Anxiety Reactions and Coping Modalities with the COVID-19 Pandemic: A Cross-Sectional Study Comparing a Population of Religious Patients with Mental Illness and their Health Caregivers

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Abstract

This study evaluates the nature and intensity of anxiety, interpretations of the COVID-19 pandemic and coping modalities of hospitalized patients with mental illness compared with their caregivers. One hundred and fifty-one subjects were evaluated with a specially designed questionnaire. Psychiatric inpatients reported more anxiety and more negative feelings than staff members and healthy subjects, but inpatients felt protected by the hospital and Ministry of Health (MoH) measures. Despite this anxiety, inpatients reported a lower compliance with MoH instructions than staff and healthy subjects and gave more fatalistic interpretations to the pandemic. Haredi study participants reported less anxiety, more optimism and had a higher sense of control regarding the pandemic compared to non-religious participants.

Keywords COVID-19 · Anxiety · Coping · Religion · Haredi

Introduction

Many consider the COVID-19 pandemic crisis to be a medical “black swan” event—“black swan” being a phenomenon defined as “an unpredictable event beyond what is normally expected and has potentially severe consequences. Such events are characterized by their extreme rarity and severe impact” (Taleb, 2007). Reasons for this phenomenon include the disease’s rapid spreading affecting both developed and non-developed countries. Exceptional measures have generally been implemented

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by the WHO (WHO, 2020) and worldwide governments to inform citizens of its danger and to prevent contamination. This extraordinary situation has consequences not only for public health, but also affecting employment, social and family life, education, leisure and mental health (UNESCO, 2020; UNIDO, 2020).

COVID-19 in the Israeli Population and Haredi Community

At the outset of this study, on April 20th, along with many other countries around the world, Israel was in the midst of the COVID-19 pandemic. However, its spread was relatively limited due to early drastic, and what many would consider, draconian measures (Halbfinger, Kershner, & Bergman, 2020). By mid-April that year, 14,138 people were diagnosed positive with COVID-19 on a national scale, of which 155 were affected by a severe form of the disease (as defined by the Ministry of Health), and 178 had died from the disease (Ministry of Health, 2020). Moreover, 268,572 tests had been performed, and strict measures were in place limiting travel. Also, it was compulsory to wear a mask in public places.

The Haredi Jewish population, often described as “ultra-Orthodox,” is characterized by its strict adherence to Jewish Law, its dedication to studying the holy texts and the central role of their rabbis in their lives. This population was particularly affected by COVID-19. Bnei Brak and Jerusalem, two cities with a high percentage of Haredi individuals, were among the most affected cities in Israel (Bnei Brak also known as the most densely populated cities in Israel). Well-known Haredi leaders had also been infected by COVID-19 including Yaakov Litzman (Staff, 2020), then the Minister of Health and Rabbi Yeshayahu Heber (Joffe, 2020), renowned for his profound efforts in supporting and enabling altruistic kidney donation. This situation led the government to take strict measures, including a lockdown, in Haredi neighborhoods in general, and Bnei Brak in particular, in order to try to stop the spread of the virus.

Several hypotheses have been proposed to explain the high numbers in the Haredi population with COVID-19 infection. These include the high population density of ultra-Orthodox neighborhoods and the crucial importance of public gathering activities in the Haredi way of life (Malach, Cahaner, & Choshen, 2016; Banka, 2020; Kasstan, 2020), including collective prayers, Talmudic studies, weddings and funerals.

COVID-19 in the Psychiatric Population

The psychiatric consequences of the pandemic have begun to be evaluated in the literature (Aten et al., 2019; Torales et al., 2020), both in the general population and among caregivers (Simione & Gnagnarella, 2020; Sun et al., 2020). For example, some studies have described a worsening sense of isolation and the development of symptoms of panic disorder, anxiety, depression and post-traumatic stress disorder (Qiu et al., 2020; Wang et al., 2020). A recent study carried out in Israel on the general population showed that 20.2% reported a worsening of their psychological well-being during the COVID-19 period (Central Bureau of Statistics, 2020).

