Prediction of Mental Health by Religious Orientation and the Mediating Role of Death Anxiety Among Nurses in the Covid-19 Pandemic

Akram Farhadi
Bushehr University of Medical Sciences
Hamed Javadian
Bushehr University of Medical Sciences
Pouya Farokhnezhad Afshar (farokhnezhad.p@iums.ac.ir)
Iran University of Medical Sciences

Research Article

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Abstract

Background: The COVID-19 pandemic has been around for more than a year as a global problem, with nurses being among the first groups involved in treating epidemics. In addition to becoming infected and dying from the disease, nurses also suffer from death anxiety, affecting their mental health. It is necessary to investigate the modulating factors of this anxiety. The purpose of this study was to predict mental health by religious orientation and the mediating role of death anxiety among nurses in the COVID-19 pandemic.

Methods: The present descriptive-analytical and cross-sectional study was conducted on 208 nurses working in the Central Hospital for the Treatment of COVID-19 patients in the Persian Gulf Martyrs Hospital in Bushehr, who were enrolled in the census. Data collection tools were the General Health Questionnaire-28 (GHQ-28), the Templer's Death Anxiety Scale (DAS), and the Revised Religious Orientation Scale (ROS). Data were analyzed by SPSS version 22 software using the Pearson correlation test and multiple regression analysis.

Results: Among the subjects, 53.5% of nurses experienced high death anxiety. According to the findings, death anxiety had a significant negative effect on mental health ($P<0.001$, $\beta=-0.54$). Intrinsic religious orientation led to a reduction in death anxiety ($P=0.01$, $\beta=-0.16$) and improved mental health ($P<0.001$, $\beta=0.40$), while extrinsic socially-oriented religiousness resulted in increased death anxiety ($P<0.001$, $\beta=0.19$) and decreased mental health ($P<0.001$, $\beta=-0.20$).

Conclusion: The prevalence of death anxiety in the COVID-19 pandemic was high in nurses, which led to a decrease in their mental health. The results of this study revealed that the intrinsic religious orientation had a positive effect on reducing death anxiety and promoting mental health.

1. Background

The COVID-19 pandemic started in December 2019 in Wuhan, China, and quickly became a global crisis [1]. Healthcare providers were the first group to be affected by the pandemic, which put them at the highest risk [2]. Nurses experienced problems such as death anxiety, depression, and mental health following the onset of disease-related deaths [3]. Various studies have reported that the prevalence of conditions such as anxiety is 37% and depression is about 43% in nurses [4, 5]. The mental health of nurses increases the quality of nursing services, and decreases the incidence of medical errors [6]. Several occupational factors in the nursing profession can lead to anxiety, including frequent contact with patients during the outbreak of new and unknown diseases [7].

Anxiety is the reaction to an unknown, internal and ambiguous danger, and originates from conflict; death anxiety is one of the known types of anxiety [8]. Recent extensive studies have shown that death anxiety caused by these diseases is higher among nurses than in other medical professions [9, 10]. The death of a patient causes emotions such as fear of disability, loss of control, and meaninglessness, so it can have a negative impact on the mental health of nurses [11].

Death anxiety is defined as conscious or unconscious distress associated with fear of death [12]. Death anxiety is one of the most important sources of psychological disorders, the study of which is of particular importance in the field of mental health [13]. The phenomenon of death can set the stage for psychological disorders such as depression and anxiety [14]. Yalom has identified death anxiety as a key factor involved in mental health [15]. Long-term death anxiety can lead to job burnout, decreased efficiency and effectiveness in the workplace, excessive absenteeism, reduced patient satisfaction, leaving the nursing profession, marital problems, alcohol and drug abuse, reduced creativity, incompatibility with colleagues, depression, and even suicide in nurses. Death anxiety has adverse effects on the quality of nursing services and is a stressor for nurses [16, 17]. There is a vague positive or negative correlation between anxiety disorder and religious orientation [18].

