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Death Anxiety and Religiosity as Predictors of Psychological Problems in Elderly Patients with Chronic Illnesses

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Abstract

Objectives: The main objectives of the current study were to determine how religiosity and death anxiety affect the psychological health of older individuals with chronic illnesses. Furthermore, to explore differences in death anxiety and religiosity concerning the demographic variable (gender).

Method: The cross-sectional research design was applied. The sample consisted of 200 participants, age range of 60-90 years (*Mage*=67.34; SD=7.35) suffering from various chronic illnesses, including hypertension, arthritis, asthma, diabetes, coronary heart disease, and hepatitis.

Results: Multiple regression analyses showed that death anxiety was a significant predictor of psychological problems, while the religious practice negatively predicted psychological problems (depression and stress) whereas religious beliefs negatively predicted psychological problems (anxiety and stress) respectively. The findings revealed significant gender differences in psychological problems.

Conclusion: Death anxiety and religiosity significantly predicted psychological problems. Gender differences were also found in the psychological problems among elderly patients.

***Keywords*:** Death anxiety, religiosity, psychological problems, old age, chronic illness

Introduction

Aging is assumed to be a universal and physiological process, yet it is considered a critical and challenging life period in which a transition occurs from adulthood to old age (WHO, 2015). Growing older is an inevitable part of life, and it is fundamentally related to various issues, including physical decline, emotional losses, and social changes that transform the overall wellbeing of older adults (Cruz-Jentoft et al., 2019). In addition to the physical changes that occur naturally as people age, they also experience a significant decline in cognitive function, sensory perception, and physical strength, as well as an increased likelihood of psychological problems (Carpenter et al., 2022; Luo et al., 2020). As older adults become more alert of their limited lifespan, they become increasingly aware of their limited longevity, and this knowledge of mortality causes them to feel more anxious about dying

(Özteke Kozan & Kesici, 2023).

Death anxiety, sometimes referred to as thanatophobia, is typified by an overwhelming fear of growing old and the dying process (Kets de Vries, 2021). In addition to the emotional, psychological, or biological responses to death that cause physical and mental degeneration in older individuals, the realization of death's inevitable nature causes emotions of loneliness and uncontrolled grief (Firestone & Catlett, 2016). Fear of death has been demonstrated to influence a wide range of psychological phenomena that underline the development of depression, health related anxiety, social anxiety, panic disorders, phobias, and other mental health issues (Gürbüz & Yorulmaz, 2024). When older individuals recognize their anxiousness, concerns are a constant aspect of their lives. Along with challenges of chronic illness (including hypertension, arthritis, asthma, diabetes, coronary heart disease, and hepatitis) they experience major changes in how they perceive risks, deal with uncertainty, and cope with life's challenges, which can sometimes exacerbate the symptoms of psychological problems (Dumitru et al., 2025).

To deal with their fear of dying, older people employ a variety of coping methods. These might be adaptive (like forming healthy relationships) or maladaptive (like avoiding hospitals or death scenarios) and are linked to higher anxiety levels (Coromac-Medrano et al., 2022). According to the theory of terror management, a profound fear of dying can be intensified by mortality awareness and a wish to survive (Greenberg et al., 1986). This perspective holds that people's cultural beliefs serve as either antagonists or buffers to help them overcome their fear of dying. Cultural beliefs, such as the religious belief in life after death, are linked to reduced anxiety (Heidaranlu et al., 2024).

Religiosity is defined as believing in, practicing, demonstrating, or possessing both internal (persons' faith or spiritual experiences) and external (engagement in the practices of religion, ceremonies, or social gatherings) aspects of religion (Holdcroft, 2006). Greater participation in religious activities is a prominent feature of older individuals. This rush toward religion in later life may stem from an awareness of the meaning of life, appreciation for prior experiences, or above all, realization of life's transient nature and nearness of demise (Krause & Hayward, 2016). In old age, religiosity provided a framework for comprehending and dealing with age-related psychological challenges. This helps elderly individuals, particularly those with chronic illness, connect with a higher power, which guides them to become more resilient, optimistic and lowers their death anxiety (Husain et al., 2024; Koenig, 2012).

