



**NEAR EAST UNIVERSITY
INSTITUTE OF GRADUATE STUDIES
DEPARTMENT OF NURSING**

**Determining the Anxiety Level on the Perception of COVID—19
Among the congregation of a church in Northern Cyprus**

M.Sc. THESIS

RAWLINGS ERHAUYI LAWANI

**Nicosia
May, 2022**

Rawlings Lawani

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MASTER

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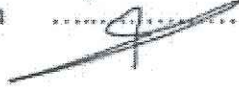
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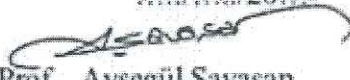
May, 2022

APPROVAL

We certify that we have read the thesis submitted by Rawlings Erhauyi Lawani titled “Determining the Anxiety Level on the Perception of COVID—19 Among the congregation of a church in Northern Cyprus” and that in our combined opinion it is fully adequate, in scope and in quality, as a thesis for the degree of Master of Educational Sciences.

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Declaration

I hereby declare that all information, documents, analysis and results in this thesis have been collected and presented according to the academic rules and ethical guidelines of Institute of Graduate Studies, Near East University. I also declare that as required by these rules and conduct, I have fully cited and referenced information and data that are not original to this study.

Rawlings Erhauyi Lawani

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Thank you!

Rawlings Erhauyi Lawani

Abstract

Determining the Anxiety Level on the Perception of COVID—19 Among the congregation of a church in Northern Cyprus.

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Aim: This study aims to determine the anxiety level of Perception of COVID—19 Among the congregation of a church in Northern Cyprus.

Materials and Methods: This research utilizes a cross sectional descriptive quantitative research design and The research targeted are (N=234) who are member of church and accept to be in research.

Data Collection: To collect data, a google form link was sent over to participants to answer a survey. The survey contained the socio demographic form and COVID-19 anxiety scale.

Results: The mean age of the participants was $27,86 \pm 5,32$ (min:19, max:45), 38,0% of them were in the female. 58,8% of the participants in the study are university student, 46,2% of participants also got a job.

Data Analysis: The data gathered through Google Forms was transferred to SPSS for statistical analysis which was used to present the demographic as well as clinical characteristics of the participants. A correlation test of distributions of the demographic information of the participants was carried out and an ANOVA t-test was conducted to determine the relationship between the variables.

Results and Discussion: The overall mean score that the participants received from the scale was judged to be 5,66 5,04 during the first lock down of the Covid-19 experiment. And the overall mean score was calculated to be 4,44 with a standard deviation of 3,29 during the past two weeks from now. There was a statistically significant difference (p 0.05) between the overall mean scores of the subjects on the "Covid-19 anxiety scale during lock down" and the scores they had received during the previous two weeks.

Conclusions The findings leave us with a conclusion that during the lockdown more participants were negatively impacted on their life. Based on these findings, policymakers can better manage the COVID-19 pandemic's impact.

Key Words: covid-19, anxiety, pandemic, mental Health.

TÜRKÇE ÖZET

Amaç: Bu çalışma, Kuzey Kıbrıs'ta bir kilise cemaatinde COVID-19 Algısı'nın kaygı düzeyini belirlemeyi amaçlamaktadır.

Gereç ve Yöntemler: Bu araştırma, kesitsel, tanımlayıcı bir araştırma deseninde olup, 234 (N=234) gönüllü kilise üyesi ile yapılmıştır.

Veri Toplama: Veri toplamak için katılımcılara bir google formu bağlantısı gönderildi. Anket sosyo demografik formu ve COVID-19 kaygı ölçeğini içeriyordu.

Bulgular: Katılımcıların yaş ortalaması $27,86 \pm 5,32$ (min:19, max:45) olup, %38,0'ı kadındır. Araştırmaya katılanların %58,8'i üniversite öğrencisi, %46,2'si de iş bulmuştur.

Veri Analizi: Verilerin analizinde SPSS programi kullanılmıştır. Katılımcıların demografik bilgilerinin dağılımlarının korelasyon testi ve değişkenler arasındaki ilişkiyi belirlemek için ANOVA t testi yapılmıştır.

Sonuçlar ve Tartışma: Covid-19 deneyinin ilk karantina sırasında katılımcıların ölçekten aldıkları genel ortalama puan 5,66 5,04 olarak değerlendirildi. ve genel ortalama puan, bundan sonraki iki hafta boyunca 3,29 standart sapma ile 4,44 olarak hesaplandı. "Kilitlenme sırasında Covid-19 kaygı ölçeği"ndeki deneklerin genel ortalama puanları ile önceki iki hafta boyunca aldıkları puanlar arasında istatistiksel olarak anlamlı bir fark (p 0.05) vardı.

Sonuçlar Bulgular: karantina sırasında daha fazla katılımcının hayatlarını olumsuz yönde etkilediği sonucuna varmamızı sağlıyor. Bu bulgulara dayanarak, politika yapıcılar COVID-19 pandemisinin etkisini daha iyi yönetebilir.

Anahtar Kelimeler: Covid-19, anksiyete, pandemi, ruh sağlığı.

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CHAPTER I

1. Introduction

On December 31 December 31, 2019, the World Health Organization reported the discovery of a new viral pneumonia strain originating in Wuhan, China (WHO, 2020a). As of March 23 March 23, 2020, this unique coronavirus (COVID-19) had rapidly spread over the world, infecting over 294,110 people in 187 nations and killing 12,944 people (WHO, 2020b)

SARS-CoV-2, now known as COVID-19, was declared a Public Health Emergency of International Concern by WHO on January 30, 2020. (WHO 2020c). COVID-19 was designated a worldwide crisis by WHO on March 11, 2020. pandemic, making it the first coronavirus to be declared a pandemic (WHO 2020c). As of this writing, 412 Million Virus cases have been recorded, with 5.82 Million death ("COVID Live - Coronavirus Statistics - Worldometer," 2022).

Public health and social interventions have been adopted worldwide to stop the spread of the disease. However, compliance with these procedures by the general public is critical to successfully limiting the epidemic.

1.1 Isolation and its effects

In the treatment and control of the virus, isolation of patients is essential to curb the spread of the disease. CDC (2022) explains isolation as a method of separating those who have COVID-19 verified or suspected from those who have not. Isolated people are usually required should stay at home until it is safe for them to interact with others. Anyone unwell or infected at home should keep to themselves or wear a well-fitting mask when they must be among others.

Social isolation though it curbs the spread of the virus, has been shown to have mental implications.

In actuality, isolation and quarantine have different definitions, but both entail a person being separated from their loved ones, typical activities, and routines for the goal of infection protection. The adverse effects of decreased physical activity and nutritional modifications increased the psychological impact of confinement and isolation. (Füzéki et al., 2020) Such alterations can have a significant and long-term psychological impact (Jassim et al., 2021).

Isolation, social distance, and quarantine are among the measures used to combat the Coronavirus illness 2019 (COVID-19). Quarantine and other forms of lockdown have shown promise in reducing COVID-19 infections and deaths (Füzéki et al., 2020).

