

Psychological Self-Care and Well-being in the COVID-19 Pandemic: Religious Beliefs Coping Strategies in a Sample of Iranians

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Abstract

Objective: The coronavirus disease 2019 (COVID-19) pandemic has profoundly impacted human health, resulting in significant psychological and epidemiological consequences. Religious beliefs may serve as an important resource for coping with the COVID-19 pandemic and for supporting health care. This study aimed to examine psychological self-care and well-being during the COVID-19 pandemic and to assess the role of religious beliefs as a coping strategy in a sample of Iranians.

Methods: This cross-sectional correlational study was conducted on 250 patients with COVID-19 in Babol, Iran, from August 2022 to May 2023. Data were collected using a demographic characteristics questionnaire, as well as the Religious Beliefs, Psychological Well-being, and Psychological Self-care scales.

Results: The mean scores for religious beliefs, psychological well-being, and self-care were 173.8 ± 18.6 , 67.4 ± 13.7 , and 115.4 ± 15.9 , respectively. A significant positive association was found between the beliefs and ethics dimensions of religious beliefs with the dimensions of psychological well-being (except personal growth) ($P < 0.05$). Additionally, the mean score of religious beliefs was significantly and positively associated with the dimensions of self-care (except developing and maintaining social systems) ($P < 0.05$). Moreover, the ethical dimension of religious beliefs was significantly and positively associated with the dimensions of self-care (except developing and maintaining social systems and physical self-care) ($P < 0.05$). After adjustment for other variables, religious beliefs were positively associated with psychological well-being ($\beta = 0.332$, 95% CI: 0.150 to 0.338, $P = 0.0001$) and self-care ($\beta = 0.345$, 95% CI: 0.187 to 0.405, $P = 0.0001$).

Conclusion: Adherence to religious beliefs and ethical values may promote psychological well-being and self-care in patients with COVID-19. These factors may also play an important role in addressing future health crises.

Keywords: COVID-19, Religion, Psychological Well-being, Self-care

Introduction

The coronavirus disease 2019 (COVID-19) has emerged as one of the most significant global health crises of the recent century. By 2020, nearly all countries had been affected, with more than 50 million confirmed cases worldwide.¹ Throughout history, infectious diseases have caused considerable devastation across societies.² The pandemic imposed substantial physiological and psychological burdens¹ and has played a critical role in shaping mental health outcomes, which are intrinsically linked to global public health.³

COVID-19 is an emerging disease of significant global concern, with profound negative impacts on quality of life.⁴ Following a diagnosis, patients frequently experience substantial psychological distress, often as debilitating as the physical symptoms, including anxiety, depression, and persistent negative affect.^{5,6} Many patients also report acute episodes of panic, characterized by initial shock and denial.^{7,8} Furthermore, treatment protocols necessitated isolation from family and restricted face-to-face contact, which severely impaired patients' social support systems.⁹ Therefore, providing health care services while maintaining patients' psychological well-being is a complex endeavor. Unaddressed psychological distress may intensify over time, adversely affecting mental health and functional recovery and, in extreme cases, contributing to adverse clinical outcomes.^{10,11} Consequently, there is an urgent need for appropriate psychological and clinical consultations. In this regard, Khamis et al. (2020) demonstrated that the COVID-19 pandemic has a significant impact on mental health, underscoring the necessity for immediate psychological, social, and administrative interventions to mitigate these risks.¹²

Religious and existential well-being is characterized by a sense of acceptance, positive affect, and a harmonious relationship with a higher power, others, and oneself, a state achieved through dynamic, coordinated cognitive and emotional processes. This construct is closely related to the concept of self-transcendence and serves as a reflection of an individual's core value system.¹³ Utilizing religious and spiritual beliefs can act as a constructive coping strategy for fostering psychological health.¹⁴ Furthermore, these beliefs are fundamental to navigating disease-related challenges, serving as a protective factor against psychological morbidity and a viable method for promoting mental health in patients.¹⁵ Research suggests that religious beliefs represent a set of spiritual resources and capacities that enhance individual adaptability and mental well-being.¹⁶

