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The Spread of COVID19 in the Pakistan: Anxiety, Depression and Post-Traumatic Stress Disorder

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Abstract: ***The first to be detected in Wuhan, China, was COVID-19 recognized as a coronavirus disease at the end of 2019. The disorder is very infectious and has a steadily growing worldwide prevalence. Because of its global circulation, the World Health Organization (WHO) recognized the pandemic as is the normal practice in such pandemics, a lockout is normally forced into all public areas to restrict the transmission of the disease and to minimize the risk for new cases. However, health care providers are sadly left to contend with the many problems that occur as a consequence of this situation. The people in general take those action. The mean anxiety rate in general was 19.01 ± 9.2, 18.12 ± 10 and 20,12 ± 12.0. The number of participants with mild to extremely serious depression was 81 (72.3%); moderate to extremely severe anxiety is 96 (85.7%); and 101 (90.1%). moderate to intense stress levels were recorded. It is obvious that many neurological disorders such as anxiety, stress and depression impact a large number of health professionals. It is vital for government action to ensure the mental health of health care provider is controlled consistently and to try to reduce their burdens. A large number of Pakistani participants in this study experienced fear, fatigue, and depression. Approximately 89% of health care providers feared their families, while 80% feared that COVID-19 might come on their own. This is a comparative figure for Wuhan, where only 50,4% of health care provider patients treated for COVID-19 were depressed, 44.6% had anxiety, 34% had insomnia, and a significant proportion had depression, anxiety, (560 [44.6 percent]), insomnia, and distress (899[71.5 percent]). (527 [34.0 percent])***
Keywords: COVID-19, Mental health, health care providers, public awareness, government action

I. INTRODUCTION

First, as a result of the pandemic a large number of cases lead to a growing number of hours of working for health workers, often with insufficient funding and questionable facilities. Secondly, they face physical pain and breathing problems when wearing personal protective equipment, which is important for protecting them from virus exposure. A major concern for the [1] health care providers is the fact that many health care providers are unable to fulfil their duties as a matter of urgency, because little is understood about the current virus/disease, which results in no guidelines or evidence-driven clinical therapies prevalent.

The psychological reaction of health care providers in an outbreak can be depending on several factors, including feeling vulnerable to illness, lack of monitoring, viral transmission, family wellbeing and isolation. Other factors, such as a lack of personal protective equipment's, medications, and a growing amount of real and reported events, may lead to stress and anxiety in health care providers. This can relate to different degrees of intensity of emotional pressure, which can lead to isolation and impudence and can lead to tension, anxiety, irritation, mental tiredness and depression.

A large number of Pakistani participants in this study experienced fear, fatigue, and depression. Approximately 89% of health care providers feared their families, while 80% feared that COVID-19 might come on their own. These numbers can be [2] contrasted with Wuhan, of which just 50% (50.4%), 44.6% of health care providers with a care of COVID-19 patients had depression, 34% insomnia (634[50.4%]), anxiety (560[44.6%]), insomnia (427[34.0%] and distress) were present in HACSs. This number was similar to the figure for Wuhan (899 [71.5 percent])

This high incidence of anxiety, depression, and stress in Pakistan can be certified by factors such as inadequate facilities for patient treatment, mass recognition and insufficient compliance with safety measures. The persistence of consequences for healthcare staff is also significant. Many studies have shown that elevated levels of anxiety, depression, stress and even post-traumatic stress disorder in many HCP were found, even after a period of time following an outbreak

Then there is a very good fear that the infection will spread to your relatives and friends, and autoinoculation will take place This anxiety drives HCPs to get alone, change their everyday habits and even reduce their social support systems, all in the expectation of keeping others theoretically safe.

Furthermore, a highly infectious illness, such as the HCPs that are specifically engaged in the care of a COVID-19, which experience a stigma while the pandemic has led to a 'superhero' status at the other end of the continuum. This brings meaning and gratitude to the job, on the one hand; on the other, it exerts more responsibility on employees and leaves less room for mistakes. [3] Because of its dramatic nature, the media reinforce the "super hero" status, encouraging the need for social reinforcement, inspiration, and gratitude.

Secondly, they are confronted with physical disorders and, at times, with respiratory problems when wearing personal protective equipment's , which are necessary to prevent them from being exposed to the virus. Another major challenge facing HCPs is that since nothing is understood about the current virus/disease, and no guidelines or clinical therapies based on research are common, many HCPs are unprepared to take on their duties, and there is also an extremely valid fear of autoinoculation and the possibility that the virus may spread to your friends and relatives. This anxiety drives HCPs to get alone, change their everyday habits and even reduce their social support systems, all in the expectation of keeping others theoretically safe.

