

Association between Death Anxiety, Religiosity and Coping Strategies with HIV Patients

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Abstract

In the 21st century, HIV poses enormous problems and burdens and is a serious worldwide health concern. This study looked into how people with HIV's perceptions of death, their level of religiosity, and their coping mechanisms. From July 2023 to March 2023, a correlational study design was conducted in Pakistan's District Faisalabad. Promoting psychological well-being and creating specialized therapies for this population depend on an understanding of these aspects. An extensive evaluation of mortality anxiety, religion, and coping mechanisms was done on a sample (N=100) of HIV-positive men and women. The goal of the study is to understand how these psychological variables interact and affect the adjustment and health of HIV-positive people. For the assessment of the current study, several questionnaires were used. The target population for the current study was chosen using the purposeful sampling technique. Percentages, means, standard deviations, and bivariate correlation were calculated as part of the study's descriptive and correlational analyses. Multiple linear regression and t-tests on

independent samples analyses for inferential statistics were also carried out to test the study's hypotheses. The results showed a significant average difference in scores for the Religiosity Scale ($t(98) = 2.904, p < 0.005$) and Coping Strategies Scale ($t(98) = 3.350, p < 0.005$). This demonstrated that the individuals' reported levels of religiosity and coping mechanisms differ according to gender. According to the Death Anxiety Scale's mean difference finding ($t(98) = -1.434, p > .001$), there were no discernible differences in reported levels of death anxiety between the gender. The findings have important ramifications for those who live with HIV, their families, medical professionals, and researchers. The value and significance for Pakistani culture are concluded by the current study.

Key Words: Death anxiety, religiosity, coping strategies, HIV patients, adults.

Introduction

Human immunodeficiency virus (HIV), which causes a range of diseases, affects the immune system in humans. Newborn children can contract it from their infected moms during breastfeeding, pregnancy, or even childbirth. It is transferred through sharing needles, unprotected sex, and contact with specific bodily fluids of a person who has been diagnosed as HIV positive. There are a number of neurological illnesses that have been linked to HIV. That is why this virus severely infects the central nervous system and is documented in several cases. The majority of neurological disorders, including meningitis, Alzheimer's disease, neuropathy, and neurological infections, sometimes don't show symptoms until late in the course of the illness. This in-depth study's objective is to identify and comprehend the psychological disorders typically present in HIV patients while highlighting the steps needed to control this sickness. In both developed and developing countries, HIV infections and the disease they cause are typically more common in heterosexuals, intravenous (iv) drug users, homosexual men, and children born to infected mothers. We reviewed the data that is currently

available on the timing of the onset of AIDS following the development of HIV infection, the proportion of HIV-positive individuals who will ultimately develop the disease, the behavior of the infection over time, and the pattern of disease movement in people who engage in new sexual or needle-sharing relationships. Numerous research is produced to study HIV transmission using this knowledge. The majority of them are purposely oversimplified, and as we gain more knowledge, they get more complex.²

One of the biggest challenges in the fight against HIV infection is finding ways to eliminate the persistent viral reservoir, which contains integrated replication-competent provirus within host cellular DNA. Viruses from this reservoir induce rebound viremia when antiretroviral medication (ART) is interrupted, which leads to new infection outbreaks. Both the host immune system and ART cannot remove this reservoir. Despite the fact that numerous research has concentrated on these topics, there is still debate over the cells and tissues that harbor persistent viruses, the size of the reservoir, and the most efficient techniques to target it. In this Viewpoint article³ a number of subject-matter experts discuss the anatomy of the viral reservoir, the best ways to analyze it, and the most effective ways to combat this source of chronic infection⁴.

