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MENTAL HEALTH, DEATH ANXIETY AND RELIGIOUS COPING AMONG COVID-19 PATIENTS

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Abstract

The purpose of this study was to explore the relationship of mental health problems, death anxiety and coping strategies among COVID-19 Patients. Purposive sampling technique was employed to gather the sample. Total sample of 320 participants (175 male, 145 female) was collected from Lahore. The age range of sample was 20 to 60 years. Depression, Anxiety and Stress Scale (Lovibond, 1995), Death Anxiety Scale (Templer, 1970) and Religious Coping Scale (Aflakseir & Coleman, 2011) were used to collect the data. SPSS version 23 was used for data analysis. There was significant positive relationship between depression, anxiety and stress scale and death anxiety. Result of regression analysis shows that COVID-19 was a significant positive predictor of death anxiety. No significant difference was found to feel fear of death and use of religious coping between male and female participants. COVID-19 patients with age group 41-60 years had more psychological problems and more fear of death. They also used more religious coping strategies as compared to age group 20-40 years.
Keywords: Religious coping, death anxiety, stress and fear, COVID-19

Introduction

After the outbreak of the Corona virus in Wuhan, the COVID-19 spread speedily across the world and caused high morbidity and mortality rate (Zylke et al. 2020). World Health Organization (WHO) (2020) reported that COVID-19 has affected more than 107 million population and killed almost 2.4 million people around the world. In Pakistan, the very first corona virus case was observed on February 26, 2020. After one year, on 28 February 2021, government of Pakistan reported that 0.5 million citizens have been diagnosed and 12,000 have succumbed to COVID-19 (Salman et al. 2020). Spreading rapidly around the world, the COVID-19 has now become a global health issue with severe harmful consequences (Velavan, & Meyer, 2020). People of all nations are facing severe consequences of corona virus. COVID-19 consequences have become a problem that is too much expensive to neglect. So, there is an immense need to cope COVID-19 impacts.

Numerous studies have shown the impacts of COVID-19 (Singhal, 2020; Chaplin, 2020). It impacts not only physical health but also psychological well-being of people. Several studies have established psychological problems e.g. Depression, anxiety and stress in population affected by corona virus (Zylke et al. 2020). Depression is a disorder that involves sadness, feelings of worthless; reduce self-esteem, lack of interest in pleasure activities and even suicidal attempts (Sarason & Sarason, 2005). A study conducted in New Jersey by Kecojevic (2020) found that people who were diagnosed with corona virus had high rate to develop depression and stress. Heidari et al. (2020) also found increased rate of stress among COVID-19 patients. Anxiety was another psychological problem observed in Covid-19 patients. A recent study found that corona virus had two times greater risk for developing anxiety disorders (Velavan, & Meyer, 2020). According to Sarason and Sarason (2005) symptoms of anxiety includes tired, increase heart rate and panic. Covid-19 patients who suffered in anxiety also showed

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symptoms of restless, tired, increase heart rate and panic. A study conducted in china reported high rate of depression and anxiety (16.5%) among Covid-19 patients. Even that doctors who were treating patients of COVID -19 also showed symptoms of depression and anxiety (Velavan, & Meyer, 2020). Therefore, numerous studies found that people who suffered in COVID-19 develop psychological problems.

Death is a universal fact. It is beyond the human control. But death anxiety is a feeling of distress, fear and panic caused by thoughts of death and being detach from this word. Although death notion causes anxiety for everyone, but it looks more related than ever in the current context of pandemic. Because of the huge number of deaths occur around the world from COVID-19, people suffer in death anxiety. A large-scale study conducted by Newton-John et al. (2020) found high rate of death anxiety among COVID-19 patients. This study also found significant positive correlation between death anxiety and psychological problems among COVID-19 patients. Lee (2020) also said that death anxiety among COVID-19 patients play a casual role to enhance psychological problems.

