Fear of COVID-19, death depression and death anxiety: Religious coping as a mediator

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Abstract
The COVID-19 pandemic has affected the well-being and mental health of populations worldwide. This study sought to examine whether religious coping mediated the relationship between COVID-19-related fear and death distress. We administered an online survey to 390 adult participants (66.15% females; $M_{age} = 30.85 \pm 10.19$ years) across Turkey. Participants completed a series of questionnaires measuring the fear they had experienced during the COVID-19 pandemic, their levels of religious coping and their levels of death anxiety and depression. Our findings revealed that (a) fear of COVID-19 was associated with positive religious coping, negative religious coping, death anxiety and death distress; (b) negative religious coping was associated with death anxiety and depression and (c) negative religious coping mediated the relationship between fear of COVID-19 and death anxiety and depression. These results highlight the detrimental effect of negative religious coping in increasing the adverse effect of the COVID-19 fear on death depression.

Keywords
Death anxiety, death depression, death distress, fear of COVID-19, negative religious coping, positive religious coping

Introduction
Pandemics of infectious diseases have existed throughout human history. Humans have been affected by outbreaks and epidemics for thousands of years, and diseases have always had many challenges leading to deadly pandemics and epidemics (Nokhodian et al., 2020). As of 25 November 2021, coronavirus disease infected more than 258,830,430 confirmed cases and caused more than 5,174,640 deaths globally (World Health Organization, 2021), leading to a universal health crisis.
worse than earlier pandemics and epidemics. Older people and those with pre-existing medical conditions are particularly at higher risk of developing the symptom of this disease. People engage in various protective behaviours to prevent themselves against the disease including limited in-person contact, face covering and frequent handwashing (Doyumğaç et al., 2021; Tanhan, 2020; Tümkaya et al., 2021; Yıldırım & Güler, 2022). The COVID-19 pandemic has impacted not only the physical health of people around the globe but also psychological health including the experience of death distress. This study addresses how religious coping explains the impact of fear related to the infectious disease on death distress.

The salient characteristics of the COVID-19 pandemic consist of high levels of fear, anxiety, stress, uncertainty, infection and mortality rate. As such, infectious diseases like the current pandemic have led to more fear and anxiety than other diseases. Fear of COVID-19 is an unpleasant emotion or an unhealthy response to any threats or danger such as fear of being harmed psychologically and physically (Zhang et al., 2020). Fear of COVID-19 among people is particularly high because of the rapid transmission rate and high deaths. This fear undoubtedly affects well-being and mental health outcomes all over the world (Yıldırım & Güler, 2021). Researchers found a wide range of indicators that increase fear of COVID-19 including personal relevance factors (e.g. personal health, prevention of risk and danger for loved ones), psychological vulnerability factors (e.g. health anxiety, worry and intolerance of uncertainty) and media exposure (e.g. regular and social media) (Mertens et al., 2020). As such, prevention and intervention related to mental health outcomes are essential in times of pandemic (Pakpour & Griffiths, 2020; Yıldırım, 2021).

A cross-cultural investigation on the fear of COVID-19 found that men and women of all age groups in countries such as Spain, Italy, Serbia, Croatia, Slovenia, Slovakia, and Bosnia and Herzegovina experienced high levels of fear of COVID-19 and loneliness due to negative effect of the COVID-19 pandemic (Lo Coco et al., 2021). Studies have also indicated that fear of COVID-19 shares a significant positive relationship with depression, anxiety, stress and perceived risk of COVID-19 (Yıldırım et al., 2020), which may, in turn, increase the likelihood of increased suicidal thoughts (Kaparounaki et al., 2020). Furthermore, although limited, the impact of fear of COVID-19 on coping strategies has been studied in the context of the pandemic. Fear of COVID-19 was found to diminish adaptive coping and increase maladaptive coping which in turn led to greater symptoms of negative mental health outcomes such as anxiety, depression and stress (Oti-Boadi et al., 2022; Yıldırım, Arslan, & Alkahtani, 2022). Also, fear of COVID-19 was found to moderate the indirect impact between religiosity and affective components of subjective well-being via meaning-making; the indirect effect was stronger for individuals with high fear compared to individuals with low fear (Krok et al., 2021). This suggests that fear of COVID-19 can be detrimental to the well-being and mental health of individuals in times of health crisis.