The full termination of all biological functions within an organism's body is referred to as death. Another definition of death is the final, irreversible cessation of all brain activity, including that of the brainstem. In truth, a person with a dead brain typically qualifies as dead under legal rules. Usually, an organism's remains begin to disintegrate right away when it passes away. All living things experience death, which is an inevitable process. One of the organisms that are biologically immortal is *Turritopsis dohrnii*. Even yet, they are still susceptible to diseases and other causes of death. It has been difficult to determine a person's death date. When the heartbeat and breathing stopped, that was the traditional definition of death. However, the invention of CPR meant that it was no longer a fatal condition. Brain death was the next option, but there are different definitions of this term. Some people believe that all brain activity must cease. Some individuals believe that

even if their brainstem is still functioning, they should still be regarded as entirely died because they no longer have any personality or sense of self.⁵

Death anxiety is a result of a variety of fears, including those of pain, being far from one's loved ones, and knowing that one is about to die. According to⁶, there are three types of death-related phobias: Predator death anxiety comes in three different forms: (1) predator death anxiety (caused by a person being hurt physically or psychologically by another) (2) Predator death anxiety, which is brought on by external stimuli that could be physically or psychologically harmful, and (3) Existential death anxiety, which results from the knowledge that all life must eventually come to an end. People frequently employ denial to battle their fear of dying, but using it excessively is usually hazardous. Numerous researchers have identified four distinct types of death⁷ anxiety: worry about a loved one's impending death, own death anxiety, anxiety about a loved one's impending death, and personal dying anxiety.⁷ People with HIV may experience death anxiety for a number of reasons, including social support. In reality, a wide range of motivating factors that encourage social contacts and partnerships are referred to as social support. It has also been described as a communication system that fosters intimacy, cooperation, emotional development, and healthy pursuits. Typically, a person's family serves as a significant basis for their social network and personal relationships. It primarily refers to the support given by important people in a person's life when they are dealing with challenging situations. These important individuals frequently provide both practical assistance and emotional support, which can be defined in a variety of ways. The six categories of social assistance are: services, information, emotional support, socialization or companionship, consultation, and financial help. Distress tolerance, a word frequently employed in studies on emotional entropy, has been shown to affect people's fear about dying.⁸

Contrarily, stress-relieving coping strategies seek to proactively reduce it. When conditions are seen as changeable, this style of coping is more likely. Examples of problem-focused strategies include developing new skills, finding alternatives, identifying sources of enjoyment, or establishing new standards

of behavior. One coping strategy is asking for help from others⁹, which can be beneficial for both emotional needs and problem-solving. In order to cope with stressful circumstances, the majority of people use both emotionally oriented and problem-focused coping strategies. According to studies, many individuals resort to religion to provide solace in their life and help them get through difficult times¹⁰. People look for ways to cope with the fear, helplessness, and rage that often accompany death anxiety. However, since this topic is taboo, it may be difficult or even impossible to discuss death dread. They are left with little choice than to link their issues to religious customs and rituals. Religions provide a space for people to process their emotional pain, deal with existential questions about life and death, and consider the nature of existence. Most people who explore religion feel they are becoming more self-aware, more respectful of others, and more empathic toward their feelings and well-being. Generosity and compassion are prominent ways in which these emotions express themselves. When one challenges their protective reactions to death dread, they are inspired to live in the present, approach death with restraint, and honestly embrace the joy and pain of living. Although more religious participation is not a guarantee of comfort, Alvarado claimed that a strong religious belief and a strong confidence in the afterlife could diminish the fear of dying¹¹.

Materials and Methods

Study Design

In the current study, correlational research was used to ascertain the link between the variables. The goal of correlational research designs is to examine the link between the variables while choosing participants who are a certain age. This allowed for the identification and evaluation of their differences¹². The study comprised 100 HIV-positive persons, 50 males and 50 females, ranging in age from 18 to 60. The sample's mean score was 37.15, and the standard deviation was 10.53. Thumb rule estimates 200 data, however only 100 data were actually obtained due to the patients' severe conditions and environmental circumstances¹³.