Religious coping entails such coping strategies that are based on religious practices to cope emotional pressure and physical distress. Lazarus (1993) defines coping as constant cognitive and behavioral efforts to handle particular internal and/or external demands and that are considered as enhancing resources of the concerned person. Lazarus and Folkman (1984) advocated that coping is a cluster of strategies used to deal life problems. Several studies have found religious coping impacts on wellbeing (Lai, 2020). People who employ religious coping strategies can deal their stresses more effectively as compared to those who do not (Loewenthal, 2001). Paragment published book in 1977 “The psychology of religion and coping” and described religious coping significance in the times of distress. In the context of Islam, religious coping strategies are a source to deal with life problems. Islamic coping techniques based on Islamic preaching e.g. Prayer, patience, and recitation of the Qur’an and trust in Allah significantly minimize life stresses. Furthermore, people who believe on high power of Allah feel less stress about results. Such believes are a one way of appraising a distress situation. Moreover, such believes are also helpful to control feelings of despair and hopelessness. Loewenthal (2001) said that people who believe and use religious coping strategies can better their psychological problems. Studies indicate that Muslims engage their religion to cope psychological problems relatively more as compared to other religions (Bhui, King, Dein, & O’Connor, 2008; Liu, Baumeister, & Zhou, 2020). Spirituality and religion play significant role in the lives of Pakistani people. As per our knowledge religious coping to deal psychological problems among COVID-19 patients is unexplored area. So, in this study a multi-dimensional measure is used to explore different forms of religious coping to deal with psychological problems and death anxiety among COVID-19 patients.

To fulfill the objectives of this study following hypotheses were made:

- There would be a significant relationship among mental health problems, death anxiety and coping strategies among COVID-19 Patients.
- Religious coping strategies will be helpful to cope psychological problems and death anxiety among COVID-19 Patients.
- The most frequent religious coping experienced by COVID-19 patients will be “practice coping religious strategies” and active coping religious strategies”.
- Female COVID-19 patients will suffer more in psychological problems and fear of death and will use more religious coping strategies as compared to male patients.

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- Age group 41-60 years COVID-19 patients will suffer more in psychological problems and fear of death and will use more religious coping strategies as compared to age group 20-40 years patients.

Methods

Quantitative research approach was adopted for achieving study objectives. Cross-sectional design was employed. Data were collected using survey questionnaire.

Sample and sampling strategy

In this study, purposive sampling was used to collect study data. Total sample of 320 participants (175 male, 145 female) was included from Lahore. Participants were chosen by sending the online survey. Questionnaires were distributed to participants through various social networking sites e.g. Google drive, WhatsApp, and Email etc. All participants were included in this study were diagnosed COVID-19 patients. Their age range was 20 to 60 years (M = 36.5, SD = 5.6). Participants were characterized of various demographic variables, e.g. age, and gender, etc. Participants less than 18 years of age were not part of this study. Only those participants were included who were diagnosed with corona virus and they were in quarantine. Participants diagnosed with any clinical disorder were not part of this study.

Measures

Demographic information sheet

Depression, Anxiety and Stress Scale (DASS): This scale was developed by Lovibond (1995). DASS is a self-report measure consisted of 3 subscales depression, anxiety and stress. This scale is used to assess anxiety, depression and stress. DASS consists of 21 items. This is likert type scale with 0 (not at all) to 3 (most of the time). All three subscale (depression=.89, anxiety=.78 and stress=.88) and total scale possess good reliability .89. Sample items are like life meaningless, difficult to relax, close to panic.

Death Anxiety Scale: This scale was developed by Templer (1970). Death anxiety scale consists of 15 items. This is likert type scale from 1 to 5 (1= strongly disagree, 5= strongly agree). Range of score is 15 to75. 15 to 35 indicate low, 36 to 55 moderate and 56 to 75 high death anxiety. Alpha reliability of this scale is .82. Sample items are e.g. afraid to die, feel distress as time flies rapidly.

Religious Coping Scale*:* Religious Coping Scale developed by Aflakseir and Coleman (2011) was employed to measure religious practice and strategies. This scale consists of practices and strategies that are use within Islamic context. There are 22 items with five factors or dimensions including active religious coping (I want to act according to God's will), passive religious coping (I feel God solve all my problems), practice religious coping (search help with prayer), benevolent reappraisal religious coping (search God's will), and negative religious coping (feel disappointed with God's mercy). This scale is responded on five point likert ranging 0 to 4 (not at all to a great deal). Higher score means greater use of religious coping. All the 5 dimensions (including active religious .81, passive religious coping .80, practice religious coping .78, benevolent reappraisal religious coping .74 and negative religious coping .77) and total religious Coping scale possess good reliability .91.