Literature Review

According to previous literature, a common psychological problem in older age is anxiety, particularly death anxiety, which is frequently brought on by a decline in physical activity, a smaller social network, a lack of financial independence, and chronic illness (Salmani & Zoghi, 2022). A study found that the prevalence of death anxiety in elderly people was influenced by age, education, the presence of chronic diseases, perceived psychological and physical health, commitment to religion, satisfaction with life, and relationships with others (Sebea et al., 2021; Greenblatt-Kimron et al., 2021). Research findings revealed a negative relationship between death anxiety and religiosity. It also showed that older individuals experienced acute death anxiety because of the COVID-19 pandemic, which altered their perspective on death (Mahamid et al., 2023; Khademi et al., 2020).

Furthermore, studies demonstrated that the way that people perceive death is also greatly influenced by their religious and cultural beliefs. In contrast to individualist cultures, where people are concerned with their mortality, collectivist cultures are concerned with the death of those who are close to them (Eyetsemitan, 2025; Plusnin et al., 2021). In a collectivistic society where, religious faith greatly influences the beliefs of individuals, religiosity serves as a protective barrier against the fear of death (Jiang et al., 2023).

In the context of Pakistani culture, a study found that religiosity among Muslim patients of age 26.6 years on average is linked to higher levels of optimism, lower levels of sadness, and a reduced fear of mortality (Abbas et al., 2022). Another study in Pakistan examined older individuals' anxiety related to approaching death, specifically about aging, beliefs in religion, and psychological problems. The study's conclusion showed that religious beliefs and the fear of aging both increase death anxiety (Husain et al., 2024). As indicated by another indigenous study, belief in an afterlife mediates the relationship between religiosity and depression (Ghayas et al., 2021). According to the results of a study conducted on Muslim Population in Pakistan, there is a significant negative relationship between religiosity and death anxiety, which could potentially help in alleviating symptoms associated with anxiety (Saleem & Saleem, 2020).

In the Pakistani cultural context, where Islamic beliefs strongly influence perceptions of illness, physical suffering, and death, elderly patients with chronic illnesses may experience heightened death anxiety due to increased awareness of mortality. In this case religiosity may serve as a coping resource by fostering acceptance, patience, and trust in God, yet it may also intensify fears related to accountability and the afterlife. Psychological problems in older adults often remain underrecognized in Pakistan because of associated stigma and limited geriatric mental health services. Therefore, examining death anxiety and religiosity as predictors of psychological problems in chronically ill elderly individuals is essential to understand their combined impact within this indigenous cultural framework and to guide culturally appropriate mental health interventions.

Hypotheses

The study's hypotheses are as follows:

H1: There would be a positive relationship between death anxiety and psychological problems (depression, anxiety, and stress) in elderly patients with chronic illness.

H2: There would be a negative correlation between religiosity (religious practice and religious belief) and psychological problems in elderly patients with chronic illnesses.

H3: Death anxiety would be a positive predictor of psychological problems in elderly patients with chronic illnesses.

H4: Religiosity (religious practice and religious belief) would be a negative predictor of psychological problems in elderly patients with chronic illnesses.

H5: There would be significant gender differences in study variables (i.e., death anxiety, religiosity, and psychological problems) in elderly patients with chronic illnesses.

Method

Research Design

The present study employed a cross-sectional research design to investigate correlations between variables.

Participants

The study sample comprised 200 older adults (112 men; 88 women) diagnosed with chronic illnesses, such as hepatitis, coronary heart disease, diabetes, asthma, arthritis, and high blood pressure. The method $N > 50 + 8K$, where K is the number of predictors, was used to calculate the sample size (Tabachnick & Fidell, 2013). The sample size, according to the formula, was 74, but we select approximately 3 times larger sample size to deal with the issue of missing values and enhance the generalizability of research findings. The current study's participants were between the ages of 60 and 90 (M_{age} = 67.34; SD = 7.35). A sample of the population was selected using a purposive sampling strategy from community settings, as well as various government and private hospitals. Additionally,

participants were recruited from old age homes, located in Faisalabad and Lahore cities.

