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Comparison of Death Anxiety Components in Married and Unmarried Elderly Individuals

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ABSTRACT

This study aimed to compare the components of death anxiety—pure death anxiety, general factor, and fear of pain and surgery—between married and unmarried elderly individuals residing in Shiraz. The research employed a causal-comparative design. The statistical population included all elderly members of the Jahandidegan Center in Shiraz in 2025. Using convenience sampling, 90 participants (52 married and 41 unmarried) were selected and matched by gender and marital status. Data were collected using the Templer Death Anxiety Scale, a 15-item self-report questionnaire measuring various aspects of death anxiety. Descriptive statistics and inferential analyses were conducted using SPSS version 26. Assumptions of normality and homogeneity of variances were confirmed, and multivariate analysis of variance (MANOVA) was used to examine group differences. The results of the MANOVA showed no statistically significant differences between married and unmarried elderly individuals in the overall combination of death anxiety components (Wilks' Lambda = 0.978, F = 0.67, p = 0.574, η^2 = 0.022). Univariate analyses also revealed no significant group differences across individual components: pure death anxiety (F = 0.40, p = 0.528), general factor (F = 0.22, p = 0.638), and fear of pain and surgery (F = 0.32, p = 0.575). All effect sizes were negligible. The findings suggest that marital status does not significantly influence levels of death anxiety or its components among elderly individuals in Shiraz. Psychological, spiritual, and social protective factors may play more central roles in shaping death-related fears in old age than demographic variables such as marital status. These results highlight the importance of holistic and inclusive mental health approaches for all elderly individuals, regardless of their marital condition.

Keywords: Death Anxiety, Elderly, Marital Status, Aging, Shiraz

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Introduction

Aging, as a multidimensional and inevitable process, introduces individuals to various psychological, emotional, and existential challenges. Among these, death anxiety stands as a pivotal and deeply rooted concern, especially in older adulthood. Death anxiety, often defined as the emotional distress or

apprehension associated with the anticipation of death or the process of dying, is particularly salient in elderly individuals as they approach the final stages of life. This psychological construct is shaped by a variety of personal, cultural, spiritual, and relational factors, making it a complex and multifaceted phenomenon in geriatric mental health studies (1-3).

The prevalence and intensity of death anxiety among the elderly have been consistently addressed in empirical literature. Studies indicate that factors such as psychological well-being, loneliness, religious beliefs, perceived social support, and even personality traits play significant roles in moderating or exacerbating death-related fears in older populations (4-7). The transition to old age is often marked by life events such as retirement, chronic illness, bereavement, and social withdrawal, all of which may increase existential contemplation and elevate anxiety levels related to death (8, 9). In this context, the variable of marital status emerges as an influential factor with potential buffering or aggravating effects on psychological distress in later life.

Marriage is widely recognized as a protective factor against psychological disorders, including death anxiety. Spouses often serve as sources of emotional, practical, and social support, contributing to a sense of belonging and meaning that can mitigate fears related to mortality (10-12). Conversely, being unmarried—whether due to widowhood, divorce, or lifelong singleness—may heighten feelings of isolation and vulnerability, leading to elevated death anxiety (5, 13, 14). The absence of close companionship in late life may deprive individuals of critical emotional support, leading to reduced psychological resilience when confronting existential threats (15, 16).

Within Iranian culture, where family ties and collectivistic values are deeply embedded, the role of marital relationships in shaping psychological outcomes among the elderly takes on added significance. Studies conducted in Iran have shown that variables such as spiritual well-being, mindfulness, and religious commitment are frequently linked to reduced death anxiety among older adults (17-19). These factors are often amplified or diminished depending on marital dynamics, thus emphasizing the need to explore death anxiety through a culturally nuanced and relationship-sensitive lens.

Recent findings during and after the COVID-19 pandemic have added further complexity to the understanding of death anxiety. The global health crisis magnified older adults' vulnerability, not only physically but also psychologically, as media exposure and actual mortality rates intensified the collective awareness of death (20-22). During this period, researchers highlighted the moderating role of psychological hardiness, existential vacuum, and spiritual health in elderly populations' responses to death-related concerns (6, 13, 15). Within such a context, the presence or absence of a marital partner could either serve as a coping resource or exacerbate the emotional burden, depending on the nature and quality of the relationship.