Religion can predict comfort and happiness; most studies on religious orientation have been on two main dimensions, intrinsic and extrinsic [19]. Intrinsic personally-oriented religiousness means an inner commitment to religious beliefs in all aspects of life, but an extrinsic personally-oriented religiousness is to perform external religious rites [20]. In a study, there is a negative relationship between intrinsic religious orientation and the symptoms of depression and anxiety, and a positive relationship between extrinsic religious orientation and anxiety [19]. According to the study context in which all subjects were Muslim and considering the importance and rate of death anxiety in certain professions such as nursing and the great impact of this issue on the mental health of nurses and the care process provided by them, this issue needs to be monitored at different times, as well as effective psychological interventions should be performed in case of a severe increase in death anxiety, due to its negative effects on nursing mental health, which are the most important force against COVID-19 in the health system. Therefore, this study aimed to predict mental health by religious orientation and the mediating role of death anxiety among nurses in the COVID-19 pandemic.

2. Methods

2.1. Study design

The present descriptive-analytical and cross-sectional study were conducted on a total of 208 nurses working in the Persian Gulf Martyrs Hospital in Bushehr (southern Iran) in 2020.

2.2. Participants

Due to the limited number of nurses working in this hospital, the census method was used for sampling. Inclusion criteria were satisfaction with participation in the study and exclusion criteria were incomplete questionnaires. After explaining the objectives of the study, written informed consent was obtained from all research units. This study hypothesized that religious orientation has a direct relationship with mental health. On the other hand, a direct relationship with death anxiety can have an indirect effect on mental health.

2.3. Data collection

Data collection tools were the General Health Questionnaire-28 (GHQ-28), the Templer's Death Anxiety Scale (DAS), and the Revised Religious Orientation Scale (ROS).

- The Religious Orientation Scale (ROS; Gorsuch and McPherson; 1989) measures three factors, including intrinsic religious orientation, extrinsic socially-oriented religiousness, and extrinsic personally oriented religiousness. The rating of this 14-item scale is based on a 5-point Likert scale (zero: strongly disagree to four: strongly agree). This scale can be used for people with different levels of education. The reliability of the Persian version has been checked by the internal consistency method. The reliability of its subscales was obtained from Cronbach's alpha method in Iran from 0.61 to 0.85. The construct validity of this scale also confirmed the existence of three factors [21].
- The General Health Questionnaire-28 (GHQ-28) is a 28-item scale developed by Goldberg and Hillier (1979), which has four sub-scales and each scale has seven questions, including physical symptoms, anxiety and sleep disorder symptoms, social functioning, and depression symptoms. The questions are scored from 0 to 3. On each scale from a score of 6 and above and in total a questionnaire from a score of 22 and above indicate pathological symptoms. The cut-off points of the whole questionnaire include none or the minimum limit (0–6), mild (7–11), moderate (12–16), and severe (17–21). The validity and reliability of this questionnaire have been confirmed in Iran [22]. In the test-retest reliability method, the reliability coefficient was 0.72 for the whole questionnaire and significant for the subtests of physical symptoms, anxiety, and insomnia, social dysfunction, and depression ($P < 0.001$). The reliability coefficient with split-half analysis was 0.93 for the whole scale and 0.86, 0.84, 0.68, and 0.77 for the subscales, respectively. All these coefficients were significant at a significance level of $P < 0.001$ [23].
- Templer's Death Anxiety Scale (DAS) was designed by Templer in 1970 to measure death anxiety, which has been the most used of its kind. This scale includes 15 questions and 5 dimensions (fear of death, fear of pain and illness, death-related thoughts, time passing and short life, and fear of future). The participants mark their answers to each question with "Yes" or "No" options. The answer "Yes" indicates the presence of anxiety in the person. Thus, scores on this scale can range from 0 to 15. High scores indicate high death anxiety. Studies have shown that this scale has acceptable validity and reliability. Templer (1970) obtained the Cronbach's alpha coefficient of 0.83 [24, 25].

2.4. Data analysis

Descriptive findings were reported using mean, standard deviation, frequency, and percentage. First, the Pearson correlation test was performed to examine the relationships between variables. Then, the "Enter Method" of multiple regression analysis was carried out to evaluate the predictive power of religious orientation and death anxiety for mental health. An independent t-test was performed to examine the mean differences between the two sexes, and an ANOVA test was used to calculate the mean differences between different marital statuses, levels of education, and wards. Data were analyzed using SPSS version 22 software ($\alpha = 0.01$).

Data were analyzed via V.23 software and descriptive findings were reported using mean, standard deviation, frequency, and percentage.

