ADVANCE SOCIAL SCIENCE ARCHIVE JOURNAL
Available Online: https://assajournal.com
Vol. 04 No. 02. Oct-Dec 2025.Page#.2349-2359
Print ISSN: 3006-2497 Online ISSN: 3006-2500
Platform & Workflow by: Open Journal Systems
https://doi.org/10.5281/zenodo.17842860

Comparing Quality of Life and Resilience Among COVID-19 Affected and Non-Affected Populations

Ammarah Riasat
Department of Professional Psychology, BAHRIA University Islamabad
ammarah.riasat@yahoo.com
Dr. Noshi Iram Zaman
Department of Professional Psychology, BAHRIA University Islamabad
noshirum@yahoo.com
Sarah Wasim
Department of Professional Psychology, BAHRIA University Islamabad
wasimsarah7@gmail.com

ABSTRACT
This cross-sectional comparative study examined the role of resilience and religiosity (intrinsic and extrinsic) in buffering the perceived impact of COVID-19 on quality of life among 400 Pakistani adults (200 COVID-affected, 200 non-affected). Data were collected online using the COV19-QoL scale, Resilience Scale (RS-14), and Muslim Religiosity Scale. Results revealed moderate COVID-19 impact on quality of life in both groups, with no significant difference between affected and non-affected participants. However, COVID-affected individuals reported significantly lower resilience and higher extrinsic religiosity. Resilience and intrinsic religiosity strongly predicted lower perceived impact, whereas extrinsic religiosity predicted greater impact, together explaining 62% of variance. Resilience partially mediated the relationships between both dimensions of religiosity and COVID-19 impact on quality of life. Males and participants with chronic physical illness experienced greater deterioration. Findings highlight the protective role of intrinsic religiosity and resilience, and the risk associated with extrinsic religiosity, in a Muslim-majority context. Results support Faith-Resilience Theory and suggest that culturally sensitive, religiously integrated resilience-building interventions are essential for mitigating pandemic-related psychological distress.

Keywords: *COVID-19, Quality of Life, Resilience, Intrinsic Religiosity, Extrinsic Religiosity, Mediation, Pakistan, Mental Health, Faith-Resilience Theory*

Introduction

The COVID-19 pandemic, declared by the World Health Organization in March 2020, rapidly became one of the most severe global health crises in modern history. Emerging in Wuhan, China, in late 2019, the novel coronavirus (SARS-CoV-2) spread across continents, infecting millions and causing widespread mortality, economic collapse, and unprecedented social restrictions (WHO, 2020). By mid-2021, over 182 million confirmed cases and nearly 4 million deaths had been recorded worldwide (WHO, 2021). In Pakistan, the first cases were reported in February 2020 among pilgrims returning from Iran. Despite border closures and thermal screening, community transmission escalated quickly, prompting nationwide lockdowns, closure of educational institutions, markets, mosques, and workplaces, and severe restrictions on movement (Naqvi et al., 2020; Sarwar et al., 2020). These measures, while necessary to curb

viral spread, profoundly disrupted daily life, triggered panic buying, financial insecurity, and heightened fear of infection or death.

Beyond direct physiological effects, COVID-19 exerted a significant toll on mental health and quality of life (QoL) globally and in Pakistan. Social isolation, uncertainty, grief, and loss of livelihood contributed to increased anxiety, depression, stress, and reduced overall well-being (Holmes et al., 2020; Mukhtar, 2020). Quality of life, defined by the WHO as individuals' perceptions of their position in life within the context of their culture, values, goals, and concerns (WHOQoL Group, 1993), emerged as a critical outcome during the pandemic. Studies consistently reported deterioration in both physical and psychological domains of QoL, driven by fear of contagion, enforced quarantine, sedentary behavior, and limited access to healthcare (Repišti et al., 2020; Nguyen et al., 2020; Zhang & Ma, 2020).

Two psychological resources, resilience and religiosity have been identified as potential buffers against the adverse effects of crises. Resilience, the ability to adapt successfully and maintain mental equilibrium in the face of significant adversity (Masten, 2015; American Psychological Association, 2018), has been shown to mitigate depression, anxiety, and lowered QoL during the pandemic (Prime et al., 2020; Yıldırım et al., 2020). Religiosity, particularly in Muslim-majority contexts such as Pakistan (where over 96% of the population is Muslim), serves as a salient coping mechanism. Intrinsic religiosity deep personal faith and spiritual commitment promotes meaning-making, hope, and emotional regulation, whereas extrinsic religiosity focuses more on social or instrumental benefits (Khan, 2014). Research indicates that intrinsic religiosity and religious coping are associated with lower distress and better mental health outcomes during traumatic events, including pandemics (Bentzen, 2020; Koenig, 2020; Pirutinsky et al., 2020).