Religious and spiritual beliefs serve as significant psychological resources that foster resilience among COVID-19 patients. These dimensions often facilitate a reduction in pain, anxiety, and depressive symptoms, thereby contributing to more robust and sustained clinical recovery. Emerging evidence suggests that spirituality and religiosity are deeply integrated into the human experience, acting as essential components of holistic well-being.^{17,18} Within the framework of positive psychology, psychological health is conceptualized as a multi-dimensional construct operating across both mental and physiological domains.¹⁹ Psychological well-being, defined as the subjective experience of quality of life and optimal mental functioning, is instrumental in ensuring adaptive life performance.^{20,21} Individuals who exhibit higher levels of psychological well-being typically demonstrate a propensity for positive affect and more constructive appraisals of life events.²² Consistent with these findings, research indicates that individuals maintaining strong religious or spiritual beliefs consistently report higher levels of happiness and superior psychological well-being.²³

Research consistently underscores the preventive function of religiosity in mitigating mental disorders. Individuals who adhere to stronger religious beliefs and engage in dedicated religious practices exhibit superior mental health and enhanced adaptability when confronted with life-threatening circumstances.²⁴ Religious engagements serves as a significant protective factor in promoting post-traumatic mental health throughout the COVID-19 pandemic.²⁵

Self-care is defined as a series of learned, conscious, and purposeful activities aimed at enhancing quality of life and overall health.^{26,27} Fundamentally, this construct emphasizes the assumption of personal responsibility for preventing illness and injury through the consistent implementation of health-oriented behaviors.²⁸ Empirical research has further demonstrated a positive and significant correlation between the engagement in religious practices and adherence to self-care protocols among patients diagnosed with diabetes and cancer.^{29,30} Religious coping behaviors, including reliance on divine trust, participation in collective rituals, and the practice of prayer, serve as critical determinants of health-related behaviors, exerting a positive influence on individual's self-care adherence. Consequently, the integral role of religious belief systems in patient self-care during high-stress scenarios, such as global epidemics, warrants significant attention.³¹

Given that religion offers a potentially potent, yet under-researched, framework for mobilizing patient engagement in crisis management, it is imperative for health professionals and policymakers to integrate these spiritual dimensions into public health strategies to effectively address complex health challenges, such as those presented by the COVID-19 pandemic.³² Given that religious engagement may serve as a significant determinant in bolstering both physical and psychological well-being during such crises, this study aims to examine the associations between religious beliefs, psychological self-care, and mental well-being in patients diagnosed with COVID-19.

Methods

This cross-sectional, correlational study was conducted between August 2022 and May 2023 at Ayatollah Rouhani and Shahid Yahyanejad Hospitals in Babol, Mazandaran Province, Iran. These two public tertiary referral centers, affiliated with Babol University of Medical Sciences, have over 30 years of clinical experience and serve patients from across the region. The study population comprised hospitalized patients with a confirmed diagnosis of COVID-19, based on clinical symptoms and paraclinical findings, including positive polymerase chain reaction (PCR) test results, and chest computed tomography (CT) scan/ Chest X-Ray findings consistent with COVID-19 pneumonia. Eligible participants were recruited through the researcher's visits to both hospitals, in accordance with the predefined inclusion criteria.

The inclusion criteria were as follows: providing written informed consent; proficiency in the Persian language; age between 18 and 70 years; a positive polymerase chain reaction (PCR) test for COVID-19; had at least a fifth-grad education, and the absence of any severe physical or mental disorders (e.g., acute medical emergencies, severe cognitive impairment, severe psychiatric conditions requiring immediate psychiatric intervention). Exclusion criteria comprised an unstable general condition that precluded questionnaire completion, incomplete responses, or unwillingness to continue participation in the study.

Thank you for pointing this out. It has defined as: Acute medical emergencies, severe cognitive impairment, severe psychiatric conditions requiring immediate psychiatric intervention.

The researcher initiated the study by introducing the study objectives to eligible patients and inviting them to participate. Following an assessment of the eligibility criteria, the demographic data of qualified participants was recorded in the study questionnaires by the researcher. Participants then received detailed instructions on how to complete the instruments, while being assured of data confidentiality and anonymity. The questionnaires were administered using a self-report method, allowing participants sufficient time for completion before returning them to the researcher. This study was conducted in accordance with the Declaration of Helsinki, and written informed consent was obtained from all participants prior to their enrollment. Ethical approval was granted by the Ethics Committee of Babol University of Medical Sciences under the approval code IR.MUBABOL.REC.1401.063.

