

Death and Dysfunctional Anxieties, COVID Stress and Loneliness during the Pandemic: Basis for Intervention Program Development

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Abstract

Background: Death, dysfunctional anxiety, COVID stress, and loneliness were examined to establish an intervention program. This descriptive quantitative study measured four variables using four standardized questionnaires. **Purpose:** The study aimed to assess the relationship that exists among the variables and eventually come up with a program that addresses the research findings. **Method:** This convenience sample study included 699 students and employees from a city in Region VI, Western Visayas, during the COVID-19 pandemic. **Results:** Results showed that roughly equal numbers of men and women aged 18 to 29 are unmarried or living alone and married and living with their kids, parents, or elderly parents. Most of them are students, while some work in person, from home, or are unemployed. Death and dysfunctional anxiety do not affect responses. There is some concern about contamination and mild worry about the COVID-19 infection, but little traumatic stress. Most responders are lonely. Death anxiety, COVID threat, traumatic stress, and loneliness vary greatly between men and women. Living status groups strongly affect all categories except loneliness. **Conclusion:** Death anxiety is significantly associated with all factors except dysfunctional anxiety, which was associated with all COVID stress characteristics. From these, the Department of Health where respondents live may tighten the implementation of their COVID-19 Response Program, which includes verification, contact tracing, rapid risk assessment, case measures, treatment of patients, vaccination, risk communication, prevention, rehabilitation, and other support activities.

Keywords

Death and Dysfunctional Anxieties, COVID Stress, Loneliness

1. Introduction

Researchers looked into the connections between mortality, dysfunctional anxiety, COVID stress, and isolation in order to come up with a workable answer. In this descriptive quantitative study, four parameters were evaluated using four standardized questionnaires to determine the relationship between the variables. To do a causal analysis, or to assess the degree to which two or more items are related to one another, was the overarching purpose of the study. This study using a convenience sample was carried out during the COVID-19 pandemic in 2020 with the participation of 699 students and workers from a city located in Region VI, Western Visayas. According to the findings, roughly an equal number of men and women between the ages of 18 and 29 are either single and living alone or married and living with either their own children or their spouse's parents. Those who are married and living with their own children are more likely to be single than those who are married and living with their spouse's parents. The vast majority of them are students, although a few of them work full- or part-time from home jobs, while the rest of them are either unemployed or looking for work. The effects of death and dysfunctional anxiety have little bearing on the responses. In spite of moderate concerns about emotional reactions, stress is typically the result of outside factors of contamination and the COVID-19 infection, there is only a minimal amount of traumatic stress evident. The overwhelming majority of those who respond do so on their own. There are significant differences between how men and women react to the possibility of death, the COVID threat, post-traumatic stress disorder, and feelings of isolation. The living conditions of social groupings have a significant impact on all of these, with the exception of loneliness.

2. Introduction

Coronavirus virus disease 2019 (COVID-19) is a pandemic that has wrapped the whole world around itself, making people fear for their lives, jobs, and almost everything else. With the advent of COVID-19, the world went under siege; lockdowns were imposed; people were quarantined in homes, offices, and schools; and the world changed the dynamics of its social interaction to fight the pandemic. With the rising number of people getting infected and dying, various factors impact the psychological well-being of people (Abdelghani et al., 2021). The COVID-19 pandemic's instilling of fear and the corresponding impact of lockdown measures have had a variety of negative effects on the mental health and wellbeing of entire societies, affecting communities at every level imaginable.

Death anxiety largely increased among people, especially those who had seen their loved ones die because of it. Death anxiety is defined as a feeling of uncertainty, fear, anxiety, and unsafety related to death or near-death (Malinauskaite et al., 2017). Studies have shown that the pandemic has increased death anxiety among people as they tend to become more vigilant. The present pandemic has created a sense of uncertainty, chaos, and confusion among people as they have

become unsure regarding whether they have contracted the virus and, if yes, whether they will survive or not. Safety has become one of the most prominent stakes in the current situation (Pradhan et al., 2020).

As part of being vigilant, people are also becoming more concerned with their own safety and the safety of their loved ones, especially when they need to leave the comforts of their homes. With these, people are not only developing anxiety towards death but also some dysfunctional anxieties that are being associated with the pandemic. Similarly, dysfunctional anxiety is also a response to stress whenever the human body experiences physiological changes (Roy-Byrne, 2015). Throughout the pandemic, people experienced fear of getting infected with the virus, which resulted in excessive stress and anxiety (Hall et al., 2008; Rehman et al., 2021). Anxiety leads to a nearly identical set of symptoms as stress: insomnia, difficulty concentrating, fatigue, muscle tension, and irritability. However, there is a fine line between stress and anxiety. Both are emotional reactions, but stress is typically the result of outside factors.

