




Awareness, Psychological State, and Coping Skills among the Frontline Doctors during the COVID-19 Pandemic—A Cross-Sectional Study

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Abstract

Background Frontline doctors managing the current novel coronavirus 2019 (COVID-19) pandemic work under stressful conditions due to change in workload, working pattern, and worries about the infection to themselves and families with frequently changing treatment protocols. Their psychological well-being is necessary for the effective management of the health crisis.

Objectives This study aims to assess the psychological state and worries of frontline doctors while dealing with the COVID-19 pandemic, the various coping skills employed by them for maintaining their mental health, and the knowledge about illness and related myths and misinformation among them. A further objective is to compare the above between two groups of frontline doctors: the consultants and the junior residents (JR) working in the hospital.

Materials and Methods A total of 164 participants (76 consultants and 88 JRs) were cross-sectionally evaluated online using a prevalidated questionnaire within a period of 3 months after obtaining institutional ethics approval

Statistical Analysis The study sample and results were described using descriptive analysis. The association between the categorical variables was measured using chi-squared test.

Results Most participants frequently updated themselves through reliable sources (consultants = 92%, JR = 73.9%) predominantly from the hospital task force and university. Overall, 71% of consultants and 58% of JRs were worried about being infected. JRs were significantly more worried about the spread of infection due to faulty sterilization of the protective equipment as compared to the consultants ($p = 0.031$). Most participants were worried about their families getting infected (consultants = 79%, JR = 89.8%). Both consultants (18.4%) and JRs (35.2%) had sleep disturbances. Although most did not have syndromal depressive features and COVID-19-related anxiety, tiredness (45.1%) and worrying too much (47.5%) were the most common psychological symptoms. Almost all participants (consultants = 76.3%, JR = 80.7%) used multiple coping styles, such as avoiding thinking about COVID-19, listening to music, and physical activities.

Keywords

- ▶ COVID-19
- ▶ frontline doctors
- ▶ psychological state
- ▶ coping mechanism

Conclusion Frontline doctors overall reported higher worries regarding their family being infected and protective equipment-related issues, whereas they had less core depressive and anxiety symptoms. They had adequate COVID-19-related awareness and used multiple coping skills.

Introduction

The novel coronavirus (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2]) identified in China at the end of 2019 has a high contagion potential. Coronavirus disease 2019 (COVID-19), secondary to SARS-CoV-2, has been declared as a pandemic by World Health Organization on March 11, 2020 as a result of its worldwide transmission.¹ The pandemic has strained the healthcare systems of many countries including India.² Spread of infection, biological risk, and mechanism involved in causing the illness and measures for prevention and treatment of COVID-19 are still evolving. The healthcare workers (HCWs) work in stressful conditions during the handling of COVID-19.³ In such situations, the psychological distress secondary to the illness or while taking care of the patients may get neglected. This may create gaps in the coping mechanisms and the overall burden of the disease, warranting the need for psychiatric evaluation and early intervention these HCWs.^{4,5}

Studies have shown that the HCWs who are working frontline, directly involved with diagnosis, treatment, and care of the positive or suspected COVID-19 positive patients, undergo psychological stress themselves.^{6,7} Increase in workload, changes in work patterns in most of the hospitals, use and lack of protective gear, being quarantined due to many reasons, the stigma associated with the same, clear protocols, lack of medicines, and worries about getting infected themselves and their families may add to the psychological burden of the HCW.^{4,8}

Psychological well-being leads to better functioning and adaptability. In a study conducted in SARS-infected patients, including HCWs during SARS pandemic, it was seen that the HCWs were less stressed than the general population (healthy controls) and had better adaptive responses with a positive attitude toward the control of the illness. This could indicate less psychiatric morbidity.⁹ Knowledge, attitude, and practices were assessed in the general population, the findings of which were found to be useful for policy-making and health workers for health education.¹⁰ Thus, correct information is essential to form a correct attitude, which directly translates to better patient care, better self-care, and overall functioning of the healthcare system.

Our study attempts to evaluate the psychological well-being of frontline doctors working at the initial assessment, wards, and the intensive care units during the initial few months of the COVID-19. This study aims to assess the knowledge about illness and the related myths and misinformation among the frontline doctors working in COVID-19 care, assess their psychological state and the worries, and to assess various coping skills employed by them for

maintaining their mental health. A further objective is to compare these between two groups of frontline doctors: the consultants and the junior residents (JR) working in the hospital.