Despite extensive documentation of COVID-19's psychological impact, few studies have directly compared QoL and resilience between individuals who contracted the virus (affected) and those who did not (non-affected), particularly in developing or Muslim-majority countries. Most existing research has examined either clinical survivors or the general population separately, leaving unclear whether direct infection exacerbates impairment beyond the widespread effects of lockdowns and fear. Moreover, the protective roles of resilience and different dimensions of religiosity in these two groups remain underexplored in South Asian cultural contexts where faith is a central life domain.

The present study addressed these gaps by examining differences in COVID-19-related impact on quality of life (COV19-QoL) and resilience between COVID-affected and non-affected Pakistani adults, while investigating the buffering role of intrinsic and extrinsic religiosity. We hypothesized that: (1) COVID-affected individuals would report greater negative impact on QoL and lower resilience than non-affected individuals; (2) higher resilience and intrinsic religiosity would predict lower COV19-QoL, whereas extrinsic religiosity would predict higher impact; and (3) resilience would partially mediate the relationship between religiosity and COV19-QoL. By elucidating these dynamics in a highly religious developing nation, this research aims to inform culturally sensitive mental health interventions during and beyond the pandemic.

Review of Literature

The COVID-19 pandemic significantly impaired quality of life (QoL) across physical, psychological, social, and environmental domains. Defined by the World Health Organization as individuals' perceptions of their position in life within their cultural context, values, and goals (WHOQoL Group, 1993), QoL became a key indicator of pandemic-related distress. Global evidence consistently demonstrated deterioration in both infected and non-infected populations. Studies from China, Italy, India, the UK, and the Philippines revealed elevated

depression, anxiety, insomnia, and reduced health-related QoL, linked to lockdown-induced isolation, fear of infection, physical inactivity, and economic uncertainty (Repišti et al., 2020; Qi et al., 2020; Nguyen et al., 2020; Amerio et al., 2020; White & Boor, 2020; Rabacal et al., 2020). Physical health concerns often dominated, with individuals reporting greater worry about deterioration of bodily functions than mental health (Repišti et al., 2020). Younger adults and those with pre-existing conditions typically experienced stronger negative impacts than older adults or healthy individuals (Zhang & Ma, 2020; Kazmi et al., 2020). Even clinically stable COVID-19 patients exhibited higher depression and poorer daily functioning than the general population (Ma et al., 2020). These findings highlight that the pandemic affected QoL through both direct viral consequences and indirect societal restrictions.

Religiosity emerged as a prominent protective factor during the crisis. Conceptualised as commitment to religious beliefs, practices, and values (Ebaugh et al., 2006), religiosity is frequently divided into intrinsic (genuine internalised faith) and extrinsic (instrumental or socially motivated) dimensions (Allport & Ross, 1967; Khan, 2014). Intrinsic religiosity consistently predicted better mental health outcomes, lower stress, anxiety, depression, and enhanced QoL, whereas extrinsic orientation showed weaker or sometimes negative associations (Watson et al., 2002; Steffen & Masters, 2005; Pirutinsky et al., 2020). During COVID-19, religious practices and prayer increased globally as individuals sought meaning, comfort, and hope (Bentzen, 2020). In Muslim-majority contexts such as Pakistan, religious coping was particularly salient; individuals with health anxieties relied on faith to reduce distress (Ali et al., 2018). Positive religious coping correlated negatively with perceived stress and positively with QoL across diverse samples, including university students, nurses, and chronically ill patients (Gardener et al., 2014; Bagheri-Nesami et al., 2017). Moreover, religiosity demonstrated physiological benefits, including strengthened immune function and lower inflammatory markers, potentially mitigating vulnerability to viral infections (Koenig & Cohen, 2002; Sephton et al., 2001).

