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Existential anxiety amid COVID-19 pandemic in Kashmir: A cross-sectional study

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Abstract:

BACKGROUND: Existential anxiety (EA) revolves around the question of ultimate concern related to life and death. It gets more prominent when there is an exposure to stressful experiences where the stress is profound and resources seem insufficient. The objective was to measure the prevalence and magnitude of EA in the study population from the Kashmir valley during the COVID-19 pandemic.

MATERIALS AND METHODS: In this cross-sectional study, data were collected through social media. All the participants belonging to the Kashmir valley were included. EA questionnaire developed by Weems *et al.* was used.

RESULTS: A total of 132 subjects were included. The prevalence of EA concerns was death 55%, fate 62%, emptiness 73%, meaninglessness 32%, guilt 55%, and condemnation 64%. The mean EA score was 5.0. EA was higher in those who had been diagnosed with mental illness ever in their life by a psychiatrist than those who had no such history. EA score was much higher in those who had ever felt a need to visit a psychiatrist than those who had not. There was no statistically significant difference in the mean scores of EA for those who never felt this need and those who felt this need since the start of the COVID-19 pandemic.

CONCLUSION: There was a high prevalence of EA in the study population from the Kashmir valley. Relative concerns were more prevalent than absolute concerns. EA score was higher among those who had mental health issues compared to others.

Keywords:

Anxiety, death, existentialism, life, mental health

Introduction

Existential anxiety (EA) revolves around the question of ultimate concern related to life and death.^[1] It arises when people lose a sense of safety.^[2]

Tillich demarcates EA as related to three domains of apprehension.^[3] The domains are anxiety related to fate and death, emptiness and meaninglessness, and that of guilt and condemnation.^[4]

EA gets more prominent when there is an exposure to stressful experiences.^[5] Since COVID-19 is one such stressful event,

this study was conducted with the aim of measuring the EA, the prevalence and magnitude, in the Kashmiri population during the COVID-19 pandemic.

Objectives

- Primary objective: To measure the prevalence and magnitude of EA in the study population from Kashmir valley during the COVID-19 pandemic
- Secondary objectives:
 - To find the sociodemographic correlates of EA in the study population, and
 - To find the relationship between stress related to COVID-19 and EA.

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Materials and Methods

India is one of those countries that have taken some of the strictest measures to contain the threat of COVID-19. Amidst such strict lockdown, the idea of a community-based door to door survey was far-fetched. Therefore, the use of social media platforms like WhatsApp and Facebook was made where the questionnaire was shared so that those interested, could willingly participate if they wished. This was a cross-sectional study. Google forms were used and settings were so fixed that allowed a single participant to fill the questionnaire only once. The time period for data collection was set to be 4 weeks. Data collection was started on April 20, 2020. All the participants belonging to the Kashmir valley were included.

Our outcomes of interest were the EA concerns prevalent among the respondents according to Tillich's theory of EA which include apprehensions related to death, fate, meaninglessness, emptiness, condemnation, and guilt.^[3] We also tried to find out the mean score of EA to get an idea of the magnitude of the EA present among the respondents. The sociodemographic correlates that we analyzed were age, gender, residence, marital status, education, and profession. We also tried to find out the relationship between mental health status and EA. We tried to find out the relationship between stress related to COVID-19 and EA by taking "felt the need to visit a psychiatrist since the start of COVID-19 pandemic" as a proxy indicator for stress related to COVID-19 and compared the EA scores of those who never felt the need to visit a psychiatrist or therapist with the EA scores of those who felt this need since the start of COVID-19 pandemic.