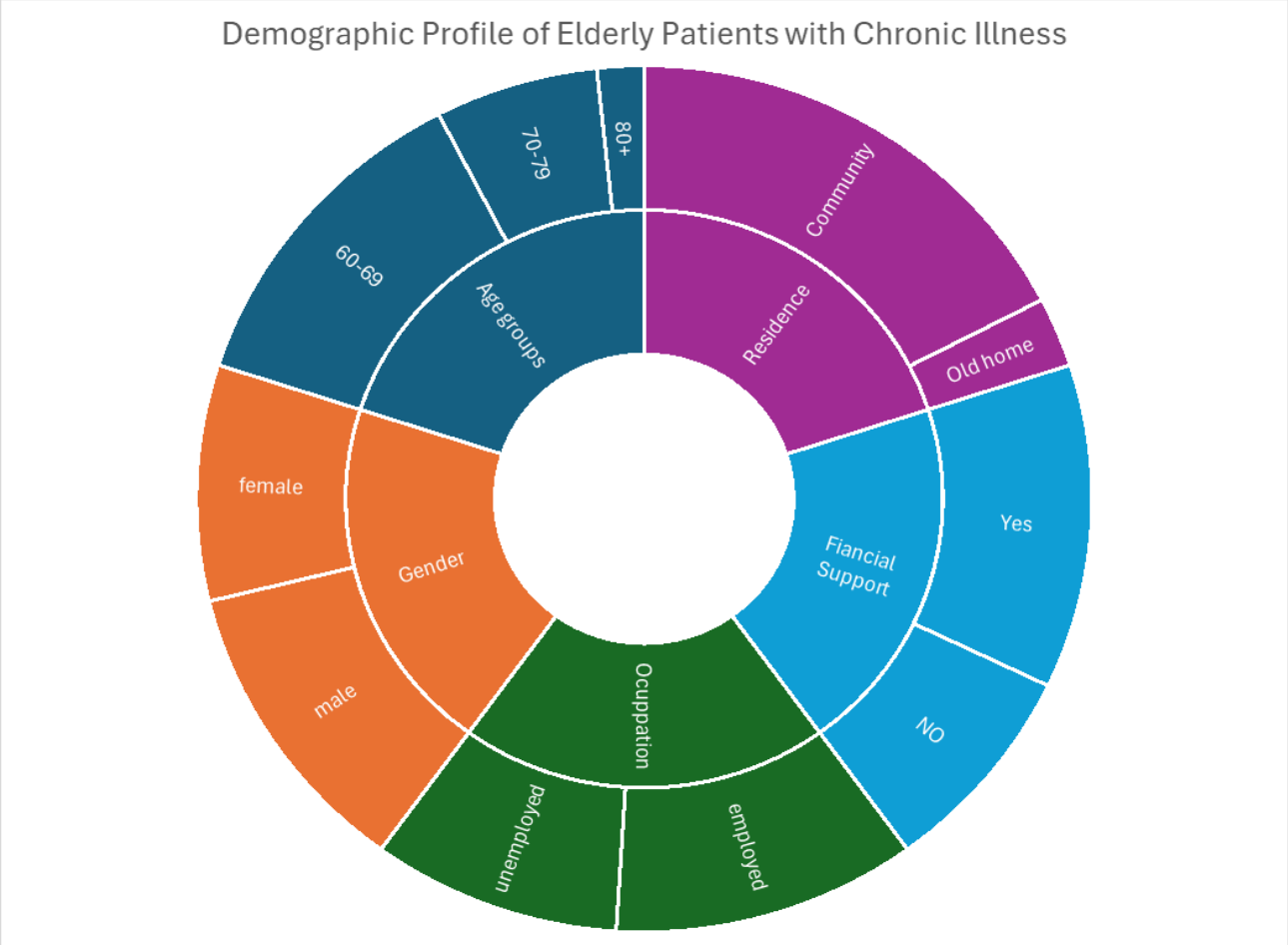
Measures

Demographic Information Sheet.