Resilience, defined as the capacity to maintain or regain mental health despite significant adversity (Masten, 2015; American Psychological Association, 2018), also buffered pandemic-related impairment. High resilience was associated with lower anxiety, depression, stress, and better QoL among both COVID-19 patients and the general population (Zhang et al., 2020; Lipskaya-Velikovsky, 2021; Zhou et al., 2020). Longitudinal and cross-sectional studies confirmed that resilient individuals perceived crises as less threatening and recovered faster (Prime et al., 2020; Yıldırım et al., 2020). Resilience mediated relationships between pandemic stressors and psychological outcomes, transforming potential trauma into opportunities for growth (thriving theory; O'Leary, 1998). Protective factors included social support, optimism, self-efficacy, and, notably, religious faith (faith-resilience model; Manning, 2014). In religious societies, belief in divine purpose fostered meaning-making and perseverance, enhancing adaptive coping (Brodsky, 2000; Tarakeshwar et al., 2006).

Although extensive research documented the individual roles of religiosity and resilience in mitigating COVID-19's impact on QoL, comparative studies between virus-affected and non-affected populations remain scarce, especially in developing or Muslim-majority countries. Existing evidence primarily examined either clinical survivors or community samples separately, leaving unclear whether direct infection exacerbates QoL impairment beyond the universal effects of lockdowns and fear. Furthermore, the interplay of intrinsic and extrinsic religiosity with resilience in these distinct groups has received minimal attention in South Asian contexts where Islam profoundly shapes coping and worldview. The present study addresses these gaps by directly comparing COVID-19-related QoL impact and resilience levels between affected and

non-affected Pakistani adults while examining the differential contributions of intrinsic and extrinsic religiosity.

Theoretical Framework

The present study is grounded in Faith-Resilience Theory (Manning, 2014; Walsh, 2009) and the Two-Dimensional Model of Religiosity (Allport & Ross, 1967). Faith-Resilience Theory posits that a strong belief in the divine fosters meaning-making, hope, and adaptive coping during adversity, thereby enhancing resilience and protecting psychological well-being and quality of life (QoL). Empirical evidence supports this framework across diverse crises, showing that individuals with deep spiritual faith exhibit greater resilience, faster recovery from trauma, and improved QoL outcomes (Gunnestad & Thwala, 2011; Tarakeshwar et al., 2006; Brodsky, 2000). In the context of the COVID-19 pandemic—an unprecedented global stressor characterised by fear, isolation, and uncertainty—this theory provides a robust explanation for why religiosity may buffer the negative impact on QoL, particularly in a highly religious society such as Pakistan.

Religiosity is conceptualised according to Allport and Ross's (1967) two-dimensional model. Intrinsic religiosity reflects genuine internalisation of faith as a central life motive, guiding values, behaviour, and meaning-making. Extrinsic religiosity, in contrast, treats religion instrumentally—for social support, security, or status. Prior research consistently demonstrates that intrinsic religiosity is associated with positive mental health outcomes (lower stress, anxiety, and depression; higher well-being), whereas extrinsic religiosity often correlates with poorer psychological adjustment (Pirutinsky et al., 2020; Watson et al., 2002). Resilience, defined as the capacity to maintain or regain mental health despite significant adversity (Masten, 2015), is positioned as the mechanism through which religiosity influences perceived COVID-19-related QoL deterioration.

The proposed conceptual model (Figure 1) illustrates resilience as a partial mediator between both dimensions of religiosity and COVID-19 impact on quality of life (COV19-QoL). Higher intrinsic religiosity is expected to strengthen resilience, thereby reducing perceived negative impact on QoL. Conversely, higher extrinsic religiosity is hypothesised to weaken resilience (or be negatively linked to it), thereby increasing perceived QoL impairment.

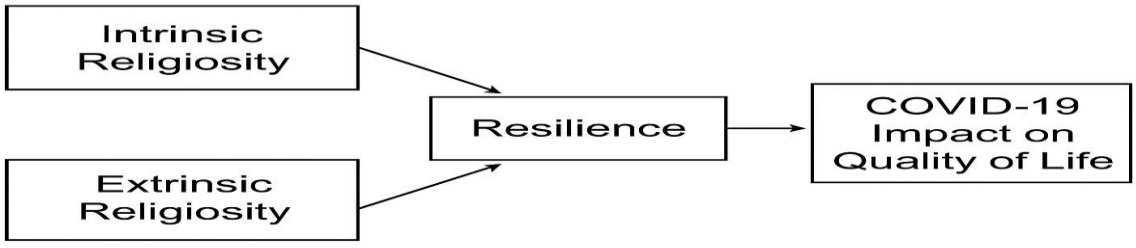

Figure 1. Conceptual model: Resilience as a mediator between religiosity and COVID-19 impact on quality of life.