Stress can be explained in terms of feeling emotional and physical tension and getting infected, while anxiety strives with the amount of uncertainty this pandemic brought to the world as people were unsure of everything around them. Triggers of stress can be short-lived, such as a job appointment, an argument with a loved one, or a long-term argument, disability, discrimination, chronic illness, etc. Also, people under stress suffer from mental and physical symptoms such as irritability, anger, fatigue, muscle pain, indigestion, and trouble sleeping. Stress and anxiety about getting infected multiplied among the masses, and social isolation increased those fears and stressors to an extent. Studies have shown the COVID-19 fear has been associated with functional impairment leading to suicidal ideation, hopelessness, and cognitive deficits (Lee, 2020), along with anxiety, stress, and depression related to getting adjusted to the new normal as well as the fear of getting infected (Cao et al., 2020; Haleem et al., 2020). This then leads to different emotions and behaviors in humankind, such as their fear of death, anxiety, stress, and even loneliness.

Loneliness, however, is defined as the feeling of being alone and finding no support within the physical or psychological realms. It is the lack of contact or minimal contact with people. With the advent of the pandemic, social isolation was one way to be safe from contracting the virus. But the studies have highlighted that social isolation has impacted individuals psychologically, as it is one of the leading causes of anxiety, depression, fear, and stress (Pietrabissa & Simpson, 2020). Another study has highlighted that prolonged social isolation has adverse effects on physical and emotional health (Cacioppo & Hawkley, 2003) and can have a significant impact on mood and subjective well-being among individuals (Nardone & Speciani, 2015). Since humans are socially charged beings, social isolation was a great setback that people had to face. Staying away from loved ones and maintaining distance is a difficult thing to do, which propagates many well-being issues. This social isolation has led to a feeling of being alone and finding no support within the community. Many people reported that dur-

ing the pandemic, due to the social distancing, they felt lonely. With all these problems taking place, this research aimed to investigate the patterns of death and dysfunctional anxiety, stress associated with the COVID pandemic, and loneliness among individuals in one province in the Western Visayas. Overall, the study aimed to assess the relationship that exists among the variables and eventually come up with a program that addresses the research findings. Moreover, this study aimed to contribute to the literature associated with its four variables and to help policymakers and professionals provide more subjective and effective interventions to manage the issues across populations. Lastly, the study wanted to provide information and guidelines to help the participants seek help and manage their anxieties and loneliness related to the pandemic. It will allow the institutions to make specific policies and interventions that will help in providing guidance and assistance in managing their issues and combating the after-effects of COVID-19. Since this study also encountered some limitations, such as the number of participants included, restricted mobility to gather data, and inadequate resources, among others, several recommendations were also mentioned for future researchers.

3. Literature Review

3.1. Death Anxiety

Death is an inevitable truth of the living being's cycle of life, and death is the end to it. Studies have shown that pandemics heightened the fight and flight response in an individual, along with increasing the fear of death, largely based on confusion, uncertainty, and chaos (Pradhan et al., 2020). According to the BBC report (2020), the pandemic has put the world in an indefinite period of mortality, where the world's love is in chaos and there is no safety or wellbeing. Being salient indicated the timeliness of the virus that spread across the world and the number of people the world lost to COVID-19.

The recent COVID-19 pandemic has triggered a surge in anxiety across the globe. Much of the public's behavioral and emotional response to the virus can be understood through the framework of terror management theory, which proposes that fear of death drives much of human behavior (Menziez & Menziez, 2020). According to the Terror Management Theory, how people deal with their fear of dying frequently influences how they behave. Using this perspective, authors have argued that the fear of mortality can be experienced at two levels: the contextual, discussing the inevitability of death, and the dispositional, the individual difference in how every other person reacts to this fear. This fear indicates that dysfunctional regulation of fear of death can lead to anxiety and consequent psychological conditions (Pyszczynski et al., 2020).

A Brazilian study investigated how and under what conditions concerns associated with death and anxiety correlate with well-being in COVID-19. According to the study's findings (Silva et al., 2021), anxiety in the face of COVID-19 acted as a mediator between individual differences in death fear and people's well-being. Thus, the study highlighted the basic ground of the COVID-19 fear, which

revolved around the fear of death, its impact on the life choices people were making, and the negative psychological consequences it has on people's mental wellbeing. Another study in Lebanon was conducted to provide insights on the impact of COVID-19 on individuals at the level of fear in Lebanon. Death anxiety was identified as the most significant predictor of fear related to the COVID-19 pandemic. Considering the negative psychological effects of fear, it is necessary to educate adults on how to deal with death anxiety and implement psychological interventions and counseling programs to relieve fear and improve the mental health of Lebanese adults (Chalhoub, Koubeissy, Fares, & Abou-Abbas, 2022). Another study's findings suggested that sociodemographic factors like COVID-19 fear, gender, and occupation have an impact on the pandemic process. As a result of this study, it was determined that death anxiety was relatively high during the COVID-19 pandemic process (Özgüç, Serin, & Tanrıverdi, 2021).