Research evidence points toward the interaction of marital status with other intrapersonal and interpersonal variables. For instance, Zhang and colleagues found that self-esteem mediated the relationship between meaning in life and death anxiety in elderly populations, while social support strengthened this pathway (8). In a similar vein, Zhou emphasized that interventions such as Tai Chi reduced death anxiety in elderly individuals living alone by enhancing their psychological capital and perceived social support (4). These findings suggest that relational contexts—marital or otherwise—play a central role in modulating emotional responses to mortality.

In the Iranian setting, several studies have highlighted the psychological vulnerabilities of unmarried elderly individuals. Ghasemi and colleagues reported a strong inverse relationship between religious attitudes and death anxiety, particularly among those with limited social support (2). Likewise, Haji Hasani and Naderi found that both spiritual health and perceived social support significantly predicted lower levels of death anxiety in elderly populations (12). These findings align with broader meta-analytic evidence suggesting that loneliness is a consistent predictor of death anxiety among older adults (7, 23).

Despite the growing body of international and domestic research, limited attention has been paid to directly comparing married and unmarried elderly individuals with respect to the specific components of death anxiety—such as fear of the dying process, fear of the unknown, and anxiety triggered by physical pain or surgical interventions. Addressing this gap, the present study seeks to explore whether marital status differentiates elderly individuals in Shiraz in terms of their experience of death anxiety and its psychological subdimensions.

This investigation is particularly relevant in light of psychological models that integrate emotional resilience, cognitive appraisal, and socio-spiritual constructs. For example, studies by Tabe-Bardbar and colleagues underscore how personality types and mental health significantly contribute to variations in death anxiety (24). Other findings have shown that death anxiety is not only influenced by individual cognitive patterns but also by existential awareness and perceived life meaning—variables often shaped through intimate relationships and shared life narratives (25, 26).

Furthermore, psychological well-being in elderly populations is increasingly viewed through the lens of integrated models that encompass spiritual, social, and emotional domains. Hamidi and colleagues, for example, developed a model wherein perceived social support predicted lower death anxiety through the mediating role of psychological well-being among older adults who had experienced COVID-19 (6). Similarly, Nasab et al. proposed a structural model indicating that loneliness and dysfunctional attitudes increased death anxiety, while spiritual health served as a mediating buffer (10). These integrative approaches underscore the importance of examining interpersonal contexts such as marriage in relation to death-related anxiety.

Taken together, the existing literature provides a compelling rationale for examining the relationship between marital status and death anxiety in the elderly. Yet, few empirical studies have explicitly compared married and unmarried older adults on distinct death anxiety dimensions in the Iranian context. Considering Shiraz as a major urban center with a diverse elderly population and established community centers, this study is well-positioned to fill this empirical gap. It aims to contribute to the existing literature by providing insights into how relational factors—specifically marital status—intersect with psychological responses to death in later life. Accordingly, the present study was designed to compare the levels and dimensions of death anxiety between married and unmarried elderly individuals residing in Shiraz.

Methods and Materials

Study Design and Participants

This research employed a causal-comparative design to explore potential differences in death anxiety components between married and unmarried elderly individuals. The statistical population consisted of all elderly men and women, both married and unmarried, who were members of the Jahandidگان Center in

Shiraz in the year 2025. The sampling method was convenience-based, and a total of 90 elderly individuals were selected to participate in the study. The sample size was determined in accordance with methodological guidance provided by Delavar (2016), which recommends a minimum of 30 participants per group for causal-comparative studies. To enhance the validity of the findings, the researchers selected 45 married and 45 unmarried elderly individuals, ensuring demographic matching in terms of gender and marital status to control for potential confounding variables.

Data Collection

The primary data collection instrument used in this study was the Templer Death Anxiety Scale (DAS), developed in 1970. This self-administered questionnaire is one of the most widely used tools for measuring anxiety related to death and consists of 15 dichotomous (yes/no) items. The scale includes subcomponents such as pure death anxiety, general death factor, and fear related to pain and surgery. Each "yes" response indicates the presence of death anxiety and is scored as one point, resulting in a possible range of 0 to 15. A higher total score reflects a higher level of death anxiety. Typically, scores from 0–6 indicate low death anxiety, 7–9 moderate anxiety, and 10–15 high anxiety. An alternative approach classifies scores using the sample mean and standard deviation, where scores above +1 SD are interpreted as high and those below -1 SD as low. The reliability of the scale has been supported by various studies: Templer (1970) reported a test-retest reliability coefficient of 0.83. In subsequent validations, Cronbach's alpha coefficients ranged from 0.49 to 0.85 across different populations. In Iranian samples, research by Ghasempour et al. (2012) found an alpha coefficient of 0.65, while Rajabi and Bahrani (2001) reported 0.78, and a more recent study by Soleimani and Zoghi (2022) found the reliability to be 0.85. The validity of the scale has also been supported through factor analysis and content validity in previous local and international research.