Hypothesis

Based on the theoretical framework and empirical literature, the following hypotheses were tested:

1. There will be significant relationships among resilience, intrinsic/extrinsic religiosity, and COVID-19 impact on quality of life.
2. COVID-affected individuals will report greater negative impact on quality of life (higher COV19-QoL scores) than non-affected individuals.

3. Individuals with chronic physical illness will report greater negative impact on quality of life than healthy individuals.
4. Higher resilience and higher intrinsic religiosity will predict lower COVID-19 impact on quality of life.
5. Higher extrinsic religiosity will predict greater COVID-19 impact on quality of life.
6. Females will exhibit higher levels of resilience and religiosity than males.
7. Resilience will partially mediate the relationship between religiosity (both intrinsic and extrinsic dimensions) and COVID-19 impact on quality of life.

This integrated framework is particularly relevant in Muslim-majority Pakistan, where religion permeates daily life and serves as a primary coping resource during crises. By examining how faith-based resilience buffers pandemic-related QoL deterioration in both affected and non-affected groups, the study extends Faith-Resilience Theory to a non-Western, highly religious context.

Methods

Research Design

A cross-sectional comparative design was employed to examine differences in COVID-19-related impact on quality of life (COV19-QoL), resilience, and religiosity between coronavirus-affected and non-affected Pakistani adults, as well as the predictive and mediating roles of resilience and religiosity.

Participants

The sample comprised 400 adults (51.5% female) aged 18–65 years (M = 29.84, SD = 9.68). Two equal groups were formed:

- COVID-affected group (n = 200): individuals who had tested positive for SARS-CoV-2 (via PCR or physician diagnosis) and experienced symptoms, recruited through snowball sampling.
- Non-affected group (n = 200): individuals with no history of COVID-19 diagnosis or symptoms, recruited via convenience sampling.

Inclusion criteria were age ≥ 18 years, ability to read Urdu, and access to the internet. Exclusion criteria included current severe psychiatric illness or cognitive impairment that could interfere with comprehension. Participants were primarily urban residents from Punjab (58%), Sindh (22%), and Khyber Pakhtunkhwa (12%). Most were single (62%), highly educated (78% bachelor's or higher), and from middle socioeconomic backgrounds. Demographic characteristics are presented in Table 1.

Measures

- Demographic Information Sheet: A brief questionnaire collected age, gender, education, marital status, occupation, monthly income, province, history of COVID-19 infection, and presence of chronic physical illness.
- COVID-19 Impact on Quality of Life: This 6-item scale assesses perceived deterioration in physical health, psychological health, social relationships, and overall QoL due to the pandemic. Items (e.g., "My physical health has worsened because of the coronavirus pandemic") are rated on a 5-point Likert scale (1 = completely disagree, 5 = completely agree). Higher scores indicate greater negative impact. The original scale showed good reliability (α = .85). The Urdu-translated version used in the present study demonstrated excellent internal consistency (α = .91).
- Resilience Scale: The RS-14 is a 14-item abbreviated version of the original Resilience Scale measuring personal competence and acceptance of self and life. Items (e.g., "I usually take things in stride") are scored on a 7-point Likert scale (1 = disagree, 7 =

agree). Higher total scores reflect greater resilience. The Urdu version has established validity and reliability among Pakistani samples (α = .90–.93). Cronbach's alpha in the current study was .94.

- Muslim Religiosity Scale: This indigenous 28-item scale assesses religiosity among Muslims on two dimensions: Intrinsic Religiosity (14 items; e.g., "My faith gives meaning to my life") and Extrinsic Religiosity (14 items; e.g., "I pray to gain respect in society"). Responses are recorded on a 5-point Likert scale (1 = strongly disagree, 5 = strongly agree). Higher subscale scores indicate stronger intrinsic or extrinsic orientation. The scale has demonstrated strong psychometric properties in Pakistani populations (α = .88 for intrinsic, α = .85 for extrinsic). In the present sample, Cronbach's alphas were .92 (intrinsic) and .89 (extrinsic).