[4] Not unexpectedly, the mental health of HCPs is affected by both of these factors. 18-57 percent of HCPs experienced serious mental and psychological issues both before and after the outbreak of extreme acute respiratory syndrome (SARS) in 2003. HCPs experienced dysphoria and stress during 2015, when Middle East Respiratory Syndrome (MERS) was also caused by coronavirus.

II. MATERIALS AND METHOD

Mental wellbeing effects for health workers across epidemics and pandemics have been identified by several other surveys. High levels of stress, anxiety, depression and even after traumatic stress disorder (PTSD) have in many cases occurred even after some time after these events.

Consequently, it is particularly critical to recognize those HCPs who are most at risk for burnout and who are more likely to be anxious, depressed or stressed in this pandemic to be assisted where appropriate. The causes responsible for this tension should also be identified and addressed. In this analysis, we shall ascertain the prevalence and causative factors of HCPs affected by anxiousness, depression and stress.

The thesis took place at several Karachi hospitals in Pakistan in May 2020. The participants were invited to all health professionals (HCPs) placed in COVID-19 isolation wards. This analysis was finished by a group of 112 HCPs. The English version of the Stress Scale of Depression Anxiety 21 was developed in a well-organized way (DASS-21). DASS-21 is a validated 21-point self-report instrument for measuring three associated negative mental conditions: depression, anxiety and stress. In the online form there are also different explanations why HCPs believe that fear, stress and depression are the predisposing factors. There are some explanations for choosing participants, depending on their own.

SPSS Version 21.0 was used to process the collected data (IBM Corp, Armonk, NJ). For anxiety, stress and depression values average and standard deviation (SD) were determined. The magnitude of DASS-21 and explanations for health care workers predisposing to anxiety, stress and depression were measured as frequencies and percentages.

III.RESULTS

64 (57.1 percent) of the 112 HCP participants were male and 48 (42.9 percent) were female. were women (47.1 percent). The total mean anxieties score was 19.01 ± 9.2, 18.12 ± 10, depression, tension 20.12 ± 12.0. 81 participants (72.3%) had mild to very severe depression, 96 were moderate to very severe anxiety (85.7%), and 101 were moderates to intense stress levels (90.1%), and participants were very high.

TABLE 1
Data regarding the health care workers having different level of stress, anxiety and depression

DASS-21	Depression		Anxiety		Stress	
Normal	Male (n=64)	Female (n=48)	Male (n=64)	Female (n=48)	Male (n=64)	Female (n=48)
Mild	6 (9.3%)	5 (10.4%)	0	5 (10.4%)	2 (3.1%)	2 (4.1%)
Moderate	8 (12.5%)	12 (25%)	3(4.6)%	8 (16.6%)	4 (6.2%)	3 (6.2%)
Severe	16 (25%)	7 (14.5%)	15 (23.4%)	10 (20.8)	16 (25%)	13 (27%)
Extremely Severe	25 (39%)	2(41.6%)	32 (50%)	17 (35.4%)	29 (45.3%)	22 (45.8%)

IV. DISCUSSION

The psychological reaction of HCPs to an illness may be based on several factors, such as a sensitivity to illness, a loss of control over the situation, the dissemination of the virus, their family's health and their isolation. Factors such as the lack of IPPs, medications etc. and a growing number of real and reported cases may also add to the strain and anxiety of HCPs.

These factors can contribute to different psychological levels and intensity, which leads to a sense of solitude which helplessness and may lead to tension, anxiety, irritability, mental tiredness and depression. A large number of Pakistani participants in this study experienced fear, fatigue, and depression. Approximately 89% of HCPs feared their families, while 80% feared that COVID-19 might come on their own. These numbers can be contrasted with Wuhan, of which just 50% (50.4%), 44.6% of HCPs with a care of COVID-19 patients had depression, 34% insomnia (634[50.4%]), anxiety (560[44.6%]), insomnia (427[34.0%] and distress) were present in HACSs. This number was similar to the figure for Wuhan (899 [71.5 percent])

This high incidence of anxiety, depression, and stress in Pakistan can be certified by factors such as inadequate facilities for patient treatment, mass recognition and insufficient compliance with safety measures. The persistence of consequences for healthcare staff is also significant. Many studies have shown that elevated levels of anxiety, depression, stress and even PTSD in many HCP were found, even after a period of time following an outbreak

Furthermore, a highly infectious illness, such as the HCPs that are specifically engaged in the care of a COVID-19, which experience a stigma while the pandemic has led to a 'superhero' status at the other end of the continuum. This brings meaning and gratitude to the job, on the one hand; on the other, it exerts more responsibility on employees and leaves less room for mistakes. Because of its dramatic nature, the media reinforce the "super hero" status, encouraging the need for social reinforcement, inspiration, and gratitude.