One large study of 810 Australians specifically explored fears of death in the context of the pandemic (Newton-John, Chambers, Menzies, & Menzies, 2020). The findings revealed a significant positive correlation between death anxiety and anxious beliefs and behaviors related to COVID-19 (e.g., estimated likelihood of contracting the virus, estimated likelihood of wearing a mask in public, etc.), in addition to self-reported health anxiety and overall psychological distress. Furthermore, participant responses to items assessing beliefs surrounding the virus indicated a heightened perception of threat. For example, when participants were asked how likely they would be to die if they contracted COVID-19 in the next 18 months, the mean likelihood estimate was 22%, a figure more than 11 times the actual Australian case fatality rate of 2%.

3.2. Dysfunctional Anxiety

People struggled to adjust to the new normal since they were uncertain of what would happen. During a pandemic, professionals showed high rates of post-traumatic stress, anxiety, depression, hyperarousal, anger, loss of motivation, and fear of contracting the virus (Mosolova et al., 2020; Wang et al., 2020). Being on the front lines of a pandemic is unpleasant, and knowing this terrible illness can kill them has increased professionals' anxiety and stress. During pandemics, COVID-19 stress syndrome has been found to cause obsessive-compulsive cleaning and post-traumatic stress (Taylor, 2021).

Almost 500 studies on coronaviruses and fear, anxiety, stress, uncertainty, and phobias have been published in the COVID-19 research database (Saladino et al., 2020). COVID-19-related fear is a leading source of suicide ideation, hopelessness, and coping deficits (Lee, 2020). It's linked to fatal cognition and death anxiety. Clinical investigations have linked COVID-19 dread and the new normal to anxiety and depression (Goyal et al., 2020; Chakraborty & Chatterjee, 2020; Huang & Zhao, 2020). New behaviors require intentional and thoughtful change, according to research. The pandemic prevented people from thinking or making smart life adjustments. To minimize infection, the epidemic necessitated

social separation, masks, and cleanliness inspections. The persistent worry about infecting oneself and loved ones created a vicious cycle of discomfort, fear, anxiety, and stress (Khademian et al., 2021; Cheng et al., 2020).

The pandemic has caused global panic, which has increased psychological problems and suicide rates (Mamun & Griffiths, 2020). Wang and colleagues (2020) found considerable psychological distress such as stress, depression, and anxiety in Chinese nationals, and other studies have shown the same (Qiu et al., 2020). Pandemics require stress and worry. Infection now means death or near-death, so people fear it. A qualitative study of critical COVID-19 survivors found that the near-death experience terrified them and made them worried about health care (Hodkinson, Gina, & Schneider, 2022).

During the pandemic, nonpsychotic psychiatric outpatients were assessed for dysfunctional coronavirus anxiety using the CAS and network analysis. 7.8% had malfunctioning coronavirus anxiety (CAS 5). Health worry, physical obsession, and subjective anxiety were higher in dysfunctional coronavirus anxiety patients. The health worry node (Item 6 of the WI) had the highest correlations with coronavirus anxiety nodes (Kim et al., 2022).

3.3. COVID Stress

Cohen et al. (quoted by Girma et al., 2021) define “stress” as “a process where environmental demands exceed an organism’s adaptive capacity, resulting in psychological and biological changes that may put people at risk for disease.” Stress during an infectious disease outbreak can lead to fear, worry, worsened chronic health issues, and increased substance use (CDC, 2020). Most COVID-19 patients have mild to moderate respiratory disease and recover without treatment. However, older people and those with cardiovascular disease, diabetes, chronic lung disease, and cancer are more likely to suffer severe illnesses that may lead to mortality (World Health Organization, 2020a). COVID-19 outbreaks stress high-risk patients. Chronic stress causes noncompliance with treatment regimens, worsening disease and causing concomitant health issues like hypertension, heart attack, stroke, diabetes, and obesity. 10 COVID-19 outbreaks interrupt chronic disease patients’ sleep, stress, physical activity, and mental health, which should be addressed (Kendzierska, Zhu, & Gershon, 2021). Chronic illness may worsen the mental health and psychological effects of the COVID-19 pandemic (Fiorillo & Gorwood, 2020). Chronic disease patients were more distressed during COVID-19 outbreaks in Greece and northeast Ethiopia (Louvardi, Pelekasis, Chrousos, & Darviri, 2020; Addis, Nega, & Miretu, 2021). USA chronic disease and disability patients expressed moderate perceived stress (Umucu & Lee, 2020). Chronic conditions and disabilities may increase their risk of COVID-19 complications, which can increase stress and worsen health and well-being (World Health Organization, 2020b). Shifting health services to urgent COVID-19 patients may interrupt chronic disease patients’ continuous care, worsening their health and stress (Kendzierska et al., 2021). COVID-19 fear, like all phobias, is an anxiety-like disorder based on persistent, excessive, unreasona-