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- The Pearson correlation test was performed to examine the relationships between variables.
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3. Results

The study participants were 208 nurses, 106 (51%) were male. The mean age of participants was 32.45 ± 6.45 years. The mean work experience was 9.88 ± 7.98 years for men and 8.57 ± 7.08 years for women, and the mean working hours of the participants were 45.99 ± 16.37 hours per week. Other demographic variables are shown in Table 1.

Table 1
Demographic variables of nurses participating in the study

Variables		Male, N (%)	Female, N (%)
Marital status	Single	43 (40.6)	43 (42.2)
	Married	61 (57.5)	56 (54.9)
	Divorced	2 (1.9)	3 (2.9)
Educational level	High school	35 (33)	8 (7.8)
	Associate Degree	3 (2.8)	1 (1)
	Bachelor's degree	64 (60.4)	79 (77.5)
	Master's degree	4 (3.7)	14 (13.7)
Hospital wards	Intensive care unit	30 (28.3)	16 (15.7)
	Operating room	15 (14.2)	15 (14.7)
	Oncology	2 (1.9)	2 (2)
	Psychiatry	7 (6.6)	1 (1)
	General section	9 (8.5)	7 (6.9)
	Hemodialysis	38 (35.8)	51 (50)
	Nursing station	1 (0.9)	4 (3.9)

53.50% of nurses scored 7 or higher on the DAS. The mean total score of death anxiety of nurses was 6.84 ± 4.35 and the mean total score of mental health was 62.07 ± 12.76. The difference in the mean death anxiety between the two sexes was significant (males: 5.83 ± 4.70 and females: 7.90 ± 3.69, P = 0.001). There was no significant difference between death anxiety score and different marital status, education levels, and wards. No significant correlation was found between death anxiety and age, work experience, and working hours per week.

As shown in Table 2, all dimensions of death anxiety and mental health are inversely correlated, but the intrinsic religious orientation had a positive and significant correlation with all dimensions of death anxiety. The extrinsic personally oriented religiousness had a positive and direct correlation with the dimension of depression, and the extrinsic socially-oriented religiousness had a negative and significant correlation with the dimensions of physical symptoms, anxiety symptoms, and sleep disorders.

Table 2
Correlation between death anxiety and mental health of nurses

		Death anxiety					Mental health				Religious orient	
		Fear of death	Fear of pain and illness	Death related thoughts	Passing time and short life	Fear of future	Physical symptoms	Anxiety symptoms and sleep disorders	Social functioning	Symptoms of depression	Intrinsic religious orientation	E p o re
Death anxiety	Fear of death	1	0.60**	0.59**	0.60**	0.51**	0.42**	− .037**	-0.39**	-0.36**	0.27**	0
	Fear of pain and illness		1	0.58**	0.64**	0.43**	-0.37**	-0.32**	-0.47**	-0.39**	0.81**	0
	Death related thoughts			1	0.72**	0.56**	-0.35**	-0.28**	-0.39**	-0.41**	0.18**	0
	Passing time and short life				1	0.54**	-0.48**	-0.38**	-0.50**	-0.46**	0.31	0
	Fear of future					1	-0.29**	-0.31**	-0.28**	-0.37**	0.23**	0
Mental health	Physical symptoms						1	0.73**	0.68**	0.60**	0.20**	-0
	Anxiety symptoms and sleep disorders							1	0.71**	0.63**	0.31**	0
	Social functioning								1	0.66**	0.19**	0
	Symptoms of depression									1	0.30**	0
Religious orientation	intrinsic religious orientation										1	0
	extrinsic personally oriented religiousness											1
	extrinsic socially-oriented religiousness											

**** P < 0.001, * P < 0.01**

The multiple regression analysis for the dimensions of death anxiety and mental health showed that fear of death can only predict the physical symptoms of mental health and fear of pain and illness can predict the symptoms of depression, and passing time and short life can predict all aspects of mental health. The intrinsic religious orientation can predict all aspects of mental health. The extrinsic personally oriented religiousness can only explain the symptoms of anxiety and sleep disorders, and the extrinsic socially-oriented religiousness can predict physical symptoms, anxiety symptoms and sleep disorder, and social functioning (full information is shown in Table 3 and Fig. 1).