The adverse impact of COVID-19 on psychological health can be more devastating than expected in long term. People who experience mental health challenges during pandemics may be at the risk of engaging in suicidal behaviours including suicide attempts, suicidal ideation and actual suicide (Mamun & Griffiths, 2020). The COVID-19-related stressors have caused people to experience common mental health problems such as anxiety, depression, panic and social isolation, which in turn led to actual suicide in different countries such as Bangladesh and India (Goyal et al., 2020; Mamun & Griffiths, 2020). People may suffer from symptoms of death distress during the pandemic (Yıldırım & Güler, 2021).

Death distress

Death distress is a multidimensional construct and is typically characterized by death anxiety, death depression and death obsession (Dadfar & Lester, 2020). Death anxiety is defined as
dysfunctional emotional reactions and experiences of grief, fear and discontent related to death. Death depression is defined as the frequent experience of dysfunctional emotions, including sadness, hopelessness and loneliness concerning one’s own death and the death of others. Death obsession refers to continuous and repetitive thoughts about the death of oneself and significant others (Abdel-Khalek, 1998; Dadfar & Lester, 2020). The three components of death distress are moderately related to each other yet distinct components (Lester, 2003). People who experience death distress suffer from symptoms of anxiety, depression and obsession related to death. Females experience more death distress than males (Abdel-Khalek, 2005). Regarding the conceptual link between the three components of death distress, it can be assumed that death depression starts with death anxiety and death obsession. Empirical evidence suggests that death anxiety and death obsession collectively accounted for a significant amount of variance in death depression (Rajabi & Nobandegani, 2017).

Research showed that death distress is associated with increased levels of mental health challenges or psychopathologies such as anxiety, stress and depression (Iverach et al., 2014). Experience of excessive levels of death distress elicits a risk of engagement in suicidal behaviours (Yıldırım & Güler, 2021). Evidence from the context of the COVID-19 pandemic indicated that death distress was associated with greater COVID-19-related risk and lesser experiences of happiness and positive thinking (Yıldırım & Güler, 2021). Death obsession was negatively and significantly related to subjective well-being and mindful awareness and positively and significantly related to coronavirus experiences such as suffering stress (Arslan, 2022). Positive psychological strengths like positivity (Yıldırım & Güler, 2021) and mindfulness (Arslan, 2022) served as mediators to mitigate the negative impacts of coronavirus experiences on death distress in general public and university students.

Religious coping as a mediator

Many people around the world use religion as a way of coping with mental health challenges. Religiosity is found to contribute to better well-being, mental health and physical health (Koenig, 2012). Religious coping refers to a variety of efforts of using religious beliefs or practices to deal with life stressors. These involve beliefs and behaviours such as confession, prayer, seeking spiritual and personal support from others and acceptance of events for the sake of God (Pargament, 1997; Pargament et al., 2005). Religious coping can be best represented as positive religious coping and negative religious coping (Pargament et al., 2000). Positive religious coping refers to a secure spiritual attachment, positive religious appraisal and spiritual connectedness to others to ease the adverse consequences of life stressors. However, negative religious coping represents dissatisfaction and conflict with God and others alongside challenges to seek meaning and significance in life. Depending on involvement in positive and negative coping styles, religious coping may be favourable or unfavourable (Pargament et al., 2000). Positive religious coping is typically related to better psychological health, adjustment and resiliency, while negative religious coping is usually linked to poor well-being and mental health problems (Koenig, 2018; Pargament et al., 2011). Religious beliefs can contribute to the reduction in the levels of fear and anxiety as they conduce a sense of security (Exline et al., 2014) and buffer internal and external stressors via effective ways of coping (Lichtenthal et al., 2011).