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1.2 Anxiety and depression due to Covid-19

The high rate of transmission and death has caused not a little scare in different countries and communities worldwide as the outbreak has caused significant changes to the public's way of life. Although the government of nations have made substantial efforts to trace infection and spread of the disease across the globe and provided medical pieces of equipment to tackle to trace, cure and prevent the further spread of the disease and variants, the impact on the mental health of the public is not given as much attention.

For example,(Liu et al. (2020) & Lee S. (2020). reports in a recent large study of persons who are very sensitive to coronavirus infection (i.e., Chinese medical workers), the prevalence rate of traumatic stress was 73.4 percent, depression was 50.7 percent, generalized anxiety was 44.7 percent, and sleeplessness was 36.1 percent.

Kapetanios K. et al. (2021) showed using countrywide data to investigate the incidence of stress, anxiety, depression, and burnout among health care professionals in Cyprus who manage COVID-19 patients that the emergence of COVID-19 as a global pandemic has had a significant impact on the mental health of front-line healthcare personnel burnout among health care professionals in Cyprus who manage COVID-19 patients. The study also looks at the mechanisms that lead to the emergence of these illnesses to build more effective preventive measures.

Trumello C. (2020) tested medical professionals on anxiety, depression, psychological stress, professional quality of life (compassion satisfaction, burnout, and compassion fatigue), and attitudes toward psychological help. Professionals who worked with COVID-19 patients had significantly greater stress, burnout, secondary trauma, anxiety, and despair. Professionals working in locations with more excellent rates of contagion had higher levels of stress and burnout and lower levels of compassion satisfaction. There were no interaction effects between working (or not working) with COVID-19 patients and working (or not working) in locations with a more severe pandemic spread.

In the group of professionals who dealt with COVID-19 patients, the percentage of professionals who considered seeking psychological treatment was twice that of those who did not engage with COVID-19 patients. The overall findings suggest that the mental health of front-line healthcare professionals deserves more attention and specific preventative and intervention initiatives.

1.3 Social media influence on the COVID-19 Pandemic

Social media platforms have been a critical component in distributing knowledge, yet, there are several benefits and drawbacks to consider (González-Padilla & Tortolero-Blanco, 2020).

"Our shared adversary is #COVID-19, but our opponent is also an 'infodemic' of disinformation," said António Guterres, Secretary-General of the World Health Organization, on March 27. To combat the #coronavirus, we must spread facts and research as soon as possible" (United Nations, 2020). Therefore, it is critical to develop effective social media tactics that deliver accurate information regarding COVID-19 prevention measures.

Social Media has the potential for public misinformation on preventive and corrective measures against COVID-19.

According to a recent analysis analyzing media habits during the Pandemic, 40% of individuals use social media for news now than they did before COVID-19 (Havas Media Group, 2020). However, even though people consume more news on social media, a recent poll by Axios-Harris found that out of 13 different sources of news, respondents said they trusted news or information posted on social media the least (Harris Insights and Analytics, 2020).

1.4 Roles of nurses in curbing COVID-19

During the COVID-19 Pandemic, nurses have significant roles and duties. They will continue to be on the front lines of patient treatment in hospitals and actively participate in community assessment and monitoring. In addition, nurses must ensure that all patients acquire personalized, high-quality services irrespective of their infectious condition. They will also plan for anticipated COVID-19–related outbreaks, which

increase the demand for nursing and healthcare services that might affect overload systems (Fawaz et al., 2020).

The COVID-19 epidemic delivered a hard lesson about the interconnectivity and fragility of the numerous systems we rely on every day. The most severely damaged system was health care, and the function of caregivers inside that system emerged as a centerpiece. For the first time, many people realized why nurses are critical to patient care and community health. Nurses' involvement, as well as their expertise in shepherding patients through a pandemic, will continue to be crucial in restoring public health and planning for the following health catastrophe, if and when it occurs (Elmhurst University, 2021)

1.5 Correcting Side Effects of COVID -19

The side effects of covid-19 may range from the physiological effects of isolation and misinformation from social media. The Covid-19 epidemic put people under much stress for a long time. As a result, academics have become more interested in evaluating social and communal unrest to provide psychological help to the general public. This enhanced focus might aid in the management of the current crisis and any potential epidemics and pandemics. Individuals' reactions to the security measures used to combat the epidemic varied depending on the social position they played. Because they are more susceptible to stress, certain people appear to be at a higher risk of experiencing anxious, depressed, or post-traumatic symptoms (Orgilés et al., 2020)

1.6 Aim of the Study

In this thesis, the researcher will test the impact of the Perception of Covid-19 on the anxiety level and mental health of Christian Community in Cyprus. Studies have shown that the pandemic has had a negative effect on the mental health of medical practitioners and patients alike with difference in country rates. This study however, focuses on the

effects on the mental health of christian community in (TRNC).there is no available literature about the spread of coronavirus amongst the Christian community in Cyprus, therefore, this thesis seeks to refill that gap and to ensure that awareness, quality education, and societal health is maintained in the global fight against COVID-19.

1.7 Research Questions

1. What is the anxiety level of Cyprus Christian Community during Covid-19 pandemic?
2. Is there any correlation between socio-demographic characteristics and anxiety level of Cyprus Christian Community durinf Covid-29 pandemic?

1.8 Scope Of The Study

In this thesis, the researcher will test the impact of the Perception of Covid-19 on the anxiety level and metal health of Christian Community in Cyprus. Studies have shown that the pandemic has had a negative effect on the mental health of medical practitioners and patients alike with difference in country rates. This study however, focuses on the effects on the mental health of Christian community in Cyprus.

CHAPTER TWO

LITERATURE REVIEW

Preamble

This chapter conducted a literature study on determining the anxiety level on the perception of COVID—19. The pertinent ideas, theories, and empirical review were conducted in order to offer an understanding of the research in order to have a good analysis to improve decision making, conclusion, and suggestions.

Concept of Anxiety

The most frequent mental health condition in our culture is anxiety. Anxiety disorders are assumed to be caused by a malfunction in the brain's emotional processing center rather than the higher cognitive centers. The limbic system of the brain, which includes the hippocampus, amygdala, hypothalamus, and thalamus, is in charge of the majority of emotional processing. Individuals suffering from anxiety disorders may exhibit increased activity in these locations (Alam, 2020). Anxiety is a subjective sense of tension, uncertainty, uneasiness, and concern connected with stimulation of the nervous system (Spielberger, 1983). A high degree of anxiety makes it difficult for a person to live a regular life, since it interferes with activities and social interactions. Anxiety is one of the many types of emotional and behavioural problems (Rachel and Chidsey, 2005).

According to (CHOC.org, 2019), there are several forms of anxiety disorders, these include Phobias which is an extreme, illogical dread of a scenario, live being, location, or item is a form of anxiety disorder (Legg, 2020) . , Generalized Anxiety, panic Disorder (PD), social anxiety Disorder, Obsessive Compulsive Disorder (OCD) and

Post Traumatic Stress Disorder (PTSD), Separation Anxiety Disorder.