ble, or inflated dread of an object, animal, person, or situation, according to [Aro-ra and colleagues \(2020\)](#). Avoiding phobia triggers causes anxiety and misery. Thus, COVID fear is an extreme worry about getting COVID-19, followed by excessive anxiety over physiological symptoms and severe distress over personal, vocational, and family loss.

3.4. Loneliness

Social isolation has been shown to harm mental and physical health. Social isolation in older people has been extensively investigated ([Alpass & Neville, 2003](#); [Hawton et al., 2011](#)). Avoiding social or meaningful ties is difficult since it goes against human nature. Researchers and health experts recommended social isolation as the only mature response to the pandemic, which spread to millions of individuals quickly. Offices, schools, and markets were closed, and people were quarantined at home. Studies show that many people, especially children and adolescents, have lived in physical isolation from friends, peers, instructors, extended relatives, and other community members. Social isolation causes bewilderment, anxiety, frustration, rage, and post-traumatic stress ([Brooks et al., 2020](#)). These studies also found that people fear infection, boredom, financial loss, frustration, and stigma, which constantly navigate death ([Hossain et al., 2020](#)).

Hospital employees who got the virus and were contacted within nine days of quarantine showed severe stress disorders. In the same study, these employees were more likely to report weariness, insomnia, irritation, alienation, anxiety, poor focus, and work-related issues, and many were considering quitting. Thus, it was instructive that social isolation caused acute stress disorder symptoms ([Brooks et al., 2020](#)). In a previous study, quarantined parents and children reported four times higher and more severe post-traumatic stress symptoms than those who were not. 30% of parents experienced trauma-related symptoms ([Sprang & Silman, 2013](#)). Thus, quarantine, even before COVID-19, negatively affected mental health because people were isolated from their loved ones, which triggered many deep-rooted worries and vulnerabilities. Depression, anxiety, post traumatic stress, insomnia, exhaustion, and poor job performance, especially among health workers, have been connected to pandemic social isolation ([Banerjee & Rai, 2020](#)).

4. Methods

4.1. Research Design

A quantitative research design, particularly descriptive-correlational, was used in this study. According to [Bhandari \(2022\)](#), quantitative research is the process of collecting and analyzing numerical data, which can be used to find patterns and averages, make predictions, test causal relationships, and generalize results to wider populations. [Bhandari \(2022\)](#) further specified that the correlational research design investigates relationships between variables without the researcher controlling or manipulating any of them. In this study, the researcher used a

quantitative correlational research design to determine whether the four variables are related to each other. In this method, four standardized questionnaires were employed to gather quantitative data from the respondents. After the data gathering, the data were collected, analyzed, interpreted, and discussed. Hence, in this paper, the researcher statistically described the respondents' profiles, tested them, and correlated death, dysfunction, COVID stress, and loneliness among the respondents being studied.

4.2. Participants

Residents from a certain city in Region VI, Western Visayas, were asked to participate in this study during the COVID-19 pandemic. The researcher used convenience sampling because it is a technique for gathering samples by taking those who are conveniently located close to a location (Edgar & Manz, 2017). Through convenience sampling, the researcher was able to recruit a total of six hundred ninety-nine (699) participants who were asked to answer the four standardized questionnaires.

Exclusion and Inclusion Criteria

Both males and females participated in the study. People who were 17 or older and had varied living statuses and different professions were included, while below 17 students or children were excluded.

4.3. Measure

- **Death Anxiety Questionnaire (DAQ)** This tool was utilized in determining the death anxiety of the respondents. The Conte and his colleagues (1982) test evaluates the four distinct aspects of death anxiety, including fear of the unknown, fear of suffering, fear of loneliness, and fear of personal extinction. Possible total scores range from 0 to 30, with higher scores reflecting more death anxiety (Conte, Weiner, & Plutchik, 1982).

- **Coronavirus Anxiety Scale (CAS)** This test was used to measure respondents' dysfunctional anxiety associated with the coronavirus crisis. The CAS consists of 5 items accompanied by a 5-point Likert scale (0 = never to 4 = every day) that measures the presence and frequency of anxiety symptoms precipitated by attending to the pandemic (operationalized as thinking, reading, listening, or consuming information about COVID-19). The five items capture the five principal symptoms of coronavirus-related anxiety: specifically, difficulty sleeping, feeling paralyzed or frozen, nausea or stomach problems, loss of appetite, and dizziness, lightheadedness, or faintness. A CAS total score of 9 indicates probable dysfunctional coronavirus-related anxiety.