Methods

Setting and Participants

A cross-sectional study was conducted in a tertiary care hospital in South India. We assessed our parameters via an online questionnaire (Google Form), validated by two subject experts. The questionnaire was sent via institution e-mail and WhatsApp (of the investigators) to 140 JRs (first and second year) and 150 consultants (senior residents, assistant professors, associate professors, and professors) who were working in the COVID-19-designated area for 3 months till July 2020. Total 164 participants responded that comprised of 50.66% consultants and 62.85% JRs.

Tools

A self-reported, 25 item questionnaire was given to consenting participants. This questionnaire was divided into four sections: basic information; awareness (about COVID-19); psychological state and worries about self, family, and work; and the coping skills employed. Majority of questions had yes/ no answers. For questions that used the range/extent of worries using a Likert scale, the score was from 1 to 10 (1—not worried at all, 10—extremely worried) and a few questions had multiple-choice responses. The questionnaire would proceed to the next section only when each question was completed before the final submission. The questionnaire took around 10 to 15 minutes to fill.

Procedure

The primary investigator (PI) first created a semistructured proforma on Google Forms that was then sent to all the consultants and JRs working in the tertiary care hospital by the PI through E-mails or WhatsApp. The filled Google Forms were directly returned to the E-mail of the PI, without the identification of the sender. For any doubts/queries, the PI or coinvestigator was contacted over phone or E-mail. This virtual form of assessment was done keeping in mind the current COVID-19 pandemic situation and requirement for social distancing.

Informed consent was taken from the participants before the formal survey about their willingness to participate. After confirmation, the participant was directed to complete the self-reported questionnaire. None of HCWs were tested positive for COVID-19 at the time of filling questionnaire.

Approval for the study was taken by the institutional ethics committee.

Statistical Analysis

The study sample and results were described using descriptive analysis. Depending on the sample, the association between the categorical variables was measured using chi-squared test. Statistical Package for the Social Sciences version 20 was used to analyze the data collected. *p*-Value of < 0.05 was considered as statistically significant (mentioned in bold in the tables).

Results

The mean age of consultants was 37.6 years (standard deviation [SD]: 8.86 years), and that of JRs was 27 years (SD: 1.39 years). There was a preponderance of men among the con-

sultants, while women were more among the JRs (*p* = 0.003). Consultants were most likely to be married (consultants = 82.9%, JRs = 18.2%) (*p* < 0.000) as detailed in ►Table 1. Further details of the whole sample are also included in ►Table 1.

Overall, 71% of consultants and 58% of JRs were worried about being infected. Consultants had heard of a significantly greater number of myths (*p* = 0.001) and were worried to a greater extent regarding COVID-19-related rumors (*p* = 0.000004). The data regarding myths and rumors are presented in ►Table 2. They had also updated themselves better than JR (*p* = 0.002). Of both consultants and JR, most used multiple sources of information regarding COVID-19; the predominant source of information was from the hospital task force and university. JRs differed significantly regarding quality of sleep (*p* = 0.005) with 35.2% having worsening of sleep as compared to 18.4% in the consultants group. Further details are given in ►Table 1.