The relevant demographic information (e.g., gender, age, education, illness type, and duration of the illness) was sorted to take the reflection of diverse population and enhance the study generalizability (See figure 1 & 2).

Figure 1

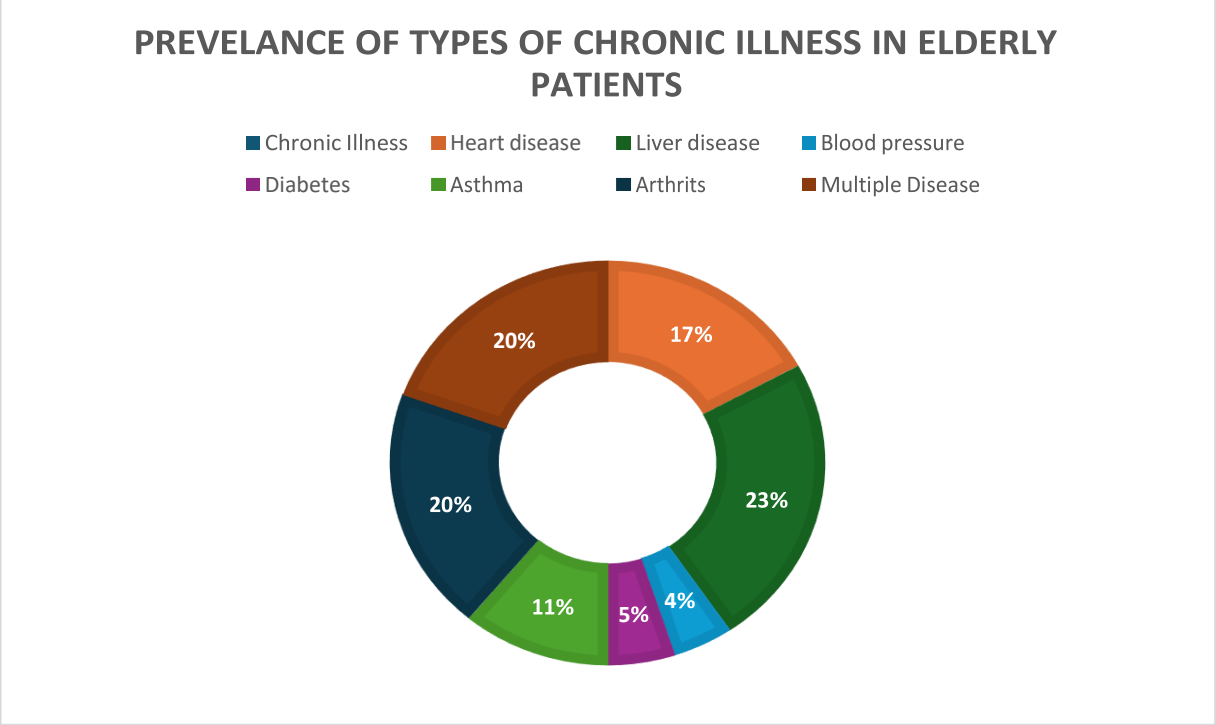
Demographic Profile of Elderly Patients with Chronic Illness



The figure shows various demographic characteristics of elderly patient's study sample based on their gender, age group, residence, presence of financial support and occupation.

Figure 2

Prevalence of Types of Chronic Illness in Elderly Patients



The figure shows the prevalence of types of chronic illness in elderly patients. It depicts that the ratio of liver disease is highest among elderly, following arthritis and multiple diseases. While the heart disease is the third and the asthma as a fourth most prevalent disease. Blood pressure and diabetes are at the lowest prevalent illnesses among this study sample.

