

## Original Article

# The Relationship between Covid-19 Phobia and Religious Coping

### **Burcin Isik, RN, PhD**

Associate Professor, Gaziantep Islam Science and Technology University, Faculty of Health Sciences, Department of Nursing, Gaziantep, Turkey

### **Zeynep Gungormus, RN, PhD**

Professor, Gaziantep Islam Science and Technology University, Faculty of Health Sciences, Department of Nursing, Gaziantep, Turkey

### **Emine Karacan, PhD**

Assistant Prof Gaziantep Islam Science and Technology University, Health Services Vocational School, Gaziantep, Turkey

**Correspondence:** Burcin Isik, RN, PhD, Associate Professor, Gaziantep Islam Science and Technology University, Faculty of Health Sciences, Department of Nursing, Gaziantep, Turkey  
E-mail: burcin2201@gmail.com

### **Abstract**

**Background:** The COVID-19 pandemic has caused intense fear and anxiety in individuals, giving rise to a psychological condition known as "COVID-19 phobia." During this period, religious coping has emerged as an important psychological support mechanism for individuals coping with stress and uncertainty.

**Objective:** This study was designed as a cross-sectional, descriptive, and correlational study to investigate the relationship between individuals' COVID-19 phobia and religious coping style.

**Method:** This study was conducted in Turkey from December 2020 to May 2021 with 812 participants aged 18 and older. Data were collected online using a Personal Information Form, the COVID-19 Phobia Scale, and the Religious Coping Scale. Analyses were carried out with SPSS 23.0, including descriptive statistics, t-tests, ANOVA, and Pearson correlation.

**Findings:** Descriptive analyses indicated that participants reported moderate levels of COVID-19 phobia and a high tendency toward positive religious coping. Correlation analysis demonstrated a significant relationship between COVID-19 phobia and both dimensions of religious coping. Additionally, inferential tests showed that COVID-19 phobia and religious coping levels differed significantly according to certain socio-demographic variables, including gender, age, and compliance with protective measures ( $p < 0.05$ ).

**Conclusion:** The study found that the average score on the Covid-19 Phobia scale was moderate, and there was a highly significant positive correlation between Covid-19 Phobia and Religious Coping. Additionally, it was determined that some socio-demographic variables influenced fear of COVID-19 and both positive and negative religious coping.

**Key words:** COVID-19; COVID-19 phobia; Religious coping; Positive religious coping; Negative religious coping

### **Introduction**

Throughout history, humanity has witnessed various pandemics, some of which have been more devastating than others (Gursu and Bayindir). A pandemic is defined as a disease and/or health crisis that infects a large part of people, animals, or plants in a short time (TDK, 2020). The COVID-19 pandemic has also rapidly affected the whole world in a short time and has become one of

the most significant health crises of recent times, threatening individuals, societies, and states (Gashi, 2020a; Siraz et al., 2020).

The high rate of disease spread has caused intense concern worldwide. This process has given rise to concerns such as contracting the disease, being at risk of infection, and being afraid of unwittingly harming loved ones, such as family members, friends, and relatives. All these concerns, information

pollution about the disease, uncertainties about the course of disease, inability to control the disease, high number of COVID-19 variants, and rapidly increased deaths from COVID-19 have caused people to have serious psychological and spiritual distress, fear, and anxiety of death (Gashi, 2020a; Gursu & Bayindir, 2016; Siraz et al., 2020). In addition, delayed solutions to prevent the pandemic have brought mental problems, leading people to look for different understandings and searches to figure out, make sense of, and cope with the current health crisis (Gashi, 2020b).

In fact, while the Black Plague had persisted in England, English people believed in a complete submission to the authoritarian power of the church and went to the church in droves to beg and pray God to stop the black death. However, when they realized that even the clergy died from the disease, they considered that the disease was sent down to them by God, whereby the most important ritual to be done would be prayer rites, and thus God could forgive them (Karaimamoglu & Gumus, 2020). These studies are significant in terms of showing that people always seek to understand, make sense of, and cope with the disasters they come across. Pandemics increase people's existential concerns about themselves and their relatives, causing them to reevaluate their daily lives, future plans, and priorities in life, and thus lead them to seek/develop strategies to cope with such life events (Gashi, 2020b; Shiraz et al., 2020). They generally focus on religious beliefs during such events (Gashi, 2020b). Religion has a strong role in people's coping with stressful situations.

Coping is a healthy and compulsory change process that enables people to participate actively in life and makes them strong and dynamic in every negative situation (Pargament, 1997). Religious coping is considered to provide moral support to individuals in accepting stressful events and help them get rid of distress by giving meaning to struggling with problems (Kizilgecit et al. 2020; Eryucel, 2013). When people are stuck in difficult situations, they orient to religion, even if temporarily, remember God/Allah, feel a need for religious shelter, and come closer to religious

centers. A danger that leaves human beings helpless and powerless leads people to tend to resort to a savior and divine help in a metaphysical sense (Hokelekli, 2013). This keeps people's hope alive in times of crisis and is defined as a religious coping strategy (Gashi, 2020b; Sabanciogullari & Yilmaz, 2019).

Studies have reported that individuals who use religious coping methods have less stress, depression, and fear than those who do not. This kind of coping with positive effects is considered "positive religious coping", including praying, feeling to have a secure relationship with God/Allah, and hoping for God/Allah's help. On the contrary, people may move away from religious life gradually, thinking God/Allah punishes and does not love them due to the stressful situations they come across. This is considered "negative religious coping", including spiritual/religious discontent and questioning the pandemic and the power of God/Allah (Eryucel, 2013; Gashi, 2020b; Sabanciogullari & Yilmaz, 2019; Yagli, 2020). In this regard, it is important to determine the effects of religious coping, which keeps people's mental health alive in crisis times, on individuals who are afraid of contracting the COVID-19 disease. Therefore, this study aimed to determine the relationship between people's fear of contracting COVID-19 and their religious coping methods.