Data Analysis

Following ethical approval from the Biomedical Research Ethics Committee of Islamic Azad University, Shiraz Branch, data collection commenced. After obtaining informed consent, the researcher distributed the questionnaires to the 90 selected participants from the Jahandidگان Center. Once completed questionnaires were collected, data were entered and analyzed using SPSS version 26. Descriptive statistics were first used to summarize the demographic variables and core research variables separately for the married and unmarried groups. Prior to inferential testing, key statistical assumptions were examined, including the normality of variable distributions (using skewness and kurtosis indices) and the homogeneity of variances (via Levene's test). For the main inferential analysis, Multivariate Analysis of Variance (MANOVA) was conducted to compare the levels of death anxiety and its components between the two groups.

Findings and Results

The demographic characteristics of the participants in this study are as follows. The sample consisted of 52 married and 41 unmarried elderly individuals from the Jahandidگان Center in Shiraz. In the married group, gender was evenly distributed, with 26 women (50%) and 26 men (50%). In contrast, the unmarried group included a higher proportion of women, with 28 (68.3%) female participants and 13 (31.7%) male participants. Regarding educational attainment, among the married elderly, 25 individuals (48%) had less

than a high school diploma, 17 (32.7%) had completed high school, and 9 (17.3%) had obtained a university degree. In the unmarried group, 19 participants (46.3%) had less than a high school education, 17 (41.5%) held a high school diploma, and 5 (12.2%) had university-level education. These demographic distributions allowed for meaningful comparison across marital status groups while also highlighting differences in gender and educational background.

Table 1. Mean and Standard Deviation of Death Anxiety and Its Components in Married and Unmarried Elderly Groups

Variable	Married Elderly Group (n = 52)		Unmarried Elderly Group (n = 41)	
	Mean	SD	Mean	SD
Pure Death Anxiety	3.50	1.88	3.24	2.04
General Factor	2.95	1.54	3.11	1.69
Fear of Pain and Surgery	2.18	1.51	2.00	1.60
Total Death Anxiety	8.63	4.28	8.35	4.74

The descriptive findings presented in Table 1 illustrate the mean scores and standard deviations for total death anxiety and its three subcomponents—pure death anxiety, general factor, and fear of pain and surgery—across married and unmarried elderly individuals. The mean score for total death anxiety in the married group was 8.63 (SD = 4.28), slightly higher than the unmarried group, which had a mean of 8.35 (SD = 4.74). For pure death anxiety, married participants scored a mean of 3.50 (SD = 1.88), compared to 3.24 (SD = 2.04) in the unmarried group. On the general factor component, unmarried elderly showed a slightly higher mean (M = 3.11, SD = 1.69) than their married counterparts (M = 2.95, SD = 1.54). Similarly, in the fear of pain and surgery subscale, the married group had a mean of 2.18 (SD = 1.51), marginally higher than the unmarried group's mean of 2.00 (SD = 1.60). Overall, the mean differences across groups were relatively small, indicating generally similar levels of death anxiety and its components between the two groups at the descriptive level.

Before conducting the main inferential analyses, the necessary statistical assumptions were examined and confirmed. The normality of the distribution for the dependent variables—total death anxiety and its components—was assessed using skewness and kurtosis indices, all of which fell within the acceptable range of ±2, indicating no significant deviation from normality. Additionally, the homogeneity of variances between the married and unmarried groups was tested using Levene's test, and the results showed no significant violations, confirming that the assumption of equal variances was met. Therefore, the data were deemed suitable for further analysis using multivariate analysis of variance (MANOVA).

Table 2. Multivariate Test Results for Overall Differences in Death Anxiety Components Between Married and Unmarried Elderly

Test Type	Value	F Statistic	df	p-value	Partial Eta Squared
Wilks' Lambda	0.978	0.67	3	0.574	0.022

The results of the multivariate analysis of variance (MANOVA), presented in Table 2, indicate that there were no statistically significant overall differences between married and unmarried elderly individuals regarding the combined set of death anxiety components. Wilks' Lambda value was 0.978, with an associated F statistic of 0.67 and a p-value of 0.574, which is well above the conventional threshold of 0.05. The partial eta squared value of 0.022 also indicates a very small effect size. These findings suggest that marital status

does not significantly influence the overall pattern of death anxiety components among elderly individuals in this sample.