Short Muslim Practice and Belief Scale (SMPBS; AlMarri et al., 2009; Urdu Version Ghayas & Batool, 2016).

This scale comprises nine items, with four items of the scale assessing religious practice and five evaluating religious beliefs. A five-point Likert-type scale, with 1 indicating "strongly disagree" and 5 indicating "strongly agree," is used to rate each item. The scale's alpha reliability was .83 (for original) and .80 (for Urdu version) indicated strong internal consistency. The scale has been widely used in different studies which strengthens its validity proof (Ghayas & Batool, 2016).

Arabic Death Anxiety Scale (ADAS; Abdel-Khalek, 2004; Urdu Version Ghayas & Batool, 2016).

ADAS is a five-point Likert-type scale with response types ranging from 1 to 5, in which 1 represents " no", 2 " little bit", 3 " almost", 4 " a lot," and 5 " very much". The alpha reliabilities range between .88 to .93. The associations among ASDA and Templer's DAS are .60 to .74, indicating great convergent validity of the ASDA in contradiction of the DAS among three Arabic countries. The Cronbach Alpha for Urdu version of ASDA (Ghayas & Batool, 2016) was .92.

Depression Anxiety Stress Scale (DASS-21; Lovibond & Lovibond, 1995; Urdu Version Aslam, 2007).

DASS-21 has three self-reported subscales, each with seven items, that measure psychological problems like stress, anxiety, and depression. The Likert-type scale has four points, with 0 indicating

"never" and 3 indicating "almost always." Strong internal consistency is shown by the subscales' Cronbach's alpha reliability values, which are .91 for depression, .84 for anxiety, and .90 for stress (Aslam, 2007).

Procedure

Permission to gather data was obtained via email from the authors of the original and translated scale. An institutional authority letter was used to obtain permission from the Medical Superintendents (MS) of various government and private hospitals of Faisalabad city, and following the data collection request, a study synopsis was submitted to the hospital authorities for approval of data collection. Telephonic permissions were sought out from various old home authorities. Before administering the scales, research participants gave their informed consent.

Necessary information was provided to participants about the nature and objectives of the study. Research protocol was administered after getting the consent of participants in individual setting.

Results

Table 1

Inter-correlations between Study Variables (i.e. Death Anxiety, Religiosity Domains and Psychological Problems) in Elderly People with Chronic Illness (N=200)

	Variables	1	2	3	4	5	6	*M*	*SD*	*α*
1	Death Anxiety	1						63.76	21.47	.93
2	Ril-Practice	.10	1					14.04	4.04	.76
3	Ril- belief	.09	.44***	1				19.96	3.25	.76
4	Depression	.15*	-.28***	-.21**	1			7.23	4.94	.78
5	Anxiety	.46***	-.07	-.17*	.46***	1		5.92	3.94	.73
6	Stress	.29***	-.27***	-.23***	.58***	.53***	1	8.92	4.52	.76

Note. *p<.05, **p<.01, ***p<.001; Ril_practice: Religious Practice, Ril_beliefs: Religious Beliefs.

A non-significant relationship was found between death anxiety and religiosity domains. Death Anxiety is positively correlated with depression, anxiety, and stress revealing that higher levels of death anxiety are associated with increased psychological problems. Religious practice positively correlated with religious belief while both domains are negatively correlated with depression, anxiety, and stress.

Table 2

Multiple Regression Analysis (Stepwise Method) to See the Effects of Death Anxiety and Religiosity Sub-Domains (Religious Practices and Beliefs) as Predictor Variables of Psychological Problems (Depression, Anxiety, and Stress) in Elderly Patients (N = 200)