A previous study by our team (Iancu et al., 2005) highlighted the vulnerability of the psychiatric population during a previous coronavirus epidemic (SARS). The research showed higher anxiety reactions for inpatients in a psychiatry ward compared to staff. Moreover, we reported that patients felt more protected by the authorities (Ministry of health and other medical authorities managing the medical crisis) and the hospital. During the current COVID-19 pandemic, it appears, to date, that no studies have similarly compared reactions to the stress of the crisis between psychiatry inpatients and their staff. Considering the current context of the rapidly spreading COVID-19 pandemic, and the government and media's preoccupation about how to contain it and how to manage it, it would be important to evaluate the reactions of this subpopulation of those experiencing severe mental illness who are hospitalized.

Based on the model from our previous investigation during the SARS epidemic, this study evaluates the intensity and principal causes of anxiety, feelings of control and protection against the disease, cultural interpretations of the phenomenon and various coping aspects. The study compares different subgroups: psychiatric inpatients, staff members and healthy people that do not work in the hospital.

In a second stage of the analyses, the study focuses on the religious subsector—Haredi and non-Haredi population—in order to identify specific religious coping methods and vulnerabilities (Bilu & Witztum, 1993; Greenberg & Witztum, 2013).

We considered the study to be important since it may contribute to the understanding of the psychiatric consequences of COVID-19, particularly in vulnerable populations. In addition, the findings may be helpful in order to detect vulnerable populations with regard to the inevitable stress of the situation and to adapt infection prevention campaigns with cultural nuances and specificities in order to make these more efficient.

Material and Methods

Sample

The sample included 151 subjects between the ages of 18–65, male and female of three different groups: patients from the open inpatient psychiatric wards of the Mayanei Hayeshua Medical Center, hospital staff members and individuals from the community without known mental illness (“healthy control participants”). Mayanei Hayeshua is located in the Haredi city of Bnei Brak, a city particularly affected by the COVID-19 virus at the date of the study, and which included two internal medicine wards for the treatment of severe expression of COVID-19.

The patients were diagnosed according to DSM-5 criteria and recruited on a volunteer basis in the (separate) male and female inpatient psychiatry wards of Mayanei Hayeshua Medical Center. Patients with legal guardianship were not recruited.

All staff members from the psychiatric wards were invited to participate in the study as a comparison sampling group, including psychiatrists, psychologists, nurses, nurse aids, social workers, teachers, art and occupational therapists. The

volunteer participants completed the anonymous questionnaire and returned it to the researchers.

Healthy control participants, without any association with the hospital, were randomly recruited from the general population by means of distribution of questionnaires in the community.

All groups (patients, staff members and healthy control participants) included Haredi and non-Haredi participants. Religious orientation was not a criterion of inclusion or exclusion. Due to the absence of Internet connection, smartphones and computers in many Haredi households, and in order to avoid any selection bias, the questionnaire was circulated in paper form only.

The study was approved by the Mayanei Hayeshua Medical Center Helsinki Committee for ethical research.

Assessment

The study was carried out between April 20th, and May 17th, 2020. The recruitment of participants was limited to one month, notably at the initial peak of Israeli public awareness and concern and at the time of extensive government measures to stop the spread of COVID-19.

The participants completed a questionnaire in Hebrew containing several items:

Demographic data Age and gender.

Religious group affiliation Participants indicated subgroup affiliation: Haredi (Lithuanian, Hassidic, Sephardic) (Greenberg & Witztum, 2001), national religious, traditional and secular. A free field was proposed for other religions or subgroups.

Anxiety scale Anxiety was evaluated with the six-item short-form of the Spielberger State–Trait Anxiety Inventory (STAI) (Spielberger, Sydeman, Owen, & Marsh, 1999). Participants were asked to evaluate on a Likert scale from 1 to 4 (1 = not at all and 4 = very), to what extent they felt each one of the following feelings applied to them with regard to the current COVID-19 crisis: “comfortable,” “anguished,” “at ease,” “nervous,” “concerned” and “good.”

In the Spielberger anxiety scale (short form), for the statistical analysis, three items were reversed (“comfortable,” “at ease” and “good”) and summed up with the other items to an anxiety score of 6 (low anxiety) to 24 (high anxiety). Reliability of the scale was high: alpha Cronbach = 0.82. Regarding the scale of negative feelings, one of the items (“I feel indifferent”) was found unassociated with the rest and was excluded. The other four items were summed up to indicate a “negative feelings” score of 4 (low) to 20 (high). Reliability of the scale was high: alpha Cronbach = 0.85.