Studies showed that using positive religious coping to cope with stress during the COVID-19 pandemic significantly contributed to the quality of life after controlling for demographic (e.g. gender, age and marital status) and personal and clinical factors (e.g. history of pre-existing physical and psychological conditions like illnesses, depressive and anxiety disorders) (Abdullah et al., 2021). Negative religious coping was found to be associated with greater experience of fear of
COVID-19, stress, anxiety and depression, while positive religious coping was related to fewer symptoms of stress and depression (Yıldırım, Arslan, & Alkahtani, 2022). Another study conducted during the COVID-19 pandemic reported a direct link between religious coping and mental health outcomes such as loneliness by showing a negative relationship between positive religious coping and loneliness and a positive relationship between negative religious coping and loneliness (Yıldırım, Kızılgeçit, et al., 2021). Furthermore, positive religious coping was associated with greater satisfaction with life and satisfaction with social support during the pandemic with fear of COVID-19 serving as a significant mediator between negative religious coping and satisfaction with life and satisfaction with social support (Dobrakowski et al., 2021). In addition, the role of negative religious coping in reducing overall well-being, satisfaction with life and quality of life has been reported in many other studies (Hebert et al., 2009; Kadiroğlu et al., 2021; Rababa et al., 2021; Scandrett & Mitchell, 2009). Moreover, research showed that religious coping styles can serve as a mediator in the association between stressors and psychological outcomes such as well-being (Helder et al., 2002). This suggests that adaptive religious coping contributes to positive well-being, mental health and positive functioning, while maladaptive religious coping is detrimental to psychological health. Considering that religious coping and religiosity provide psychological resources that help people to cope with suffering (Ghoncheh et al., 2021), it is plausible to assume that religious coping may assist people to mitigate their fear of COVID-19 and death distress. Accordingly, religious coping appears to mediate the relationship between fear of COVID-19 and death distress.

**Present study**

To the best of our knowledge, no study has yet been carried out in Turkey among young adults to investigate how fear of COVID-19 contributes to death distress (death depression and death anxiety). This study also intends to identify the role of religious coping in the experience of death distress. Understanding the underlying psychological mechanism related to the presence of fear of pandemic among young adults in the context of Islamic religious coping will substantially contribute to our understanding of the prevention and intervention programmes to be developed by mental health professionals, health authorities and policymakers on how to effectively manage and support young people. As such, we first hypothesized that fear of COVID-19 will be significantly and positively associated with negative religious coping, death depression and death anxiety whereas fear of COVID-19 will be significantly and negatively associated with positive religious coping. Second, positive religious coping will be significantly and negatively associated with death depression and death anxiety, while negative religious coping will be significantly and positively associated with death depression and death anxiety. Finally, we expected that positive and negative religious coping styles will mediate the associations between fear of COVID-19 and death depression and death anxiety. The structural model is presented in Figure 1.

**Method**

**Participants**

This study included 390 Turkish-speaking young adults from the general public in Turkey. Participants were 66.15% females and ranged in age from 18 to 50 years ($M=30.85$, standard deviation ($SD$)=$10.19$). More than half of the participants (53.08%) were single, followed by married (45.64%) and divorced/separated (1.28%). They self-identified their socioeconomic status (SES) as follows: below average = 85.64% and average = 14.36%. Of the participants, 17.95% of them tested positive for COVID-19 (see Table 1).
Fear of COVID-19. Fear related to COVID-19 disease was assessed using the Fear of COVID-19 Scale (Ahorsu et al., 2022). This self-report scale includes seven items scored on a Likert-type scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). A total score was calculated, with higher scores indicating greater fear associated with infectious disease. The scale was validated in Turkish by Satici et al. (2021). In this study, Cronbach’s $\alpha$ was .89.

Death distress. Death distress was evaluated using the Death Distress Scale (Dadfar & Lester, 2020). The scale includes nine self-reported items with three dimensions: death depression, death anxiety and death obsession. In this study, we focused only on death depression and death anxiety. Total scores for death depression and death anxiety were calculated, with higher scores indicating greater depression and anxiety corresponding to death. Psychometric properties of the scale in

![Figure 1](image_url). Mediation model depicting the associations between variables.

*p < .05, **p < .001.

Table 1. Characteristics of the sample.

| Variable                        | Group          | Frequency | Percentage |
|---------------------------------|----------------|-----------|------------|
| Gender                          | Male           | 132       | 33.85      |
|                                 | Female         | 258       | 66.15      |
| Marital status                  | Single         | 207       | 53.08      |
|                                 | Married        | 178       | 45.64      |
|                                 | Divorced/separated | 5    | 1.28        |
| Economic level                  | Below average  | 334       | 85.64      |
|                                 | Above average  | 56        | 14.36      |
| COVID-19 experience             | Yes            | 70        | 17.95      |
|                                 | No             | 320       | 82.05      |
Turkish were examined by Yıldırım and Güler (2021). In this study, Cronbach’s α was .84 for death depression and .91 for death anxiety.