Depression)							
Model$_1$		*B*	*SE*	*β*	*t*	R^2	ΔR^2
1	Ril_practice	-.34	.08	-.28***	-4.11	.07	.07
2	Ril_practice	-.36	.08	-.30***	-4.46	.11	.10
	Death Anxiety	.04	.01	.18**	2.81		
Anxiety							
Model$_2$		*B*	*SE*	*β*	*t*	R^2	ΔR^2
1	Death Anxiety	.08	.01	.46***	7.45	.21	.21
2	Death Anxiety	.09	.01	.49***	7.99	.26	.26
	Ril_beliefs	-.26	.07	-.22***	-3.59		
Stress							
Model$_3$		*B*	*SE*	*β*	*t*	R^2	ΔR^2
1	Death Anxiety	.06	.01	.29***	4.36	.08	.08
2	Death Anxiety	.06	.01	.32***	5.06	.18	.17
	Ril_practice	-.34	.07	-.30***	-4.70		
3	Death Anxiety	.07	.01	.33***	5.24	.20	.18
	Ril_practice	-.26	.08	-.23***	-3.29		
	Ril_beliefs	-.22	.09	-.16*	-2.26		

Note. Model 1: step 1: F (198) = 16.96, p < .001, step 2: F (197) =12.72, p < .001;Model 2: Step 1: F (198) = 55.61, p < .001, Step 2: F (197) =35.96, p < .001 ;Model 3: Step 1; F (198) = 19.06, p < .001, Step 2; F (197) =21.61 , p < .001, Step 3; F (196) = 16.41, p < .001

Three separate multiple regression analyses were performed. The result of the first multiple regression analyses (with depression as an outcome variable) indicated that in step 1 religious practice emerged as the most significant predictor of depression, and it explained 7% of the variance in model 1. In step 2, religious practice along with death anxiety added 3% of the additional variance, and the total variance reached to 10%.

In model 2 (fear-based anxiety was an outcome variable), the death anxiety emerged as most significant predictor of fear-based anxiety in step 1 with 21% of variance and in the next step religious beliefs a sub- domain of religiosity has added up with death anxiety and accounted for a 5% of an additional variance in the model and total variance reached to 26%.

In model 3 (stress was treated as an outcome variable) death anxiety again emerged as a most significant predictor of stress with 8% of the variance in the model while death anxiety along with domain of religious practice added 10% of the variance in the model and the total variance reached up to 18%. While death anxiety, religious practice further including religious beliefs significantly predicted stress and the total variance reached up to 20% by accounting 2% of additional variance in the model.

Table 3

Independent Sample t-test showing Gender Differences on Death Anxiety, Religiosity, and Psychological Problems in Elderly Patients with Chronic Illnesses

DVs	Gender			*95% CI*			
	Men	Women					
	M(SD)	*M(SD)*	*t*	*df*	*LL*	*UL*	*Cohen's d*
Death Anxiety	61.53(21.66)	66.60(21.07)	-1.67	189.45	-11.06	.90	0.237
Religiosity	34.13(6.36)	33.83(6.03)	.33	191.07	-1.44	2.03	0.048
Depression	13.02(9.92)	16.32(9.58)	-2.37**	189.71	-6.03	-.56	0.338
Anxiety	10.82(8.09)	13.14(7.47)	-2.09*	192.86	-4.49	-.13	0.297
Stress	16.45(9.13)	19.64(8.68)	-2.52**	190.87	-5.68	-.69	0.357

Note. *p<.05, **p<.01

Table 3 shows the results of the independent sample t-test for gender differences among study variables, i.e., death anxiety, religiosity, and psychological problems (depression, anxiety, and stress). According to the results, men exhibit less death anxiety than women however, this difference is not statistically significant. Men and women did not differ significantly on the scores of religiosity. Women, however, experienced significantly higher levels of psychological problems (depression, anxiety and stress) as compared to men.

Discussion

The current study aims to gain insight into the interplay between death anxiety, religiosity, and psychological problems in older individuals with chronic illnesses. The study findings indicated that among elderly patients with chronic illnesses, there was a significant relationship between death anxiety, religiosity, and psychological problems. The findings revealed that death anxiety is positively connected to psychological problems (such as depression, anxiety, and stress). While religiosity has a negative association with the psychological concerns (see Table 1). The results of H1 are consistent with the research findings in Western contexts, where studies have also shown a negative association between aspects of religiosity and psychological issues like anxiety, depression, and stress. Additionally, the results indicate that older individuals who have higher levels of religious coping skills, stronger religious beliefs and values, and a greater capacity to forgive others suffered less from depression (Yoon & Lee, 2013; Chamberlain & Hall, 2000).