Table 3
Multiple regression analysis of death anxiety and mental health of nurses

		Mental health											
		Physical symptoms			Anxiety symptoms, and sleep disorder			Social functioning			Depression		
		B	β	P	B	β	P	B	β	P	B	β	P
Death anxiety	Fear of death	-0.65	-0.17	0.03	-0.47	-0.12	0.17	-0.16	-0.05	0.51	0.18	0.04	0.61
	Fear of pain and illness	-0.29	-0.11	0.20	-0.45	-0.15	0.08	-0.61	-0.27	0.001	-0.52	-0.17	0.03
	Death related thoughts	0.30	0.09	0.29	0.48	0.14	0.13	0.10	0.04	0.66	-0.15	-0.04	0.64
	Passing time and short life	-1.23	-1.37	< 0.001	-0.91	-0.25	0.01	-0.91	-0.33	0.001	-1.07	-0.28	0.004
	Fear of future	0.24	0.04	0.53	-0.90	-0.02	0.83	0.28	0.06	0.39	-0.19	-0.03	0.67
Religious orientation	Intrinsic religious orientation	0.24	0.26	0.001	0.40	0.40	< 0.001	0.20	0.26	0.001	0.26	0.25	0.001
	Extrinsic personally oriented religiousness	-0.19	-0.13	0.06	-0.29	-0.18	0.007	-0.08	-0.07	0.26	-0.22	-0.13	0.06
	Extrinsic socially-oriented religiousness	-0.29	-0.18	0.02	-0.33	-0.19	0.02	-0.25	-0.19	0.02	0.03	0.02	0.82
Constant		22.94			19.24			21.98			16.27		
F		11.55			10.66			12.85			11.04		
R^2		0.29			0.27			0.31			0.28		

4. Discussion

The purpose of this study was to predict mental health by religious orientation and the mediating role of death anxiety among nurses in the COVID-19 pandemic. The findings showed that more than half of nurses experience high death anxiety. Women had higher death anxiety than men. Intrinsic religious orientation had a direct and significant correlation with all dimensions of mental health. Extrinsic socially-oriented religiousness was inversely and significantly correlated with the dimensions of physical symptoms, anxiety symptoms, and sleep disorders, but extrinsic personally oriented religiousness was not significantly correlated with mental health. All dimensions of mental health had a significant inverse correlation with death anxiety. Dimensions of fear of death and passing time and short life were able to predict changes in the subscale of physical symptoms and the subscale of anxiety symptoms and sleep disorders. Dimensions of fear of pain and illness and passing time and short life were able to predict changes in the subscale of social functioning. Dimensions of passing time and short life and fear of future were able to predict subscale of changes in depressive symptoms.

Death anxiety scores were significantly different in different marital statuses, education levels, and wards. These results were not found in demographic variables and death anxiety in a study by Moudi et al [26]. However, some studies had different results and showed that nurses with younger ages and working in intensive care units experience more death anxiety [27, 28]. This difference could be related to the type of disease and the epidemic, because the COVID-19 pandemic affected all age groups, all departments of the hospital, and caused a great deal of fear among healthcare professionals.

The findings of this study showed that the dimensions of death anxiety can predict changes in the dimensions of mental health in nurses during the COVID-19 pandemic. These findings were also observed in other studies [26, 29]. Anxiety can endanger health by affecting physical and mental functions [30]. Constant exposure to the patients, responsibility for human health, clinical procedures, and dealing with dying patients and emergencies can reduce the optimal performance of nurses [31]. Death anxiety is one of the stresses experienced by nurses in the workplace [32]. This problem is exacerbated during the COVID-19 epidemic because of problems such as the absence of effective prevention and treatment, along with high infection rates, but all healthcare professionals at risk. According to reports, healthcare workers experience 56% of work stress and anxiety during the COVID-19 pandemic [33].

In this study, the intrinsic religious orientation had a negative effect on death anxiety but the extrinsic socially-oriented religiousness increased death anxiety and the extrinsic personally oriented religiousness had no effect on death anxiety. The religious orientation sometimes reduces death anxiety, but this should change one's attitude toward change, and only intrinsic religious orientation can change attitudes [34]. Explaining this finding, it can be said that one of the results of panic management theory is related to fear of death. A common feature in the worldview of people who believe in heavenly religions is the assurance of the existence of a kind of life after death; one of the most important functions of religion is to reduce the panic associated with one's mortality. Given that all the nurses participating in this study were Muslims and believed in eternal life after death, this belief could lead to a reduction in their death anxiety.