EA questionnaire (EAQ) developed by Weems *et al.* was used for measuring EA among the study participants.^[1] This scale is a 13 item scale with questions to be answered in the form of "yes" or "no" based on whether the respondents agreed with the given question or not. For each concern there are two questions; one positively scored (a "yes" indicates that there is some EA) and another negatively scored (a "yes" indicates there's no EA). For fate there are 3 items; one positively scored and two negatively scored. Weems *et al.* found adequate internal consistency (coefficient $\alpha = 0.71$) and test-retest reliability ($r = 0.72, P < 0.001$) of EAQ at 2 weeks. The score was obtained by taking the total number of items endorsing for EA for a person. The score ranges from 0 to 13. EAQ is the most thoroughly evaluated questionnaire for measuring EA and research has continued to support the instrument's validity across different populations.^[6,7] So we chose EAQ as the appropriate instrument for measuring EA for our population amongst all the questionnaires that have been developed to measure EA till now.

Study size: We circulated the questionnaire through WhatsApp and Facebook and waited for responses. It was shared again after a week's interval from the previous date up to 4 weeks. After the completion of 4 weeks, whatever number of responses were received were all taken for evaluation.

Statistical analysis: The categorical variables were summarized as percentages, whereas the continuous data were summarized as mean and standard deviation. Appropriate statistical tests were applied wherever required.

In our questionnaire which was shared with the participants, the following lines were written, "We, in an attempt to measure EA in light of COVID-19, need your valuable time to respond to below mentioned questions. There are no right or wrong answers, the responses are to be based on your choice." This explained the process of research. Adding further the following lines were written, "Your participation in this research will be voluntary and you will participate anonymously". Thus informed consent was implied on behalf of the participants who filled the questionnaire. The researchers' contact details and designation at their respective institutions were shared with every participant.

Results

Initially, we had 140 participants. Eight were excluded, 7 of whom were from outside the Kashmir valley, and one transgender (excluded because of his already marginalized status in the society and the stress that entails). Therefore, a total of 132 subjects were taken for the final analysis.

In this study, about 52% of subjects were male, 68% belonged to the age-group of 15–30 years. The mean age was 27.9 years with a standard deviation of 8.1 years. Around 39% were married. About 57% belonged to urban areas. All the participants in our study were literate. Medical professionals formed about 14% of the participants [Table 1].

The responses to the EA questionnaire are given in Table 2. Based on the responses in Table 2, the prevalence of EA concerns was calculated as shown in Table 3.

The prevalence of EA concerns among the respondents was calculated by taking the percentage of respondents positively endorsing at least one item in each of the six facets of EA. The percentages were as death 55%, fate 62%, emptiness 73%, meaninglessness 32%, guilt 55%, and condemnation 64%.

The mean EA score in our study was 5.0 with a standard deviation of 3.2. We divided the participants into three

Table 1: Sociodemographic characteristics of the study participants

Characteristic	Categories	n (%)
Age group*	15-30	90 (68.2)
	31-45	38 (28.8)
	46-60	4 (3.0)
Gender	Female	64 (48.6)
	Male	68 (51.5)
Marital status	Married	52 (39.4)
	Unmarried	80 (60.6)
Area	Rural	57 (43.2)
	Urban	75 (56.8)
Region	Central Kashmir	32 (24.2)
	North Kashmir	90 (68.2)
	South Kashmir	10 (7.6)
Education	10 th	17 (12.9)
	12 th	9 (6.8)
	Graduation	24 (18.2)
	Postgraduation	53 (40.2)
Occupation	Professional	29 (22.0)
	Medical professional	19 (14.4)
	Nonmedical	54 (40.9)
	Student	52 (39.4)
Religion	Unemployed	7 (5.3)
	Atheist	1 (0.8)
	Islam	130 (98.5)
	Sikhism	1 (0.8)
	Total	132 (100.0)