Inclusion/Exclusion Criteria

HIV patients that are participating include both male and female individuals (18 to 60 years old). HIV patients who accept to participate in the study after giving their informed consent. HIV patients who agreed to participate in the study's interviews or fill out the study's questionnaires. After checking the patient's medical records, it was determined that the illness was caused by HIV infection. Anyone who practices a certain religion, identifies with that religion, or has strong spiritual beliefs is regarded as religious. The inclusion and exclusion criteria ought to be viewed as fundamental guidelines that could alter depending on the precise research study or systematic review being conducted. Researchers may choose to modify these criteria in order to accomplish the specific goals of their study. Reviewing relevant databases and the material that is already out there will help you understand the topic completely¹⁴ The recruitment materials for the study and the informed consent form made the criteria very clear.

Procedure

Adult HIV/AIDS patients who have received inpatient therapy as well as outpatients at Tehsil Headquarter Hospital (THQ) Shahkot and Allied Hospital Faisalabad were invited to participate in this study after giving their formal consent. The Punjabi province is where these hospitals are situated. A formal approval from the Medical Superintendent of the aforementioned hospitals was obtained upon request after receiving a letter of clearance from the Riphah International University Faisalabad Campus for psychological study on HIV/AIDS sufferers. Among HIV/AIDS patients, a correlational study was conducted between death anxiety, religiosity, and coping mechanisms. In this regard, a research study that was conducted included 100 patients who had AIDS. Both men and women were among the patients. Participants in the current poll answered questions that had been created specifically for conducting research studies on these kinds of deadly diseases. The scale of these issues was selected as the questionnaire for this reason. After receiving formal consent from the original authors of each of these scales, an informed consent was obtained from the respondents¹⁵ who filled out the questionnaires and gave all pertinent information. These

questionnaires and the patients' private information were gathered under strict confidentiality for the sole goal of conducting a psychological analysis of their state of mind in order to conduct a precise and accurate research study. Data collection was examined using IBM SPSS version 23.0. Both descriptive and inferential statistics were used to analyze the data. Simple counts, simple percentages, the mean, the standard deviation, and bivariate were all included in descriptive analysis. To assess the study's hypotheses, inferential statistics such as person correlation and t-tests of independent samples analyses were used.

Results

The study's goal was to determine the "Association between Death Anxiety, Religiosity, and Coping Strategies Among HIV Patients." The research's findings are presented in the current chapter. Data analysis was done using SPSS 23 (Statistical Procedure for Social Science). Initially, describe the demographic variables using descriptive analysis and sample reliability analysis. Second, bivariate associations between religion, fear of dying, and coping mechanisms were examined. The two-tailed independent sample t test was used to explore the relationship between the participant's family structure and domicile and to measure additional gender-diverse factors. Additionally, a graphic representation of the mean scores of significant outcomes has been provided.

Table I: Socio demographics characteristics of association between Death Anxiety, Religiosity and Coping Strategies among HIV patients measure in sample (N = 100)

<i>Baseline Characteristics</i>	<i>F</i>	<i>(%)</i>	<i>M</i>	<i>SD</i>
Age			37.15	10.53
Gender				
Male	50	50		
Female	50	50		
Total	100	100		

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Education		
Uneducated	3	3
Matric or below	57	57
Intermediate	20	20
Graduation	12	12
MSc or above	8	8
Total	100	100
Residence		
Rural	25	25
Urban	75	75
Total	100	100
Family type		
Nuclear	66	66
Joint	34	34
Total	100	100
Social Economic Status		
Lower	51	51
Middle	46	46
Upper	3	3

Table 1: Describes the demographic features of the sample of participants in the study and provides an outline of their demographic information. Demographic factors were age, gender, education, place of residence, family type, and socioeconomic level. All of the demographics used in the current study, in frequency and proportion.