Table 3. Univariate ANOVA Results for Differences in Death Anxiety Components Between Married and Unmarried Elderly

Variable	Mean (Married)	Mean (Unmarried)	Mean Difference	Sum of Squares	F Value	p-value	Partial Eta Squared
Pure Death Anxiety	3.50	3.24	0.26	1.53	0.40	0.528	0.004
General Factor	2.95	3.11	-0.16	0.58	0.22	0.638	0.002
Fear of Pain and Surgery	2.18	2.00	0.18	0.76	0.32	0.575	0.003

As shown in Table 3, the univariate ANOVA results for each component of death anxiety also revealed no statistically significant differences between the two groups. For pure death anxiety, the mean difference between married (M = 3.50) and unmarried (M = 3.24) individuals was 0.26 (F = 0.40, p = 0.528), which is not statistically significant. The general factor showed a mean difference of -0.16 (F = 0.22, p = 0.638), and the fear of pain and surgery subcomponent revealed a difference of 0.18 (F = 0.32, p = 0.575). All p-values were greater than 0.05, and the associated effect sizes (partial eta squared) were extremely small, ranging from 0.002 to 0.004. These results confirm that marital status did not significantly impact any individual component of death anxiety in this elderly population.

Discussion and Conclusion

The purpose of this study was to compare the levels and dimensions of death anxiety between married and unmarried elderly individuals in Shiraz. Based on the results obtained from descriptive and inferential analyses, no statistically significant differences were found between the two groups in terms of overall death anxiety or its components, including pure death anxiety, general death anxiety, and fear of pain and surgery. These findings challenge the common assumption that marital status significantly influences death anxiety in older adults and suggest that other factors may play more influential roles in shaping end-of-life anxiety.

The results of the multivariate analysis (MANOVA) revealed no significant differences between married and unmarried elderly individuals with respect to the composite set of death anxiety components. This is consistent with findings reported by (5), who found that although loneliness significantly predicted death anxiety during the COVID-19 pandemic, marital status alone did not emerge as a strong independent predictor when other variables such as psychological hardiness and social support were controlled. Similarly, (14) found that the quality and type of interpersonal relationships, not merely their existence, were more critical in explaining variance in death anxiety among older individuals. The absence of a significant difference in the current study might be explained by the possibility that both groups had access to alternative sources of emotional support—such as children, extended family, or community networks—that compensated for the presence or absence of a spouse.

Another possible explanation for these findings lies in the role of spiritual and cognitive protective factors that operate across marital statuses. As highlighted by (12), spiritual health and perceived social support substantially reduce death anxiety regardless of one's marital condition. In many Iranian cultural contexts, where spiritual beliefs about life, death, and the afterlife are deeply internalized, such factors may function as buffers against death-related fears. This protective influence of spiritual meaning and internal coping

mechanisms may dilute the impact of marital status on death anxiety, which helps explain the statistical similarity observed between married and unmarried participants in the present study.

Moreover, the lack of significant group differences aligns with the perspective proposed by (15), who emphasized the mediating role of mindfulness between loneliness and death anxiety. If both married and unmarried elderly individuals possess mindfulness or emotional regulation capacities, it is plausible that such psychological traits mitigate death anxiety, rendering the variable of marital status less influential. Similarly, the model developed by (6) indicated that psychological well-being mediated the relationship between perceived social support and death anxiety in elderly individuals with COVID-19 experience, further demonstrating the primacy of internal states over demographic variables.

The non-significant differences observed across the three components of death anxiety—pure anxiety about death, general existential fear, and fear of pain and surgery—further reinforce this interpretation. As shown in studies such as (13) and (21), these subcomponents are shaped by existential factors such as psychological hardiness, resilience, and spiritual beliefs, rather than marital status per se. The findings of (24) also support this view, suggesting that personality types and mental health indicators more robustly predict levels of death anxiety than sociodemographic characteristics.

Notably, in the present study, both groups demonstrated relatively similar mean scores for total death anxiety and each of its dimensions. This homogeneity may reflect a broader pattern of cultural adaptation to mortality among the elderly population in Shiraz. As (19) noted, mindfulness and tolerance of ambiguity significantly reduce death anxiety and improve sleep quality in elderly individuals, implying that internal coping strategies are universally applicable regardless of marital context. These findings align with (4), who demonstrated that elderly individuals living alone benefited from Tai Chi practices by enhancing their social support and psychological capital, ultimately reducing their death anxiety.