Anxiety disorders are now the most prevalent kind of mental disease in the United States, impacting around 40 million individuals, or almost one in every five people.

According to the World Health Organization (WHO), there are nearly 300 million individuals throughout the world who suffer from some kind of anxiety illness (Tim Newman, 2018).

Anxiety is a frequent and unwelcome visitor in the lives of many people, including those in our social circles, within our families, and in our communities as a whole.

It creates a low-level hum that lurks in the crevices of our collective consciousness, and it appears to be spreading across society like a non-contagious cognitive disease.

Barnes & Noble, the biggest book shop in the United States, reported in August 2018 a significant increase in the number of books that were sold; the increase was equivalent to a 25 percent increase compared to June 2017. According to a wry observation made in a recent press release, "[w]e may be living in an uneasy country (Newman, 2018a)."

Generalized anxiety disorder, often known as GAD, is characterised by abnormally high levels of concern and anxiety that are disproportionate to the circumstances of one's ordinary life. People who suffer from the symptoms of generalised anxiety disorder have a tendency to constantly anticipate the worst-case scenario and are unable to stop worrying about their health, finances, families, jobs, or schools (Casarella, 2021).

They have an ongoing and excessive preoccupation with a variety of various sources of anxiety. People who suffer from GAD may have an unrealistic fear of negative outcomes and may worry excessively about their finances, health, families, jobs, and other aspects of their lives. People who suffer from generalised anxiety disorder have

trouble keeping their worries in check. It's possible that they worry more than is justified about actual occurrences, or that they anticipate the worst possible outcome even when there is no obvious cause to be concerned (Anxiety & Depression Association of America, 2019).

GAD and PD are often misdiagnosed, with symptoms commonly attributed to physical reasons. Identifying confounding factors and concomitant diseases is critical in GAD and PD diagnosis. Screening and monitoring technologies may assist diagnose and track therapeutic response. The GAD-7 and the Panic Severity Scale are free diagnostic tools. Depending on the patient, a variety of therapy techniques may be required. Medication (such as selective serotonin reuptake inhibitors) and/or psychotherapy are often used in treatment. CBT is one of the most researched psychotherapy therapies (Locke, Kirst, & Shultz, 2015) .

A diagnosis of GAD is made when a person exhibits three or more symptoms, including difficulty controlling concern on more days than not over a period of at least six months, and meets the diagnostic criteria. This distinguishes generalised anxiety disorder (GAD) from concern that may be associated with a particular stress or event for a shorter length of time.

Yang et al., (2021) shows that In 2019, it was estimated that there were 45.82 million incident cases of anxiety disorders (with a 95 percent uncertainty interval (UI) ranging from 37.14 million to 55.62 million), 301.39 million prevalent cases (with a 95 percent UI ranging from 252.63 million to 356.00 million), and 28.68 million disability-adjusted life years (DALYs). The current absolute number of anxiety disorders has grown by 50 percent since 1990, despite the fact that the total age-standardized burden rate of anxiety disorders has remained steady over the previous three decades. We found enormous differences in the age-standardized burden rate as well as the increasing trend

of anxiety disorders depending on the gender, nation, and age of the patient. In 2019, bullying victimisation was responsible for 7.07 percent of the worldwide DALYs owing to anxiety disorders. This was mostly the case among the population aged 5–39 years old, and the percentage grew in practically all countries and territories compared to 1990.

In addition to being the most common mental diseases, anxiety disorders are connected with significant health care expenses and a high disease burden. Anxiety disorders impact up to 33.7% of the population, according to major community-based studies. These illnesses are grossly underdiagnosed and undertreated. Anxiety disorder prevalence rates have not altered in recent years. Prevalence rates vary greatly among cultures. This diversity is more likely attributable to methodological variations than cultural effects. Anxiety disorders are persistent, although their prevalence naturally decreases with age. Anxiety disorders and other mental problems are highly comorbid (Bandelow & Michaelis, 2015). In any given year, GAD affects 6.8 million individuals, which is equivalent to 3.1 percent of the population of the United States. Women have a more than twofold increased risk of being afflicted. The onset of the condition is slow and may occur at any point in one's life; however, the risk is greatest between the ages of 10 and 30. There is evidence that biological variables, family history, and life events, especially stressful ones, have a role in the development of generalised anxiety disorder (GAD), despite the fact that the precise origin of GAD is unclear (Anxiety & Depression Association of America, 2019). In a review of 32 studies carried out by (William C, Megan J, Lindsay A, & Jeanette A, 2019), Many studies showed a link between religious practises such as religious instruction or spirituality or faith or prayer or worship and decreased anxiety (stress). A variety of patient demographics were

shown to have these effects. Religious-based therapeutic interventions have been shown to be effective in treating anxiety.

Conversely, Among the 7235 papers screened by (Forouhari et al., 2019), 13 publications with 5620 participants fulfilled inclusion criteria for this meta-analysis.

The correlation value was -0.08 (95 percent confidence interval [CI] = -0.19, -0.03), indicating that anxiety and sadness decreased (P 0.001) with increased religious inclination. Characteristics like sex and religion might have contributed to a lack of homogeneity among participants. The corrected pooled r of 0.06 (95 percent CI= 0.16, 0.04) was derived using the fill-and-trim approach. A lack of connection between religious inclination and mental health issues was found in the study.

Positive internal spirituality/religion (S/R) thoughts and feelings predict less anxiety, whereas negative internal S/R thoughts and emotions predict more anxiety symptoms. Conversely, visible S/R actions are marginally related with anxiety, and the impact direction is unknown(Bethany & David H, 2020) .

Rosmarin & Leidl, (2020) showed that anxiety symptoms may be linked to S/R's behavioral aspects such as the number of times they attend religious services and the amount of time they spend in prayer. A number of studies have found positive correlations, others have found negative correlations, and still others have found no correlation at all. Anxiety is much more strongly and consistently associated with S/R internal aspects like beliefs, attitude and motivation. Lower levels of anxiety are strongly linked to a variety of positive beliefs, including a stronger faith in God, a more secure religious attachment, an intrinsic religious drive, and religious gratitude, all of which have effect sizes ranging from the medium to large. When it comes to anxiety symptoms, negative S/R attitudes and beliefs, such as a belief in punishment for God,

a lack of faith in God, fear of God, and extrinsic religious motivation, all have a strong correlation with clinical and statistically significant increases in anxiety.

Anxiety and The Covid-19 Pandemic

Prior to the year 2020, mental disorders were the leading causes of the burden that was placed on global health, with depressive and anxiety disorders being the leading contributors to this burden (Santomauro et al., 2021).