*Age was categorized into 3 groups. The actual age range was from 15 to 60 years

Table 2: Items and responses for the existential anxiety questionnaire

Item	Response	
	No	Yes
1. I often think about death and this causes me anxiety. (D)	91 (68.9)	41 (31.1)
2. I am not anxious about fate because I am resigned to it. R (F)	59 (44.7)	73 (55.3)
3. I often feel anxious because I am worried that life may have no meaning. (M)	91 (68.9)	41 (31.1)
4. I am not worried about nor think about being guilty. R (G)	61 (46.2)	71 (53.8)
5. I often feel anxious because of feelings of guilt. (G)	67 (50.8)	65 (49.2)
6. I often feel anxious because I feel condemned. (C)	106 (80.3)	26 (19.7)
7. I never think about emptiness. R (E)	74 (56.1)	58 (43.9)
8. I often think that things that were once important in life are empty. (E)	72 (54.5)	60 (45.5)
9. I never feel anxious about being condemned. R (C)	76 (57.6)	56 (42.4)
10. I am not anxious about death because I am prepared for whatever it may bring. R (D)	62 (47.0)	70 (53.0)
11. I often think about fate and it causes me to feel anxious. (F)	87 (65.9)	45 (34.1)
12. I am not anxious about fate because I am sure that things will work out. R (F)	38 (28.8)	94 (71.2)
13. I know life has meaning. R (M)	13 (9.8)	119 (90.2)

R=Reverse scored item, C=Condemnation, D=Death, E=Emptiness, F=Fate, G=Guilt, M=Meaninglessness

levels based on EA score with a score of 0–2 (about one standard deviation below mean) classified as low EA, 3–8 as moderate EA, and 9–13 (about one standard deviation above mean) as high EA. In our study, 60% had moderate EA while around 14% had a high EA score and 26% had low EA.

For assessing EA, we wanted to know about the mental health status of respondents as shown in Table 4.

Around 15% of the subjects had ever been diagnosed for a mental illness.

Presently 6% of the subjects were on psychiatric medications. About 36% (48 subjects) felt a need to visit a psychiatrist. About 4% of the subjects felt that the need arose after the start of the COVID-19 pandemic.

There was no correlation between age and EA score, ($r = 0.00, P > 0.05$). Furthermore, no relationship of EA score was found with gender, marital status, and residence [Table 5]. EA was higher in those who had ever been diagnosed for mental illness by a psychiatrist than those who had no such issues ($U = 788, N1 = 112, N2 = 20, P < 0.05$). EA score was much higher in those who had ever felt a need to visit a psychiatrist than those who never felt so [Table 5]. There was no statistically significant difference in the mean scores of EA for those who never felt this need and those who felt this need since the start of the COVID-19 pandemic ($U = 34.5, N1 = 84, N2 = 5, P > 0.05$).

The EA did not vary between different professions $F(3,128) = 0.63, P > 0.05$. Also, it did not vary across different educational qualifications, $F(4,127) = 0.19, P > 0.05$.

We computed “mental health status” by taking those who had either “been diagnosed for a mental illness” or “were on psychiatric medications” or “had ever felt a need to visit a psychiatrist” in one group and those who fulfilled none of these criteria in the other group. There was a mean difference of 2.4 in the EA scores of the two groups, $t(130) = 4.37, P < 0.001$.

Discussion

EA revolves around the apprehensions regarding the meaning of life and death.^[1] Tillich demarcates EA as related to three domains of apprehension.^[3] Each domain is comprised of two concerns, a relative concern, and an ultimate concern. The first domain is anxiety related to fate and death. The anxiety related to death is an ultimate concern because of an inevitable end to a human life that nobody has control over. The anxiety related to fate, however, is a relative concern as there’s a desire to know destiny which cannot be fulfilled. The second domain talks about

emptiness (a relative concern) and meaninglessness (an ultimate concern). Emptiness refers to the concern about the loss of confidence in some beliefs while as meaninglessness is the concern that life may actually ultimately be without a definite purpose. The third domain is that of guilt (relative concern, that our behavior has not met our own set standards) and condemnation (ultimate concern that one's life has not met certain universal standards).^[4]

Only a limited number of studies have been conducted keeping this topic as the central theme of the studies. However, EA usually creeps and settles in the minds of people when faced with some distress, and confronted with certain struggles in life. It has been found that EA increases during the periods of stress.^[5] Weems *et al.* noted the salience of EA among disaster-exposed youth.^[4] COVID-19 is one of the most stressful periods of human life that history has ever witnessed.