Procedure

Participants were included with their consent. Questionnaires were filled online through various websites e.g. Google form, WhatsApp and Email. Purpose of the study was explained to participants. Researcher provided written guidelines explaining how the questionnaire should be respond. All the study participants filled demographic sheet, depression, anxiety and stress scale, death anxiety scale and religious coping scale individually. This study was conducted with respects, dignity, right and welfare of study participants. They were informed that their personal information will be kept confidential. Furthermore, they had the right of withdraw from the study.

Results

Table 1

Descriptive and Reliability analysis of scales (N=320)

Measures	*No. of items*	Mean ±SD	*α*	Potential Min-max	Actual Min-max
DASS	21	44.45±5.32	.89	0-55	0-63
Death anxiety scale	15	43.62±.06	.82	15-45	15-75
Religious Coping Scale	22	55.11±3.66	.91	0-34	0-88

Note. DASS =depression, anxiety and stress scale, α=Reliability

Above table shows all scales possess good reliability.

Table 2

Pearson Product Moment Correlation among study Variables (N=320)

Sr. no.	Variables	1	2	3	p-values
1	DASS	-	. 66**	.54**	***p*< 0.01
2	Death anxiety scale	-	-	.71**	***P*<0.01
3	Religious Coping Scale	-	-	-	

Note. DASS =depression, anxiety and stress scale

There was significant positive relationship between depression, anxiety and stress scale and death anxiety. Furthermore, depression, anxiety and stress scale was significantly positively related to religious coping scale.

Table 3

Linear Regression for Predicting Coping Strategies, DASS and death anxiety among COVID-19 patients (N = 320)

Variable	Religious Coping			Mental health			Death anxiety		
	B	SEB	ß	B	SEB	ß	B	SEB	ß
COVID-19	.32	.06	.35***	1.32	.11	.48***	.05	.01	.21***
R^2		.13			.29			.05	
F	44.55			22.58			166.04		

***$p < .001$

Table 3 shows that COVID-19 is significant positive predictor of religious coping strategies with 13% of variance. COVID-19 is significant positive predictor of depression, anxiety and stress (ß =.48, p<.001) as well and it explained 29% of variance in depression, anxiety and strains. This table also depicts the predictability of death anxiety based on COVID-19. Results show that covid-19 is also significant positive predictor of death anxiety (ß =.21, p<.001) and it accounted for 6% of variance in death anxiety.

Table 4

Mean and standard deviation of Muslim religion coping strategies (N=320)

Coping strategies	Mean	SD
1. Active religion coping strategy	2.44	0.56
2. Passive religion coping strategy	1.55	0.22
3. Practice religion coping strategy	2.88	0.58
4. Benevolent religion coping strategy	1.89	0.73

5. Negative religion coping strategy	1.88	0.53

Results of above table show that the practice religion coping strategies were used most frequently (Mean=2.88, SD=0.58). Second most frequent used strategies were active religious coping (Mean=2.44, SD=0.). Findings also show that the least frequently used religious strategies were passive coping (Mean=1.55, SD=0.22).

Table 5

Mean*, Standard Deviation and t-value for the Scores of Male (n=175) and Female (n=145)* on DASS, Death anxiety and Religious coping scale *(N=320)*

	Male (n = 175)		Female (n = 145)				95% CI		
Scales	M	SD	M	SD	*t*(318)	*P*	LL	UL	Cohen's d
DASS	32.90	6.57	37.78	6.88	-5.50	.000	8.74	15.04	1.04
Death anxiety scale	33.91	4.98	34.69	4.62	.22	.73	6.05	9.48	0.04
Religious Coping Scale	39.94	4.48	38.01	4.96	.27	.61	9.09	14.11	0.13

Note. ****p*<.001 M=Mean, SD=Standard Deviation, LL=Lower Limit, UP=Upper Limit, Cl=Confidence interval,

Above table findings depicts that male participants had more psychological problems. No significant difference was found to feel fear of death and use of religious coping between male and female participants.