V. CONCLUSIONS

Given the findings of this report, it is evident that an unprecedented number of health staff are affected by the COVID-19 pandemic. It can also be shown that many of the factors which can cause HCPs to suffer these illness, for example the free provision of personal protective equipment to all healthcare workers, the promotion of general awareness about COVID-19 and better infrastructure can all be done by the government to encourage lighter working hours.

Our survey found that the health professionals showed elevated levels of angst, stress and depression, causing alarm. Both the government and health organizations are responsible for protecting healthcare populations around the world's psychological well-being and for maintaining a safe working atmosphere. As anxiety, depression, and stress are high among HCPs who care patients receiving COVID-19, it is essential to devote resources to foster the well-being of frontline clinicians in mental health.

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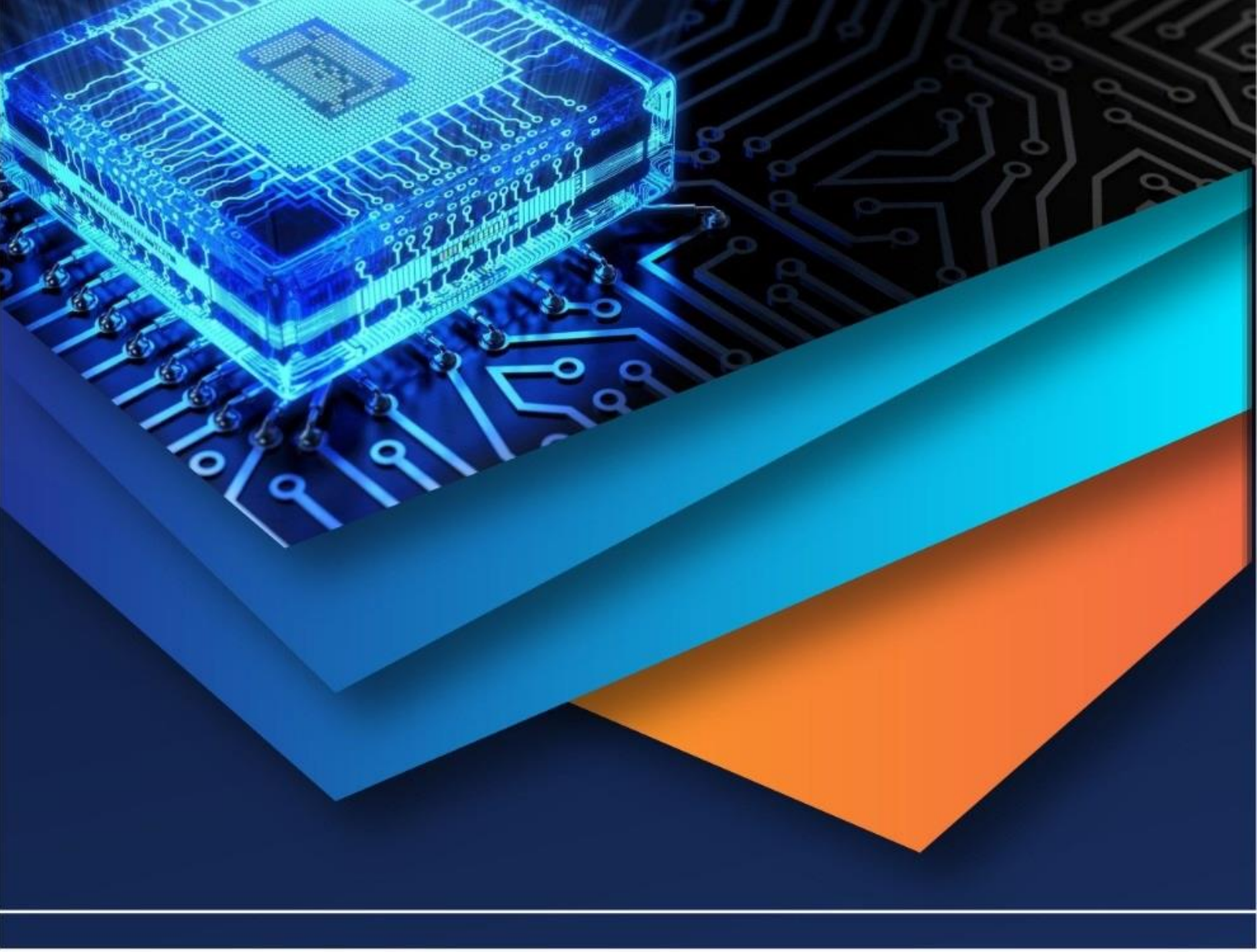

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