

Revisiting COVID-19 and Occupational Mental Health

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ABSTRACT

This cross-sectional study aimed to describe the frequency of psychological sequelae of COVID-19 in healthcare workers (HCWs) conducted at The Aga University Hospital, from May to July 2020. The data collection was done online using a demographics questionnaire, concern of COVID-19 scale, Generalised Anxiety Disorder, and Impact of event scale. A total of 560 responses were received. Nearly 25% of participants had moderate to severe anxiety or psychological distress due to COVID-19. Female responders reported more anxiety compared to males. ($p = 0.001$). The doctors and nurses reported significant psychological distress ($p = 0.046$). The participants with moderate to severe anxiety and psychological distress reported statistically significant high levels of concern of the following: inadequate protective measures, contracting and spreading COVID-19, medical violence, and deteriorating quality of patient interaction due to COVID-19. The COVID-19 pandemic has highlighted areas of development for occupational healthcare policy development in Pakistan. Implementation of contextualised solutions, especially psychosocial determinants is necessary to mitigate the invisible mental health burden and its impact on HCWs in Pakistan.

Key Words: *Occupational mental health, Pakistan, Anxiety, Depression.*

How to cite this article: Mansoor M, Najam S. Revisiting COVID-19 and Occupational Mental Health. *J Coll Physicians Surg Pak* 2023; **33(04)**:477-478.

The study invitation and proforma link were circulated via institutional e-mail address to about 10000 employees following approval from the Ethics review committee. All HCWs including health service providers, health management and support workers, working full-time and part-time in clinical or non-clinical areas, with an organisational e-mail address. English literate and willing to consent for the study were included. Data were collected anonymously, from May till July 2020. Five hundred and sixty responses were received over the course of three weeks. In addition to information on baseline demographics perception of COVID-19 scale, GAD-7 scale, and impact of event scale were also used.

Data were analysed on SPSS 19.0. The authors calculated the mean and standard deviation for continuous variables and the frequencies and percentages for categorical variables. Frequencies for each item of the scales used were calculated; perception of COVID-19, generalised anxiety disorder-7 (GAD-7), and impact of event scale (IES-R). The authors then stratified the age, gender, education, occupation, area of work, work experience, past psychiatric history, and perception of COVID-19 to control for effect modifiers. The post-stratification chi-square test measured the effect on outcome variables.

The p-value was set to <0.05 . The HCWs with moderate to severe scores on any of the study scales received a self-help-pamphlet and were advised to seek out formal psychiatric help using the employee mental health pathway in the hospital after completion of the study results.¹

Among the study participants 61.6% ($n=345$) were females and 38.4% ($n=215$) were males. Two hundred and sixty-eight (47.9%) of the participants were aged 21-30 years, 30% ($n=168$) were 31-40 years old, 12.3% ($n=69$) were 41-50 years old and 9.8% ($n=55$) of the study participants were 51 years or older. 60.2% ($n=337$) of participants were ever married, and 39.8% ($n=223$) were never married.

The majority of the participants 15.4% ($n=86$) had no children, 32% ($n=179$) had 1-2 children, and 12.9% ($n=72$) had 3 or more children. The living setup of 58% ($n=325$) participants was joint and 42% ($n=235$) participants resided in a nuclear family setup. The education level of study participants was postgraduate for 46.6% ($n=261$) participants, 45.4% ($n=254$) were graduates, and 8% ($n=45$) were undergraduates. The majority of responses were from doctors 28.4% ($n=159$) and nurses 20.7% ($n=116$); followed by management staff 15.7% ($n=88$), healthcare support staff 13.2% ($n=74$), technicians 9.1% ($n=51$), others 8.8% ($n=49$), and pharmacists 4.1% ($n=23$). Three hundred and ninety-nine (71.3%) study participants worked in clinical areas of the hospital, and 25.9% ($n=145$) were non-clinical HCWs and 2.9% ($n=16$) participants did not respond to this question. Ninety-five respondents (17%) reported having medical or surgical comorbidities, and 83.0% ($n=465$) reported none. Majority of the participants (95.7%, $n=536$), denied prior mental health issues, and only 4.3% ($n=24$), reported a history

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Received: August 02, 2022; Revised: November 19, 2022;

Accepted: December 09, 2022

DOI: <https://doi.org/10.29271/jcpsp.2023.04.477>

of psychiatric illness, 6.8% (n=38) of study participants had contracted COVID-19 at the time of the study, and 39.3% (n=220) of participants had a history of COVID-19 exposure.

Anxiety was screened using the GAD-7 scale, 42.3% (n=237) had no anxiety, 30.4% (n=170) had mild anxiety, 16.3% (n=91) had moderate anxiety, and 11.1% (n=62) had severe anxiety. In total, 27.4% (n=153) of participants had moderate to severe anxiety symptoms. Female responders reported more anxiety compared to males. This was statistically significant ($p=0.001$). The responders with 1-2 children also had statistically significant increase in anxiety ($p=0.032$). Other demographic factors include age, marital status, living setup, and years of clinical experience, etc did not show a statistically significant relation.

The psychological distress of COVID-19 was measured using IES-R. Out of the participants, 60.7% (n=340) participants reported no psychological distress, 14.5% (n=81) had mild psychological distress, 4.5% (n=25) had a moderate psychological distress, and 20.4% (n=114) had symptoms of severe psychological distress. Overall, almost one-fourth of participants had moderate to severe anxiety or psychological distress due to COVID-19. The doctors and nurses reported statistically significant psychological distress ($p=0.046$) compared to other healthcare workers.

Based on GAD-7 and IES-R scales, participants with moderate to severe anxiety and psychological distress had a statistically significant relationship with a high level of concern of inadequate protective measures in the work setting ($p=0.049$), contracting COVID-19 themselves ($p<0.001$), their family members ($p=0.0010$), and of colleagues in direct contact with COVID-19 ($p=0.001$).

A similar concern about medical violence by patients and families secondary to COVID-19 complications were seen ($p<0.001$). The participants also reported statistically significant concern regarding the deterioration in the quality of patient interaction due to COVID-19 ($p<0.001$). No significant relationship with a personal history of COVID-19 or psychiatric illness was seen.

The majority of Pakistani hospitals are government-run and have limited resources, for example, PPE, safety, and security. The underlying causes of medical violence greatly vary and range from insufficient resources for seeking adequate medical help for COVID-19, hearing the bad prognosis of a loved one or a family member passing away due to COVID-19.²

Based on this study results, an integrated occupational mental healthcare is recommended within the healthcare system.

The government of Pakistan has recently acknowledged the need for mental health support for front-line healthcare workers as part of the MHPSS (mental health and psychosocial support) initiative, however, occupational mental health services per se continue to remain non-existent.³ The authors further recommend that healthcare policymakers need to continuously study and address the social determinants of mental health such as financial remuneration, housing, cost of child support, domestic support, health coverage, and old-age benefits, as they play a wider role in influencing mental well-being of HCWs on a larger scale.

COMPETING INTEREST:

The authors declared no competing interest.

AUTHORS' CONTRIBUTION:

MM, SN: Equally involved in the concept and design of the study; involved in drafting, revision, and review of the manuscript along with the final approval.

Both authors are in agreement to be accountable for all aspects of the study.

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