Table 2: *Descriptive Statistics of Research Questionnaires HIV patients in term of Death Anxiety, Religiosity and Coping Strategies (N=100)*

Range

<i>Scales</i>	<i>K</i>	<i>M</i>	<i>SD</i>	<i>A</i>	<i>Potential</i>	<i>Actual</i>	<i>Sk</i>	<i>Kurtosis</i>
CS	13	54.11	9.688	.81	13-52	71	.117	-1.264
CRS	14	43.97	14.961	.89	14-70	66	.450	-.920
DA	15	10.54	2.664	.88	15-75	17	.574	-.658

Note: *k* = No of items, *M* = Mean, *SD* = Standard Deviation, α = Cronbach's alpha, *Sk* = Skewness, *CS*= coping Strategies scale, *CRS*= Centrality Religiosity Scale & *DA*= Death Anxiety

Table 2: The outcome described the descriptive statistics for the Death Anxiety Scale, Religiosity Scale, and Coping Strategies Scale, including mean, standard deviation, range, skewness, and kurtosis. The results also showed that the alpha reliability coefficient for the overall Coping Scale score was considerably high, as it was 0.81, for the Religiosity Scale it was 0.89, and for the Death Anxiety Scale it was 0.88. Additionally, it was found that the measures allowed for the continuation of the sample's overall analysis.

Table 3: *Correlation Matrix between Death Anxiety, Religiosity and Coping Strategies among HIV patients (N = 100)*

Variables	CS	CRS	DA
CS	1	.792***	-.543***
CRS		1	-.517***
DA			1

Note: *CS*= Coping Scale, *CRS*= Centrality Religiosity Scale & *DA*= Death Anxiety *** $p < .05$.

Table 3: The results demonstrated relationships between the death anxiety scale, the religiosity scale, and the coping strategies scale. Religiosity

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and Coping Strategies had a substantial positive association ($r=.792^{***}$, $p \geq 0.001$) and a significant negative link ($r= -.543^{***}$, $p \leq 0.5$) respectively. Religion and fear of dying are significantly inversely associated ($r = -.517^{***}$, $p \geq 0.5$).

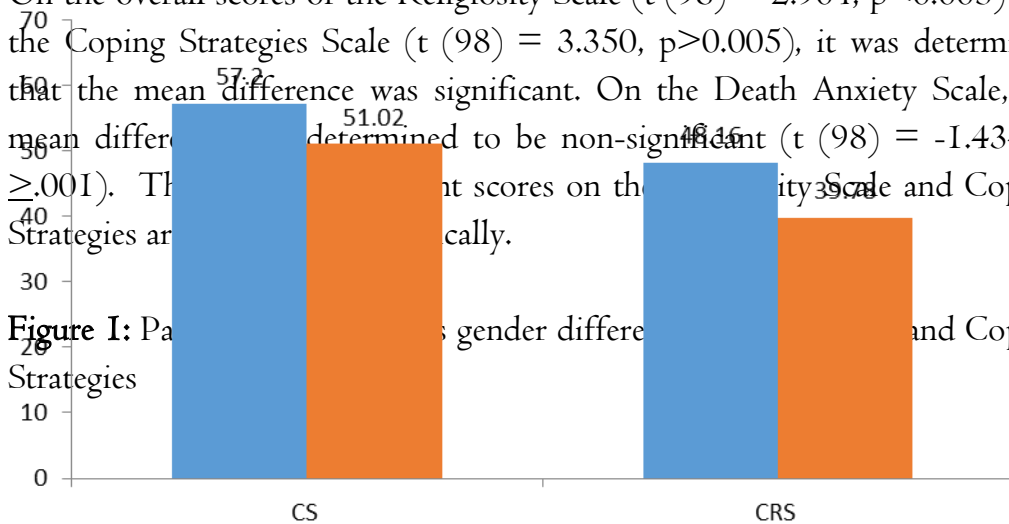
Table 4: Participant's responses gender differences of Death Anxiety, Religiosity and Coping Strategies among HIV patients (N=100)

Variables	Boys (n = 50)		Girls (n = 50)		t(98)	P
	M	SD	M	SD		
CS	57.20	9.049	51.02	9.395	3.350	.001
CRS	48.16	14.940	39.78	13.899	2.904	.005
DA	10.16	2.510	10.92	2.784	-1.434	.155