### **Material and Methods**

**Aim:** This study was designed to investigate the relationship between individuals' COVID-19 phobia and religious coping style.

**Design:** This study was performed as a cross-sectional, descriptive, and correlational study.

**Setting and Sample:** This study was conducted in a large-scale general in Turkey during December 2020 and May 2021. We successfully obtained responses from 812 volunteer individuals aged over 18 years, healthy or infected with the COVID-19 virus. Individuals, illiterate and under 18 years of age, were excluded from the study.

**Data Collection Tools:** Data collection was carried out online between December 2020 and May 2021. This study used the items from Arpaci et al. (2020) to measure the

individuals' COVID-19 phobia, and Eksi & Sayin (2016) to measure the individuals' level of religious coping styles. In order to gather socio-demographic data "Information Form" was used.

*Information Form* consists of questions such as gender, age, marital status, education level, working status, profession, income status, smoking and alcohol use, rules to be protected from the COVID-19 virus, religious belief level, and so on.

**COVID-19 Phobia Scale (C19P-S)** was developed by Arpaci et al. (2020), and is a self-report instrument with a five-point Likert-type scale to assess the levels of COVID-19 phobia. The scale comprises 4 subscales and 20 items. All items are rated on a 5-point scale from "strongly disagree (1)" to "strongly agree (5)." 1, 5, 9, 13, 17, and 20th items for "Psychological Subscale", 2, 6, 10, 14, and 18th items for "Somatic Subscale", 3, 7, 11, 15, and 19th items for "Social Subscale", 4, 8, 12, and 16th items for "Economic Subscale". Subscale scores are obtained by the total score of the answers given to the items of that subscale. The scores on the scale can range between 20 and 100, and a higher score indicates a greater phobia in the respective subscales and total scale. Cronbach's alpha coefficient of the 20 items was 0.925, and subscale reliabilities ranged from 0.851 to 0.903. In our study, Cronbach's alpha was found for the total as .94, for "Psychological Subscale" 0.86, "Somatic Subscale" 0.87, "Social Subscale" 0.85, and "Economic Subscale" 0.77.

**The Religious Coping Scale** was developed by Abu-Raiya et al. (2008), and the adaptation study to Turkish was carried out by Eksi and Sayin (2016). The scale is a four-point Likert-type scale and consists of two subscales and 10 items. 1, 2, 3, 4, 5, 6, 7 are items for Positive Religious Coping, and 8, 9, 10 are for Negative Religious Coping. Positive and Negative Religious Coping scores are calculated separately. A total religious coping score cannot be obtained. The raw score that can be taken from the positive religious coping subscale varies between 7 and 28, and the negative score from the negative religious coping subscale varies between 3 and 12. The Cronbach's alpha internal consistency coefficient of the scale was calculated as .91 for the positive religious coping subscale, and .90 for the

negative religious coping subscale. While the higher score from the positive religious coping subscale reflects more positive religious coping, the higher score from the negative religious coping subscale reflects more negative religious coping (Eksi and Sayin, 2016).

**Data Analysis:** Data were evaluated by using the IBM SPSS Statistics 23.0 programme. In this study, for categorical variables, frequency distribution (number, percentage), and for numerical variables, descriptive statistics (mean, standard deviation) are given. An independent sample t-test was used to determine the difference between two groups, and one-way analysis of variance (One Way ANOVA) was used to determine the difference between more than two groups. Levene's test was used for homogeneity of variance, and then Scheffe and Tamhane's T2 were used as multiple comparison tests to determine from which group or groups the difference originated. The Scheffe test was used to determine the difference between the groups in the variables providing variance homogeneity, and Tamhane's T2 test was used to determine the difference between the groups in the variables that did not provide the variance homogeneity. In addition, Pearson correlation analysis was used to examine the relationship between two numerical variables. Statistical significance was evaluated at the significance level of 0.05.

**The Ethical Aspect of the Study:** The study was approved by the Gaziantep Islam Science and Technology University Non-Clinical Research Ethics Committee (Protocol No. 2021/27) and was conducted in accordance with the Declaration of Helsinki concerning the Ethical Principles for Medical Research Involving Human Subjects. At the start of the study, a written informed consent form was signed by individuals who agreed to participate after being provided with information about the study's purpose. The survey was anonymous, conducted electronically, and did not require participants to provide any personal data.

**Limitations of the Study:** Some limitations must be considered when applying these results to the population. First, the sample cannot be generalized because it was limited to 861 individuals. Additionally, the data are

based on the opinions of these individuals themselves.

## **Results**

Of the participants, 32% were 15-25 years old, 75% were female, 52.5% were married, 51% had children, 60% had associate/bachelor's degree, 61.7% lived in a metropolitan area, % 28.8% were unemployed, 28.1% worked in health sector, 42.8% had income equal to expenses, and 84.6% did not have a chronic disease. In addition, 98% wore masks to protect themselves from the COVID-19, 89% obeyed social distance rules, 94.3% obeyed personal hygiene rules, 14% caught the COVID-19 virus, 73.3% knew a person in the close vicinity who caught the COVID-19 virus, 21.9% considered quitting smoking to protect themselves from the COVID-19 virus, 12.3% stopped smoking, 17.5% considered to stop using alcohol to protect themselves from the COVID-19 virus, 13.4% stopped using alcohol, 71.9% were afraid of catching the COVID-19 virus, and 60.2% reported to have moderate religious beliefs.

The participants' mean scores were  $50.6 \pm 18.2$  on the Coronavirus 19 Phobia (CP19-S) scale, and  $19.4 \pm 6.3$ ,  $9.2 \pm 4.8$ ,  $13.7 \pm 5.5$ ,  $8.1 \pm 3.8$ ,  $22.4 \pm 5.4$ , and  $6.9 \pm 2.9$  on the Psychological, Somatic, Social and Economic, Positive Religious Coping, and Negative Religious Coping subscales, respectively.