The sample size was determined based on an estimated correlation coefficient of 0.2 between religious beliefs, self-care, and psychological well-being. Utilizing the relevant statistical formula, with a 95% confidence level and 80% statistical power, a sample size of 250 participants was calculated, which accounts for a 20% attrition rate

$$n \geq \left\{ \frac{+Z_{1-\beta}}{\frac{1}{2} \frac{1+r}{1-r}} \right\}^2 + 3$$

A total of 286 hospitalized patients with COVID-19, who were hospitalized at Rouhani and Yahyanejad hospitals and had a positive PCR test, were evaluated for eligibility, of whom 36 were excluded. Data were collected using four instruments designed to meet the research objectives: a demographic characteristics questionnaire (including age, gender, education level, occupation, and place of residence), along with validated scales assessing religious beliefs, psychological self-care, and psychological well-being.

The religious beliefs scale consisted of 70 items categorized into ten subdomains: the relationship between an individual and God, the relationship between an individual and the hereafter, religious leaders, individual ethics, social relations, livelihood, family, physical dimensions, humanity, and nature. Responses were scored on a four-point Likert scale, ranging from 1 (completely disagree) to 4 (completely agree). This study utilized the religious orientation questionnaire developed by Dr. Azerbaijani. Total scores ranged from 70 to 280, with higher scores indicating a greater degree of religiosity. The reliability, content validity, and construct validity of this scale have been previously verified in Iran.³³ The reliability of the questionnaire was confirmed, with Cronbach's alpha coefficients of 0.91 for the total scale, and 0.85 and 0.83 for the beliefs and ethics dimensions, respectively.³⁴

Psychological self-care was assessed using the Psychological Self-Care Questionnaire, developed by Yunibhand in 1999, consists of 46 items. Respondents indicate the the amount of time spent on their behaviors over the past week using a four-point scale: 1 (never), 2 (sometimes), 3 (rarely), and 4 (always). This instrument comprises seven subscales: self awareness, effectiveness of communication, effectiveness of time, coping with problems, developing and maintaining a social support system, religious activities, and physical self-care. Total scores range from 46 to 184, with higher scores representing a greater level of psychological self-care. The validity and reliability of the original instrument have been well-established, with subscale reliability reported as Cronbach's alpha coefficients ranging from 0.82 to 0.90.^{35,36} Miratabar et al. (2022) verified the validity of the Iranian version of this scale. Structural equation modeling was employed to assess the correlations among variables, and confirmatory factor analysis (CFA) performed using Amos 21 software confirmed the seven-subscale structure, indicating a good model fit. The Cronbach's alpha coefficient for the 46- item questionnaire was 0.70.³⁷

Psychological well-being was assessed using the 18-item Psychological Well-Being Questionnaire, developed by Ryff. Responses are scored on a six-point Likert scale ranging from 1 (completely disagree) to 6 (completely agree). This instrument comprises six subscales, each containing three items.³⁸ Ryff's theory of psychological well-being encompasses self acceptance, positive relationships with others, autonomy, environmental mastery, purpose in life, and personal growth.³⁹ Total scores range from 18 to 108, with higher scores indicating greater psychological well-being. The test-retest reliability coefficient for the total scale was reported as 0.82, with subscale coefficients of 0.70 for self-acceptance, 0.77 for positive relationships with others, 0.78 for autonomy, 0.77 for environmental mastery, 0.71 for purpose in life, and 0.78 for personal growth. This study utilized the validated Persian version of the questionnaire.³⁸

Data were analyzed using SPSS version 24 software. Quantitative variables were described using mean and standard deviation, while qualitative variables were expressed as frequencies and percentages. Pearson correlation test was employed to evaluate the relationships between variables. Simple and multiple linear regressions were conducted to determine the association between religious

beliefs with psychological well-being and self-care in patients with COVID-19. A P value of less than 0.05 was considered statistically significant.

Results

Out of the initial 286 patients infected with COVID-19, 250 completed the study and were included in the final analysis. The mean age of the participants was 49.63 ± 12.65 years, with an age range of 20 to 70 years. The sample comprised 44% men and 56% women. The majority of patients were urban residents (55.2%) and held a diploma or lower level of education (74.8%). Regarding occupational status, housewives constituted the largest group (41.6%). A substantial proportion of patients (89.6%) had a hospital stay of five days or longer. The mean scores for religious beliefs, psychological well-being, and self-care were 173.8 ± 18.6 , 67.4 ± 13.7 , and 115.4 ± 15.9 , respectively [Table 1].