Table 3: Prevalence of existential anxiety concerns among the study subjects

Existential anxiety concern	n (%)
Death	73 (55.3)
Fate	82 (62.1)
Emptiness	96 (72.7)
Meaninglessness	42 (31.8)
Guilt	72 (54.5)
Condemnation	84 (63.6)

Table 4: Mental health status of respondents'

Mental health status	n (%)
Ever diagnosed with any mental illness by a psychiatrist	20 (15.2)
On psychiatric medication	8 (6.1)
Ever felt a need to visit a psychiatrist or therapist	48 (36.4)
When did you feel the need to visit a psychiatrist or therapist?	
Before COVID-19	43 (32.6)
Since the start of COVID-19 pandemic	5 (3.8)
Never	84 (63.6)

Table 5: Relationship of existential anxiety score with different characteristics of study subjects

Characteristic	n	Mean (SD) EA Score MD	95%CI of difference	t (df)	P	
Gender						
Male	68	4.7 (3.2)	-0.6	1.7to0.5	-1.11 (130)	0.268
Female	64	5.3 (3.2)				
Marital status						
Married	52	4.6 (2.9)	-0.6	1.7to0.6	-0.96 (130)	0.337
Unmarried	80	5.2 (3.4)				
Residence						
Rural	57	4.9 (3.2)	-0.2	1.4to0.9	-0.46 (130)	0.647
Urban	75	5.1 (3.3)				
Have you ever felt a need to visit a psychiatrist or therapist?						
Yes	48	6.5 (3.6)	2.4	1.3to3.5	4.36 (130)	<0.001
No	84	4.1 (2.6)				

SD=Standard deviation, CI=Confidence interval, MD=Mean difference, EA=Existential anxiety

There was almost equal participation from males and females in our study. The mean age of respondents was around 28 years.

The prevalence of EA concerns in our study was high. This may be because the study was conducted during the COVID pandemic. More than 50% of the respondents expressed their apprehensions about all the EA concerns except for meaninglessness in which case the prevalence was about 32%. Since there is more than 50% prevalence of almost all EA concerns, it needs to be kept in mind that every other person may be having some kind of EA concern bothering him/her and might need help in this regard. This needs to be taken more seriously during the current pandemic. The prevalence was higher compared to the research conducted by Weems *et al.*^[1] One of the reasons for this could be the political conflict that is at the center of the Kashmir valley for decades plus this study being conducted during the crisis created by the COVID-19 pandemic. However, the mean score was comparable to this study. We could not determine absolutely what amount of EA was increased due to COVID-19 and what the baseline EA before COVID-19 was. For that before and after study needed to be conducted but unfortunately, nobody can foresee a pandemic. Moreover, no studies have been conducted on EA in Kashmir which could be used for comparison.

Except for the third domain of EA, the relative concerns are more prevalent compared to absolute concerns which may be because relative concerns are more important for people in everyday life. Similar findings were noted by Berman *et al.* in 2006.^[6]

There was no correlation of age, gender, and marital status with EA similar to the findings by Weems *et al.*^[1] EA was higher in those who had ever been diagnosed for mental illness by a psychiatrist than those who had no such issues. EA score was much higher in those who

had ever felt a need to visit a psychiatrist than those who never felt such a need. All this is theoretically plausible and is consistent with the findings of other studies.^[1,4] There was no statistically significant difference in the mean scores of EA for those who never felt this need and those who felt this need since the start of the COVID-19 pandemic. This may be because the sample of people who felt the need to visit a psychiatrist since the start of the pandemic was very low in our study which may be because overall the threat perceived due to COVID-19 might have been far less at the time this study was conducted since the number of positive cases in Kashmir was quite less with most of them being asymptomatic.^[8] For this more research needs to be conducted.