Note: CS= Coping Scale, CRS= Centrality Religiosity Scale & DA= Death Anxiety *** $p \leq .001$, ** $p \leq .005$

Table.4: Results revealed the gender disparities in the median participant replies and the size of the influence on the overall score of the assessment of the Death Anxiety Scale, Religiosity Scale, and Coping Scale. On the overall scores of the Religiosity Scale ($t(98) = 2.904$, $p < 0.005$) and the Coping Strategies Scale ($t(98) = 3.350$, $p > 0.005$), it was determined that the mean difference was significant. On the Death Anxiety Scale, the mean difference was determined to be non-significant ($t(98) = -1.434$, $p \geq .001$). The mean scores on the Centrality Religiosity Scale and Coping Strategies are significantly different.

Figure I: Participant's gender differences in Coping Strategies and Coping



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Figure I indicates that participant responses to the Religiosity Scale and the Coping Strategies Scale differed by gender. In the sample, males scored higher on religiosity and coping mechanisms than did females.

Table 5: Participant's responses family type differences in Death Anxiety, Religiosity and Coping Strategies (N=100)

Variables	Joint Family (n = 66)		Nuclear Family (n = 34)		t(98)	P
	M	SD	M	SD		
CS	56.38	9.725	49.71	8.062	3.436	.001
CRS	46.68	14.606	38.71	14.423	2.598	.011
DA	9.98	2.317	11.62	2.985	-3.020	.003

Note: CS= Coping Strategies Scale, CRS= Centrality Religiosity Scale & DA= Death Anxiety ***p<.001, **p<.005.

Table 5: Results revealed the average participant responses, family type differences, and effect size on the estimated death anxiety, religiosity, and coping scale total scores. On the overall scores of the Coping Strategies Scale and the Death Anxiety Scale, the mean difference was found to be statistically significant (t (98) = 3.436, p>0.005, and 0.003, p>0.005). On the Religiosity Scale, the mean difference was found to be non-significant (t (98) = 2.598, p >0.005).

Table 6: Participant's responses Residence, mean and standard deviation differences in Death Anxiety, Religiosity and Coping Strategies(N=100)

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Variables	Urban (<i>n</i> = 75)		Rural (<i>n</i> = 25)		<i>t</i> (98)	<i>P</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
CS	56.36	8.956	47.36	8.751	4.376	.000
CRS	47.53	14.163	33.28	12.088	4.510	.000
DA	10.33	2.559	11.16	2.925	-1.349	.180

Note: CS= Coping Scale, CRS= Centrality Religiosity Scale & DA= Death Anxiety ****p*<.001, ***p*<.005.

Table 6: Results revealed the average participant responses, residence differences, and effect size on the evaluation's final score for the Coping, Death Anxiety, and Religion scales. On the overall scores of the Religiosity Scale (*t* (98) = 4.510, *p*>0.005) and the Coping Strategies Scale (*t* (98) = 4.376, *p* .005), the mean difference was determined to be ¹⁶significant. On the Death Anxiety Scale, the mean difference was determined to be non-significant (*t* (98) = -1.349, *p* ≥0.001).

Discussion

The goal of the current study was to determine how HIV patients' coping mechanisms, level of religion, and fear of dying related to one another. The findings shed important light on both any potential protective factors and the psychological effects of living with HIV. This discussion will include an overview of the important findings, a comparison with prior work, an interpretation of their implications, a look at potential mechanisms, and an explanation of the findings. The current study concentrated on a particular group of HIV patients, which may not accurately reflect the range of HIV-positive people's experiences. Due to societal and cultural stigmatization, conducting research on touchy subjects like HIV, death anxiety, and religiosity in Pakistan can be difficult. In many societies, including Pakistan, HIV-related stigma and prejudice are pervasive, which may affect people's

