ORIGINAL ARTICLE

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

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Abstract

Background: The COVID-19 pandemic has been around for more than a year as a global problem, the 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. This study aimed 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 who enrolled in the census in the Persian Gulf Martyrs Hospital in Bushehr. 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 v.22 software using the Pearson correlation test and multiple regression analysis (α=0.01).

Results: According to the findings, death anxiety significantly and negatively affected mental health ($P<0.001$, β=-0.54). Intrinsic religious orientation led to a reduction in death anxiety ($P=0.01$, β=-0.16) and improved mental health ($P<0.001$, β=0.40), while extrinsic socially-oriented religiousness resulted in increased death anxiety ($P<0.001$, β=0.19) and decreased mental health ($P<0.001$, β=-0.20).

Conclusion: More than half of the nurses had death anxiety in the COVID-19 epidemic, which decreased their mental health. This study revealed that the intrinsic religious orientation positively reduced death anxiety and promoted mental health.

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Introduction

The COVID-19 pandemic started in December 2019 in Wuhan, China, and quickly became a global crisis.[1] Healthcare providers were the first group affected by the pandemic, which put them at the highest risk.[2] Nurses experienced death anxiety, depression, and mental health problems 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 death anxiety, including frequent contact with patients during the outbreak of new and unknown diseases.[7]

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 negatively impact the mental health of nurses.[11] Death anxiety is one of the most important sources of psychological disorders, which has particular importance in the mental health field.[12] The phenomenon of death can set the stage for psychological disorders such as depression and anxiety.[13] Yalom has identified death anxiety as a key factor in mental health.[14] 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.[15, 16] There is a vague positive or negative correlation between anxiety disorder and religious orientation.[17]

Religion can predict comfort and happiness; most studies on religious orientation have been on two main dimensions, intrinsic and extrinsic.[18] 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.[19] A study showed a negative relationship between intrinsic religious orientation and the symptoms of depression and anxiety and a positive relationship between extrinsic religious orientation and anxiety.[18]

Most past studies have been conducted in countries where Christianity is the predominant religion and society has been individualistic. According to the study context, all subjects were Iranian Muslims with collectivist culture.Given the 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, dealth anxiety needs to be monitored at different times, and 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.

Methods

Study Design

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

Participants

The sample size was calculated at 190 with G-Power software (ρ=0.3, α=0.01, 1-β=0.95).[20, 21] Due to the limited number of nurses working in this hospital, the targeted method was used,, which means all nurses were included in the study (208 nurses). Inclusion criteria were satisfaction with participation in the study, and exclusion criteria were incomplete questionnaires. After explaining the study's objectives, 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 indirectly affect mental health.

Data Collection Tools

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 internal consistency method has checked the reliability of the Persian version. 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.[22]

- 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, a score of 6 and above and overall 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.[23] In the test-retest reliability method, the reliability coefficient was 0.72 for the whole questionnaire. It was also significant for the subtests of physical symptoms, anxiety, 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. All these coefficients were significant at a significance level of $P<0.001$.[24]

- Templer designed Templer's Death Anxiety Scale (DAS) in 1970 to measure death anxiety, which was the most frequently used scale. 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. For example, Templer (1970) obtained Cronbach's alpha coefficient of 0.83.[25, 26]

Statistical Analysis

Data were analyzed via SPSS version 22 software, and descriptive findings were reported using mean, standard deviation, frequency, and percentage (α=0.01).

- Descriptive findings were reported using mean, standard deviation, frequency, and percentage.

- An independent sample 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.

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

- The "Enter Method" of multiple regression analysis was conducted to evaluate the predictive power of religious orientation and death anxiety for mental health.

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. Table 1 shows other demographic variables.

53.50% of nurses scored 7 or higher on the DAS. The mean total score of death anxiety among nurses was 6.84±4.35, and the mean total score for 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 scores and marital statuses, 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.

The multiple regression analysis for the dimensions of death anxiety and mental health showed that fear of death could only predict the physical symptoms of mental health and fear of pain and illness can predict the symptoms of depression. Moreover, 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, sleep disorders, and social functioning (full information is shown in Table 3 and Figure 1).

Discussion

This study aimed to predict mental health by religious orientation and the mediating role of death anxiety among nurses in the COVID-19 pandemic.

Table 1: Demographic variables of nurses participating in the study

Variables		Male, N (%)	Female, N (%)	P value
Marital status	Single	43 (40.6)	43 (42.2)	P=0.12
	Married	61 (57.5)	56 (54.9)	
	Divorced	2 (1.9)	3 (2.9)	
Educational level	High school	35 (33)	8 (7.8)	P=0.2
	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)	P=0.15
	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)	