Table 1: Descriptive Results of Demographic Characteristics, Religious Beliefs, Psychological Well-being, and Self-care among COVID-19 Patients (N = 250)

Variable	N	%	Variable	Mean (SD)	Min (Max)
Age(yr)			Religious beliefs	173.8(18.6)	(124-233)
<35	35	14	beliefs	111.4(12.3)	(82-148)
35-50	87	34.8	ethics	62.4(8.3)	(39-85)
>50	128	51.2	Psychological well-being	67.4(13.7)	(30-108)
Gender			self-acceptance	11.5(3.3)	(5-18)
female	140	56	Relationship with others	11.5(3.4)	(5-18)
male	110	44	autonomy	11.5(3.2)	(5-18)
Residency			Mastery of the environment	10.7(3.2)	(5-18)
Urban	138	55.2	Purpose in life	11.3(3.4)	(4-33)
Rural	112	44.8	Personal growth	10.9(3.3)	(3-18)
Education level			Self-care	115.4(15.9)	(73-184)
≤Diploma	187	74.8	self awareness	17.6(4.2)	(7-28)
≥ Diploma	63	25.2	Communication effectiveness	29.3(7.1)	(12-48)
Occupation			dealing with problems	12.9(3.5)	(5-20)
Housewives	104	41.6	Development and maintenance of social systems	17.03(5.0)	(7-28)
Self-employed	74	29.6	Time effectiveness	5.07(1.6)	(2-8)
Employed	24	9.6	Individual activities	15.6(5.1)	(6-24)
Unworked	21	8.4	Physical self-care	17.81 (3.9)	(7-28)
Other	27	10.8			
part					
Lung	58	23.2			
Infectious	96	38.4			
Internal	42	16.8			
Other	54	21.6			
Number of days of hospitalization					
<5 day	26	10.4			
≥5 day	224	89.6			

A significant positive correlation was observed between religious beliefs and self-care ($\rho = 0.387$, $P = 0.0001$), as well as between religious beliefs and psychological well-being ($\rho = 0.375$, $P = 0.0001$). Additionally, a significant positive correlation existed between psychological well-being and self-care scores ($\rho = 0.376$, $P = 0.0001$) [Figure 1].

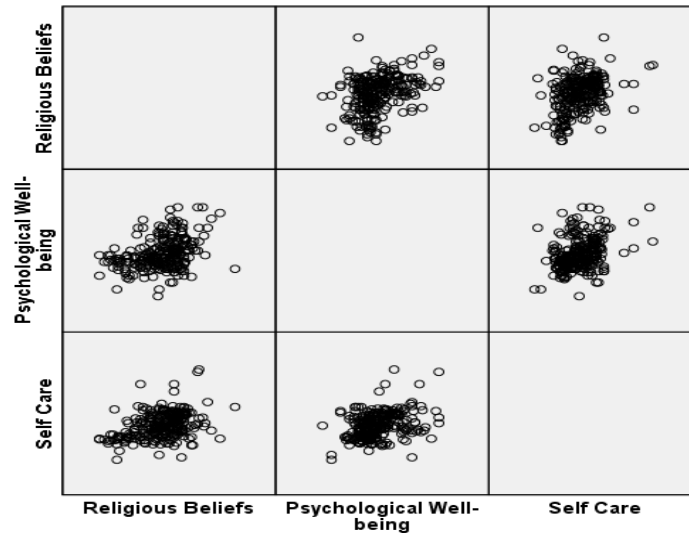


Figure 1: Correlation coefficient matrix between Religious Beliefs, Mental Well-being, and Self-care in COVID-19 patients (N=250)

Significant positive correlations were observed between the 'beliefs' and 'ethics' dimensions of religious beliefs and most dimensions of psychological well-being, with the exception of the 'personal growth' subscale ($P < 0.05$). Furthermore, significant positive correlations were found between the mean religious beliefs score and self-care dimensions, except for the 'development and maintenance of social systems' subscale. Similarly, religious ethics demonstrated significant positive correlations with self-care dimensions, excluding both 'development and maintenance of social systems' and 'physical self-care' ($P < 0.05$) [Table 2].