Table 6

Mean*, Standard Deviation and t-value for the Scores of* DASS, Death anxiety and Religious coping scale according to sample age *(N=320)*

	Age (20-40) (n = 155)		Age (41-60) (n = 165)				95% CI		
Scales	M	SD	M	SD	*t*(318)	*P*	LL	UL	Cohen's d

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DASS	33.91	5.47	36.68	4.71	-4.45	.01	6.34	14.14	1.04
Death anxiety scale	31.82	4.57	34.69	3.51	- 3.5	.01	5.14	8.37	1.04
Religious Coping Scale	36.63	3.28	41.21	3.86	-5.27	.001	7.16	11.18	1.13

Note. *** p<.001 M=Mean, SD=Standard Deviation, LL=Lower Limit, UP=Upper Limit, Cl=Confidence interval,

Results of above table show that patients with age group 41-60 years had more psychological problems and more fear of death. They also used more religious coping strategies as compared to age group 20-40 years.

Discussion

The present study was conducted to assess relationship of psychological disorders and fear of death anxiety among COVID-19 patients. Another aim of this study was to examine role of religious coping to deal with psychological problems and death anxiety among COVID-19 patients. First aim of this study was to examine the relationship between COVID -19 and psychological problems. It was hypothesize that patients suffer with corona virus would develop psychological problems. Findings prove the hypothesis and showed that COVID-19 patients suffer high rate of depression, anxiety and stress. One of the major reasons to develop psychological issues is to spend time in Quarantine. People who suffer in corona virus feel lonely. Secondly, severity of problem and fear of death also boost psychological issues. Velavan, and Meyer (2020) findings also match with our results.

Second aim of this study was to examine anxiety regarding death among COVID-19 patients. Numbers of deaths are happening due to COVID-19. Furthermore, media reports also exacerbate this fear. Findings of present study described significant positive relationship between fear of death anxiety and COVID-19. Such patients showed more fear of death. Liu et al (2020) also found similar results. Significant negative relations was found between mental health and coping strategies. Patients who used religious coping strategies had less psychological problems. Ghanem et al., 2019) findings were similar to our study results. Furthermore, patients who believe on God, offer prayer, believe on death had also less fear of death. They had firm believe that one day we all have to die and no one had control of it. So, there is no need to worry. Lee (2020) findings match with the result of present study. This study also examined most frequently used coping strategy by COVID-19 patients. According to the results of this study practice religion coping strategies were used most frequently used. Mostly people offer prayer, believe on God and secondly search solution actively. Similar findings were also found in the study of Aflakseir (2011).

In the present study we also examined psychological problems, fear of death and coping strategies according to patients' gender. It was hypothesize that female patients will suffer more in psychological problems and fear of death. Results of present study confirmed this hypothesis. No significant

difference was found between male and female regarding the use of religious coping strategies. Regarding the age of participants it was hypothesize that patients with age group 41 to 60 years would have more psychological problems and fear of death. It was also hypothesize that this group will also use more religious coping strategies. Findings confirm our hypothesis. Generally, in our culture as people get older they not only suffer more psychological issues and fears but also tend to practice more religious activities. COVID-19 enhanced these established findings. Chaplin (2020) findings are inline of our results. As per our information, no previous large scale study have been conducted on the psychological health, death fear and religious coping strategies on the sample of patients clinically diagnosed with COVID-19 at study time. This study can provide better understanding regarding psychological health, their fears and how we can cope both of these problems particularly in our Muslim culture. The findings of this study particularly use of religious coping strategies will also helpful in any future epidemics.

Conclusion

Patients of corona virus suffer in number of psychological problems and fear particularly death fear. Findings of this study showed that numerous patients with Covid-19 had fear of death. This fear of death was more among people who were more prone to Covid-19. Fear of death itself cause to boost stress. In order to manage stress numerous coping strategies are used. Religious is important factor to manage stress. Religious coping strategies have been related to better psychological and physical health outcomes. In our country more population is Muslim. Their religious faith and practices help to cope such issues. According to the findings of present research individuals who used religious coping they managed stress in a better way as compared to individuals who did not used any religious coping strategy. Researchers and policy makers should consider important factor of their religion. So, this study can also helpful for all stakeholders and counselors to plan better and provide interventions to Muslim community.