Procedure

Ethical approval was obtained from the Institutional Review Board of the Department of Psychology, University of [Name]. Data were collected online from March to August 2021 via Google Forms disseminated through social media platforms (WhatsApp, Facebook, Instagram) and email. Participants first viewed an informed consent page detailing the study purpose, voluntary nature, confidentiality, and right to withdraw. Consent was indicated by clicking "I agree to participate." The demographic sheet was presented first, followed by the three scales in counterbalanced order. Completion took approximately 20–25 minutes. No incentives were offered. For the affected group, initial contacts were identified through personal and professional networks and asked to forward the link to others who had recovered from COVID-19.

Data Analysis

Data were analysed using IBM SPSS 26.0 and Hayes' PROCESS macro (v4.0). Descriptive statistics (means, standard deviations, frequencies) were computed. Independent-samples t-tests examined group differences (affected vs. non-affected) on COV19-QoL, resilience, and religiosity dimensions. Pearson product-moment correlations assessed bivariate relationships among study variables. Hierarchical multiple regression tested the predictive effects of group status, resilience, intrinsic religiosity, and extrinsic religiosity on COV19-QoL. Mediation analysis (Model 4, PROCESS macro) with 5,000 bootstrap samples evaluated whether resilience mediated the relationship between religiosity dimensions and COV19-QoL. The significance level was set at $p < .05$.

Results

Data screening confirmed normality, linearity, and absence of multicollinearity (VIF < 2.1). Analyses were conducted using SPSS 26 and PROCESS macro v4.0 (Hayes, 2018) with 5,000 bootstrap samples. Alpha was set at .05 (two-tailed).

Sample Characteristics

The final sample comprised 400 Pakistani adults (60% female; Mage = 34.77 years, SD = 13.01). Half (n = 200) had contracted COVID-19 (confirmed by PCR/physician diagnosis and symptomatic); the other half had not. Participants were predominantly urban, highly educated (88.6% bachelor's or higher), and middle-income. Chronic physical illness was reported by 21.5% (n = 86). Detailed demographics are presented in Table 1.

Table 1 Sociodemographic Characteristics (N = 400)

Characteristic	COVID-Affected (n = 200)	Non-Affected (n = 200)	Total (N = 400)
Age (M ± SD)	34.82 ± 13.48	34.72 ± 12.56	34.77 ± 13.01
Gender (Female %)	62.0%	58.0%	60.0%
Education (≥ Bachelor's %)	89.5%	87.5%	88.6%
Married (%)	43.0%	32.5%	37.8%
Chronic physical illness (%)	24.0%	19.0%	21.5%

Psychometric Properties and Descriptive Statistics

All measures showed good to excellent reliability (Table 2). Mean COV19-QoL scores indicated moderate perceived deterioration in quality of life across the full sample (M = 2.71, SD = 0.92; possible range 1–5).

Table 2 Descriptive Statistics and Reliability (N = 400)

Variable	k	M	SD	Range	α
COV19-QoL	6	2.71	0.92	1.00–4.83	.88
Resilience (RS-14)	14	74.18	13.18	27–98	.93
Intrinsic Religiosity	13	42.44	7.99	22–60	.82
Extrinsic Religiosity	13	45.11	6.15	19–57	.73

Group Differences

Independent-samples t-tests (Table 3) revealed no significant difference in overall COV19-QoL between COVID-affected and non-affected participants, disconfirming Hypothesis 2. However, COVID-affected individuals reported significantly lower resilience (d = 0.21) and higher extrinsic religiosity (d = 0.26) than non-affected individuals.

Table 3 Group Differences on Key Variables

Variable	Affected (n=200) M (SD)	Non-Affected (n=200) M (SD)	t(398)	p	Cohen's d
COV19-QoL	2.78 (0.92)	2.63 (0.91)	1.61	.108	0.16
Resilience	72.81 (12.82)	75.54 (13.41)	-2.08	.038	0.21
Intrinsic Religiosity	42.32 (7.87)	42.56 (8.13)	-0.31	.759	0.03
Extrinsic Religiosity	45.92 (6.17)	44.32 (6.04)	2.62	.009	0.26

Correlations

Pearson correlations (Table 4) confirmed Hypothesis 1. Across the full sample and within both groups, resilience and intrinsic religiosity were strongly negatively correlated with COV19-QoL, whereas extrinsic religiosity showed positive correlations.