Table 2: Correlation coefficient matrix between Religious Beliefs, Mental Well-being, Self-care Dimensions in COVID-19 patients (N=250)

Variable	s	RB		PW						SC						
		D1	D2	D1	D2	D3	D4	D5	D6	D1	D2	D3	D4	D5	D6	D7
RB	D	1														
	1															
	D	0.64	1													
PW	2	2														
		0.00														
	01															
PW	D	0.30	0.14	1												
	1	0	8													
		0.00	0.01													
PW	01	9														
	D	0.32	0.22	0.63	1											
	2	9	0	9												
PW		0.00	0.00	0.00												
	01	01	01													
	D	0.34	0.36	0.43	0.42	1										
SC	3	4	8	8	3											
		0.00	0.00	0.00	0.00											
	01	01	0	01												

religious beliefs demonstrated a significant positive association with self-care dimensions, except for 'development and maintenance of social systems' and 'physical self-care' ($P < 0.05$) [Table 3].

Table 3: Results of Linear regression model for religious beliefs dimensions with Psychological Well-being and Self-Care in COVID- 19 patients (N=250)

Model	Dependent Variable	Independent Variable	B	SE	Beta	R ²	P-Value	95% CI Low	High
1	Psychological well-being	Beliefs	0.079	0.016	0.291	0.084	0.0001	0.046	0.111
2	D1	Ethics	0.059	0.025	0.148	0.022	0.019	0.010	0.109
3	D2	Beliefs	0.085	0.016	0.311	0.097	0.0001	0.052	0.117
4	D2	Ethics	0.089	0.025	0.220	0.048	0.0001	0.040	0.138
5	D3	Beliefs	0.085	0.015	0.332	0.110	0.0001	0.055	0.116
6	D3	Ethics	0.140	0.022	0.368	0.135	0.0001	0.096	0.184
7	D4	Beliefs	0.063	0.016	0.241	0.058	0.0001	0.031	0.094
8	D4	Ethics	0.080	0.024	0.207	0.043	0.001	0.033	0.127
9	D5	Beliefs	0.080	0.017	0.289	0.084	0.0001	0.047	0.114
10	D5	Ethics	0.082	0.026	0.198	0.039	0.002	0.031	0.132
11	D6	Beliefs	0.025	0.017	0.093	0.009	0.142	-0.008	0.058
12	D6	Ethics	0.008	0.025	0.021	0.0001	0.736	-0.041	0.058
13	Self-care	Beliefs	0.109	0.021	0.319	0.102	0.0001	0.069	0.150
14	D1	Ethics	0.120	0.031	0.236	0.056	0.0001	0.058	0.181
16	D2	Beliefs	0.108	0.036	0.186	0.035	0.003	0.037	0.179
17	D2	Ethics	0.275	0.052	0.321	0.103	0.0001	0.173	0.376
18	D3	Beliefs	0.066	0.018	0.228	0.052	0.0001	0.031	0.102
19	D3	Ethics	0.056	0.027	0.129	0.017	0.042	0.002	0.109
20	D4	Beliefs	-0.030	0.026	-0.074	0.005	0.246	-0.081	0.021
21	D4	Ethics	-0.033	0.038	-0.054	0.003	0.396	-0.108	0.043
22	D5	Beliefs	0.036	0.008	0.266	0.071	0.0001	0.019	0.052
23	D5	Ethics	0.058	0.012	0.290	0.084	0.0001	0.034	0.081
24	D6	Beliefs	0.085	0.026	0.208	0.043	0.001	0.035	0.136
25	D6	Ethics	0.219	0.036	0.360	0.130	0.0001	0.148	0.290
26	D7	Beliefs	0.050	0.020	0.155	0.024	0.014	0.010	0.090
27	D7	Ethics	0.029	0.030	0.060	0.004	0.343	-0.031	0.089

Note: *Psychological well-being; D1: Self-acceptance, D2: Relationship with others, D3: Autonomy, D4: Mastery of the environment, D5: Purpose in life, D6: Personal growth. Self-care; D1: Self awareness, D2: Communication effectiveness, D3: Dealing with problems, D4: Development and maintenance of social systems, D5: Time effectiveness, D6: Individual activities, D7: Physical self-care*

After adjusting for potential confounding variables, the positive associations remained statistically significant. Religious beliefs continued to show a significant positive association with psychological well-being ($\beta = 0.332$, 95% CI: 0.150–0.338, $P < 0.001$) and with self-care ($\beta = 0.345$, 95% CI: 0.187–0.405, $P < 0.001$) [Table 4].