**Religious coping.** Religious coping was measured using the Religious Coping Scale (Abu Raiya et al., 2008). This is a 10-item scale that includes two subscales (five items per subscale). A total score for each subscale is computed, with higher scores indicating greater positive and negative religious coping. The scale was adapted into Turkish by Ekşi and Sayın (2016). In this study, Cronbach’s α was .87 for positive religious coping and .90 for negative religious coping.

**Procedure**

A web-based online questionnaire was created utilizing an online application. A secure link was generated and advertised on social media sites which enabled us to collect data from a diverse population. Before taking part in the survey, the participants were fully informed about the purpose of the study and their rights during and after the study. An online consent was obtained from all participants. Anonymity and confidentiality of responses were assured. Participants were not compensated for their time to complete the online questionnaire. The questionnaire was administered during the second wave of the pandemic in Turkey. All the scales were presented in the same order. All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. The study protocol was reviewed and approved by Ağrı İbrahim Çeçen University.

**Data analysis**

As participants were required to answer all questions, there were no missing values in the dataset. Descriptive statistics including mean, SD, skewness and kurtosis were reported. Pearson product–moment correlation was computed to explore the relationships between the analyzed variables. SPSS macro-PROCESS (A. F. Hayes, 2013) was employed to carry out the mediation analyses. The bootstrapping method with 10,000 resamples to estimate the 95% confidence intervals (CI) was performed to show the significance of indirect effects. All data were analyzed using SPSS version 25 for Windows.

**Results**

Descriptive analyses showed that skewness and kurtosis values ranged from –0.27 to 1.28, suggesting that the analyzed variables in this had a relatively normal distribution (see Table 2). The results of correlation analysis indicated that fear of COVID-19 had a significant and negative correlation with positive religious coping and significant positive correlations with negative religious coping, death anxiety and death depression. Positive religious coping was also significantly and negatively related to negative religious coping. There was significant positive correlation between negative religious coping and death anxiety and death depression. Death anxiety was significantly and positively correlated with death depression, as reported in Table 2.

Following performing preliminary analyses, a mediation analysis was conducted to investigate the mediating role of religious coping on the association between fear of COVID-19 and death distress (see Table 3). Findings from mediation analysis indicated that fear of COVID-19 significantly predicted positive religious coping ($\beta = -.11, p < .05$) and negative religious coping ($\beta = .21, p < .001$) by accounting for 1% of the variance in positive religious coping and 5% of the variance.
in negative religious coping. Fear of COVID-19 (β = .33, \( p < .001 \)) and negative religious coping (β = .13, \( p < .05 \)) significantly predicted death depression. They explained 15% of the variance in death depression. Furthermore, fear of COVID-19 significantly predicted death anxiety (β = .16, \( p < .001 \)) by accounting for 3% of the variance in death anxiety. Religious coping failed to predict death anxiety. In addition, the indirect effect of fear of COVID-19 on death depression through negative religious coping was significant (see Table 4). These results suggest that negative religious coping mediated the association between fear of COVID-19 and death depression. Standardized indirect effects are presented in Table 4.

### Discussion

This study examined the mediating effects of positive and negative religious coping styles on the association of fear of COVID-19 with death depression and death anxiety among young adults in Turkey. The results indicated that fear of COVID-19 was a predictor of positive religious coping and negative religious coping. These results suggest that young adults who experienced fear of COVID-19 use more negative religious coping and less negative religious coping in the face of adversity. The findings are in accordance with evidence from earlier research indicating the link between fear of COVID-19 and religious coping during the pandemic (Ghoncheh et al., 2021; Yıldırım, Arslan, & Alkahtani, 2022). Similarly, studies highlighted that fear is a typical psychological consequence derived from the pandemic (Yıldırım, Arslan, & Alkahtani, 2022), and people, who have excessive fears against perceived or real, experience greater challenges with adaptive coping and are occupied with maladaptive coping (Oti-Boadi et al., 2022).