Negative feelings As in our previous study (Iancu et al., 2005), negative feelings with regard to the COVID-19 pandemic were evaluated on a Likert scale from 1 to 5. Participants were asked to what extent they experienced “worry,” “anxiety,” “depression,” “fright,” “indifference” and “hopelessness.”

Causes of Anxiety Four main causes of anxiety were evaluated on a Likert scale (from 1 to 5): “self-health,” “health of other persons,” “income” and “food supply.” A free field was proposed for other causes of anxiety.

Feeling of security to the pandemic The general feeling of “secure,” the feeling of being “protected” by Ministry of Health (MoH) instructions and the feeling of being protected by hospital protective measures (only for patients and staff members) were evaluated on a Likert scale from 1 to 5.

Feelings of safety in the hospital For staff members and inpatients, it was asked if they feel safer in hospital or at home.

Feelings of control with regard to the pandemic Participants were asked to evaluate on a Likert scale from 1 to 5 to what extent they feel they can control the pandemic and whether they are optimistic about the future.

Advisers The patients were asked whether they took advice from a Rabbi and from their family doctor and if they cooperated with Ministry of Health measures (yes/no).

Interpretation of the pandemic Patients were asked to evaluate on a Likert scale from 1 to 5, to what extent they believed the COVID-19 virus to be a consequence of the following categories: divine punishment, a sign of apocalypse, a message to humanity, message to myself or a phenomenon of the nature. A free field was proposed for other personal interpretations.

Coping methods Participants were asked to evaluate on a Likert scale from 1 to 5 to what extent they exploited usual religious customs (e.g., charity) and whether they respected Ministry of Health recommendations (e.g., wearing a mask) in order to stop the COVID-19 spreading. A free field was offered for other coping methods.

Diagnostic and Clinical severity (only for the patients). Clinical severity was evaluated by a CGI score (Guy, 2000).

Statistical Analysis

Data were analyzed using descriptive statistics, according to variables' nature. For continuous variables, both mean and standard deviation (SD) were calculated, and for categorical variables, frequencies and percentages were used. Group comparisons were performed using chi-square or *t* tests. To compare between healthy persons, staff members and psychiatric patients, we utilized one-way analysis of variance (ANOVA) models. In case of a significant outcome, Tukey's post hoc tests were used. The level of significance was set at $p=0.05$. All analyses were performed using SPSS version 25 (IBM Inc).

Results

Demographic Status

The sample included 151 subjects of three different groups: 72 healthy persons (47.7%), 31 patients from the psychiatric ward (20.5%) and 48 hospital staff members (31.8%). The number of men and women was equal (67), with missing data on 17 subjects (11.3%). Sex distribution did not differ between groups ($p=0.5$). The

average age was 34.6 (SD 11.6, range 18–65). Age differed between groups ($F=4.0$, $df=2,126$, $p=0.02$) with younger age among patients (mean 29.5, SD 10.4) compared to subjects of the community (mean 36.5, SD 12.3) ($p=0.02$) and staff, (mean 35.7, SD 10.5) ($p=0.06$).

The participants belonged to two religious' sectors, 74 were Haredi (49%) and 71 non-Haredi (47%) (mostly Jews and 3 Muslims), missing values for 6 (4.0%). Sector distribution did not differ between groups ($p=0.4$).

Fourteen patients were diagnosed with schizophrenia (45.2%), and the rest were diagnosed with mood (5, 16.1%), anxiety (5, 16.1%) or personality disorders (7, 33.3%). Average CGI of the patients was 4.7 (SD 1.0, range 2–6). (Table 1).

Comparison Between Staff Members, Inpatients and Healthy Controls

Anxiety scores and negative feelings were higher among patients compared to healthy persons and staff members ($F=4.8$, $df=2,130$, $p=0.01$; $F=11.0$, $df=2,136$, $p<0.001$, respectively). Post hoc analysis indicated that patients were significantly higher on anxiety compared to staff ($p=0.007$) and with a marginally significant