A statistically significantly high difference was found between the CP19-S total scores of females ( $52.4 \pm 18.3$ ), those with an income higher than expenses ( $52.6 \pm 19.4$ ), those who used masks to protect themselves from the COVID-19 virus ( $50.8 \pm 18.1$ ), those who obeyed social distance rules ( $51.1 \pm 18.0$ ), those who did not know a person in the close vicinity who caught the COVID-19 virus ( $52.9 \pm 19.4$ ), those who were afraid of catching the COVID-19 virus ( $55.3 \pm 17.3$ ), and those with a high level of religious belief ( $52.0 \pm 20.2$ ) ( $p < 0.05$ ) (Table 1).

A statistically significantly high difference was found between the Psychological subscale total scores of females ( $20.1 \pm 6.1$ ), those with high school diploma and below ( $20.3 \pm 6.8$ ), those with an income higher than expenses ( $19.9 \pm 6.2$ ), those who used masks

to protect themselves from the COVID-19 virus ( $19.5 \pm 6.2$ ), those who obeyed social distance rules ( $19.6 \pm 6.1$ ), those who obeyed personal hygiene rules ( $19.5 \pm 6.2$ ), those who did not know a person in the close vicinity who caught the COVID-19 virus ( $20.2 \pm 6.7$ ), those who were afraid of catching the COVID-19 virus ( $21.2 \pm 5.6$ ), and those with a moderate level of religious belief ( $19.8 \pm 6.0$ ) ( $p < 0.05$ ) (Table 1).

A statistically significant difference was found between the Somatic subscale total scores of those aged 59 and over ( $9.8 \pm 5.2$ ), females ( $9.6 \pm 5.0$ ), those with children ( $9.6 \pm 5.1$ ), those with a higher income than expenses ( $9.9 \pm 5.4$ ), those with chronic disease ( $10.2 \pm 5.8$ ), those who knew a person in the close vicinity who caught the Covid-19 virus ( $9.9 \pm 5.4$ ), those who were afraid of catching the COVID-19 virus ( $10.1 \pm 5.1$ ), and those with a high level of religious belief ( $9.8 \pm 5.5$ ) ( $p < 0.05$ ) (Table 1).

A statistically significant difference was found between the Social subscale total scores of females ( $14.2 \pm 5.5$ ), those who used masks to protect themselves from the COVID-19 virus ( $13.8 \pm 5.5$ ), those who obeyed social distance rules ( $13.9 \pm 5.4$ ), those who obeyed personal hygiene rules ( $13.8 \pm 5.5$ ), those who were afraid of catching the COVID-19 virus ( $15.1 \pm 5.2$ ), and those with a high level of religious belief ( $14.4 \pm 5.9$ ) ( $p < 0.05$ ) (Table 1).

A statistically significant difference was found between the Economic total scores of females ( $8.4 \pm 3.9$ ), those who lived in district/town/village ( $8.6 \pm 4.2$ ), those who were unemployed ( $8.7 \pm 3.8$ ), those with a higher income than expenses ( $8.6 \pm 4.1$ ), those who were afraid of catching the COVID-19 virus ( $8.7 \pm 3.8$ ), and those with a high level of religious belief ( $8.4 \pm 4.2$ ) ( $p < 0.05$ ) (Table 1).

A statistically significant difference was found between the Positive Religious Coping subscale total scores of females ( $22.7 \pm 5.0$ ), those with high school diploma and below ( $23.9 \pm 5.0$ ), those who were unemployed ( $23.2 \pm 4.9$ ), those with a higher income than expenses ( $22.9 \pm 5.3$ ), those who were infected with the COVID-19 virus ( $23.9 \pm 4.2$ ), those who knew a person in the close vicinity who caught the COVID-19

virus (22.8±5.1), and those with a high level of religious belief (25.3±3.4) (p<0.05) (Table 2).

A statistically significant difference was found between the Negative Religious Coping subscale total scores of those aged between 15-25 years (7.3±2.8), males (7.4±2.8), those with high school diploma and below (8.2±3.0), those who were unemployed (7.7±2.8), those with a higher income than expenses (7.5±2.9), those who did not use masks to protect themselves from

the COVID-19 virus (8.5±3.1), those who did not obey social distance rules (7.5±3.1), those who did not obey personal hygiene rules. (8.2±3.3), those who knew a person in the close vicinity who caught the COVID-19 virus (7.1±2.9), and those with a high level of religious belief (7.5±3.0) (p<0.05) (Table 2).

There was a highly significant positive correlation between the CP19-S total score and subscales and the Religious Coping Scale and subscales (p<0.001). (Table 3)