According to a scientific brief that was released today by the World Health Organization (WHO) , the global prevalence of anxiety and depression increased by a massive 25 percent in the first year of the COVID-19 pandemic. (World Health Organization, 2022). The unprecedented stress brought on by the social isolation brought about by the pandemic is one of the primary factors that can help to explain the increase. People's capacities to work, seek support from loved ones, and participate in their communities were all hindered as a direct result of this issue.

It has been suggested that loneliness, fear of infection, suffering and death (both for oneself and for loved ones), grief following a loss, and worries about one's financial situation are all stressors that can lead to anxiety and depression. There has been a significant correlation between exhaustion and suicidal ideation in the healthcare workforce.

The pandemic has had a negative impact on the mental health of young people, and there is a disproportionately high risk of self-harming and suicidal behaviours among this age group. It also indicates that women have been impacted more severely than men and that people with pre-existing physical health conditions, such as asthma, cancer, and heart disease, were more likely to develop symptoms of mental illness as a result of being exposed to the virus. This rise in the incidence of mental health issues has occurred at the same time that severe disruptions have been made to mental health

services, which has resulted in significant care deficits for those who are in the greatest need of it. The services for mental, neurological, and substance use conditions were the ones that were disrupted the most out of all of the essential health services that were reported by WHO Member States throughout the majority of the pandemic. Major disruptions in life-saving services for mental health, including those aimed at preventing suicide, have been reported in a number of different countries.

At the end of the year 2021, the situation had somewhat improved, but even now, far too many people are unable to obtain the treatment and assistance they require for either pre-existing mental health conditions or newly developed mental health conditions.

Because they were unable to get care in person, many people have turned to the internet for assistance. This indicates that there is an immediate need to make trustworthy and efficient digital tools readily available and easy to get to. However, there is still a significant obstacle to overcome when it comes to the creation and implementation of digital interventions in settings and countries with limited resources. disorders.

According to the available data, it does not appear that individuals who have a history of mental illness are more likely to become infected with COVID-19 than others. In the event that these individuals do become infected, however, they have a higher risk of being hospitalised, experiencing severe illness, and passing away compared to people who do not have mental disorders. People who suffer from mental disorders that are more severe, such as psychoses, and younger people who suffer from mental disorders are at an increased risk.

Theoretical framework

One theory is that worry, a characteristic of generalised anxiety disorder, is a major element in the generation of threat-related information processing biases in attention,

memory, ambiguous interpretation and problem solving. But worry and cognitive biases aren't specific to generalised anxiety disorder (Aikins & Craske, 2001).

The underpinning theory of this study is the cognitive theory of anxiety disorders.

Anxiety disorders are characterised by a disruption in information processing that is at the root of anxiety vulnerability and anxiety maintenance. This disruption can be understood as a preoccupation with or "fixation" on the idea of potential threats, as well as an associated underestimation of the individual's capacity to deal with those threats (Beck, Emery, & Greenberg, 1985). Both the assumptions and ideas that make up anxious schemas (i.e., the content of anxious people's negative automatic thoughts), as well as the worried schemas themselves, are centred on the idea that one is in danger. The themes of loss and self-devaluation in depressive negative automatic thoughts (e.g. Beck, Rush, Shaw & Emery, 1979; Beck 1987) contrast with the predominance of danger-related thoughts in the stream of consciousness of anxiety patients (e.g. Beck, Laude & Bohnert, 1974a; Hibbert, 1984; Rachman, Lopatka & Levitt, 1988). This contrast provides the basis for the content-specificity hypothesis, which states that anxiety

Anxiety disorder is characterised by an exaggerated perception of potential threats while simultaneously underestimating one's capacity to deal with challenging circumstances (Themes, 2016). This behaviour is a direct result of the activation of underlying danger schemas, as described in the following quote: "The locus of the disorder in the anxiety states is not in the affective system but in the hypervalent cognitive schemas relevant to danger that are continually presenting a view of reality as dangerous and the self as vulnerable." (The anxiety states are characterised by an ex (Beck, 1985, p. 192). When threat assessments are triggered, a multitude of feedback

loops keep anxiety at a constant level. Certain anxiety symptoms might really be dangerous in and of themselves. They may, for instance, have a negative impact on performance or be perceived as an indication of a severe mental or physical condition. These effects lead to a rise in the subjective feeling of vulnerability, and as evaluations of the level of risk grow, primitive anxiety responses also increase. These reactions, in turn, add to unfavourable responses and evaluations, and so on.

Dysfunctional schemas

Schema is a cognitive framework. But under the schema theory of emotional disease, it's the content of these structures that matters. Beck's approach considers two sorts of schema-level knowledge: beliefs and assumptions. 'I'm a failure; I'm useless; I'm weak; I'm inferior') and are regarded as absolute facts about oneself and the universe. 'If I exhibit indications of anxiety, others will think I'm inferior; having terrible thoughts indicates I am a horrible person; unexplained bodily symptoms are generally a sign of severe sickness; If I can't manage my anxiety, I am a total failure'. Assumptions are presented as 'if-then' propositions (e.g. 'if I exhibit indications of anxiousness, then everyone will reject me').

Maladaptive schemas are thought to be more rigid, inflexible, and solid than normal schemas (Beck, 1967). A schema's content is supposed to be disorder-specific. Anxiety schemas therefore incorporate assumptions and perceptions about personal domain threat (Beck et al., 1985) and impaired capacity to cope. Such as panic (Clark, 1986), social phobia (Clark & Wells, 1995) and GAD (Wells, 1995), these models highlight more specific motifs in evaluation and schemas related to problem maintenance. Views about general incapacity to cope, as well as positive and negative beliefs about worrying itself, have been linked to generalised anxiety disorder (Wells, 1995). In panic disorder,

where individuals tend to catastrophically misread physical sensations, assessments and assumptions about the threat of anxiety symptoms and other bodily occurrences prevail (Clark, 1986). Individuals with particular phobias equate a scenario or item with danger and anticipate unpleasant outcomes when exposed to the phobic stimuli (Beck et al., 1985).

It is not always the case that early experiences lead to problematic assumptions and ideas. For example, in panic disorder, faulty assumptions may form after the first panic episode, rather than before to it (Clark, personal communication). Disruptive assumptions are likely to be made if the individual is persuaded to think that panic episodes might have unfavourable outcomes such as fainting or is given uncertain information about his or her health. Patients with generalised anxiety tend to have mixed feelings about worrying (Wells, 1995). Positive ideas about worrying often form early on, whereas negative views about worrying often arise later, maybe when efforts to regulate stress fail. After failing to follow personal social self-regulation criteria, some patients acquire unfavourable preconceptions about the social self (Clark & Wells, 1995; Wells & Clark, 1997). In other circumstances, bad social self-perceptions might be linked to early shyness and timidity.

Anxiety assumptions or 'rules' impact people's judgments and behaviour. For example, a socially anxious patient may conclude that 'I should speak as little as possible to disguise my uneasiness', leading to the self-instruction 'Don't talk much; try to seem comfortable'. These assumptions, situational assessments, and behavioural imperatives are visible here. As stated later in this chapter, faulty appraisals and assumptions

frequently lead to behavioural reactions that maintain belief in threat (Salkovskis, 1991; Wells et al., 1995b).