We found that 15% of the respondents had been diagnosed with mental illness and about 6% were on drugs. The actual prevalence may be higher as the literature available on mental health issues in Kashmir hints at. According to a survey named “Muntazar, Kashmir Mental Health Survey” conducted in 2015, about 45% of Kashmiri adults have symptoms of mental distress.^[9] Since mental health issues were self-reported, it may have led to the finding of a lower prevalence of mental health issues in the study respondents because of the stigma associated with the conservative Kashmiri society. At least 4% of our study respondents marked that they never experienced any kind of stress before, but felt a need to visit a psychiatrist after the COVID-19 pandemic started. This is also very significant since a rise in the mental health issues might be seen due to COVID-19 which can be detrimental for the society as a whole.

Strengths of the study: This study is the first of its kind to be conducted in Kashmir to find out the element of EA in the Kashmiri population and to find its relationship with COVID-19. Since it was found that EA is higher among those with mental illnesses and those who were visiting a psychiatrist for any psychological issue, it confirms the results of other studies which declare that EA is higher among stress exposed people.^[4] In this study, the anonymity of the participants was completely maintained and it might have given the participants the confidence to give their true responses to those questions which are otherwise not revealed to anyone in a society where there is a stigma associated with mental health issues. We also strictly adhered to STROBE guidelines for Cross-sectional study at every step of the study.

Limitations of the study: First, this study determined the presence of EA during the current COVID-19 pandemic but the amount of increase due to COVID-19 in the EA could not be found because (for that) a before and after study needed to be conducted. Since COVID-19 is a natural pandemic, any prediction and preparedness

beforehand were not possible. Therefore, a before and after study could not be conducted. Second, since the data were collected by reaching out to people through social media, the participation was limited to literate people only and the state of mind of illiterate people could not be determined. Moreover, those who did not have access to the internet due to any reason could not participate. For that interviewing people by face to face contact was the only possibility but in the current circumstances, it was not possible due to strict lockdown being observed and because of the ethical responsibility of the researchers to not endanger people’s lives by interviewing and possibly flouting social distancing guidelines when less risky ways of contacting people were available. Third, many measures were based on self-reporting, so there might have been a source bias which was tried to be minimized by ensuring anonymity but probably might not have been completely eliminated.

Implications of the study: This study will aid psychiatrists and psychologists in tailoring their therapy as it emphasizes on keeping EA as one of the differentials in their minds while dealing with patients. Psychiatric problems during a stressful period like COVID-19 need to be seen differently from an existential point of view and perspective.

Application of the present study in the field: Since EA concerns have been found highly prevalent in our society, it should change our outlook of the society when we go in the field in the present pandemic time in the sense that whenever we encounter people especially those who have had or are having some mental health issue even minor, it should strike our mind that the person may simultaneously be going through existential crisis. The present pandemic is very likely to push people into existential crisis because of bereavement of near and dear ones, loss of livelihood, isolation, etc.

Recommendations

Longitudinal studies to determine the EA during this COVID-19 pandemic should be carried out to determine the role of COVID-19 on the development of EA that people might be facing during this period of stress. We also recommend that studies with the research question of finding out the prevalence and magnitude of EA otherwise also be carried out as this issue has not been widely addressed in the Kashmiri population. Furthermore, the means of tackling it can be suggested and advised by psychiatrists and psychologists. It’s also recommended that wherever and whenever possible community-based studies should be carried out to include people from all spheres of life.

Conclusion

There was a high prevalence of EA in the study

population from the Kashmir valley. Relative concerns were more prevalent than absolute concerns. EA score was higher among those who had mental health issues compared to others.

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Conflicts of interest

There are no conflicts of interest.

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