**Table 1. The Relationship Between Total and Subscales of the CP19-S and Descriptive Characteristics**

		CP19-S		Psychologic	Somatic	Social	Ekonomic
		n (%)	$\bar{X}\pm SS$	al Subscale	Subscale	Subscale	Subscale
			$\bar{X}\pm SS$	$\bar{X}\pm SS$	$\bar{X}\pm SS$	$\bar{X}\pm SS$	$\bar{X}\pm SS$
Age	15-25	260 (32.0)	50.7±17.1	19.4±5.7	9.1±4.6	13.7±5.3	8.3±3.7
	26-36	201 (24.8)	48.1±16.4	18.7±6.1	8.5±4.0	13.1±5.1	7.6±3.5
	37-47	246 (30.3)	52.3±19.3	20.0±6.6	9.8±5.3	14.2±5.8	8.3±3.9
	48-58	86 (10.6)	50.7±21.1	19.1±7.4	9.8±5.6	13.9±6.0	7.9±4.2
	59 ve ↑	19 (2.3)	52.1±18.2	19.4±6.9	9.8±5.2	14.5±5.6	8.2±3.1
Statistical Analysis (F/p)			1.579/0.178	1.171/0.322	<b>2.385/0.050</b>	1.083/0.364	1.273/0.279
Total ( $\bar{X}\pm SS$ )			50.6±18.2	19.4±6.3	9.2±4.8	13.7±5.5	8.1±3.8
Total (Min- Max)			20.0-100.0	6.0-30.0	5.0-25.0	5.0-25.0	4.0- 20.0
Sex	Female	609 (75.0)	52.4±18.3	20.1±6.1	9.6±5.0	14.2±5.5	8.4±3.9
	Male	203 (25.0)	45.0±16.6	17.3±6.3	8.1±3.9	12.5±5.2	7.1±3.2
Statistical Analysis (t/p)			<b>5.319/0.000</b>	<b>5.527/0.000</b>	<b>4.407/0.000</b>	<b>3.845/0.000</b>	<b>4.814/0.000</b>
Marital status	Single	386 (47.5)	50.9±17.7	19.5±5.9	9.2±4.8	13.8±5.4	8.2±3.7
	Married	426 (52.5)	50.3±18.6	19.3±6.6	9.2±4.8	13.7±5.6	7.9±3.8
Statistical Analysis (t/p)			0.509/0.611	0.546/0.585	0.031/0.975	0.158/0.875	1.260/0.208
Having child	Yes	398 (49.0)	49.9±16.8	19.4±5.8	8.8±4.4	13.5±5.2	8.1±3.6
	No	414 (51.0)	51.2±19.3	19.4±6.7	9.6±5.1	14.0±5.7	8.1±3.9
Statistical Analysis (t/p)			0.996/0.320	0.090/0.928	<b>-2.370/0.018</b>	-1.179/0.239	0.128/0.898
Educational level	High school and ↓	133 (16.4)	52.6±19.2	20.3±6.8	9.8±5.2	13.9±5.7	8.5±4.0
	Associate and Undergraduate	487 (60.0)	51.0±18.3	19.5±6.2	9.3±4.9	13.9±5.6	8.1±3.8
	Postgraduate	192 (23.6)	48.1±16.7	18.4±6.0	8.7±4.3	13.2±5.2	7.6±3.3
Statistical Analysis (F/p)			2.780/0.063	<b>3.951/0.020</b>	1.974/0.140	1.164/0.313	2.205/0.111

Living place	Big city	501 (61.7)	49.8±18.3	19.2±6.5	9.1±4.8	13.7±5.6	7.8±3.7
	Province	192 (23.6)	51.1±17.2	19.7±5.7	9.1±4.5	13.7±5.2	8.5±3.6
	District/Town/ Village	119 (14.7)	52.9±18.8	19.8±6.2	10.0±5.3	14.2±5.5	8.6±4.2
Statistical Analysis (F/p)			1.438/0.238	0.797/0.451	1.907/0.149	0.539/0.583	<b>4.065/0.018</b>
Working sector	Health sector	228 (28.1)	50.9±17.8	19.8±6.0	9.0±4.7	13.8±5.7	8.1±3.8
	Education Sector	183 (22.5)	49.7±18.5	18.8±6.4	9.1±4.8	13.7±5.6	8.0±3.6
	Service industry	89 (11.0)	48.8±20.6	19.0±7.4	9.1±5.2	13.2±6.0	7.4±4.2
	Unemployed	234(28.8)	52.6±17.5	19.9±5.9	9.8±4.9	14.2±5.2	8.7±3.8
	Other Sectors	78 (9.6)	47.5±16.7	18.4±6.2	8.9±4.5	13.1±5.1	7.0±2.8
Statistical Analysis (F/p)			1.603/0.171	1.603/0.172	1.014/0.399	0.818/0.514	<b>3.935/0.004</b>
Income expense balance	Income ↑	329 (40.5)	52.6±19.4	19.9±6.2	9.9±5.4	14.0±5.7	8.6±4.1
	Income=Expense	347 (42.8)	50.0±17.0	19.3±6.2	8.8±4.4	13.7±5.2	7.9±3.6
	Expense ↑	136 (16.7)	47.1±17.3	18.1±6.3	8.6±4.1	13.0±5.7	7.2±3.3
Statistical Analysis (F/p)			<b>4.737/0.009</b>	<b>3.991/0.019</b>	<b>5.601/0.004</b>	1.558/0.211	<b>6.731/0.001</b>
Chronic disease status	Yes	125 (15.4)	53.1±20.5	20.1±6.7	10.2±5.8	14.4±5.9	8.3±4.0
	No	687 (84.6)	50.1±17.7	19.2±6.2	9.1±4.6	13.6±5.4	8.0±3.7
Statistical Analysis (t/p)			1.549/0.123	1.418/0.157	<b>2.041/0.043</b>	1.456/0.146	0.685/0.493
Using mask to protect from COVID-19	Yes	796 (98.0)	50.8±18.1	19.5±6.2	9.2±4.8	13.8±5.5	8.1±3.8
	No	16 (2.0)	40.6±20.7	12.8±6.3	9.6±5.5	10.8±6.1	7.2±3.6
Statistical Analysis (t/p)			<b>2.225/0.026</b>	<b>4.225/0.000</b>	0.337/0.736	<b>2.178/0.030</b>	0.921/0.357
Obeying social distance rules to protect from COVID-19	Yes	723 (89.0)	51.1±18.0	19.6±6.1	9.3±4.8	13.9±5.4	8.2±3.8
	No	89 (11.0)	46.0±18.9	17.2±6.9	9.0±4.8	12.2±6.0	7.4±3.5
Statistical Analysis (t/p)			<b>2.548/0.011</b>	<b>3.461/0.001</b>	0.510/0.610	<b>2.534/0.013</b>	1.790/0.074
Obeying personal hygiene rules to protect from COVID-19	Yes	766 (94.3)	50.8±18.0	19.5±6.2	9.2±4.8	13.8±5.5	8.1±3.8
	No	46 (5.7)	47.3±19.7	17.5±6.7	9.4±5.4	12.2±5.9	8.1±3.8
Statistical Analysis (t/p)			1.266/0.206	<b>2.054/0.040</b>	0.188/0.851	<b>1.993/0.047</b>	0.018/0.986
Infected with the COVID-19 virus	Yes	114 (14.0)	49.1±19.7	18.5±6.5	9.5±5.1	12.9±5.7	8.1±3.9
	No	698 (86.0)	50.8±17.9	19.5±6.2	9.2±4.8	13.9±5.5	8.1±3.8
Statistical Analysis (t/p)			0.917/0.360	1.553/0.121	0.620/0.536	1.842/0.066	0.086/0.932
Having a person in the close vicinity who caught the COVID-19 virus	Yes	595 (73.3)	49.7±17.6	19.1±6.1	9.0±4.5	13.5±5.4	8.0±3.7
	No	217 (26.7)	52.9±19.4	20.2±6.7	9.9±5.4	14.3±5.6	8.3±3.9
Statistical Analysis (t/p)			<b>2.221/0.027</b>	<b>2.368/0.018</b>	<b>2.136/0.033</b>	1.838/0.066	1.035/0.301
Considering quit	Yes	178(21.9)	50.0±17.7	19.3±6.2	9.0±4.5	13.5±5.6	8.0±3.8