Table 2: Correlation between death anxiety and mental health of nurses

		Death anxiety					Mental health				Religious orientation		
		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	Extrinsic personally oriented religiousness	Extrinsic socially-oriented religiousness
Death anxiety	Fear of death	1	0.60**	0.59**	0.60**	0.51**	0.42**	-0.037**	-0.39**	-0.36**	0.27**	0.23**	0.11
	Fear of pain and illness		1	0.58**	0.64**	0.43**	-0.37**	-0.32**	-0.47**	-0.39**	0.81**	0.90**	0.004
	Death related thoughts			1	0.72**	0.56**	-0.35**	-0.28**	-0.39**	-0.41**	0.18**	0.21	0.16**
	Passing time and short life				1	0.54**	-0.48**	-0.38**	-0.50**	-0.46**	0.31	0.60	0.08
	Fear of future					1	-0.29**	-0.31**	-0.28**	-0.37**	0.23**	0.16**	0.27**
Mental health	Physical symptoms						1	0.73**	0.68**	0.60**	0.20**	-0.003	-0.18*
	Anxiety symptoms and sleep disorders							1	0.71**	0.63**	0.31**	0.05	-0.20**
	Social functioning								1	0.66**	0.19**	0.000	-0.11
	Symptoms of depression									1	0.30**	0.17*	-0.13
Religious orientation	Intrinsic religious orientation										1	0.64**	0.14**
	Extrinsic personally oriented religiousness											1	0.31**
	Extrinsic socially-oriented religiousness												1

**P<0.001, *P<0.01

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		

B: The unstandardized beta; β: The standardized beta; P: Probability value; F: F-test; R^2: The coefficient of determination

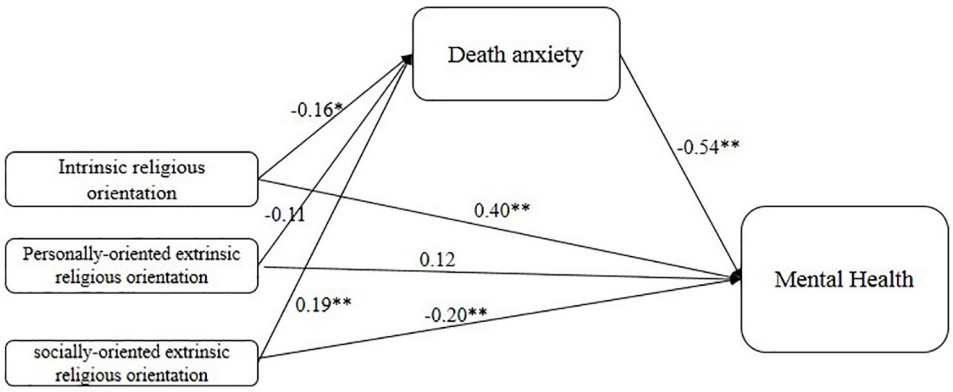

Figure 1: Relationship between variables (*P=0.01, P<0.001)

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, 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, passing time, and short life were able to predict changes in the subscale of social functioning. Dimensions of passing time, short life, and fear of the future could predict the subscale of changes in depressive symptoms.

Death anxiety scores differed significantly in marital statuses, education levels, and wards. These results were not found in demographic variables and death anxiety in a study by Moudi et al.[27] However, some studies had different results and showed that nurses of younger ages and those working in intensive care units experience more death anxiety.[28, 29] This difference could be related to the type of disease and the epidemic because the COVID-19 pandemic affected all age groups and 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 ould predict changes in nurses' mental health during the COVID-19 pandemic. These findings were also observed in other studies.[27, 30] Anxiety can endanger health by affecting physical and mental functions.[31] 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.[32] Death anxiety is one of the stresses experienced by nurses in the workplace.[33] Death anxiety is exacerbated during the COVID-19 epidemic because of problems such as the absence of effective prevention and treatment and high infection rates. According to reports, healthcare workers experience 56% of work stress and anxiety during the COVID-19 pandemic.[34]

In this study, the intrinsic religious orientation negatively affected 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 only intrinsic religious orientation can change attitudes.[35] Explaining this finding, the authors can say 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 their belief in 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 reduce their death anxiety.

The results of this study showed that intrinsic religious orientation had a positive effect on mental health. However, the extrinsic socially-oriented religiousness negatively affected mental health, and the extrinsic personally oriented religiousness did not affect mental health. In another study, both intrinsic and extrinsic dimensions of religious orientation positively reduced symptoms of anxiety and depression.[36] In general, the relationship between religiosity and psychological well-being can be complex. Contradictory findings illustrate this complexity; 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 when facing stressful life events. This difference may be because most people believe in Islam in Iran.

Moreover, 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.[37] However, the extrinsic religious orientation is mostly aimed at gaining group support and has little effect on a person's attitude and feelings.

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. Therefore, intrinsic religious orientation and extrinsic socially-oriented religiousness directly affect mental health and indirectly affect death anxiety, which can improve mental health.

Limitations

The study limitations were the cross-sectional design, the small sample size, and one city as study area, which reduce the generalizability of the findings

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Ethics Approval and Consent to Participate

The Research Ethics Committee at Bushehr University of Medical Sciences has approved this study (Ref. IR.BPUMS.REC.1399.054). Furthermore, we obtained written consent from participants.

Conflicts of interest*:* None declared.

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