- **COVID-19 Stress Scale (CSS)** This scale was used in gathering data from the respondents in terms of their stress towards COVID-19. This scale, which was developed by Taylor and his colleague (2020), consists of an 18-item Likert scale designed to assess the stress and anxiety associated with getting infected with COVID, more specifically the three domains of danger, contamination fear,

and traumatic stress symptoms related to COVID-19. Higher scores indicate greater levels of COVID-19-related distress (Taylor et al., 2020).

- **UCLA Loneliness Scale Version 3** This tool was used to determine the level of loneliness among the respondents. The scale consists of a 20-item scale designed to assess the individual's subjective feelings of loneliness as well as their feelings of social isolation. The participants rate each item from 1 (never) to 4 (often). The psychometric properties of the UCLA Loneliness Scale Version 3 range from 0.89 to 0.94. The cut-offs for loneliness severity on the UCLA-3 scale were adapted from Deckx, van den Akker, & Buntinx (2014), wherein scores from 20 - 34 denote a low degree of loneliness, 35 - 49 a moderate degree of loneliness, 50 - 64 a moderately high degree of loneliness, and 65 - 80 a high degree of loneliness.

Note: The reliability of all the scales was high.

4.4. Analysis

For the analysis of the data, several statistical tools were used with the help of the Statistical Package for the Social Sciences (SPSS) software. The respondents' demographic profile was described using descriptive tests and frequency tables employing both the frequencies and percentages of the responses. Then, the researcher determined the respondents' death anxiety, dysfunctional anxiety, COVID stress, and loneliness using the mean, standard deviation, and rank. Inferential tests were then employed to test the differences and establish correlation among the four variables. Analysis of Variance (ANOVA) tests were used to determine if there were any significant differences among the variables, while Pearson R correlation tests were used to assess the relationship between one variable and another.

5. Results

5.1. Comparison between Death and Dysfunctional Anxieties, COVID Stress and Loneliness

The comparison among the variables death and dysfunctional anxieties, COVID stress, and loneliness occurs when the respondents are grouped according to their profile, such as sex, age, living status, and current work. **Table 1** specifies the comparison between male and female respondents. With sex, the test highlighted that there is a significant difference between males' and females' death anxiety levels ($p = 0$). This means to say that males and females vary significantly when it comes to experiencing fear of the unknown, fear of suffering, fear of loneliness, and fear of personal extinction.

Also, dysfunctional anxiety, specifically when it comes to their sense of danger ($p = 0.018$) and traumatic stress ($p = 0.014$) associated with the COVID crisis, differs significantly among males and females. experienced by the respondents in terms of danger and traumatic stress. Lastly, a difference was also found to be significant between males' and females' loneliness levels ($p = 0.006$). This means that the level of death anxiety, COVID stress, and more specifically, the sense of

danger, traumatic stress, and loneliness, vary significantly between males and females. The findings of this study contradicted the results obtained from a previous study that analyzed the difference in dysfunctional anxieties between males and females. The results of these analyses demonstrated that females displayed comparably higher coronavirus-related anxiety than males ($F(17, 219) = 1.703, p = 0.05$). CAS scores were substantially higher among those who had been diagnosed with COVID-19 than those who had not ($F(17, 219) = 13.71, p = 0.001$). This was also the case for participants who had a relative or acquaintance who had been diagnosed with COVID-19 ($F(17, 219) = 3.191, p = 0.001$). Participants who reported a history of anxiety evidenced significantly higher CAS scores compared to those with no such history, and this difference was statistically significant ($F(17, 219) = 5.492, p = 0.001$) (Vally & Alowais, 2021).

The comparison among the respondents coming from different age groups. With age, the table shows that there is a significant difference between the respondents' dysfunctional anxiety levels ($p = 0$) when they are grouped according to their age. The post hoc Tukey analysis further highlights that rank 1 had a significant difference in the age range of 40 - 49 with the mean difference ($M = 3.10, p = 0.000$) and for 50 - 59 ($M = 5.21, p = 0.000$). This finding supports a previous study that concluded that a significantly positive relationship emerged between age and coronavirus anxiety ($r = 0.33, p = 0.001$). Generally, older individuals scored higher on the CAS measure (Vally & Alowais, 2021).