smoking to protect from COVID 19	No	634(78.1)	50.7±18.3	19.4±6.3	9.3±4.9	13.8±5.5	8.1±3.8
Statistical Analysis (t/p)			0.518/0.605	0.217/0.828	0.614/0.540	0.600/0.549	0.455/0.649
Quitting smoking to protect from COVID 19	Yes	100 (12.3)	50.5±16.9	19.3±5.9	9.1±4.5	13.7±5.3	8.3±3.8
	No	711 (87.6)	50.6±18.3	19.4±6.3	9.2±4.9	13.8±5.5	8.0±3.8
Statistical Analysis (t/p)			0.049/0.961	0.134/0.894	0.282/0.778	0.133/0.895	0.543/0.587
Considering quit alcohol use to protect from COVID 19	Yes	142 (17.5)	49.7±16.7	19.2±5.8	8.7±4.2	13.5±5.3	8.1±3.9
	No	670 (82.5)	50.8±18.4	19.4±6.4	9.3±4.9	13.8±5.6	8.1±3.7
Statistical Analysis (t/p)			0.643/0.521	0.365/0.715	1.445/0.150	0.574/0.566	0.045/0.964
Quitting alcohol usage to protect from COVID 19	Yes	109 (13.4)	50.3±17.2	19.3±6.1	8.9±4.2	13.7±5.4	8.2±3.7
	No	703(86.6)	50.6±18.3	19.4±6.3	9.3±4.9	13.8±5.5	8.1±3.8
Statistical Analysis (t/p)			0.192/0.847	0.147/0.883	0.791/0.430	0.021/0.983	0.265/0.791
Afraid of catching COVID 19 virus	Yes	584 (71.9)	55.3±17.3	21.2±5.6	10.1±5.1	15.1±5.2	8.7±3.8
	No	228 (28.1)	38.5±14.4	14.6±5.5	7.0±3.2	10.2±4.6	6.5±3.1
Statistical Analysis (t/p)			<b>14.029/0.000</b>	<b>15.156/0.000</b>	<b>10.090/0.000</b>	<b>13.010/0.000</b>	<b>8.363/0.000</b>
Level of religious belief	High	245 (30.2)	52.0±20.2	19.3±6.8	9.8±5.5	14.4±5.9	8.4±4.2
	Moderate	489 (60.2)	50.9±17.3	19.8±6.0	9.1±4.6	13.7±5.3	8.1±3.6
	Low	56 (6.9)	47.0±15.8	17.8±6.0	8.6±3.8	12.8±5.2	7.7±3.2
	Atheist	22 (2.7)	37.1±12.6	14.6±5.5	6.8±3.7	10.0±4.0	5.5±2.9
Statistical Analysis (F/p)			<b>5.384/0.001</b>	<b>6.099/0.000</b>	<b>3.324/0.019</b>	<b>5.125/0.002</b>	<b>4.031/0.007</b>

**Table 2. The Relationship Between Total and Sub-Dimensions of the Religious Coping Scale and Descriptive Characteristics**

	n (%)	Religious Coping Scale		
		Positive Religious Coping Subscale	Negative Religious Coping Subscale	
		$\bar{X} \pm SS$	$\bar{X} \pm SS$	
Age	15-25	260 (32.0)	22.8±5.1	7.3±2.8
	26-36	201 (24.8)	22.2±5.4	7.0±2.6
	37-47	246 (30.3)	22.1±5.3	6.7±3.2
	48-58	86 (10.6)	22.0±6.0	6.2±2.8
	59 ve↑	19 (2.3)	23.5±5.1	7.2±3.6
Statistical Analysis (F/p)			0.861/0.487	<b>2.437/0.046</b>
Total ( $\bar{X} \pm SS$ )			22.4±5.4	6.9±2.9
Total (Min- Max)			7.0-28.0	3.0-12.0
Sex	Female	609 (75.0)	22.7±5.0	6.8±2.9
	Male	203 (25.0)	21.2±6.2	7.4±2.8
Statistical Analysis (t/p)			<b>3.154/0.002</b>	<b>2.388/0.017</b>
Marital status	Single	386 (47.5)	22.2±5.5	7.0±2.8

