Muslim faith. It is believed that an individual goes to heaven if he becomes a good person in the world, and to hell, if he becomes a bad and sinful person. Again, according to this belief, an individual who dies is washed by a religious official and buried in the ground with prayers by performing a funeral prayer. Studies on death have shown that in societies with high religious beliefs, death anxiety shows itself as the fear of punishment due to being sinful after death (Okyayuz, 1995). These beliefs may be one of the most important reasons why the majority of the participants in this study experienced anxiety about postmortem. Also, the burial of individuals who died due to coronavirus without performing funeral prayers and without any relatives may be one of the reasons for this anxiety. Participants who fear pain and suffering in the premortem period may also be considered to see news or posts featuring the fatality of the disease and the painful death of patients, which are constantly shared on television or social media due to their isolation at home.

Coronavirus Anxiety Scale score is high in the patients diagnosed with COVID-19 (Vujanovic et al., 2021). However, the anxiety of those with positive RT-PCR results was significantly lower than that of those with negative RT-PCR test results. The reason of this difference can be that our study was performed with the elderly population and that the elderly patients faced the condition with maturity.

In the study, the anxiety level of those with death anxiety was higher than those without death anxiety ($p < .001$). In addition, those with positive RT-PCR test results (OR: 1.983, p : .008, 95% CI: 1.193 ~ 3.296) and those with symptoms (OR: 0.146, p : .000, 95% CI: 0.09 ~ 0.237) experienced more death anxiety. The fact that elderly individuals who are positive for RT-PCR are clear about whether they are sick or not and do not experience an unknown condition may have decreased the level of anxiety. At the same time, their anxiety can be reduced by the thought that this disease is not as difficult as they see on television or social media because they are experiencing

coronavirus disease. Death anxiety increases the level of anxiety, which is also an expected condition. The most important factor here is to state that the purpose of restrictions is to protect the elderly people in order to reduce the anxiety and panic of the epidemic process in the counseling given to the patients by the home healthcare team, and the information that the houses are safer from the outside and that the most effective way to be protected from the effects of the virus is staying home should be given in an enlightening way. Also, it is thought that explaining to the patients that their condition and symptoms are normal in a realistic way and focusing on the recovery process rather than the disease will be beneficial in reducing the anxiety level and death anxiety (Yıldırım & Abdurrahim, 2021).

Limitations of the Study

The most important limitation of this study is that the meetings with the participants could not happen face-to-face due to the pandemic measures. Another limitation is that the death anxiety scales could not be applied and the reason was that the participants were over the age of 65, there was a communication problem and the meetings by phone calls were not efficient enough. Another limitation was that the disease and symptom severity affecting the anxiety could not be assessed in detail. However, including 656 participants who were over the age of 65 and in home-isolation and questioning the participants about their social problems constitute the strengths of the study.

In conclusion, individuals with positive COVID-19 test results or those aged 65 and over who had death anxiety and negative COVID-19 test result but who were in home-isolation due to being a contact and those with negative PCR results had higher anxiety score. Therefore, psychotherapy can be used to decrease the anxiety in those who had death anxiety. People can be supported in accordance with their religious beliefs. Those with negative PCR test results in quarantine can be adequately informed about the COVID-19 and their anxiety for COVID-19 can be reduced.

Declaration of Conflicting Interests

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Ethical Approval

Institutional permission was obtained from Kayseri Provincial Health Directorate to carry out the study. Ethics committee approval was obtained from Nuh Naci Yazgan University Non-Interventional Research Ethics Committee (Decision No: 2020/12, Decision Date: September 22, 2020).

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