Also, the comparison across different ages and their COVID-related stress related to contamination and traumatic stress revealed a significant difference, obtaining $p = 0.00$ for both domains of COVID-related stress. The post hoc Tukey HSD for age and contamination was present in rank 1 and the age range 40 - 49 ($M = -3.78, p = 0.000$). However, the age had a non-significant relationship with COVID-19 stress-danger ($F(693, 5) = 2.18, p = 0.055$) and death anxiety ($F(693, 5) = 0.76, p = 0.578$).

The comparison among the respondents coming from different living statuses. In terms of living status, all the variables had a significant difference except for loneliness. Death anxiety ($p = 0.001$), dysfunctional anxiety ($p = 0.000$), and all dimensions of COVID stress, such as danger ($p = 0.00$), were all found to have a significant difference when respondents were grouped according to their living status. The post-hoc Tukey HSD revealed that in rank 1, dysfunctional anxiety and being single with children had a mean difference ($M = -4.11000$), while in rank 3, dizziness, etc. had a significant difference in married individuals with kids ($M = -2.72000$).

Dysfunctional anxiety $F(692, 6) = 13.6, p = 0.000$, COVID stress-contamination $F(692, 6) = 3.58, p = 0.002$, and traumatic stress $F(692, 6) = 9.12, p = 0.000$ significantly differ when respondents are grouped according to their current work. While COVID stress-danger $F(692, 6) = 5$ and death anxiety $F(692, 6) = 1.04, p = 0.396$ were insignificant, the findings of this research paper contradict the conclusions provided by another recent study that assessed the difference in dysfunctional anxiety that is being associated with the COVID pandemic when

respondents are grouped according to their job status. In that study, it was mentioned that coronavirus anxiety did not differ as a function of job status (Vally & Alowais, 2021).

5.2. Relationships between COVID Anxiety, COVID Stress and Death Anxiety

The correlational analysis was conducted to analyze the relationship among the variables under study. Death anxiety is shown to have a significant relationship with all the dimensions of COVID stress, but only a moderate relationship with danger ($r = 0.535$) and weak relationships with the other two dimensions of contamination ($r = 0.287$) and traumatic stress ($r = 0.089$, $p = 0.019$). It was also found to have a significant but weak relationship with loneliness ($r = 0.120$, $p = 0.001$). Another recent study (Greenblatt-Kimron, Kestler-Peleg, Even-Zohar, & Lavenda, 2021) that demonstrated a positive association between death anxiety and loneliness among older adults supports the findings of this study.

The results also revealed that there is a significant relationship between dysfunctional anxiety and all the dimensions of COVID stress. The relationship is significant but weak between dysfunctional anxiety and danger ($r = 0.365000$), significant and moderate between dysfunctional anxiety and contamination ($r = 0.461000$), and significant and high between dysfunctional anxiety and traumatic stress ($r = 0.823000$). This finding also supports a previous study that established the relationship between COVID stress and dysfunctional anxiety. The two variables were found to have strong empirical evidence in the literature, as stress and anxiety are associated with COVID-19 correlates (Chakraborty & Chatterjee, 2020; Huang & Zhao, 2020).

5.3. Proposed Intervention (Table 1)

Table 1. Proposed intervention.

Key Result Area	Objectives	Strategies/Intervention	Person involved	Evaluation
Slight degree of fear of contamination	-to lessen and/or eventually eradicate the fear of contamination related to the pandemic	1. Cognitive coping strategies: 1.1. Self-Monitoring 1.2. Cognitive Restructuring 2. Behavioral coping strategies	-Participants -Researcher	-Re-test using the Coronavirus Anxiety Scale (CAS)
Moderate worry about the dangerousness of getting infected with COVID-19	-to lessen and/or eventually eradicate the worry about the dangerousness of getting infected with COVID 19	Cognitive coping strategies: 1.1. Seminar on how to get accurate information from reliable sources 1.2 Keeping perspective	-Participants -LGUs -Researcher	-Re-test using the Coronavirus Anxiety Scale (CAS)
Moderately high degree of loneliness	-to lessen the degree of loneliness related to the pandemic	1. Distractions 2. Staying Active 3. Stay Informed 4. Connect with others 5. Practice Self Compassion	-Participants -Researcher	Re-test using the UCLA Loneliness Scale Version 3