Dysfunctional beliefs about fear of contracting the virus in the context of the COVID-19 pandemic are more likely to affect positive and negative religious coping styles in adulthood. Our beliefs and knowledge affect the way we behave, react or adapt to a new situation like the current COVID-19 pandemic. For example, irrational beliefs about COVID-19 were found to positively predict perceptions of vulnerability to the disease in the context of the COVID-19 pandemic (De Landsheer & Walburg, 2022).

Furthermore, findings from the study showed that fear of COVID-19 significantly predicted death depression and death anxiety. These findings suggest that young adults, who have difficulties in controlling fear of contracting the virus, suffer from symptoms of death depression and death anxiety. These results are consistent with those of previous studies demonstrating that greater fear of COVID-19 is positively associated with depression, anxiety and stress (Oti-Boadi et al., 2022;
Table 3. Unstandardized coefficients for the mediation model.

| Antecedent | Consequent | M₁ (Positive religious coping) | M₂ (Negative religious coping) | Y₁ (Death depression) | Y₂ (Death anxiety) |
|------------|------------|--------------------------------|--------------------------------|-----------------------|-------------------|
|            |            | Coeff. SE t p                  | Coeff. SE t p                  | Coeff. SE t p         | Coeff. SE t p     |
| X (Fear of COVID-19) | –0.05 .02 –2.25 .025 | 0.10 .02 4.32 .001 | 0.19 .03 7.11 .001 | 0.08 .03 3.03 .001 |
| M₁ (Positive religious coping) | – – – – – | – – – – | –0.07 .06 1.31 .192 | –0.08 .05 1.44 .150 |
| M₂ (Negative religious coping) | – – – – – | – – – – | 0.16 .06 2.57 .011 | 0.05 .06 0.93 .355 |
| Constant   | 10.05 .43 23.33 .001 | 6.66 .40 16.72 .001 | 3.26 .89 3.66 .001 | 7.93 .87 9.14 .001 |

SE: standard error; Coeff: unstandardized coefficient; X: independent variable; M: mediator variable; Y: dependent variable.
Yıldırım, Arslan, & Alkahtani, 2022) and negatively associated with well-being outcomes (Lathabhavan & Vispute, 2022). For example, a study with middle adults in Japan found that adults with higher levels of fear associated with disease reported greater levels of psychological distress in the context of the COVID-19 pandemic (Masuyama et al., 2022). These results indicate that fear of COVID-19 is detrimental to mental health outcomes including death distress.

In line with our mediation hypothesis, negative religious coping partially mediated the fear of COVID-19–death depression relationship. This supports the notion that fear of COVID-19 cultivates a negative religious coping style, which in turn leads to symptoms of death depression such as feeling sad when hearing the word death and dreaming of death. However, we do not argue that negative religious coping is the only mechanism underlying the fear of the COVID-19–death depression relationship; our mediation analysis shows that negative religious coping is a partial, not complete, mediator. Surely, there are other potential mediator variables that explain the fear of the COVID-19–death depression relationship. Consistent with these findings, past research indicated that dysfunctional coping strategies mediated the association between fear of COVID-19 and symptoms of depression (Oti-Boadi et al., 2022). Therefore, people with the fear of COVID-19 are more likely to engage in negative religious coping which can consequently improve mental health problems such as depression, anxiety and stress during health crises (Oti-Boadi et al., 2022; Yıldırım, Arslan, & Alkahtani, 2022).

However, we failed to provide evidence regarding the mediating role of positive religious coping in the fear of COVID-19–death depression relationship and fear of COVID-19–death anxiety relationship as well as mediating role of negative religious coping in the fear of COVID-19–death anxiety relationship. These results are relatively consistent with the findings of previous studies. For example, Yıldırım, Kızılgeçit, et al. (2021) reported that positive religious coping was not able to predict anxiety during the pandemic. Typically, there is a small correlation between positive religious coping and negative religious coping (Park et al., 2018). According to Yıldırım, Arslan, and Alkahtani (2022), positive religious coping and negative religious coping serve as different correlates and determinants of mental health problems. In line with this notion, earlier research individually investigated positive and negative religious coping in relation to mental health and well-being outcomes. Findings showed that unlike positive religious coping, negative religious coping was a much stronger and more consistent predictor of mental health and well-being outcomes (Ano & Vasconcelles, 2005; Pargament et al., 2000, 2001). As such, a positive religious coping–mental health relationship is not as clear as a negative religious coping–mental health relationship (Park et al., 2018). In the face of adversity, people largely use dysfunctional coping strategies to cope with life stressors due to the tendency of focusing on negative feelings, thoughts and behaviours rather than focusing on positive feelings, thoughts and behaviours in difficult times.