Table 4 Intercorrelations Among Study Variables (N = 400)

Variable	1	2	3	4
1. COV19-QoL	—			
2. Resilience	-.72**	—		
3. Intrinsic Religiosity	-.59**	.52**	—	
4. Extrinsic Religiosity	.42**	-.27**	-.27**	—
****p < .01**				

Predictive and Mediational Analyses

Multiple regression (Table 5) supported Hypotheses 4 and 5: resilience (β = -.53) and intrinsic religiosity (β = -.27) negatively predicted COV19-QoL, whereas extrinsic religiosity positively predicted it (β = .21). The model explained 62% of variance, $F(3,396) = 218.96$, $p < .001$.

Table 5 Multiple Regression Predicting COV19-QoL

Predictor	B	SE	β	p
Resilience	-.22	.02	-.53	<.001
Intrinsic Religiosity	-.18	.03	-.27	<.001
Extrinsic Religiosity	.19	.03	.21	<.001
R^2 = .62				

Mediation analyses (PROCESS Model 4) confirmed Hypothesis 7 (Table 6, Figures 1 & 2). Resilience partially mediated both relationships:

- Intrinsic religiosity → Resilience → COV19-QoL (indirect effect = -.19, 95% CI [-.25, -.16])
- Extrinsic religiosity → Resilience → COV19-QoL (indirect effect = .16, 95% CI [.12, .25])

Table 6 Summary of Mediation Effects

Path	Effect	SE	95% CI
Intrinsic → Resilience → COV19-QoL	-.19***	.02	[-.25, -.16]
Extrinsic → Resilience → COV19-QoL	.16***	.03	[.12, .25]

- Participants with chronic physical illness reported significantly higher COV19-QoL scores than healthy participants (M = 3.39 vs. 2.45, $t(398) = 8.12$, $p < .001$, $d = 1.14$), supporting Hypothesis 3.
- Males reported greater COV19-QoL impact than females in both the full sample and subgroups ($p < .05$), partially disconfirming Hypothesis 6 (females showed higher resilience, but not religiosity).

In summary, although direct COVID-19 infection did not increase perceived QoL deterioration beyond pandemic-wide effects, affected individuals exhibited lower resilience and higher extrinsic religiosity. Resilience and intrinsic religiosity emerged as strong protective factors, whereas extrinsic religiosity functioned as a risk factor, with resilience partially mediating both pathways.

Discussion

The present study investigated the interplay of resilience and religiosity (intrinsic and extrinsic) in mitigating the perceived negative impact of COVID-19 on quality of life (COV19-QoL) among Pakistani adults, half of whom had contracted the virus. Although direct infection did not exacerbate overall perceived QoL deterioration beyond the pandemic's universal effects, COVID-affected participants exhibited significantly lower resilience and higher extrinsic religiosity. Intrinsic religiosity and resilience emerged as robust protective factors, whereas extrinsic religiosity functioned as a risk factor, with resilience partially mediating both pathways.

Contrary to expectation, COVID-affected and non-affected participants reported comparable moderate levels of COV19-QoL deterioration. This finding aligns with evidence that the pandemic inflicted widespread psychological and lifestyle disruption regardless of infection status (Holmes et al., 2020; Kar et al., 2020). Lockdowns, economic uncertainty, fear of contagion, and social isolation affected the entire population, often overshadowing the specific trauma of illness. Pakistan's history of recurrent crises (terrorism, natural disasters, political instability) may have fostered a degree of "stress inoculation," enabling relative adaptation even amid a novel threat. However, affected individuals showed markedly lower resilience, consistent with reports that direct illness, isolation, and fear of mortality impair adaptive

capacity (Cohn-Schwartz et al., 2020; Zhang et al., 2020). Many survivors were still in the survival/recovery phase of the resilience cycle rather than thriving (Patterson & Kelleher, 2005).

Strong negative correlations between resilience, intrinsic religiosity, and COV19-QoL, and positive correlations with extrinsic religiosity, support Faith-Resilience Theory (Manning, 2014) and Allport and Ross's (1967) two-dimensional model. Intrinsic religiosity genuine internalized faith promoted meaning-making, hope, and resilience, buffering perceived QoL impairment (Pirutinsky et al., 2020; Tarakeshwar et al., 2006). In Pakistan's deeply religious context, viewing adversity as divine will or a test of faith likely fostered acceptance and perseverance. Conversely, extrinsic religiosity using religion for social status or security was associated with poorer outcomes, replicating findings among Orthodox Jews during COVID-19 (Pirutinsky et al., 2020). Instrumental religious orientation may create cognitive dissonance when external rewards (community approval, status) are disrupted by lockdowns and mosque closures.