In addition to the concern about the perceived threat to one's own life, some with contamination-related anxieties are more worried about the threat to others and may even have an exaggerated sense of responsibility. Messaging about social distancing underscores the responsibility everyone has for keeping other people from getting sick. In addition, COVID-19 may be transmitted via asymptomatic carriers through unwitting contamination. All these factors may increase fears of spreading the disease to others, as commonly reported in those with OCD symptoms motivated by fears of being responsible for harm (McKay et al., as cited by Dennis, Radnitz, & Wheaton (2021)). Fear of being responsible for a loved one contracting COVID-19 would likely be a potent trigger for these individuals. With all these things being mentioned, people experiencing a slight COVID stress related to the fear of contamination should lessen and/or eventually eradicate it. The first strategy or intervention that is deemed helpful in such cases are cognitive coping strategies such as challenging 1) one's negative thinking and 2) reducing uncertainty. Since people who are experiencing a fear of contamination are usually seen as people who also suffer from obsessive thoughts of being contaminated by the virus, it is important that they focus on their cognition or way of thinking. Cognitive coping strategies involve the conscious intellectual activity of managing stressful situations by using one's mind to combat stress-inducing thoughts. Basically, these cognitive coping strategies are part of the larger Cognitive Behavior Therapy (CBT) being offered to those who are suffering from anxiety disorders and related forms, but they could also largely help those individuals who have a fear of contamination since the nature of the problem is almost the same. According to Fenn & Byrne, whom Tull cites, "CBT is based on the notion that problems arise as a result of how we interpret or evaluate situations, thoughts, and feelings". When these interpretations and evaluations are negative, it can lead to unhealthy behaviors.

CBT works by changing unhealthy behavioral patterns by changing the interpretations that lead to them. It also teaches people the skills and cognitive strategies needed to better cope with whatever life throws their way. The first cognitive coping strategy includes self-monitoring. To a large extent, it is at the core of all the cognitive-behavioral coping strategies included in this intervention program. To address a problem or symptom, in this case, the fear of contamination, the participants need to first become aware of it. Self-monitoring can help with this. With this awareness, the participants can then take action to regulate their behaviors so they have more positive outcomes (Tull, 2022).

The second cognitive coping strategy is cognitive restructuring. How we evaluate and think about ourselves, other people, and events can have a major impact on our mood. This cognitive strategy focuses on identifying negative thoughts or evaluations, such as being contaminated with the virus, and modifying them. Cognitive restructuring involves gathering evidence about certain thoughts, recognizing how they may be misinterpreted or distorted, and then replacing them with more positive affirmations. By modifying people's thoughts, they can im-

prove their mood and make better choices about their behaviors. Aside from the above-mentioned cognitive coping strategies, several behavioral coping strategies could also be practiced (Oxford Health NHS Foundation Trust, 2020). If a person wants to wash in response to a doubt (e.g., “Are my hands actually clean?”), keep in mind that the more people react to a doubt, the more doubts occur. Also, if a person wants to wash after touching any object, keep in mind that the urge to wash will increase, and people will never be able to satisfy themselves that it is enough. In both situations, just remember to wash hands according to the government guidelines.

When a person avoids touching items in their own home, remember that the more a person avoids, the more he or she will want to avoid. Just touch items inside one’s own home as he or she usually would or as others in his or her home are doing. When trying to feel completely certain that your hands are clean, remember that complete certainty is an impossibility. Again, just wash your hands according to the government guidelines because first impressions are better and more accurate. One should just tolerate or accept the feeling of uncertainty. When one is trying to wash his or her hands “perfectly”, think that perfection will never be reached and that trying to do so will just result in ever-increasing fear and feelings of guilt and responsibility. Just follow the government guidelines and remind oneself that the guidelines state 20 seconds, not “to the point of perfection”.

Another key result of this study is the moderate worry about the dangers of getting infected with COVID-19 among the respondents. With this, it is important that people lessen and/or eventually eradicate their worry about the dangers of getting infected with COVID 19. A strategy that could help in the attainment of this objective is to reduce the uncertainty of the participants by attending a seminar on how to get accurate information from reliable sources. Some media or internet sources may exaggerate the dangers. That is why it is important that people distinguish between factual and fake news that is related to the pandemic. It’s vital to stay informed, particularly about what’s happening in one’s community, so people can follow safety precautions and do their part to slow the spread of coronaviruses. But there’s a lot of misinformation going around, as well as sensationalistic coverage that only feeds fear. It’s important to be discerning about what people read and watch.

The second cognitive coping strategy that could help people who worry about the dangers of COVID-19 is to keep their perspective. This means focusing on things one can control. There are so many things outside of one’s control, including how long the pandemic lasts, how other people behave, and what’s going to happen in communities. That is a tough thing to accept, and so many people respond by endlessly searching the Internet for answers and thinking over all the different scenarios that might happen. But as long as people are focusing on questions with unknowable answers and circumstances outside of their personal control, this strategy will get them nowhere—aside from being more anxious

about worrying about what might happen next. The last key result area of this study is that the participants have a moderately high degree of loneliness. To address these, several strategies or interventions were proposed that are regarded as helping to lessen the degree of loneliness related to the pandemic. The first strategy involves the use of distractions. Distraction works to help people avoid ruminating about everything that is wrong, which is a risk factor for becoming depressed. In this way, taking on little projects or finding other forms of distraction can help to keep one's mood level up (Cuncic, 2020). To boost one's mental health, one must find healthy distractions. This might come in the form of reading, watching shows, listening to music, or finding other activities that interest people.