desire to participate in research and give open responses. This could reduce the sample's ability to be representative and induce selection biases. Future research should think about implementing techniques to reduce stigma and preserve participants' privacy and confidentiality in order to increase participation and honest responses. The sample's ($N = 100$) sociodemographic variables are age, gender, education, place of residence, type of family, and socioeconomic position. The outcome of the demographics is exposed in frequency with the circulation % displayed. Average participant age was 37.15 and standard deviation was 10.53. 50(50%) females and 50(50%) males made up the gender split. The distribution and variability of scores on the Death Anxiety Scale, Religiosity Scale, and Coping Strategies Scale are reported using the statistics of mean, standard deviation, range, skewness, and kurtosis. These descriptive statistics aid in a better understanding of the characteristics of the research variables among the HIV patient population. Additionally, the total scores for the Coping Scale (0.81), Religiosity Scale (0.89), and Death Anxiety Scale¹⁷(0.88) had excellent alpha reliability values, demonstrating strong internal consistency for these measures.¹⁸ The findings showed that there was a statistically significant average difference between the scores on the Religiosity Scale ($t(98) = 2.904, p > 0.005$) and the Coping Strategies Scale ($t(98) = 3.350, p > 0.005$). This demonstrated that the individuals' reported levels of religion and coping methods differ according to gender. The Death Fear Scale's mean difference result showed no discernible differences in reported levels of death fear between the sexes ($t(98) = -1.434, p \geq 0.001$).

According to the first theory, HIV patients' fear of dying and religiosity would be significantly correlated. Anxiety about dying and religiosity are strongly correlated. The results of the current study, which demonstrated a strong inverse relationship between death dread and religiosity, supported this theory. These findings are consistent with prior research that has highlighted the value of religious practices and beliefs in providing solace, purpose, and support in the face of existential issues, including death dread. The negative connection between the two variables suggests that higher levels of religiosity

may be associated with lower levels of death anxiety in HIV patients. This shows that religious beliefs may serve as coping mechanisms, giving those who are dealing with death anxiety comfort and confidence¹⁵. The findings indicated a substantial correlation between death anxiety, coping mechanisms, and religiosity among HIV patients. Positive relationships between coping strategies and religiosity suggest that those with higher levels of religiosity also tended to adopt more coping strategies to deal with the challenges posed by HIV. The current finding is consistent with past research, which highlighted the significance of religious practices and beliefs as potential sources of support and resiliency for people facing serious illnesses¹⁶. According to the second hypothesis, there is a significant correlation between HIV patients' religiosity and coping mechanisms. The use of religion and coping mechanisms among HIV patients is significantly correlated. The outcomes displayed that Recent findings reinforced this notion by demonstrating a high positive correlation between religiosity and coping mechanisms. This is in line with past studies that emphasized how religious practices and beliefs can help people develop resilience and effective coping mechanisms. Higher levels of religiosity may allow individuals to turn to their faith for strength, guidance, and courage, which may in turn make it simpler for them to employ coping mechanisms. When it comes to helping HIV patients build effective coping mechanisms, religious activities and beliefs may provide a feeling of purpose and social support¹⁷.

The third hypothesis states that there is a significant correlation between HIV patients' coping mechanisms, religiosity, and worry about dying. The coping mechanisms, religiosity, and death anxiety of HIV patients are significantly correlated. The results of our investigation, which revealed significant connections between all three variables, confirmed this notion. It is possible that HIV patients who employ more coping mechanisms also have less death fear given the inverse relationship between coping mechanisms and death dread. Additionally, as there is a strong correlation between coping mechanisms and religiosity, persons who practice more religion are also likely to employ more coping mechanisms. These findings suggest that religiosity