Table 4: Results of Multiple Linear regression model for Psychological Well-being and Self-care with religious beliefs in COVID-19 patients (N=250)

Variable	Self-care					Psychological well-being				
	B	Beta	P-Value	95% CI		B	Beta	P-Value	95% CI	
s				Low	High				Low	High
Constant	52.06		0.0001	33.216	70.896			0.091	-2.242	30.424
Religious Beliefs	0.296	0.345	0.0001	0.187	0.405	0.244	0.332	0.0001	0.150	0.338
Age	0.127	0.101	0.098	-0.024	0.279	0.125	0.115	0.062	-0.006	0.256
Gender	-1.04	-0.03	0.597	-4.93	2.84	1.053	0.038	0.539	-2.319	4.425
Education level	6	3								
Education level	2.593	0.071	0.245	-1.79	6.97	0.792	0.025	0.682	-3.005	4.590
Residency	2.744	0.086	0.184	-1.31	6.80	1.365	0.050	0.445	-2.152	4.882

Note: $R^2 = .170$; $R^2 = .155$

Discussion

This study offers a novel exploration of the relationships between religious beliefs, psychological well-being, and self-care within the context of the COVID-19 pandemic. It aims to examine the association between religious beliefs, psychological self-care, and mental well-being in patients with COVID-19 infection

The study's findings revealed a significant positive association between religious beliefs and psychological well-being. Specifically, stronger religious beliefs were linked to better psychological well-being among patients with COVID-19. This result aligns with the findings of Saud et al. (2021), who found that religious beliefs can reduce stress and enhance psychological well-being during stressful events like the COVID-19 pandemic.⁴⁰ Religious coping has been identified as a major predictor of coronavirus-related situational stress. During the pandemic, as individuals experienced anxiety and stress regarding their health, religious beliefs served as an effective coping strategy.⁴¹ Furthermore, religious factors have garnered considerable research interest and are associated with improved mental and physical health outcomes. In conclusion, religion represents an emerging area of study concerning coping strategies during the COVID-19 pandemic outbreak.⁴⁰

A review of the literature showed that religious beliefs can improve the psychological well-being and life satisfaction of patients with COVID-19. The same study revealed that during stressful situations such as the pandemic, individuals without religious beliefs experienced poorer psychological well-being and greater anxiety.⁴³ In explaining these findings, it appears that faith and trust in God alleviate worries associated with severe illness, improve resilience and acceptance of the disease, prevent factors that can

cause or worsen mental disorders and other negative psychological consequences. Therefore, it can be argued that God-seeking practices help to manage psychological problems.⁴⁴

Findings indicated that improvements in religious belief dimensions were associated with enhanced psychological well-being dimensions, including self-acceptance, relationships with others, autonomy, environmental mastery, and a Purpose in life (except for personal growth). Supporting these findings, Mikaeli-Manee et al. (2021) demonstrated significant differences in the purposeful life, self-acceptance, and overall psychological well-being scores between devout and non-devout youth.⁴⁵ Furthermore, religious belief and adherence to religious practices are linked to better physical and mental health,⁴⁶ and positively influence social relationships and quality of life.²⁵

In contrast to the present study's findings, Park (2005) reported that religious beliefs can aid in the reassessment of life events, enabling individuals to perceive positive aspects and fostering personal growth.⁴⁷ Furthermore, Mikaeli-Manee et al. (2021) found that the mean scores for purposefulness and self-acceptance were lower among faithful youth. This could be explained by the idea that individuals participating in significant religious activities may have lower satisfaction with their current circumstances, leading them to constantly seek to strengthen their faith and beliefs, thus potentially accounting for the lower religious well-being observed in these youths.⁴⁵ Conversely, Krok (2015) posited that individuals more involved in religious activities are more inclined than others to seek or strengthen meaning and purpose in life, and therefore, primarily engage in these activities to pursue life goals and meaning.⁴⁸

These differences may stem from the subjects' religious beliefs and cultural backgrounds. Religious activities can serve as opportunities for personal growth, the consolidation of human virtues, and spiritual purification.⁴⁵ Religion fosters self-regulation and provides purpose and direction in life,⁴⁸ logically, this links religiosity with psychological well-being and its various dimensions. Consequently, a positive attitude toward one's original religious beliefs is warranted.⁴⁵ Such beliefs are a key component of overall health, coordinating internal forces to promote life stability, peace, symmetry, harmony, emotional well-being, and a close relationship with God.⁴⁹ Therefore, health care providers should consider patients' religious beliefs alongside physical treatment aspects to enhance their mental health.⁵⁰ Given the prevailing religious context of our society, these findings were anticipated.