### Table 4. Standardized indirect effects and 95% bias-corrected confidence interval.

| Path | Effect | SE  | Boot LLCI | Boot ULCI |
|------|--------|-----|-----------|-----------|
| Total indirect effect | .11    | .01 | -.00      | .03       |
| Fear of COVID-19 → Positive religious coping → Death depression | -.00 | .00 | -.01      | .00       |
| Fear of COVID-19 → Negative religious coping → Death depression | .02    | .01 | .00       | .03       |
| Total indirect effect | -.01  | .01 | -.02      | .00       |
| Fear of COVID-19 → Positive religious coping → Death anxiety | -.00 | .00 | -.01      | .00       |
| Fear of COVID-19 → Negative religious coping → Death anxiety | .01    | .01 | -.02      | .01       |

Number of bootstrap samples for percentile bootstrap confidence intervals: 10,000. SE: standard error; LLCI: lower limit confidence interval; ULCI: upper limit confidence interval.
Implications and limitations

During the COVID-19 pandemic, people experienced a wide range of psychosocial and mental health challenges that warrants more attention and support from mental health professionals and policymakers. Psychological resources such as coping strategies provide a baseline for mental health professionals and decision-makers to develop interventions at individual, organizational and national levels where the death distress of people of different ages can be diminished during and after the pandemic. Given continuing effect of the COVID-19 pandemic restricting face-to-face communication to some extent, online training programmes can be conducted to support the psychological health of people using different methodology and therapeutic approaches such as online photovoice (Tanhan, 2020; Tanhan & Strack, 2020) and Acceptance and Commitment Therapy (S. C. Hayes et al., 2009; Tanhan et al., 2020). We found that using negative religious coping in the face of adversity exacerbates the impact of fear associated with the disease on the experience of death distress. These results are fruitful in tailoring resourceful psychological practices at a preliminary stage, particularly for people who experienced death distress as a result of fear of COVID-19. The use of negative religious coping can be discouraged to diminish the impact of pandemic-related stressors on psychological health in challenging times of health crisis. This is an all-hands-on-deck moment as such actions should be taken for the mental health of people, and they must be empowered with positive religious strategies to ensure positive mental health.

Despite the important implications of the current findings, several limitations need to be addressed. First, our research is a cross-sectional study; therefore, causality between the analyzed variables cannot be inferred. We suggest conducting studies with longitudinal design to confirm the dynamics of coping strategies at different stages of adversities. Second, our study includes adults across Turkey only and therefore may not be generalized to other adults or nations. Next, we investigated the effect of pandemic-related fear on death distress through religious coping strategies only. To make a comprehensive decision regarding the underlying mechanism among the research variables, strength-related factors seem to be important. Additional factors of individual psychological strengths and their effects on death distress should be investigated, as people have different strengths and strategies to cope with stressors and adverse conditions. For example, it would be fruitful to study the roles of psychological resilience and stress-related growth on mental health outcomes in the face of adversity like the current pandemic. Finally, future research should examine the possible effects of other stressors related to pandemics and mediators mitigating the effects of those stressors on well-being and mental health outcomes other than just death distress.

In conclusion, this study showed the importance of religious coping strategies and their mediating roles in the association between fear of COVID-19 and death distress in Turkish young adults. These preliminary findings should be taken into account in any interventional programme to improve the psychological health of people in the face of adversity.

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Author contributions

Murat Yıldırım conceived the research idea, made the research design, analyzed the data, interpreted the results and drafted the manuscript. Muhammed Kızılgeçit collected the data.

Data availability statement

The datasets generated during and/or analyzed during this study are available from the corresponding author on reasonable request.
Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

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Informed consent

Consent was obtained from all participants included in the study.

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