Negative automatic thoughts, worries and obsessions

Automatic thoughts (Beck, 1967), self-statements (Meichenbaum, 1977), and concern (Beck, 1967) are all categories for cognition in emotional illnesses (Borkovec, Robinson, Pruzinsky & De Pree, 1983a). Activation of negative automatic thoughts in Beck's schema theory of anxiety. Automated negative assessments or interpretations of events may be linked to behavioural and emotional reactions. However, in schema theory, negative automatic thoughts are supposed to represent cognitive processes that modify and perpetuate worry.

Beck and colleagues (e.g. Beck et al., 1985) describe negative automatic thoughts as quick negative ideas that may arise outside of immediate awareness yet are susceptible to consciousness. They might be spoken or imaginary and are believed at the moment. Anxiety disorders allow for differentiation of thinking kinds. Worry and obsessions are distinct from unpleasant automatic thoughts. Wells (1994a) recommends categorising these modes of cognition. Worry may be separated from negative automatic thoughts, and both can be distinguished from obsessions (Wells, 1994a; Wells & Morrison, 1994). A chain of negatively affective thoughts aiming at issue solutions is outlined by Borkovec et al. (1983). Borkovec et al. (1983a) claim that concern is primarily a verbal process, although negative automatic thoughts may be both verbal and imaginal. Obsessions are ego-dystonic, but anxieties and NATs are not—that is, they are seen as meaningless and foreign to the self-concept. For example, a mother may consider

killing her newborn kid despite her determination not to. In general, NATs and anxieties are assessments of events, while obsessions are intrusive mental experiences that are appraised. Obsessions might be drives or ideas (e.g. Parkinson & Rachman, 1981). Obsessions (Rachman & de Silva, 1978; Salkovskis & Harrison, 1984) and worries (Wells & Morrison, 1994) are common (Wells & Morrison, 1994). Wells and Morrison (1994) evaluated two-week-old typical anxieties and obsessions in non-patients. On average, these two ways of thinking differed significantly. Worries were judged as being more vocal than obsessions, lasting longer (9 minutes vs. 2 minutes), less involuntary, and more realistic.

Behavior's role

The cognitive system encourages caution by provoking self-doubts, negative appraisals, and negative expectations. Somatic symptoms include unsteadiness, faintness, and weakness. Beck et al. (1985) suggest this is part of a basic survival strategy designed to reduce risk-taking and increase self-protection. In other cases, such as social settings, these reactions might exacerbate the threat (i.e. they interfere with social performance).

The schema model emphasises automatic and reflexive anxiety responses, although volitional anxiety responses also play a role in the maintenance of dysfunction. According to Wells and Matthews (1994), many cognitive and behavioural reactions to threat are active (at least initially) implemented and adjusted by the person to defend against danger. Sadly, some of these reactions are harmful, perpetuating danger and preventing clear disconfirming of dysfunctional beliefs and assumptions (Salkovskis, 1991; Wells et al., 1995b). For example, a social phobic afraid of rambling and talking

incoherently in public may concentrate on themselves and their spoken words. In addition to this cognitive self-monitoring method, one might mentally rehearse content to be uttered before speaking to ensure it sounds appropriate. These 'safety habits' (Salkovskis, 1991) are aimed to prevent dreaded occurrences. Anxiety is maintained through safety behaviours. For example, a person experiencing a panic attack and anticipating a disaster such as fainting may act to avert the catastrophe by sitting or relaxing. Intentionally or not, the behaviour maintains the belief in the disaster. Under these circumstances, each fear becomes a 'near-miss' rather than a denial of belief, and danger may seem more apparent. In certain cases, safety behaviours not only avoid disconfirmatory events, but also intensify symptoms, reinforcing trust in risk assessments. In social phobia, trying to mentally filter one's own speech interferes with comprehending crucial components of the situation and with perceived verbal fluency, resulting to low performance ratings (e.g. Wells et al., 1995b). Similarly, suppressing some sorts of thoughts increases the frequency of unwanted thoughts (Wegner, Schneider, Carter & White, 1987). Anxiety disorders such as obsessive compulsive disorder and generalised anxiety disorder may be affected by this impact. To regulate or repress obsessions or fears might aggravate these thoughts. In summary, safety behaviours likely maintain anxiety through many pathways:

1. Strict safety measures worsen physiological symptoms, which may be seen as proof of impending disasters. Controlling one's breathing, for example, might cause hyperventilation and respiratory alkalosis. Controlling specific ideas may lead to greater attention with thoughts and decreased control evaluations.
2. The absence of feared consequences may be ascribed to safety behaviour rather than to the absence of disaster.

3. Safety behaviours like enhanced threat alertness and reassurance seeking increase exposure to danger-related information that reinforces negative thoughts. As a result of multiple physician consultations, the health-anxious patient may be exposed to conflicting and unclear information. Thus, evidence indicating 'doctors tend to overlook severe sickness' improves risk assessments and disease conviction.

4. Safety behaviours may pollute social circumstances and negatively impact relationships. A social phobe who avoids eye contact and says nothing about themselves is tough to converse with. This may cause individuals to avoid social phobia sufferers. This impact might be regarded by the social phobic as proof that others believe they are stupid. These behaviours are linked to distinct social phobia worries, according to Wells et al (see Chapter 7 and the rating scales in the Appendix for examples).

Mental prejudices

Dangerous schemata induce biases in information processing. These biases typically distort events in ways that align with dysfunctional schemas. Thus, unfavourable thoughts and judgments persist. Processing biases include selective attention for threat-related content and biases in event interpretation.

Cognitive distortions are a term coined by Beck and associates (1989) and Burns (1989). (Beck et al., 1979, 1985; Beck, 1967; Burns, 1989). Common blunders or distortions include:

Inference made without appropriate evidence.

Selective abstraction: focusing on one facet of a situation while neglecting others.

Overgeneralization: Extrapolating a conclusion from a few discrete occurrences or scenarios.

Increasing or decreasing the significance of events: Minimisation is the same as dismissing the advantages.

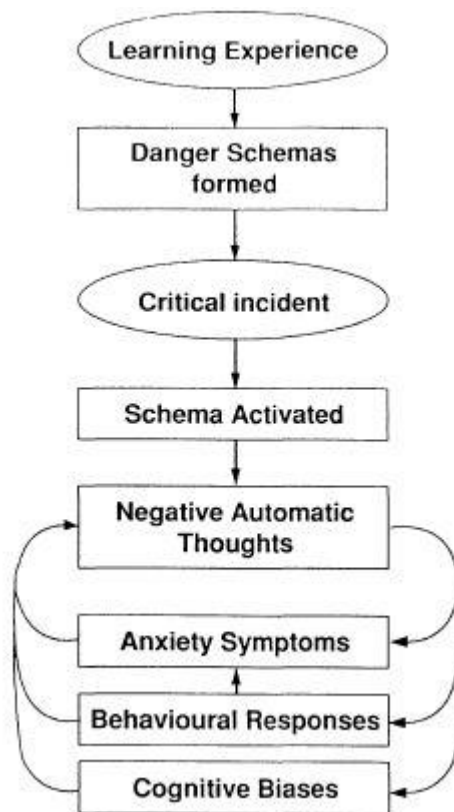
Personalising: Associating external occurrences with oneself without cause.