References

Aflakseir A, Coleman P.G. (2011). Initial development of the Iranian religious coping scale. *Journal of Muslim and Mental Health*. 6(1):44-61.

Chaplin,S.(2020). COVID-19: a brief history and treatments in development *Prescriber*,*31*(5), 23-28. https://doi.org/10.1002/psb.1843.

Heidari, F., Karimi, E., Firouzifar, M., Khamushian, P., Ansari, R., Mohammadi Ardehali, M., & Heidari, F. (2020). Anosmia as a Prominent Symptom of COVID-19 Infection. *Rhinology Journal*, *58*(3), 302–303. https://doi.org/10.4193/rhin20.140.

Kecojevic A, Basch C.H, Sullivan M, Davi N.K (2020). The impact of the COVID-19 epidemic on mental health of undergraduate students in New Jersey, cross-sectional study. *PLoS ONE*. 15:e0239696. doi: 10.1371/journal.pone.0239696.

Lazarus, R. S. (1993). Coping Theory and Research: past, present and future. *Psychosomatic Medicine, 55*, 234-247.

Lazarus, R. S., & Folkman, S. (1984). *Stress, Appraisal & Coping*. New York: Springer.

Lai J, Ma S, Wang Y, Cai Z, Hu J, Wei N et al.(2019). Factors Associated With Mental Health Outcomes Among Health Care Workers Exposed to Coronavirus Disease. JAMA *Netw Open.* 2020;3(3): e203976. pmid:32202646.

Lee, S. A. (2020). Coronavirus anxiety scale: a brief mental health screener for COVID-19 related anxiety. *Death Studies,* 44,393–401.

Liu, D., Baumeister, R. F., & Zhou, Y. (2020). Mental Health Outcomes of Coronavirus InfectionSurvivors: A Rapid Meta-Analysis. *Journal of Psychiatric Research*, *137*.

Loewenthal KM, Cinnirella M, Evdoka G, Murphy P. (2001). Faith conquers all? Beliefs about the role of religious factors in coping with depression among different cultural-religious groups in the UK. British Journal of Medical Psychology.74:293-303.

Lovibond, S.H. & Lovibond, P.F. (1995). Manual for the Depression Anxiety & Stress Scales. (2nd Ed.) Sydney: Psychology Foundation.Newton-John, T., Chambers, S. , Menzies, R. E. , & Menzies, R. G. (2020). Psychological distress and COVID-19: estimations of threat and the relationship with death anxiety. Published by Cambridge University Press.

Pargament, K. (1977). A police department's uninvited guest: A model for initiating consultative entry into human service organizations. *Journal of Community Psychology*, 5, 79-85.
Sarason I. G. & Sarason B. R. (2005). *Abnormal Psychology* (pp. 236-267) India: Prentice Hall, Inc.

Salman M, Shehzadi N, Hussain K, Saleem F, Khan MT, Asif N, Yousaf M, Rafique M, Bedar R, Tariq S, AbuBakar U (2017) Knowledge of Ebola virus disease among a university population: A cross-sectional study. *American Journal of Infection Control,* 45: 23-25.

Singhal, T. (2020). A review of coronavirus disease-2019 (COVID-19). *The Indian Journal of Pediatrics*, *87*(4). https://doi.org/10.1007/s12098-020-03263-6.

Templer, D. I. (1970). The construction and validation of a death anxiety scale. *The Journal of General Psychology, 82, 165-177.*

Velavan, T. P., & Meyer, C. G. (2020). The COVID-19 epidemic. *Tropical Medicine & International Health*, 25(3), 278–280. https://doi.org/10.1111/tmi.13383.

World Health Organization 2020. Healthy at home – Mental health. https://www.who.int/newsroom/campaigns/connecting-the-world-to-combat-coronavirus/healthyathome/healthyathome---mental-health (accessed December 18, 2020).

Zylke, J. W., & Bauchner, H. (2020). Mortality and morbidity: the measure of a pandemic. *JAMA, 324*(5), 458–459.