Table 1 Demographic characteristics of the 30 patients

<i>Gender</i>	<i>N (%)</i>
Men	67 (44.4)
Women	67 (44.4)
Missing data	17 (11.3)
<i>Mean age (SD)*</i>	34.6 (11.6)
Healthy persons	36.5 (12.3)
Inpatients	29.5 (10.4)
Staff members	35.7 (10.5)
<i>Group affiliation</i>	<i>N (%)</i>
Healthy persons	72 (47.7)
Inpatients	31 (20.5)
Staff members	48 (31.8)
<i>Religious affiliation</i>	<i>N (%)</i>
Haredi	74 (49)
Non-Haredi	71 (47)
Missing data	6 (4)
<i>Diagnosis</i>	<i>N (%)</i>
Schizophrenia	14 (45.2)
Mood disorder	5 (16.1)
Anxiety disorder	5 (16.1)
Personality disorder	7 (33.3)
<i>Mean CGI (SD)</i>	4.7 (1.0)

*Statistically significant difference between groups in this category

difference with healthy persons ($p=0.07$). Significantly higher scores were indicated for patients with negative feelings (both $ps < 0.01$).

Reasons for anxiety and general feeling of safety did not differ between groups.

Secure feelings in hospital were higher in patients compared to staff ($F=13.1$, $df=2,72$, $i < 0.001$).

Secure feelings of MoH actions tended to be higher in patients compared to both healthy persons and staff ($F=2.9$, $df=2,134$, $p=0.08$). Most patients (70.8%) replied that they feel safer in the hospital compared to only 4.8% of the staff.

Coping modes with the COVID-19 included consulting with a Rabbi or the family doctor or following MoH's instructions. No difference in consultation with Rabbis was found ($\chi^2=4.8$, $df=2$, $p=0.09$) between the different populations. Higher percent of patients (22.2%) and healthy persons (15.6%) consulted with their doctors compared to staff (0%) ($\chi^2=9.8$, $df=2$, $p < 0.01$). Higher rates of healthy persons (98.6%) and staff (97.8) learned MoH's instructions compared to patients (77.8%) ($\chi^2=17.8$, $df=2$, $p < 0.001$).

Actions to stop COVID-19. Significantly higher rates were given by healthy persons and staff members for keeping social distance ($F=15.7$, $df=2,145$, $p < 0.01$) and washing hands ($F=4.6$, $df=2,141$, $p=0.01$) compared to patients.

Table 2 Mean score on various items—differences between the study groups (standard deviation in brackets)

Item	Healthy group	Staff group	Patient group	Significance
<i>Spielberger anxiety sc</i>	14.4 (4.3)	13.3 (3.4)	16.6 (4.6)	$p=0.01$
<i>Negative feelings</i>	6.9 (3.1)	6.6 (2.4)	10.1 (4.4)	$p < 0.001$
<i>Security feelings</i>				
General	3.2 (1.1)	3.0 (1.0)	3.3 (1.2)	
In hospital	—	3.2 (0.9)	4.3 (0.9)	$p < 0.001$
MoH's instructions	3.4 (1.1)	3.2 (1.0)	3.8 (1.1)	$p < 0.001$
<i>Actions to stop COVID-19</i>				
Keep distance	4.1 (0.9)	4.0 (0.6)	3.0 (1.2)	$p < 0.001$
Stay home	3.9 (1.2)	4.0 (1.0)	3.7 (1.1)	
Wash hands	4.3 (0.9)	4.2 (0.9)	3.6 (1.2)	$p < 0.001$
Pray for myself	3.1 (1.5)	2.7 (1.4)	2.5 (1.2)	
Pray for others	3.2 (1.6)	3.0 (1.4)	2.6 (1.4)	
Give charity	2.6 (1.4)	2.5 (1.3)	2.0 (1.4)	
Keep religious laws	2.9 (1.5)	2.5 (1.3)	2.7 (1.4)	
<i>Interpretations of the pandemic</i>				
Divine punishment	1.9 (1.3)	2.0 (1.2)	2.6 (1.4)	$p=0.049$
Apocalypse	1.22 (0.6)	1.2 (0.4)	2.1 (1.4)	$p < 0.001$
Message to humanity	2.8 (1.6)	2.8 (1.4)	2.7 (1.5)	
Personal cause	1.7 (1.2)	1.5 (1.0)	1.8 (1.1)	
Natural cause	2.2 (1.5)	2.6 (1.5)	2.1 (1.5)	

Interpretations and beliefs about COVID-19. Patients significantly interpreted COVID-19 to be as a result of divine punishment ($F = 3.1$, $df = 2, 135$, $p = 0.049$) and apocalypse ($F = 13.7$, $df = 2, 134$, $p < 0.001$) compared to healthy individuals and staff members. (Table 2).