The results of this study showed that the intrinsic religious orientation had a positive effect on mental health but the extrinsic socially-oriented religiousness had a negative effect on mental health and the extrinsic personally oriented religiousness had no effect on mental health. In another study, the effect of both intrinsic and extrinsic dimensions of religious orientation was positive on reducing symptoms of anxiety and depression [35]. In general, the relationship between religiosity and psychological well-being can be complex. Contradictory findings illustrate this complexity; as for the intrinsic religious orientation, having meaning and purpose in life, feeling of belonging to a high source, hoping for God's help in difficult life situations and consequently being optimistic in

these situations and so on are resources for religious people to suffer less psychological damage in the face of stressful life events. This difference may be because the majority of people believe in Islam in Iran, the effects of extrinsic socially-oriented religiousness on individuals have decreased and only the effects of extrinsic personally oriented religiousness can lead to mental health. The intrinsic religious orientation can lead to a sense of comfort and mental health by creating a worldview of life after death and establishing a positive relationship with God [36], but the extrinsic religious orientation is mostly aimed at gaining group support and has little effect on a person's attitude and feelings.

The study limitations were the cross-sectional design, the small sample size, and the study area only in one city, which reduces the generalizability of the findings but can be a basis for knowledge and comparison for healthcare decision-makers and other studies.

5. Conclusion

According to the findings of this study, more than half of the nurses experienced high death anxiety. "Intrinsic religious orientation" and "Extrinsic socially-oriented religiousness" were the most important dimensions capable of predicting death anxiety and mental health of nurses working during the COVID-19 pandemic. Given the high prevalence of death anxiety and its impact on the mental health of nurses, by the end of the COVID-19 pandemic, it is better to plan and implement programs related to the religious and Islamic beliefs of nurses to improve the mental state to provide the basis for promoting the mental health of those in the front line of the COVID-19 infection control. In the meantime, it is recommended to pay more attention to and prioritize women in these programs.

Declarations

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Authors' contributions

AF and HJ were involved in the original conception and design of the study. Data acquisition and statistical analysis were conducted by AF, PFA, and HJ. PFA drafted the initial manuscript which has been revised with input from all other listed authors. The final manuscript has been reviewed by all the authors and approved for submission/publication.

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Availability of data and materials

The datasets generated and/or analyzed during the current study are not publicly available as individual privacy could be compromised but are available from the corresponding author on reasonable request.

Ethics approval and consent to participate

This study has been approved by the Research Ethics Committee of the Bushehr University of Medical Sciences (Ref. IR.BPUMS.REC.1399.054). We obtained written consent from participants.

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests.

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Figures

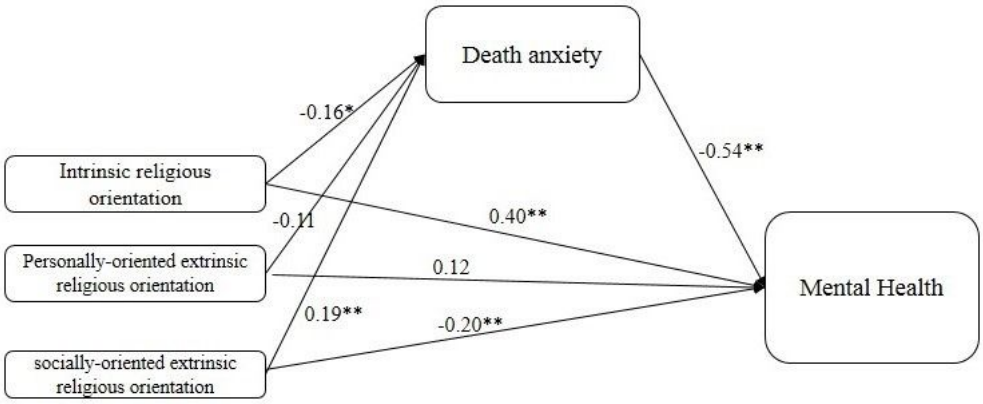

Figure 1

Relationship between variables (*: P=0.01, P<0.001)