Catastrophising: focusing on the worst potential scenario and overestimating the likelihood of it happening.

Mind reading: Assuming others dislike you when there is no proof.

Consider the case of a socially anxious individual conversing with a work colleague. The coworker abruptly ends the chat and departs. “He thinks I’m an idiot, he doesn’t like me,” the social phobe may perceive. These assessments are arbitrary inference and mind reading. The social phobe is preoccupied with negative ideas about ‘appearing dull and foolish’, and fails to detect positive signals from the work colleague, or dismisses them as proof that he is ‘just trying to be kind’. In this case, negative information is abstracted, whereas positive information is either not processed or is disregarded due to attention and inference biases.

Figure 2.1 Generic cognitive theory of anxiety disorder



Empirical Study

According to the findings of the COVID-19 Mental Disorders Collaborators, the pandemic was responsible for a 276 percent increase in the number of cases of major depressive disorders and a 256 percent increase in the number of cases of anxiety disorders around the world in the year 2020 (Daly & Robinson, 2022) .

Porter, Favara, Hittmeyer, Scott, Sánchez Jiménez, et al., (2021) found that Similar to COVID-19 mortality rates, rates of at least mild anxiety symptoms (depression) were highest in Peru at 41 percent (32 percent) (95 percent CI 38.63 percent to 43.12 percent ; (29.49–33.74)) and lowest in Vietnam at 9 percent (9 percent) (95 percent CI 8.16 percent to 10.58 percent ; (8.33–10.77)). Women were disproportionately affected in every country except Ethiopia. Pandemic-related stressors, such as health risks/expenses, economic adversity, food insecurity, and disruptions to education or employment, were risk factors for anxiety and depression, although their importance

varied by country. Prior parent-child and peer-to-peer relationships were protective factors, whereas chronic health or emotional problems are risk factors.

Santomauro et al., (2021) found an increased prevalence of major depressive disorder (regression coefficient [B] 0.9 [95 percent uncertainty interval 0.1 to 1.8; p=0.029] for human mobility, and 1.81 [79 to 283; p=0.0005] for daily SARS-CoV-2 infection), as well as anxiety disorders (regression coefficient [B] 0.9 [0.1 to 1.7; p=0.022] and The pandemic was found to have had a greater impact on younger age groups and females than it did on males (B 0.1 [0.1 to 0.2; p=0.0001] for major depressive disorder, 0.1 [0.1 to 0.2; p=0.0001] for anxiety disorders), and the pandemic had a greater impact on younger age groups than it did on older age groups (0.007 to 0.009). The study estimated that the regions that were hit the hardest by the pandemic in 2020, as measured by decreased human mobility and the daily SARS-CoV-2 infection rate, had the greatest increases in the prevalence of major depressive disorder and anxiety disorders. This was based on the fact that these regions also had the highest rates of infection with SARS-CoV-2. The study estimated that the COVID-19 pandemic caused an increase of 53.2 million additional cases of major depressive disorder worldwide, bringing the total prevalence up to 3152.9 cases (ranging from 2722.5 to 3654.9) per 100 000 people.

This represents an increase of 27.6 percent (25.1% to 30.3%). The study also estimated that there were an additional 76.2 million (64.3 to 90.6 million) cases of anxiety disorders in the world (an increase of 25.6 percent [23.0 to 28.0]), making the total prevalence of anxiety disorders 4,802.4 cases (4108.2 to 5588.6 million) per 100 000 people. Both major depressive disorder and anxiety disorders were responsible for a combined total of 49.4 million (36.6 to 68.7) disability adjusted life years (DALYs) worldwide in the year 2020 (Santomauro et al., 2021).

Chang et al., (2021) discovered at the wake of the COVID-19 pandemic, 12.3 percent of frontline healthcare professionals in general hospitals reported experiencing mental discomfort, and they assessed themselves to have a poorer social adaption status than their counterparts in psychiatric institutions. Christians and Catholics reported higher levels of psychological well-being, but Buddhists and Taoists were much less likely to suffer feelings of mental discomfort. Following up with the participants for a total of six weeks revealed that the reported poorer social adaption status of general hospital healthcare personnel was only transient and that it had improved with time. Both time and Christian or Catholic religion had good impacts on an individual's psychological well-being; however, the combination of Christian or Catholic religion and time had a negative influence on an individual's psychological well-being.

CHAPTER III

METHODOLOGY

Research Time and Design

The research was conducted between 20 June - January 2022, as a cross-sectional type.

Population and Sampling of Research

Samples of international students were obtained in Gospel Pillars International Church. The population of the research consists of N=250 students. The sample of the population was calculated according to the known sample formula and was determined as n=196 people. The study was conducted with n=234 people who agreed to participate in the study. This study was conducted at 0.5% confidence interval and 95% confidence level.

Data Collection Tools

Data were collected using the 'Socio-Demographic data form' and 'Covid-19 Anxiety Scale (CAS)'. The "Socio-demographic data form" was prepared by the researchers by the literature. 'Socio-demographic data form' was made up of 10 questions which were meant to determine their status and ensure they met the inclusion criteria for assessment. These questions were meant to determine their age, sex, marital status etc. The personal identification form questioner was also meant to forecast the participant's reactions to the *Corona Anxiety Scale (CAS)*; It is a scale consisting of 5 items developed by Lee in 2020. considering the fact that previous studies have shown that there is a direct relationship between the participant's status and their reaction to the CAS. The personal identification form therefore gave a guide to the nature of the

response in the CAS. This pattern of scaling is in line with the DSM-5's cross-cutting symptom measure. A total score of ≥ 9 on the CAS scale is indicative of a possible defective coronavirus-related anxiety. The scale consisted of 5 items in a five-point scale (*0=not at all, 1=rare, less than a day or two, 2=several days, 3=more than 7 days, 4=nearly every day over the last 2 weeks*). The lowest score to be taken from the scale is 0, and the highest score is 20. The Cronbach's alpha coefficient of the CAS is 0,92. The Cronbach's alpha coefficient in this study was determined to be 0.79.

Application of Research

The data were collected by the researchers for about 15 minutes by using 'Google Form. The two forms were administered to the participants via online social platforms and this was particularly necessary in order to avoid direct contact with the students and coupled with the fact that the restrictions placed in the country would have had a limiting effect on distribution and retrieval. The identities of the participants were also concealed in order to give confidentiality to their responses.

Inclusion Criteria

- ✓ Those who volunteered to participate in the study.