	Married	426 (52.5)	22.5±5.3	6.9±3.0
Statistical Analysis (t/p)			0.958/0.338	0.705/0.481
Having child	Yes	398 (49.0)	22.3±5.2	7.1±2.8
	No	441 (51.0)	22.4±5.5	6.8±3.0
Statistical Analysis (F/p)			-0.229/0.819	1.280/0.201
Educational level	High school and ↓	133(16.4)	23.9±5.0	8.2±3.0
	Associate and Undergraduate	487(60.0)	22.2±5.5	6.9±2.8
	Postgraduate	192 (23.6)	21.7±5.1	6.1±2.7
Statistical Analysis (F/p)			<b>6.869/0.001</b>	<b>21.877/0.000</b>
Living place	Big city	501 (61.7)	22.1±5.4	6.8±2.9
	Province	192 (23.6)	22.9±5.1	7.1±2.9
	District/Town/Village	119 (14.7)	22.7±5.4	7.1±2.9
Statistical Analysis (F/p)			1.877/0.154	1.059/0.347
Working sector	Health sector	228 (28.1)	22.7±5.0	6.6±2.7
	Education Sector	183 (22.5)	21.4±5.7	6.5±3.0
	Service industry	89 (11.0)	23.0±5.6	7.6±2.9
	Unemployed	234(28.8)	23.2±4.9	7.7±2.8
	Other Sectors	78 (9.6)	20.5±5.8	6.2±3.1
Statistical Analysis (F/p)			<b>5.989/0.000</b>	<b>7.983/0.000</b>
Income expense balance	Income ↑	329 (40.5)	22.9±5.3	7.5±2.9
	Income=Expense	347 (42.8)	21.9±5.2	6.6±2.8
	Expense ↑	136 (16.7)	22.1±5.7	6.3±3.0
Statistical Analysis (F/p)			<b>3.291/0.038</b>	<b>12.189/0.000</b>
Chronic disease status	Yes	125 (15.4)	23.0±5.0	7.1±3.0
	No	687 (84.6)	22.3±5.4	6.9±2.9
Statistical Analysis (t/p)			1.404/0.161	0.487/0.626
Using mask to protect from COVID-19	Yes	796 (98.0)	22.4±5.4	6.9±2.9
	No	16 (2.0)	22.5±5.4	8.5±3.1
Statistical Analysis (t/p)			0.063/0.095	<b>2.157/0.031</b>
Obeying social distance rules to protect from COVID-19	Yes	723 (89.0)	22.4±5.3	6.9±2.9
	No	89 (11.0)	22.5±5.7	7.5±3.1
Statistical Analysis (t/p)			0.207/0.836	<b>2.027/0.043</b>
Obeying personal hygiene rules to protect from COVID-19	Yes	766 (94.3)	22.4±5.3	6.9±2.9
	No	46 (5.7)	22.5±6.2	8.2±3.3
Statistical Analysis (t/p)			0.192/0.847	<b>2.638/0.011</b>
Infected with the COVID-19 virus	Yes	114 (14.0)	23.9±4.2	7.2±2.8
	No	698 (86.0)	22.1±5.5	6.9±2.9
Statistical Analysis (t/p)			<b>4.083/0.000</b>	1.184/0.237
Having a person in the close vicinity who caught the COVID-19 virus	Yes	595 (73.3)	22.8±5.1	7.1±2.9
	No	217 (26.7)	21.3±5.8	6.6±3.0
Statistical Analysis (t/p)			<b>3.343/0.001</b>	<b>2.007/0.045</b>
Considering quit smoking to protect from COVID 19	Yes	178(21.9)	22.2±5.3	7.0±2.9
	No	634(78.1)	22.4±5.4	6.9±2.9
Statistical Analysis (t/p)			0.456/0.648	0.133/0.895

Quitting smoking to protect from COVID 19	Yes	100(12.3)	22.1±5.6	6.5±2.9
	No	711(87.6)	22.4±5.3	7.0±2.9
Statistical Analysis (t/p)			0.611/0.541	1.409/0.159
Considering quit alcohol use to protect from COVID 19	Yes	142 (17.5)	22.3±5.4	6.8±3.0
	No	670 (82.5)	22.4±5.4	7.0±2.9
Statistical Analysis (t/p)			0.053/0.958	0.621/0.535
Quitting alcohol usage to protect from COVID 19	Yes	109 (13.4)	22.5±5.4	6.6±2.9
	No	703 (86.6)	22.4±5.4	7.0±2.9
Statistical Analysis (t/p)			0.183/0.855	1.161/0.246
Afraid of catching COVID 19 virus	Yes	584 (71.9)	22.6±5.1	7.0±2.9
	No	228 (28.1)	21.8±6.0	6.8±3.0
Statistical Analysis (t/p)			1.893/0.059	0.649/0.516
Level of religious belief	High	245 (30.2)	25.3±3.4	7.5±3.0
	Moderate	489 (60.2)	22.2±4.5	6.9±2.8
	Low	56 (6.9)	16.6±6.0	6.1±3.2
	Atheist	22 (2.7)	8.0±2.3	3.4±0.9
Statistical Analysis (F/p)			<b>153.120/0.000</b>	<b>16.365/0.000</b>

**Table 3.** The Relationship Between CP19-S and Religious Coping Scale

	Religious Coping Scale						
	1	2	3	4	5	6	7
<b>1. CP19-S Scale</b>	1	.888*	.871*	.933*	.829*	.184*	.200*
2. Psychological Subscale		1	.630*	.811*	.596*	.207*	.185*
3. Somatic Subscale			1	.748*	.747*	.136*	.183*
4. Social Subscale				1	.699*	.174*	.163*
5. Ekonomic Subscale					1	.110*	.177*
6. Positive Religious Coping Subscale						1	.467*
7. Negative Religious Coping Subscale							1

\*p<0.001

### Discussion

A growing number of recent studies emphasize the fear of COVID-19 and coping methods (especially alternative methods) (Dhama et al., 2020b, Usher et al., 2020; Kizilgecit et al., 2021). People have both physical and psychological symptoms, especially fear, during the pandemic (Karsli, 2020; Horesh et al., 2020). Religious coping protects both psychological and physical

health in the face of disaster, epidemic, disease, victimization, war, or a loss of a loved one (Pargament 1998). In this regard, the present study was conducted to examine the relationship between fear of COVID-19 and religious coping and to determine whether some socio-demographic variables affected fear of COVID-19 and religious coping.