Furthermore, Missler et al.'s (2012) research findings are also in line with the current study results as they suggest a connection between older individuals' depression symptoms and death anxiety. Fortner and Neimeyer (2010) concluded that older adults who have more psychological and physical problems are more likely to be anxious about dying. As the outcomes of the current study revealed that depressed people are found to be more religious, in our culture, the underlying reason might be that old people find mental harmony and peace when they engage themselves in various religious practices. As people become anxious due to their long-term suffering, they become more inclined towards religion. It's their belief in religion that helps them to control their psychological issues like anxiety. Moreover, the religious beliefs and practices of certain rituals, in combination, help them deal with psychological concerns. It can be explained in another way that elderly people believe that by offering prayers or any other religious ritual for their health and forgiveness, they will get an improvement in their health status.

Further study findings show that among older patients with chronic illnesses, death anxiety is a strong predictor of psychological problems like stress, anxiety, and depression (see Table 2).

Specifically, Death anxiety emerged as the most significant predictor of all types of psychological issues like depression, anxiety, and stress. Regression paths also show that all paths from death anxiety to depression, anxiety, and stress are significant; therefore, H3 was accepted. Several Western studies are aligned with the findings of the present research. According to Fortner and Neimeyer (2010), for instance, psychological discomfort is a strong predictor of increased death anxiety in older individuals. The outcomes of the current study also found that when old individuals are suffering from a chronic illness, it further leads to stress and anxiousness about their illness, and due to the prolonged course of illness, they suffer from various psychological issues. Alongside, they remained uncertain about their upcoming life, which in turn increased the level of death anxiety and resulted in depression among the elderly.

Further results of the study found that religiosity (i.e., religious belief and religious practice) is a significant predictor of psychological problems (stress, depression, and anxiety) among elderly patients with chronic illnesses (See Table 2). The studies also support these results, like Koenig et al.'s (1998) study suggested that religiosity predicted depression. The outcomes of the current study found that people suffering from depression or stress are more inclined toward practicing religion to overcome their psychological issues, and a strong belief in religion guides them in all paths of life. Furthermore, in our culture all difficult situations, whether these situations are linked to normal life or health-related issues, the elderly find more mental peace when they have a stronger belief in their religion.

Additionally, significant gender differences were found in study variables (see Table 3). The findings are in line with the previous literature that found women having higher rates of depression (Roff et al.,

2004). It is observed that psychological problems vary across genders in our culture; women are more prone to various psychological concerns as compared to men because of patriarchal influence. In such a scenario, men in our cultural context are free to express their feelings and emotions as compared to women. Women usually internalize these feelings, and in turn, it affects their psychological health in later life. The higher rate of psychological issues also amplified physical concerns in the elderly women population.

Implications

The results of this study can be applied in a variety of clinical and health care settings. Mental health professionals, including clinical and health psychologists, can help their elderly clients with chronic illnesses by using religious coping strategies as part of their counseling/ psychotherapy to uplift the levels of psychological health. Physicians can also identify the early signs of psychological problems in their patients suffering from multiple chronic illnesses. They can refer them to health counselors or health psychologists for counseling/ psychotherapy, depending on the nature of the psychological concern.

Limitations and Future Suggestions

The present research also has certain limitations. The first limitation on the findings' generalizability is that the sample was drawn from limited areas. It is recommended that samples from different regions of the country should be recruited in future studies. Second, because institutional care is stigmatized in Pakistani culture and is difficult to get, fewer older people were selected from elderly homes than from the community sample. Furthermore, the current study's cross-sectional design limits to make causal conclusions. Therefore, to further understand these psychological factors, future research must consider utilizing mixed-method approaches design

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