Table 1 Comparison of sociodemographic and COVID-19-related details

	Total <i>n</i> = 164 (%)	Consultants <i>n</i> = 76 (%)	JRs <i>n</i> = 88(%)	<i>p</i> -Value
Gender				
Male	90 (54.8)	51 (67.1)	39 (44.3)	0.003
Female	71 (43.2)	23 (30.3)	48 (54.5)	
Not to say	3 (1.8)	2 (2.6)	1 (1.1)	
Marital status				
Married	79 (48.1)	63 (82.9)	16 (18.2)	
Single	71 (43.2)	11 (14.5)	60 (68.2)	<0.000
Engaged	13 (7.9)	1 (1.3)	12 (13.6)	
Divorced	1 (0.6)	1 (1.3)		
Myths				
Yes	66 (40.3)	41 (53.9)	25 (28.4)	0.001
No	98 (59.7)	35 (46.1)	63 (71.6)	
Worried of COVID-19 rumors				
Yes	22 (13.4)	20 (26.3)	2 (2.3)	0.000004
No	142 (86.5)	56 (73.7)	86 (97.7)	
Updated knowledge				
Yes	135 (82.3)	70 (92.1)	65 (73.9)	0.002
No	29 (17.6)	6 (7.9)	23 (26.1)	
Health comorbidity				
Yes	44 (26.8)	23 (30.3)	21 (23.9)	0.228
Worsening	6 (3.6)	01 (1.3)	05 (5.7)	0.143
Had COVID-19 like symptoms	27 (16.4)	08 (10.5)	19 (21.6)	0.044
Worries that might get COVID-19	105 (64)	54 (71.1)	51 (58.0)	0.057
Worries of COVID-19 death	23 (14)	10(13.2)	13 (14.8)	0.473
Sleep quality				
Same	90 (54.8)	51 (67.1)	39 (44.3)	0.005
Improved	29 (17.6)	11 (14.5)	18 (20.5)	
Worsened	45 (27.4)	14 (18.4)	31 (35.2)	

Abbreviations: COVID-19, coronavirus disease 2019; JRs, junior residents.

Table 2 Myths/misinformation/rumors surrounding COVID-19 in the society

Herbal/home remedies cure COVID-19
Applying bleach, soap, heat to nostrils prevents COVID-19
Drinking alcohol kills COVID-19
Dead body transmits virus; burning them will transmit virus
COVID-19 spread via pets/poultry
Doctors spread COVID-19
COVID-19 spreads through air
COVID-19 does not spread in warm weather
Bioterrorism by China
Masks are not important
Only wearing mask will prevent COVID-19
Social distancing does not help
Only elderly die of COVID-19, not young people
Once a person is negative, he/she will remain so
Once a person gets COVID-19, he/she develops lifelong immunity
It is just a flu
Quarantine is like being in prison
Hydroxychloroquine is safe for prophylactic consumption by general public
Vaccine invented by Patanjali
Masks if wore continuously can cause lung damage

Abbreviation: COVID-19, coronavirus disease 2019.

We evaluated specific concerns about the personal protective equipment (PPE) and COVID-19. Although most agreed that adequate PPEs were provided currently, more than half of the consultants and JRs worried about certain aspects related to PPE use, as given in **Table 3**. JRs were significantly more worried about the spread of infection due to faulty sterilization ($p = 0.031$).

Majority of the participants did not have syndromal depression or anxiety; however, few symptoms were numerically more in the JR group. In the JR group, 53% worried

too much and 50% felt nervous and were unable to relax. Also, about 57% among them had sleep disturbances, 53% felt more tired, and 50% had poor appetite. Overall tiredness (45.1%) was the most common depressive symptom and worrying too much (47.5%) was the most common anxiety symptom. The JR group reported significantly more restlessness ($p = 0.020$), decreased pleasure ($p = 0.022$), difficulty with sleep ($p = 0.00002$), poor appetite ($p = 0.004$), negative thoughts about self ($p = 0.002$), and difficulty in concentration ($p = 0.007$) as compared to the consultants (**Table 4**).

Only 43.4% of consultants reported worries of magnitude 4 or less related to COVID-19 and family. Those who worried more about getting infected with COVID-19 had significantly more nervousness ($p < 0.0001$), could not stop worrying ($p = 0.013$), could not relax ($p = 0.027$), and worried too much ($p = 0.034$). Worry about stigma was low with 63.2% consultants scoring 4 or less. When asked regarding the extent of their current worries regarding family members getting infected, 79% scored more than or equal to 4 in both questions. Most (68.4%) did not find their family time to be reduced.

In the JR group, 52.3% gave a score of 4 or less in total related to worrying about getting infected by COVID-19. Those who worried about contracting COVID-19 infection had significantly more nervousness and difficulty to stop worrying ($p < 0.0001$ for both), tiredness ($p = 0.001$) poor sleep ($p = 0.002$), poor appetite ($p = 0.012$), inability to relax ($p = 0.022$), having too many worries ($p = 0.025$), decreased interest ($p = 0.030$), feeling down ($p = 0.042$), and having a bad feeling about self ($p = 0.009$). Most also worried about their family getting infected—89.8% scoring more than 4 in the Likert scale, with 25% scoring the highest score of 10.