In parallel with the literature, the participants aged 59 years and older had significantly higher psychological fear of COVID-19 (Kizilgecit et al., 2021, Arisoy and Cay, 2021, Dhama et al. 2020b, Usher et al., 2020), and those aged between 15-25 years had significantly higher negative religious coping (Kandemir, 2020 and Gashi, 2020a). The pandemic deeply affects every part of society, from small to large, and age has been reported as a risk factor for the disease since the beginning of the pandemic. This is the reason why the fear of COVID-19 is higher in older individuals than in young people, considering that the first restrictions to prevent the disease in both Turkey and across the world are mostly focused on elderly individuals. In addition, the tendency and interest in religious issues decrease by the decrease of age; and praying, considering religious values, realizing the significance of religion, and interest in religious issues increase by the increase of age (Argyle, 1992). This may be because children/young people think that God/Allah punishes them because they did not encounter different crises, and therefore they have spiritual/religious discontent and question the pandemic and the power of God.

Along with the literature, females exhibited significantly higher fear of COVID-19 (Siraz et al., 2020, Bakioglu et al., 2020, Horesh et al., 2020, Limcaoco et al., 2020, Ozdin et al., 2020, Reizer et al., 2020, Wang et al., 2020) and higher levels of positive religious coping (Dogan and Karaca, 2021, Ayten and Sagir, 2014, Gencer and Cengil, 2020). Meanwhile, males showed significantly higher levels of negative religious coping (Gashi, (2020b, Yildirim et al., 2021, Angin, 2021, Gencer and Cengil, 2020). This may be because women tend to be affected differently by crises, pandemics, or social events, and their reactions to stressful events, including seeking help, differ from those of men. Additionally, women are more aware of their emotions than men and are more willing to openly admit their fears (Azaiza et al. 2010). Studies have shown that women are more impacted by COVID-19 news on social media than men, leading to greater fear of death (Horesh et al., 2020; Laato et al., 2020). Negative religious coping reflects a less secure relationship with God/Allah

during stressful events, as individuals interpret these events as divine punishment and believe they do not receive divine help (Pargament, 1998). This suggests that during the COVID-19 pandemic, men are more likely to engage in negative religious coping by viewing the disease as a "divine punishment." In such cases, men tend to use religious coping methods more than women, considering the disease a punishment from God/Allah.

Those with children had significantly higher somatic fear of COVID-19. This result is comparable with those reported by Dogan and Karaca (2021), Arpacioğlu et al., (2021), Arisoy and Cay (2021), and Kaya and Isik (2021). This suggests that having children causes individuals to be more afraid of death, and that a thought of losing their children, uneasiness about children in case of contracting the disease, and concerns about the future of children increase the fear of COVID-19.

Those with a high school diploma or below had significantly higher psychological fear of COVID-19 and positive and negative religious coping levels. Studies about the fear of COVID-19 reported education level as an important variable affecting the fear of COVID-19 (Bakioglu et al., 2020; Dogan and Duzel, 2020). Education level is an important factor for individuals to have access to the right information during the pandemic and interpret it correctly in the fight against the fear of COVID-19. Education level is also an important variable that affects one's economic status and income level. Therefore, economic status may also be effective in obtaining this result. Gashi (2020b) and Dogan and Karaca (2021) also found high levels of positive religious coping in individuals with a high school diploma or below. Individuals with a low level of education tend to resort to religious orientations more because they behave more emotionally during the crisis, do not know enough about the issue, and do not have enough information about solutions and precautions. Yildirim et al., (2021) found higher negative religious coping levels in those with bachelor's and master's degrees than in those with a high school diploma or below. The result of our study does not comply with those in the literature. This

suggests that education level, one of the factors affecting negative religious coping, should be addressed through further in-depth studies.

Those who lived in districts/towns/villages had significantly higher economic fear of COVID-19. This result is similar to those reported by Arisoy and Cay (2021). This result may be related to the social relations and frequency of communication among people in their places of residence. Those living in smaller settlements have tighter relationships and higher communication levels; however, those living in the city tend to have an active life, and their social ties are relatively weak, increasing their fear of COVID-19 (Acikgoz, 2007).

In line with the literature, our study found that those who were unemployed had significantly higher economic fear of COVID-19 (Kaya and Isik, 2021), positive religious coping levels (Gashi, 2020a, Reger et al., 2020, Thunstrom et al., 2020, Tian et al., 2020), and negative religious coping levels. This is an expected result as unemployed individuals have more economic difficulties due to the pandemic and more fear/stress/anxiety due to financial concerns during the pandemic. Individuals feel economic anxiety in epidemics/crises, therefore need to take shelter in a supernatural power (Gashi, 2020b), causing them to turn to supernatural powers in stressful life events. This result suggests that individuals are deprived of financial support due to their low/poor economic situation and feel weak in severe pandemics/crises such as COVID-19; therefore, they shelter in supernatural power and hope for God's help. However, our results of significantly higher negative religious coping levels in unemployed individuals do not comply with those in the literature. Although this may be because they consider that God/Allah punishes them and they tend to question this supernatural power more, further in-depth studies should be conducted in this regard.

Those with a higher income than expenses had significantly higher fear of COVID-19 and positive and negative religious coping levels. Kaya and Isik (2021) also determined that those with a higher income than expenses had more fear of COVID-19. The

obscurity created by the pandemics/crises in the whole world and the unpredictability of their economic effects and consequences are stressful for all individuals, regardless of their income levels. As individuals feel more economic anxiety/fear/uncertainty due to financial concerns during the pandemic, they need more to take shelter in a supernatural power (Gursu & Bayindir, 2016). Our results suggesting higher positive religious coping levels and fear of COVID-19 in those with a higher income than expenses may be because individuals in our sample need to take shelter in a supernatural power more in order not to lose their economic power. Yildirim et al. (2021) found that those with a higher income than expenses had higher negative religious coping levels. Considering the uncertainty of the COVID-19 pandemic, individuals may tend to take shelter in a supernatural power, while they may also tend to question this power.