may protect HIV patients by lowering the impact of death dread and encouraging the use of effective coping mechanisms. The fourth hypothesis states that there would be gender differences among HIV patients in terms of death dread, religiosity, and coping mechanisms. It was hypothesized that there are gender differences in the fear of dying, religiosity, and coping mechanisms among HIV patients. The results of our analysis did not support this hypothesis because none of the variables showed statistically significant gender differences. Earlier research, however, revealed gender differences in HIV-positive individuals' psychological experiences and coping strategies. The fact that there were no gender differences in our study does not imply that there were none in the general population, it is imperative to keep in mind. The relationship between HIV patients' death anxiety, religiosity, and coping mechanisms may be further explored in future studies with larger sample sizes¹⁸. The put forward theories are supported by current research. The findings show that among HIV patients, there are substantial correlations between death anxiety and religion, religiosity and coping mechanisms, and all three factors taken together. By highlighting the significance of religion as a potential protective factor and facilitator of coping strategies in the setting of HIV, our findings add to the body of material already in existence.

Limitations

Before making any inferences concerning the association between death dread, religiosity, and coping mechanisms among HIV patients, it is important to be aware of the study's shortcomings. First, selecting the sample itself could introduce bias, which might limit how broadly the findings can be applied. If the sample is only drawn from specific geographic areas or healthcare facilities, it might not accurately represent the entire population of HIV patients. Second, it is challenging to determine causal relationships between variables when employing a cross-sectional approach. Instead of explaining out how these connections are related, the study's findings can only be interpreted as associations. Third, when using self-report measures to assess death anxiety, religion, and coping mechanisms, there is a possibility of

response biases like social desirability bias or remembrance bias. The validity and accuracy of the presented data may be impacted by this reliance on self-report measures. Due to the complexity and diversity of the assessment of religiosity itself, it may also be challenging to encompass the full range of religious concepts, practices, and spirituality. Additionally, the conclusions may be constrained by the cultural and social context, which limits their applicability to people from diverse cultural and religious backgrounds.

Recommendations

HIV patients should be encouraged by medical personnel to express their concerns and anxieties of passing away. By fostering a safe and judgment-free environment, patients can discuss their worries more freely and seek the appropriate support. Respect and acknowledgement are due to Pakistani HIV sufferers' religious and cultural values.¹⁹ Recognize the importance of Islam in their lives and provide solutions with Islamic values and policing in mind. Medical experts should look at the spiritual and religious practices of HIV patients. Knowing a person's level of religious importance might help develop solutions that align with their values and provide them a sense of security and support. Include spiritual care in the patient's course of therapy if they have HIV. Provide patients with resources, such as volunteer work, spiritual therapy, or support groups, that can give them a space to explore their spiritual convictions and find solace in their faith. By implementing coping skills training programs created especially for HIV patients, you can promote the development of coping abilities. The primary goal of these programs ought to be the development of adaptive coping mechanisms, such as breathing exercises, mindfulness practices, cognitive re-framing, and problem-solving skills. Encourage social support by assisting in the formation of HIV patient support networks or peer support groups. We can provide opportunities for discussing coping mechanisms, lessen loneliness, and foster a sense of community and support by bringing people together who have experienced similar situations.

Conclusion

The study looked into how HIV patients' coping mechanisms, religiosity,

and fear of dying related. The findings shed light on how these variables interact and what that implications for the mental health of HIV-positive individuals. The results indicated a possible association between higher levels of death fear and higher levels of religiosity among HIV patients, showing a positive link between death anxiety and religiosity. This implies that people turn to religion as a coping mechanism when they are faced with existential concerns and anxiety related to HIV and mortality. The study also demonstrates a connection between religiosity and HIV patients' use of religious coping methods. This suggests that those who are more religious have a tendency to rely on their religious convictions, customs, and rituals to help them deal with the stress and emotional difficulties brought on by receiving an HIV diagnosis.

The findings also emphasize the significance of helping this population develop effective coping skills in order to reduce death phobia and improve psychological wellness. These findings help us better understand the psychological factors affecting HIV patients and can be utilized to build targeted interventions and support programs that take into account people's religion, coping methods, and anxieties about death and mortality.

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