The present study found a positive association between religious beliefs and self-care, aligning with previous research by Goudarzian et al. (2019), Sharif Nia et al. (2017), and Heidari et al. (2013).^{29,51,52} Similarly, Shiri-Mohammadabad and Afshani (2021) reported that religiosity promoted self-care among women.³¹ Further supporting these findings, a positive and significant relationship exists between religious and self-care-related behaviors,⁵³ and a linear relationship was observed between religious coping and self-care behaviors.⁵¹

A literature review revealed that during stressful periods, such as the COVID-19 pandemic, religious beliefs and trust in God can alleviate stress and positively influence self-care practices. They found a positive and significant relationship between religious beliefs and self-care activities, even among patients with COVID-19.⁵⁴ Furthermore, Heidari et al. (2017) found that by increasing life expectancy, religious beliefs can enhance the level of self-care activities and improve the quality of life for patients.³⁰ Since an individual's decision to adopt care-oriented behaviors is influenced by social conditions, including religious values and beliefs, special attention should be paid to the social context of life in order to promote self-care performance.³¹

This study's major finding reveals a significant and positive correlation between various dimensions of religious beliefs and dimensions of self-care in COVID-19 patients, with the exception of the development and maintenance of social systems. This positive association is consistent with prior research. Cockerham (2016), for example, found that individuals holding strong religious beliefs reported lower levels of physical disability and depression.⁵⁵ Religion contribute to health promotion by motivating individuals towards healthy behaviors and adherence to healthy lifestyles, while also discouraging

unhealthy habits.⁵⁶ Crucially, religion plays a decisive role in health maintenance by providing vital support during times of stress and illness.⁵⁶

Religious beliefs can enhance an individual's resilience to adverse situations by fostering meaningful relationships and facilitating problem-solving through coping mechanisms for traumatic events.⁵¹ Moreover, religiosity has been shown to positively and significantly affect women's self-care behavior.³¹ Religion contributes to health by influencing people's health behaviors.⁵⁷ Consequently, religious beliefs can motivate individuals to healthfully manage their daily activities, thereby increasing life expectancy and inner strength, which ultimately translates into more self-care behaviors.⁵⁸

The present study found no significant association between demographic characteristics and psychological well-being and self-care. This aligns with the research by Blbas et al. (2020), who reported no significant correlation between COVID-related anxiety and variables such as marital status, education level, job, and income.⁵⁹ In contrast, Asadi et al. (2021) found associations between demographic factors and COVID-19 anxiety and self-care behaviors. Specifically, COVID-induced anxiety was higher in women than in men, whereas men demonstrated greater self-care behaviors. Additionally, individuals with lower education levels reported less anxiety than those with higher education.⁶⁰ It is seen that psychological well-being and self-care are complex constructs influenced by numerous factors. Demographic characteristics might play a smaller role compared to other psychological, social, or environmental factors. Therefore, further research in this field is warranted.

Conclusion

The findings of the present study stress the importance of religious beliefs as a variable affecting psychological well-being and self-care among patients with COVID -19. Religious beliefs continue to play a major role in ensuring psychological well-being and self-care which requires further clinical research. Therefore, clinical professionals and health workers are recommended to emphasize religious beliefs to promote the psychological well-being and self-care of patients with COVID -19. The previous studies about self-care were mostly carried out in the field of medicine and in patients than healthy people. Therefore; it has particular importance that further research is done in this field.

Limitations

This study has several limitations. First, its findings are situated within a specific Iranian cultural context, which may limit their broader applicability. Moreover, the cross-sectional design precludes the inference of causal relationships. Additionally, the reliance on self-reported questionnaires may lead to an over- or underestimation of the variables measured. Data collection was also potentially affected by the challenging environment during the COVID-19 pandemic, which may have impacted the accuracy of participants' responses. Finally, although the study was conducted at two major public hospitals affiliated with Babol University of Medical Sciences, which are among the most prominent referral centers in Mazandaran Province, the geographical restriction to these two centers limits the generalizability of the results. Future research could explore other religious and spiritual factors to expand upon these findings.

Disclosure

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