Regression analyses confirmed that higher resilience and intrinsic religiosity independently predicted lower COV19-QoL, whereas extrinsic religiosity predicted greater impairment, collectively explaining 62% of variance. Mediation analyses further revealed resilience as a key mechanism: intrinsic religiosity enhanced resilience, which in turn reduced perceived QoL deterioration; extrinsic religiosity weakened resilience, amplifying negative impact. These results extend prior work showing partial mediation of religiosity–well-being links by positive virtues including resilience (Sharma & Singh, 2019) and highlight resilience's central role in religious coping during crises (Min et al., 2013).

Additional findings underscored vulnerability among males and individuals with chronic illness. Males reported greater QoL impairment, possibly reflecting breadwinner stress, job loss, and restricted social/religious activities (mosque closure) in a patriarchal society (Algahtani et al., 2021). Females exhibited higher resilience, consistent with gender differences in emotional expression and social support-seeking (Bonanno et al., 2007). Chronically ill participants perceived significantly worse QoL, driven by heightened mortality risk, treatment inaccessibility, and financial burden especially painful in a resource-constrained healthcare system. Strengths include the balanced affected/non-affected design, use of culturally validated indigenous measures, and examination of religiosity dimensions in a highly religious Muslim-majority context. Limitations are the cross-sectional design (precluding causality), online convenience/snowball sampling (potential education/internet-access bias), and self-report measures. Future longitudinal research should track recovery trajectories and test resilience-building interventions incorporating intrinsic religious elements.

While COVID-19's societal disruptions affected QoL broadly, lower resilience distinguished those who fell ill. Intrinsic religiosity and resilience served as critical protective resources, whereas extrinsic religiosity compounded vulnerability. These findings have clear implications for mental health practice in religious societies: interventions should strengthen genuine spiritual connection and resilience skills (e.g., meaning-making, acceptance, social support) rather than ritualistic or status-oriented religious practice. Religiously integrated resilience training drawing on Islamic concepts of sabr (patient perseverance) and tawakkul (trust in divine wisdom) offers a culturally congruent pathway to mitigate future crises.

Conclusion

The present study demonstrates that resilience and intrinsic religiosity serve as powerful protective factors against the perceived negative impact of COVID-19 on quality of life in a Pakistani sample, whereas extrinsic religiosity acts as a risk factor. Although direct infection did not intensify overall QoL deterioration beyond the pandemic's universal effects both affected

and non-affected participants reported moderate impairment COVID-affected individuals exhibited significantly lower resilience and higher extrinsic religiosity. Resilience partially mediated the pathways from both intrinsic and extrinsic religiosity to COV19-QoL, confirming its central role in religious coping. Males and those with chronic physical illnesses emerged as particularly vulnerable, experiencing greater QoL deterioration. These findings align with Faith-Resilience Theory and highlight the differential outcomes of genuine versus instrumental religious orientation during crises in a Muslim-majority context.

The results carry important implications for mental health practice and policy in religious societies. Interventions should prioritise strengthening intrinsic religiosity and resilience through culturally congruent approaches such as integrating Islamic concepts of sabr (perseverance), tawakkul (trust in God), and gratitude alongside evidence-based techniques like CBT, mindfulness, and self-efficacy training. Mental health professionals are encouraged to incorporate spiritually integrated resilience-building programs, especially for males and chronically ill individuals. Future research should employ longitudinal and mixed-method designs, include less-educated and lower-income groups, and explore additional predictors of pandemic-related QoL across cultures. Despite limitations of online sampling and cross-sectional design, this study underscores the value of faith-based resources in mitigating the psychological toll of global health crises, offering a pathway toward enhanced coping and recovery in Pakistan and similar contexts.