Furthermore, the similarity of scores may be partly attributed to broader shifts in social structures that support elderly well-being. Community engagement programs, religious centers, and intergenerational family systems may play a role in alleviating isolation and enhancing existential meaning for both married and unmarried individuals. According to (11), psychological hardiness and religious practices such as prayer serve as significant psychological resources that transcend marital boundaries in reducing death anxiety.

While previous research, including that of (18), emphasized the role of marital intimacy and self-compassion in predicting psychological well-being and death anxiety, these variables may not necessarily differ between married and unmarried elderly if alternative sources of support or intrapersonal strengths are present. In other words, while being married might offer structural support, the perceived quality and internal interpretation of one's relationships—and of life itself—may be more influential in shaping end-of-life emotional states.

The findings are also congruent with the meta-analytic review by (27), who concluded that death anxiety in Iranian elderly populations varies considerably depending on mediating psychological constructs such as resilience, hope, and spirituality. In line with this, (22) proposed that COVID-19 anxiety and psychological hardiness mediate the relationship between hope and death anxiety in elderly women, again indicating that psychological frameworks hold more predictive power than demographic attributes such as marital status.

Another important consideration is the evolving nature of aging experiences in modern societies. As highlighted by (8), self-esteem mediates the relationship between meaning in life and death anxiety, and this

construct is not exclusively contingent on being in a marital relationship. Elderly individuals may derive self-worth and existential meaning from diverse life roles, such as being parents, community members, or spiritual beings. These roles could buffer against death anxiety as effectively as—or even more than—marital roles.

Finally, some researchers, such as (17) and (26), have argued that perceived social support—whether from a spouse, children, peers, or community—plays a central role in shaping elderly individuals' death anxiety. Therefore, marital status as a binary variable may not capture the complexity of interpersonal and spiritual support systems available to the elderly. This theoretical perspective supports the current study's finding that marital status alone does not significantly predict variations in death anxiety components.

This study, while methodologically sound and theoretically grounded, is not without limitations. First, the sample was selected using a convenience sampling method from a specific community center in Shiraz, which may limit the generalizability of the findings to other elderly populations in Iran or different cultural contexts. Second, although the study focused on marital status as the main variable of interest, it did not account for the quality or duration of marital relationships, which could significantly influence psychological outcomes. Third, the study relied solely on self-report measures, which are susceptible to social desirability and memory biases. Fourth, the cross-sectional design prevents any causal inference about the relationship between marital status and death anxiety. Fifth, potential confounding variables such as physical health status, financial security, or living arrangements were not included in the analysis. Sixth, while religious and spiritual beliefs are known to be influential, the study did not formally assess them despite their strong relevance to death anxiety. Lastly, psychological constructs like depression, loneliness, or meaning in life—which may mediate or moderate the relationship between marital status and death anxiety—were not measured, limiting the depth of analysis.

Future studies should aim to include more diverse samples from different regions, ethnic groups, and socioeconomic backgrounds to enhance external validity. Longitudinal designs are recommended to examine how changes in marital status over time influence death anxiety trajectories in elderly populations. Additionally, future research should integrate multidimensional assessments of marital quality, emotional intimacy, and spousal support to better understand their psychological implications. The inclusion of mediating variables such as spirituality, coping styles, personality traits, and meaning in life could provide a more comprehensive understanding of the underlying mechanisms. Studies could also explore how gender differences interact with marital status in predicting death anxiety. Moreover, qualitative approaches could yield rich insights into the subjective experiences of elderly individuals regarding death and relational life. Finally, interventional studies should evaluate the effectiveness of group therapies, mindfulness training, or spiritual counseling in reducing death anxiety, particularly for unmarried or socially isolated elderly individuals.

From a practical standpoint, mental health professionals, gerontologists, and community caregivers should avoid overemphasizing marital status as a determinant of psychological vulnerability in elderly populations. Instead, interventions should focus on enhancing psychological resilience, promoting spiritual well-being, and strengthening social support networks regardless of marital condition. Community programs aimed at increasing engagement, purpose, and social connection may benefit both married and unmarried elderly individuals. Tailored support services, including grief counseling, mindfulness training, and

psychoeducation on end-of-life coping strategies, should be made widely accessible. Health policy makers should consider integrating mental health screening and death anxiety assessments into routine elderly care, especially in community centers and religious institutions. Additionally, training for family members and caregivers on emotional support strategies can be instrumental in reducing existential distress in older adults. Lastly, public awareness campaigns can help destigmatize discussions around death and promote open, culturally sensitive conversations about aging and mortality.

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Authors' Contributions

All authors equally contributed to this study.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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