Exclusion Criteria

- ✓ Those who do not know English

Data Analysis

Statistical Package for Social Sciences software version (SPSS) 21.0 (IBM SPSS Corp.; Armonk, NY, USA) was used for statistical analysis. Frequency, percentage, mean and standard deviation were used for descriptive statistics. The conformity of the data to the normal distribution was tested with the Kolmogorov Smirnov Test, and the Independent

t Test was used to evaluate the difference between the variables. Pearson Correlation Test was used to compare the scale means. The level of significance for all tests was set at $p < 0.05$.

Ethical Consideration

Consent was obtained from each participant prior to participating in this study's questionnaire survey. All participants were vividly aware of the aims and objectives of the study before they consented to participate. During the study, no sensitive personal data was obtained and data collected was made strictly confidential, hence ethical standard was strictly adhered to. In order to carry out the study, "Institutional Permit" from department of nursing in Near East University is affiliated, and "Ethics Committee Permission" from Near East University Ethics Committee (YDU/2022/1531).

Study Limitations

The major limitation of this study is that, the limited to Gospel Pillars International Church.

CHAPTER IV

Findings and Discussion

During this research 234 responses are collected. The results obtained were based on the feedback gotten from the participants the two forms administered.

Table 1 - Variable Characteristics of Participants

Variable Characteristics	Mean Score		
Age	Min: 19 Max: 45 Mean: 27,86 ± 5,32		
		n	%
Gender	Female	145	62,0
	Male	89	38,0
Marital Status	Single	162	69,2
	Married	72	30,8
Job Status	Yes	108	46,2
	No	126	53,8
Household	Alone	66	28,2
	Family	104	44,4
	Friends	64	27,4
Being in Cyprus	Yes	220	94,0
During the Covid-19 Pandemic	No	14	6,0

Table 1 shows the socio-demographic characteristics of the participants. The mean age of the participants was $27,86 \pm 5,32$ (min:19, max:45), 38,0% of them were in the female. 58,8% of the participants in the study are university student, 46,2% of participants also got a job.

Table 2 - Average Anxiety Scale

Coronavirus Anxiety Scale Items	During the Covid-19 First Lock Down	Last Two Weeks From Now
I feel dizzy, lightheaded, or faint, when I read or listened to news about the coronavirus	1,09±1,48	0,65±0,79
I had trouble falling or staying asleep because I was thinking about the coronavirus	1,44±1,43	0,97±0,94
I felt paralyzed or frozen when I thought about or was exposed to information about the coronavirus	1,26±1,141	1,10±0,91
I lost interest in eating when I thought about or was exposed to information about the coronavirus	1,03±0,98	0,95±0,92
I felt nauseous or had stomach problems when I thought about or was exposed to information about the coronavirus	0,83±0,90	0,86±0,88

	5,66±5,04	4,44±3,29
Total	<p style="text-align: center;"><i>p</i>: 0,001</p> <p style="text-align: center;"><i>t</i>: -6,050</p>	

The average score distributions of the participants' Covid-19 anxiety scale is given in Table 2. According to the findings, the overall mean score that the participants received from the scale was judged to be 5,66 5,04 during the first lock down of the Covid-19 experiment. And the overall mean score was calculated to be 4,44 with a standard deviation of 3,29 during the past two weeks from now. There was a statistically significant difference ($p < 0.05$) between the overall mean scores of the subjects on the "Covid-19 anxiety scale during lock down" and the scores they had received during the previous two weeks. demonstrates the stress level experienced by Covis-19 throughout the initial lockdown and the subsequent two weeks. There was a correlation between the total score that each participant had on the 'Covid-19 Anxiety Score' and the ($p < 0.05$, $r = 0.807$), although it was just a weak statistically significant correlation.

Table 3 - Job Status Anxiety Scale

			During the Covid-19 First Lock Down	Last Two Weeks From Now
Job Status	Yes	3,84±2,83	P: 0,032	P:0,009
	No	4,94±3,57	T: -2,161	T: -2,619

Table 3 shows about relations between job status and Covid-19 Anxiety Scale means of participants.

Table 4 - Job Status Anxiety Scale

Coronavirus Anxiety Scale	During the Covid-19 First Lock Down
Last Two Weeks From Now	r: 0,807 p: 0,001

Table 4 shows that anxiety level of Covis-19 during first lock down and last two weeks. There was a weak statistically significant correlation between the participants' total score on the 'Covid-19 Anxiety Score' and the ($p < 0.05$, $r = 0.807$).

Chapter V

Discussion

The propagation and infection of the Corona virus have caused a substantial degree of unease to be felt in a variety of communities all around the world, including the people that are local to the area (Porter et al., 2021).

The results of this study, which was carried out with the goal of establishing the anxiety level on the perception of COVID—19 amongst the Christian Community in Cyprus, indicated that the mean age is 27.86, with a standard deviation of 5.32 years. In addition, ladies accounted for 62 percent of those who participated in the survey, while males made up 38 percent. Only 28.2 percent of people lived by themselves, and only 53.8 percent of people did not have jobs.

The outcomes of the study indicate that the overwhelming majority of respondents are telling the truth about the threat that is posed by the virus. The average score on the coronavirus anxiety scale was 5.66, while the score for anxiety weeks away from the time the survey was performed was 4.44. The overall mean score was 5.66.

Because anxiety has such a substantial impact on productivity, it is a crucial indicator to measure in relation to a pandemic that is as widespread as the one that was caused by the coronavirus (katrielrechovot, 2019; World Health Organization, 2018). The decrease in the mean values of anxiety levels during the first phase of the lock down, which was enforced in April 2020 and within the past few weeks, demonstrates that the respondents are becoming less concerned about the severity of the disease. This phase of the lock down was enforced in April 2020. In the beginning, the lock down was imposed in April of 2020.

The statement that "I had trouble falling or staying asleep because I was thinking about the coronavirus" (1,441,43) had the highest mean value of the anxiety scale during the first lock-down, but that value had dropped to (0,970,94) within the last two weeks from the time of the survey. This indicates that the students' anxiety levels have decreased significantly. This is a clear indication that the amount of anxiety has greatly lowered. Following the delivery of covid-19, there was a significant decrease in the sample's overall levels of anxiety, as indicated by the difference of 0.49 in the mean value. The question that was just mentioned and the statement "I feel dizzy, lightheaded, or faint when I read or listened to news about the coronavirus," which both have a mean value of 0.49, display the greatest disparity in their respective mean value distributions among the time periods that were taken into consideration. Both of these statements have a mean value of 0.49.

Table 3 presents the mean values as well as the correlation between holding down a job and having high levels of anxiety measured with the Covid-19 scale. The findings of the study indicate that those respondents who are currently without jobs had, on average, higher levels of anxiety than those respondents who are currently employed. The observed mean for respondents with jobs is 3,842,83, and the observed mean value for those without work is, with a P-value of 0.0032 during the first lock down and a:0,009 within 2 weeks of when the poll was carried out, the difference between the two groups is significant (4,943,57). The difference in these two means is one that can be considered statistically significant. According to the findings, one of the most crucial factors that plays a role in determining the amount of anxiety that respondents experience is whether or not they have a job. This can be traced back to the concerns around the accessibility of drugs and medical care in the event that an individual becomes infected with the virus. According to the findings, having a Job is a significant

factor that plays a role in determining the amount of anxiety that respondents experience.