Most of the JRs (80.7%) and consultants (76.3%) used several coping skills together to deal with their distress. While listening to music (15.86%), watching movies (13.88%) were the most commonly employed coping skills by JRs, while physical exercise (17.45%) and praying (12%) were used in a significantly higher number by the consultants (p -values of 0.0002 and 0.001, respectively). Comparing the two groups, listening to music ($p = 0.003$) and smoking/alcohol use ($p = 0.010$) were significantly more in JRs (**Table 5**).

Table 3 Distribution and comparison of PPEs-related worries

Worries (answered Yes)	Consultants $n = 76$ (%)	JRs $n = 88$ (%)	p -Value
Given adequate PPEs to prevent transmission	75 (98.7)	82 (93.2)	0.085
Worried due to eventual lack of PPEs	42 (55.3)	59 (67.0)	0.081
Worried being infected during donning/doffing	50 (65.8)	50 (56.8)	0.155
Worry of spread of infection due to reused PPEs	47 (61.8)	59 (67.0)	0.297
Worry due to faulty sterilization	32 (42.1)	51 (58.0)	0.031*
Worry that PPEs may not provide 100% protection	39 (51.3)	53 (60.2)	0.161
Worry of spread of infection due to damaged PPEs	43 (56.6)	53 (60.2)	0.377

Abbreviations: JRs, junior residents; PPE, personal protective equipment.

*Significant value $p < 0.05$

Table 4 Distribution and comparison of anxiety and depressive symptoms

		Total n = 164 (%)	Consultants n = 76 (%)	JRs n = 88 (%)	p-Value
Feeling nervous, anxious or on edge	Not at all	91 (55.4)	47 (61.8)	44 (50)	0.054
	Several days	54 (32.9)	20 (26.3)	34 (38.6)	
	More than half of the days	13 (7.9)	4 (5.3)	9 (10.2)	
	Nearly everyday	6 (3.6)	5 (6.6)	1 (1.1)	
Not being able to stop or control worrying	Not at all	100 (60.9)	47 (61.8)	53 (60.2)	0.433
	Several days	51 (31.1)	21 (27.6)	30 (34.1)	
	More than half of the days	8 (4.8)	4 (5.3)	4 (4.5)	
	Nearly everyday	5 (3)	4 (5.3)	1 (1.1)	
Trouble relaxing	Not at all	92 (56.1)	48 (63.2)	44 (50)	0.302
	Several days	53 (32.3)	21 (27.6)	32 (36.4)	
	More than half of the days	14 (8.5)	6 (7.9)	8 (9.1)	
	Nearly everyday	5 (3)	1 (1.3)	4 (4.5)	
Being so restless that it is hard to sit still	Not at all	114 (69.5)	61 (80.3)	53 (60.2)	0.020
	Several days	37 (22.5)	10 (13.2)	27 (30.7)	
	More than half of the days	8 (4.8)	4 (5.3)	4 (4.5)	
	Nearly everyday	5 (3)	1 (1.3)	4 (4.5)	
Feeling afraid as if something awful might happen	Not at all	111 (67.6)	48 (63.2)	63 (71.6)	0.538
	Several days	34 (20.7)	17 (22.4)	17 (19.3)	
	More than half of the days	15 (9.1)	8 (10.5)	7 (8)	
	Nearly everyday	4 (2.4)	3 (3.9)	1 (1.1)	
Little interest or pleasure in doing things	Not at all	105(64)	57 (75)	48 (54.5)	0.022
	Several days	39 (23.7)	15 (19.7)	24 (27.3)	
	More than half of the days	12 (7.3)	2 (2.6)	10 (11.4)	
	Nearly everyday	8 (4.8)	2 (2.6)	6 (6.8)	
Feeling down, depressed, or hopeless	Not at all	102 (62.1)	53 (69.7)	49 (55.7)	0.234
	Several days	39 (23.7)	16 (21.1)	23 (26.1)	
	More than half of the days	15 (9.1)	4 (5.3)	11 (12.5)	
	Nearly everyday	8 (4.8)	3 (3.9)	5 (5.7)	
Trouble falling or staying asleep, or sleeping too much	Not at all	97 (59.1)	59 (77.6)	38 (43.2)	0.00002
	Several days	39 (23.7)	10 (13.2)	29 (33)	
	More than half of the days	12 (7.3)	5 (6.6)	7 (8)	
	Nearly everyday	16 (9.7)	2 (2.6)	14 (15.9)	
Feeling tired or having little energy	Not at all	90 (54.8)	49 (64.5)	41 (46.6)	0.067
	Several days	50 (30.4)	21 (27.6)	29 (33)	
	More than half of the days	13 (7.9)	3 (3.9)	10 (11.4)	
	Nearly everyday	11 (6.7)	3 (3.9)	8 (9.1)	
Poor appetite or overeating	Not at all	99 (60.3)	55 (72.4)	44 (50)	0.004
	Several days	37 (22.5)	16 (21.1)	21 (23.9)	
	More than half of the days	12 (7.3)	2 (2.6)	10 (11.4)	
	Nearly everyday	16 (9.7)	3 (3.9)	13 (14.8)	
Negative thoughts about self	Not at all	118 (71.9)	64 (84.2)	54 (61.4)	0.002
	Several days	32 (19.5)	7 (9.2)	25 (28.4)	
	More than half of the days	7 (4.2)	4 (5.3)	3 (3.4)	
	Nearly everyday	7 (4.2)	1 (1.3)	6 (6.8)	
Trouble concentrating on things	Not at all	109 (66.4)	59 (77.6)	50 (56.8)	0.007
	Several days	40 (24.3)	11 (14.5)	29 (33)	
	More than half of the days	6 (3.6)	4 (5.3)	2 (2.3)	
	Nearly everyday	9 (5.4)	2 (2.6)	7 (8.0)	