Those with chronic disease had significantly higher somatic fear of COVID-19. Horesh et al. (2020) have stated that having a chronic disease is an important risk factor in the COVID-19 pandemic. Several studies have reported that the majority of deaths due to COVID-19 occur in individuals with a chronic disease (Zhu et al., 2020). The high level of fear in individuals with chronic disease may be due to the high mortality rates of the disease in chronic patients.

Those who used masks to protect themselves from the COVID-19 virus and those who obeyed social distancing and personal hygiene rules had significantly higher negative religious coping levels than those who did not. This result shows that individuals are afraid of COVID-19 because of the ways of transmission of the disease, the unknown effects of catching the disease, the lack of information whether the disease causes a permanent physiological damage, the uncertainty about current and future effects of COVID-19 vaccines, and increased number of deaths from the disease (Kaya and Isik, 2021), and therefore they comply more with relevant precautions and obey social distance and hygiene rules. On the other hand, those who did not obey these rules were those who considered that life was completely under God/Allah's control and that they could not change anything, and

therefore, they were more inclined to engage in negative religious coping activities.

Those who were infected with the COVID-19 virus had a significantly higher level of positive religious coping. One study reported that the worship activities of individuals intensified during the pandemic, doubling their searches for "pray" on Google in April 2020. The study found a significant increase in people's searches for the terms "God, Allah, and Muhammad" on internet browsing engines. The study also determined that 55% of Americans prayed for the end of the pandemic, 15% of them rarely or never prayed before the pandemic, and 24% were non-religious (Bentzen, 2021; Dein et al. et al. 2020). At crisis times, religion can make it easier for people to cope with stressful situations beyond their control. These results suggest an increase in the number of people who want to have a secure relationship with God/Allah and hope for God/Allah's help, in other words, an increase in the number of people with positive religious coping with the pandemic. Bentzen (2021) states that the COVID-19 pandemic promotes positive religious coping.

Those who did not know a person in the close vicinity who caught the COVID-19 virus had significantly higher fear of COVID-19 than those who did, and those who knew a person in the close vicinity who caught the COVID-19 virus had significantly higher positive and negative religious coping levels than those who did not. These results may be because there are several people infected with the disease, people know that everyone in the world will definitely catch the disease, the ways of transmission of the virus/disease are not known exactly, there is a lack of information whether the disease will cause permanent physiological damage now or later, and deaths due to the disease continue (Kaya and Isik, 2021). In times of pandemics/crises, religion can make it easier for people to cope with stressful situations beyond their control (Gashi, 2020a, 2020b). Some individuals may be inclined to engage in positive religious coping activities as they consider that they establish a secure relationship with God/Allah and wait for his help by praying. However, some others may incline to engage in negative religious coping activities as they think life is completely

under God/Allah's control and they cannot change anything.

Those who were afraid of catching the COVID-19 virus had significantly higher fear of COVID-19. This may be because of the high number of people who contracted the disease, the unknown ways of transmission of the disease, the lack of information about the effects of catching COVID-19, the uncertainty about whether the disease would have a permanent physiological damage now and later, and the uncertainty about current and future effects of COVID-19 vaccines (Kaya and Isik, 2021).

In parallel with the literature, our study found that those with high/medium levels of religious belief had significantly higher fear of COVID-19 (Pirutinsky et al., 2020, Karsli, 2020, Ozcan, 2020, Gursu and Bayindir, 2016), positive religious coping levels Gashi (2020a) and Kizilgecit et al. (2021), and negative religious coping levels Yildirim et al. (2021). The number of deaths continues to increase worldwide due to the COVID-19 pandemic, which has not been fully brought under control. People have various psychological difficulties, such as fear, panic, anxiety, and phobias during pandemics (Kim and Song, 2017; Tausczik et al., 2012; Liu et al., 2005). Therefore, these results suggested that exposure to COVID-19 may have caused people to have religious coping as a method of coping with this stressor. Religious/spiritual values and practices can have a significant impact on how people interpret and deal with traumatic events. The result of our study does not comply with those in the literature; therefore, further studies can discuss in more depth the relationship between religious belief and pandemic/crisis situations. Individuals with a high level of religious belief are expected to have positive religious coping, as it helps them cope with stressful situations such as fear and anxiety, especially in crisis times. Especially during the COVID-19 period, several studies have revealed that religious belief and life are an effective mainstay for individuals in coping with the disease (Gashi 2020a; Gashi 2020b; Kizilgecit et al. 2021; Gursu and Bayindir, 2021; Pirutinsky et al., 2020). However, the uncertainty and negative effects of severe pandemics/crises

affect people's views on health, life, future, and religion; therefore, some individuals tend to take shelter in a supernatural power, while some others tend to question this power and tend to adapt negative religious coping.

Our study determined that as the fear of COVID-19 increased, the religious coping level increased. This result complies with those reported by Paksoy, 2020, Krok et al., (2021), Pirutinsky et al., 2020 and Kizilgecic et al., 2021. This result points to both supportive and protective effects of religion through the meaning-providing role of religion in coping with pandemics and the fear/anxiety caused by the disease. Undoubtedly, as fear, anxiety, and other psychological disorders increase in disasters/pandemics, religious and spiritual practices facilitate the process of coping with these disorders.

**Conclusion:** The present study determined a highly significant positive relationship between the COVID-19 phobia and religious coping. In addition, some socio-demographic variables affected the fear of COVID-19 and positive and negative religious coping. Religious belief is used by individuals in coping with both COVID-19 and similar stressful life events. Policy makers can be guided by scientific researches to be conducted to plan psycho-social services and prepare educational activities for individuals/society during and after the pandemic. In this regard, this study will contribute to the literature and society. In addition, it may be recommended to conduct similar studies using different socio-cultural groups and to make qualitative studies on socio-demographic variables.

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