The next strategy is to stay active. While it is easy to focus exclusively on how to manage mental health and loneliness directly during a crisis, people sometimes forget that their physical and mental health are delicately intertwined. If they spend weeks of isolation without getting any exercise, this will have a detrimental effect on their ability to cope mentally. They might try to practice yoga or do low-impact workouts at home by following YouTube videos. They can also go for walks around their neighborhood (or walk on a treadmill if they have one and are concerned about going outside). Staying informed is another way of staying social. In a 2020 study published in the *International Journal of Environmental Research and Public Health*, an online survey of 1210 respondents from 194 cities in China showed that people who had up-to-date health information and advice on precautionary measures had better psychological functioning and resilience (Wang, Pan, & Wan, 2020). While people do not want to feed their anxiety and fear through constant updates about the state of the virus, keeping abreast of health information may give them an edge when it comes to protecting their mental health (and, as a result, reducing the impact of loneliness). However, as mentioned previously, watching too much news, reading too many articles, and consuming too much content can be overwhelming.

Most importantly, practice self-compassion during this difficult time. If people find themselves saying things like "I shouldn't be feeling this way" or pushing away difficult emotions, this will only make their loneliness persist. Instead of resisting those feelings, find ways to be accepting of them as they come and go. This helps to take away their power and ease one's unhappiness. Remember that feelings will change. If one is still struggling, try practicing guided meditation following an app, podcast, or YouTube video.

6. Discussion

According to Assari and Moghani Lankarani (2016), demographic, socio-economic, health, and psychological determinants of death anxiety in the United States differ based on race, gender, and their intersection. The result of the study supports the idea that geriatric psychiatrists and gerontologists who wish to reduce death anxiety among elderly people may need to tailor their interventions

to race and gender. Numerous studies have shown that older women may report higher levels of death anxiety compared to their male counterparts. There are studies that show results indicating that COVID-19 anxiety is higher in males as compared to females. Such as men were anxious toward COVID-19 while females were.

Similarly, a significant difference was also observed when it came to the respondent's loneliness level when they were grouped according to their age. This means that age influences one's experience of loneliness during the pandemic. Recent Harvard research that suggests that feelings of social isolation are increasing and that older teens and young adults are the hardest hit supports these findings (Weissbourd, 2022). Also, in the recently released results of a study conducted last October by researchers highlighted 36 percent of respondents to a national survey of approximately 950 Americans reported feeling lonely "frequently" or "almost all the time or all the time" in the prior four weeks, compared with 25 percent who recalled experiencing serious issues in the two months prior to the pandemic.

According to some research, results based on other demographics, such as living status, indicated that people who had children were more conscious of contamination and experienced COVID anxiety, while young people and much older people were scared of death. Similar results were seen in the Sprang and Silman (2013) study, which revealed that parents who were quarantined had four times higher and intensified symptoms of traumatic stress as compared to others. However, the findings of this research study contradict the conclusions of another recent study about the influence of living status on loneliness. It was concluded that individuals are particularly susceptible because they are often transitioning from their "inherited families to their chosen families", meaning they lack important connections to those who can "be critical guardrails against loneliness". Students in college may be struggling to fit in and feel homesick, while those not in school can feel disconnected from important social groups or communities. Young people are also often making critical decisions about their professional and personal lives and relationships, which can add to the stress and sense of isolation (Weissbourd, 2022).

Furthermore, Silva et al. (2021) reported that COVID stress mediates death anxiety, highlighting the significant relationship between COVID stress and death anxiety. In simpler words, the stress of being in danger, traumatic stress, or the fear of being contaminated somehow increased the fear of death in the pandemic.

The results also revealed that there is a significant relationship between dysfunctional anxiety and all the dimensions of COVID stress. This finding also supports a previous study that established the relationship between COVID stress and dysfunctional anxiety. The two variables were found to have strong empirical evidence in the literature, as stress and anxiety are associated with COVID-19 correlates (Chakraborty & Chatterjee, 2020; Huang & Zhao, 2020).

Also, another study highlighted that COVID stress predicts anxiety among Filipino respondents (Montano & Acebes, 2020). Lastly, aside from having a significant relationship with the previously mentioned death anxiety, loneliness was also found to be correlated with COVID-stress dimensions such as danger and contamination. This finding agrees with another study in the United States that stated that having a good balance of sleep, work, time with family and friends, and “me time” is connected to being less lonely (Cigna, 2018).

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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