Comparison Between Religious Sectors

In the second stage of the analysis, effects on the religious subsector were analyzed.

Anxiety scores tended to be lower among the Haredi participants compared to secular participants ($F = 3.6$, $df = 1, 124$, $p = 0.06$). Group by sector interaction was not significant ($p = 0.34$).

Negative feelings were significantly lower among Haredi participants compared to secular participants ($F = 4.4$, $df = 1, 129$, $p = 0.034$). Group by sector interaction was not significant ($p = 0.26$).

Feelings of control over the spread of COVID-19 was higher among Haredi participants compared to secular participants ($F = 4.6$, $df = 1, 138$, $p = 0.034$). Group by sector interaction was not significant ($p = 0.38$).

Optimism was higher among the Haredi participants compared to secular participants ($F = 5.5$, $df = 1, 138$, $p = 0.021$). Group by sector interaction showed a tendency to significance ($F = 2.9$, $df = 2, 138$, $p = 0.06$). Haredi healthy participants and patients were more optimistic while among staff members less optimistic compared to secular participants.

General feelings of safety were higher among Haredi participants compared to secular participants ($F = 5.9$, $df = 1, 128$, $p = 0.024$). Group by sector interaction was not significant ($p = 0.48$).

Secure feelings in the hospital did not differ between Haredi and secular participants ($p = 0.48$). Group by sector interaction was not significant ($p = 0.97$). *Secure feelings of MoH actions* were slightly higher among the ultra-Orthodox compared to secular participants ($F = 3.0$, $df = 1, 126$, $p = 0.087$). Group by sector interaction was not significant ($p = 0.26$).

Among Haredi participants, the *general manner in coping with COVID-19* was, in order of importance: washing hands (mean 4.1), stay at home (4.1) and keep social distance (3.8). The *religious manner in coping* was in order: pray for others (mean = 3.4), keep religious laws (3.3), pray for myself (3.2) and give charity (2.9). The *interpretations of the COVID-19 pandemic* were in order: message to humanity (mean = 3.1), divine punishment (2.5), relates specifically to me (2.0), a phenomenon of nature (2.0) and finally a sign of the apocalypse (1.5).

Discussion

This article examines the anxiety responses and coping methods with the COVID-19 pandemic in psychiatric ward inpatients, in hospital staff members and in healthy individuals in the community.

Psychiatric Staff Members Versus Inpatients

The first part of the analysis compared psychiatric patients hospitalized in an open psychiatry ward, their staff members and healthy controls from the general population.

Psychiatric patients were more anxious and had more negative feelings than healthy persons and staff members similar to what we noted in our previous study during the SARS epidemic (Iancu et al., 2005). Paradoxically, despite this anxiety, patients themselves reported less interest regarding MoH instructions and were less likely to follow the instructions of social distance and hands washing in comparison with healthy persons and staff members. Moreover, their negative interpretation and beliefs about the COVID-19 (significantly higher rates of patients considered the epidemic as a divine punishment and apocalyptic) may also reflect a sense of fear and helplessness (Lee et al., 2016).

These data confirm the concerns regarding the vulnerability of psychiatric patients in comparison with healthy persons: not only are they more anxious, but they also feel less able to take the necessary measures to protect themselves (Bortolon et al., 2018; Lim et al., 2019).

Interestingly, patients felt safer in the hospital compared to staff members, and their secure feelings with respect to the MoH's interventions were higher compared to both healthy persons and staff ($p < 0.001$). Thus, patients seem to have confidence in the staff members and in the MoH to protect them from COVID-19. This increases the responsibility of the staff members toward patients. It may be proposed that the reason for this may be that patients under such a situation feel vulnerable and not always able to care of themselves. Therefore, they seem particularly to rely on staff members for support and reassurance. From a rehabilitation point of view (Roe et al., 2009), psychoeducation regarding the efficient prevention measures of COVID-19 contamination may be an extension of the mental health caregivers' job under the unique circumstances of a pandemic. For example, staff members can encourage efficient preventative actions, such as hand washing or social distancing, in order to decrease feelings of helplessness, and as a result, reduce the anxiety of the inpatients in such situation, with positive consequences for the patients and for public health.