A person who does not have a job will think about how much money it costs to get food and medical treatment. In the case that the respondent has a family in which he plays a substantial part in the operation and survival of the household, there is a possibility that their anxiety levels may increase owing to concern for the provision of the household. Table 4 provides an illustration of the statistical association that exists between the levels of anxiety that were experienced during the initial lockup of the Covid-19 trial and those that will be experienced in the last two weeks from now onwards. According to what we have seen, there is a somewhat weak statistical association between the variables. This shows that both time periods can be regarded as distinct things at the same moment. In the context of the current study, this lends credence to the idea that there were differences in the kinds of information and sources that were made available to respondents during the two separate time periods that were investigated. (Bisson, 2017) According to the findings of various pieces of research, one's degree of anxiety is significantly correlated with both the amount of information one receives and the credibility of the sources from which that information originates (Omid V. Ebrahimi et al., 2020; Ho et al., 2020).

Chapter VI

Conclusion

The findings of the study indicate that those who are jobless are more likely to have higher levels of worry than respondents who are already employed. This is in contrast to the situation in which respondents who are already employed. It is believed that the burden on one's finances caused by the have to pay for prospective medical bills associated to an infection is the root reason of this inequality. In addition, we find that the amount of time that elapsed between the first lock down and two weeks before to the survey is only marginally significant, which shows that there was a difference in the information sources and types that were employed.

Other variables, like as information sources and types, should be added to future studies in order to acquire a greater understanding of the levels of anxiety that Christians are experiencing as a direct result of the covid-19 pandemic. This will provide a mechanism to develop a model of how anxiety levels can be maintained at the barest minimum in a public health situation that is comparable to the one that was provided in Covid-19.

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Personal Identification Form

The following survey is prepared to measure the effect of anxiety and the Anxiety Level on the Perception of COVID—19 amongst the Turkish Republic of North Cyprus (TRNC) Christian Community. The data gathered will be used only for academic purposes, and your personal details will be kept confidential. Please answer the questions by selecting the most appropriate answer for yourself. Thank you very much for your cooperation.

1. Gender : Male Female

- 2: Age: 18-20 21-25 26-29 30+

3. What is your marital status? Single Married
4. Marital status: Single Married
5. Educational level : Illiterate Primary school Secondary school
- University student Graduate/Postgraduate
6. Do you work in an income generating job? : Yes No
7. Where did you mostly live in the COVID-19 pandemic?
 My country North Cyprus Both of my country and North Cyprus
8. Are you a student? Yes No
9. Who do you live with in Northern Cyprus? Family Friend Alone

APPENDIX 2. Coronavirus Anxiety Scale

This was a main assessment form that was used to determine the scale of anxiety of the participants as a result of the COVID-19 pandemic. They were instructed to select the option that most appropriately represented their experience and they were also told that there was no wrong or right answer. The form was an assessment concerning what they had experienced over the past two (2) weeks. Below is a detail of the form administered:

		Not at all	Rare, less than a day or two	Several days	More than 7 days	Nearly every day over the last 2 weeks
1	I felt dizzy, lightheaded, or faint, when I read or listened to news about the coronavirus.	0	1	2	3	4
2	I had trouble falling or staying asleep because I was thinking about the coronavirus.	0	1	2	3	4
3	I felt paralyzed or frozen when I thought about or was exposed to information about the coronavirus.	0	1	2	3	4
4	I lost interest in eating when I thought about or was exposed to information about the coronavirus.	0	1	2	3	4
5	I felt nauseous or had stomach problems when I thought about or was exposed to information about the coronavirus.	0	1	2	3	4



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14th March, 2022

GOSPEL PILLARS CHURCH CYPRUS.

PERMISSION TO USE OUR CHURCH TO CONDUCT YOUR RESEARCH

The above mentioned Church, having looked into your request to use our Church to conduct your research, is hereby pleased to inform you:

RAWLINGS ERHAUYI LAWANI with Student Number: 20186097

That your request has been granted. You can come to conduct your research and we promise to give you the cooperation and support you may need from us.

We wish you all the best in your academic pursuits.

Best Regards.

Yours Truly

Pastor Gabriel I. Ohanmu

For: Gospel Pillars Church Cyprus.


YAKIN DOĞU ÜNİVERSİTESİ
BİLİMSEL ARAŞTIRMALAR ETİK KURULU

ARAŞTIRMA PROJESİ DEĞERLENDİRME RAPORU

Toplantı Tarihi :31.03.2022
Toplantı No :2022/101
Proje No :1531

Yakın Doğu Üniversitesi Hemşirelik Fakültesi öğretim üyelerinden Yrd. Doç. Dr. Samineh Esmailzadeh'in sorumlu araştırmacısı olduğu, YDU/2022/101-1531 proje numaralı ve **"Determining the Anxiety Level on the Perception of COVID—19 amongst the Cyprus Christian Community"** başlıklı proje önerisi kurulumuzca değerlendirilmiş olup, etik olarak uygun bulunmuştur.

L. Çalı

Prof. Dr. Şanda Çalı
 Yakın Doğu Üniversitesi
 Bilimsel Araştırmalar Etik Kurulu Başkanı

Kurul Üyesi	Toplantıya Katılım	
	Katıldı(✓)/ Katılmadı(X)	Onay(✓)/ Ret(X)
Prof. Dr. Tamer Yılmaz	X	X
Prof. Dr. Şahan Saygı	✓	✓
Prof. Dr. Nurhan Bayraktar	✓	✓
Prof. Dr. Mehmet Özmenoğlu	✓	✓
Prof. Dr. İlker Etikan	✓	✓
Doç. Dr. Mehtap Tınazlı	✓	✓
Doç. Dr. Nilüfer Galip Çelik	✓	✓
Doç. Dr. Emil Mammadov	✓	✓
Doç. Dr. Ali Cenk Özay	✓	✓

Determining the Anxiety Level on the Perception of COVID—19 Among the congregation of a church in Northern Cyprus

ORIJINALLIK RAPORU

% 25	% 23	% 10	%
BENZERLIK ENDEKSİ	İNTERNET KAYNAKLARI	YAYINLAR	ÖĞRENCİ ÖDEVLERİ

BİRİNCİL KAYNAKLAR

1	musculoskeletalkey.com İnternet Kaynağı	% 6
2	www.coursehero.com İnternet Kaynağı	% 1
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6	www.hrhelpboard.com İnternet Kaynağı	% 1
7	www.ncbi.nlm.nih.gov İnternet Kaynağı	% 1
8	library.hee.nhs.uk İnternet Kaynağı	% 1
9	www.tandfonline.com İnternet Kaynağı	% 1