References

Allport, G. W., & Ross, J. M. (1967). Personal religious orientation and prejudice. *Journal of Personality and Social Psychology*, *5*(4), 432–443. https://doi.org/10.1037/h0021212

Algahtani, F. D., Hassan, S. U. N., Alsaif, B., & Zrieq, R. (2021). Assessment of the quality of life during COVID-19 pandemic: A cross-sectional survey from the Kingdom of Saudi Arabia. *International Journal of Environmental Research and Public Health*, *18*(3), Article 847. https://doi.org/10.3390/ijerph18030847

American Psychological Association. (2018). *The road to resilience*. https://www.apa.org/topics/resilience

Baron, R. M., & Kenny, D. A. (1986). The moderator–mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology*, *51*(6), 1173–1182. https://doi.org/10.1037/0022-3514.51.6.1173

Bhamani, M. A., Zahid, N., Azam, I., Asad, N., & Karmaliani, R. (2015). Validation of the Urdu version of Wagnild and Young's long and short Resilience Scales among 20–40 year old married female university students in Karachi. *Journal of the Pakistan Medical Association*, *65*(1), 30–36.

Bonanno, G. A., Galea, S., Bucciarelli, A., & Vlahov, D. (2007). What predicts psychological resilience after disaster? The role of demographics, resources, and life stress. *Journal of Consulting and Clinical Psychology*, *75*(5), 671–682. https://doi.org/10.1037/0022-006X.75.5.671

Hayes, A. F. (2018). *Introduction to mediation, moderation, and conditional process analysis: A regression-based approach* (2nd ed.). Guilford Press.

Holmes, E. A., O'Connor, R. C., Perry, V. H., Tracey, I., Wessely, S., Arseneault, L., Ballard, C., Christensen, H., Cohen Silver, R., Everall, I., Ford, T., John, A., Kabir, T., King, K., Madan, I., Michie, S., Przybylski, A. K., Shafran, R., Sweeney, A., … Bullmore, E. (2020). Multidisciplinary research priorities for the COVID-19 pandemic: A call for action for mental health science. *The Lancet Psychiatry*, *7*(6), 547–560. https://doi.org/10.1016/S2215-0366(20)30168-1

Khan, M. J. (2014). Construction of Muslim religiosity scale. *Islamic Studies*, *53*(1–2), 67–81.

Manning, L. K. (2014). Enduring as lived experience: Exploring the essence of spiritual resilience for women in late life. *Journal of Religion and Health*, *53*(2), 352–362. https://doi.org/10.1007/s10943-012-9639-5

Masten, A. S. (2015). *Ordinary magic: Resilience in development*. Guilford Press.

Pirutinsky, S., Cherniak, A. D., & Rosmarin, D. H. (2020). COVID-19, mental health, and religious coping among American Orthodox Jews. *Journal of Religion and Health*, *59*(5), 2288–2301. https://doi.org/10.1007/s10943-020-01061-z

Repišti, S., Jovanović, N., Kuzman, M. R., Medved, S., Jerotić, S., Ribić, E., Majstorović, T., & Russo, M. (2020). How to measure the impact of the COVID-19 pandemic on quality of life: COV19-QoL – the development, reliability and validity of a new scale. *Global Psychiatry*, *3*(2), 201–210. https://doi.org/10.2478/gp-2020-0016

Sharma, S., & Singh, K. (2019). Religion and well-being: The mediating role of positive virtues. *Journal of Religion and Health*, *58*(1), 119–131. https://doi.org/10.1007/s10943-018-0712-7

Tarakeshwar, N., Vanderwerker, L. C., Paulk, E., Pearce, M. J., Kasl, S. V., & Prigerson, H. G. (2006). Religious coping is associated with the quality of life of patients with advanced cancer. *Journal of Palliative Medicine*, *9*(3), 646–657. https://doi.org/10.1089/jpm.2006.9.646

Wagnild, G. (2009). A review of the Resilience Scale. *Journal of Nursing Measurement*, *17*(2), 105–113. https://doi.org/10.1891/1061-3749.17.2.105

World Health Organization. (2016). *Process of translation and adaptation of instruments*. https://www.who.int/substance_abuse/research_tools/translation/en/

Zhang, J., Yang, Z., Wang, X., Li, J., Dong, L., Wang, F., Li, Y., Wei, R., & Zhang, J. (2020). The relationship between resilience, anxiety and depression among patients with mild symptoms of COVID-19 in China: A cross-sectional study. *Journal of Clinical Nursing*, *29*(21–22), 4020–4029. https://doi.org/10.1111/jocn.15425