Haredi Versus Non-Haredi Population

The second part of the analysis compared subjects from the Haredi and non-Haredi subpopulation. Haredi participants were less anxious and reported significantly fewer negative feelings compared to secular subjects. Moreover, a sense of control, optimism, and general feeling of safety were higher in Haredi subjects. These data are especially important when taking into consideration that the Haredi population was particularly affected by COVID-19, especially in Bnei Brak, where this study was carried out (Ministry of Health, 2020).

Religious coping. Several studies in the past have shown that religion and spirituality can be an efficient way of coping with a wide range of mental and physical

disease and may have positive effects on anxiety, social functioning and treatment adherence (Mohr et al., 2012; Rosmarin et al., 2009; Rosmarin, Bigda-Peyton, Öngür, Pargament, & Björgvinsson, 2013a, 2013b). The present study shows the efficiency of religious coping in the particular context of COVID-19 pandemic regarding anxiety and negative feelings.

Several considerations may be suggested to explain the different findings between secular and religious populations.

First, religious manners of coping do not exclude compliance with MoH measures. Feeling secure in the hospital did not differ between Haredi and secular subjects. In addition, feeling secure in MoH's actions was even slightly higher among the ultra-Orthodox compared to secular subjects. Compliance with medical recommendations has clear foundations in Judaic religious tradition (Talmud Bavli 85a, Mishna Nedarim 4:4). These results corroborate previous studies that suggest a relationship between belief in God and credibility and expectancy in treatment (Rosmarin et al., 2013a, 2013b).

Second, feelings of optimism and control are significantly higher in the ultra-Orthodox population. As suggested by our findings, members from the Haredi subpopulation perceive the pandemic as a message from the divine or a punishment for their individual or collective behavior. As suggested by traditional texts, such catastrophic events are not necessarily fatal but can be stopped, depending on moral behavior, prayer and divine will. Third, the Haredi subpopulation reports specific ways of coping based on religious meaning and laws. According to this interpretation, religious rituals including repentance, prayer and charity (as cited in the liturgy) are efficient ways to mitigate or stop COVID-19 spread. Engaging in various religious daily activities to halt the spread of COVID-19 may reinforce feelings of control (less passive) and reduce anxiety, as noted in previous studies that have shown a positive influence of religion in coping with illness (Pirutinsky et al., 2020).

Vulnerability of the Haredi population. The specific vulnerability of the Haredi population to various effects of the COVID-19 pandemic is evident from the results of this study. Thus, among the Haredi population, manners of coping with the anxiety of COVID-19 were in order of importance: washing hands, staying at home and lastly keeping social distance. This correlates with the Haredi way of life. Frequent washing hands is a very acceptable, and even a religious obligation in varying situations (e.g., upon awakening, before meals and after relieving themselves). However, maintaining social distance is particularly challenging in this population, due to the density of population in ultra-Orthodox areas and the importance of collective religious activities (such as collective prayer in the synagogue or Talmudic studies in a *Yeshiva/Kollel*) (Kasstan, 2020; Malach et al., 2016).

These interesting findings assist in a better understanding of the Haredi population, with the central role of religion as a resource to cope with anxious situations, including medical infections such as COVID-19. Efficient and appropriately adapted manners of communication, with a focus on prevention measures, may help governments and caregivers in their challenging mission to slow the spread of COVID-19 in Haredi neighborhoods and others. This study indicates the crucial importance of cultural factors in preventative measures in a pandemic.

Study Limitations

Future studies may consider recruitment of larger sample size including healthy controls. This however may be challenging in a time of pandemic. It would be also interesting in the future to consider comparing anxiety and coping responses at two time intervals thus exploring whether any coping strategies or responses change or evolve over time. Moreover, using only validated questionnaires may improve the quality of the study, but few of them are adapted to the Haredi population in times of pandemic. More studies should be carried out in this important field to increase the understanding of various unfamiliar cultural aspects of psychiatric illness in times of stress.

Conclusion

In the specific context of a pandemic, this study highlights the necessity to identify and evaluate anxiety in various subpopulations. Some subpopulations may be more vulnerable due to cultural or illness factors. Efficient and culturally sensitive campaigns should be encouraged. Caregivers should promote active methods to prevent COVID-19 and reinforce patient feelings of control. Religious coping may represent an interesting unexplored aspect of coping with anxiety in a context of pandemic.

Declarations

Conflict of interest The authors declare that they have no conflict of interest.

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