Abbreviation: JRs, junior residents.

Discussion

We evaluated knowledge and beliefs, including myths/misinformation related to COVID-19 in frontline doctors (both consultants and postgraduates). We also assessed their worries regarding the spread of infection, PPE, stigma, and family members. We further assessed symptoms of

depression and anxiety in them. At last, we assessed their coping styles. We also compared both groups on these assessments. We deliberately chose not to use a standardized scale, as it would miss out on subclinical levels of distress. We, therefore, assessed the symptoms individually.

Knowledge and myths/misinformation related to COVID-19 may have a negative outcome on the psychological well-

Table 5 Distribution and comparison of coping skills/mechanism

Coping mechanism	Consultants	JRs	p-Value
Avoiding to think about it	29	42	0.344
Physical exercise/yoga	48	28	0.0002
Watching movies/television/serials	32	49	0.239
Listening to music/playing musical instrument/dancing	23	56	0.003
Reliving an old hobby—painting/cooking/reading books	23	24	0.278
Indoor sports/games	08	18	0.121
Talking to others (about the issue)	30	45	0.282
Praying/having faith in God/religion	33	17	0.001
Trying to solve the issue (at my level)	23	22	0.191
Sharing feelings	21	39	0.095
Smoking/alcohol use/other substances	00	08	0.010
Others	04	02	0.235
Struggling to cope	01	03	0.410

Abbreviation: JRs, junior residents.

being of the HCWs. Consultants group seemed to be more aware of the myths and beliefs prevalent in the society and worried about the same. This probably is related to greater exposure of the consultants to the patients and a wider source of information from media—both in electronic and print. Most participants in our sample obtained their information from designated hospital websites and the task force which were dedicated to provide information and update treatment protocols. When mental health problems in HCWs were reviewed in the initial stages of the pandemic, worries were related to the spread of infection and improper protective equipment.¹¹ These correlated with anxiety and sleep disturbances.¹² Thus, knowledge, beliefs, and correct information regarding the protocols of management and PPE are essential.

Accordingly, we evaluated specific worries related to various aspects of protective gear. Although most agreed that currently they were provided adequate PPE, they were worried about its availability in the future, spread of infection through faulty sterilization, reuse, and damaged PPE. With the sudden onset and spread of pandemic, HCWs who are not habituated to the use of PPEs, in the context of rushed protocols, are bound to have anxieties related to the same. This anxiety can be reduced with habituation and adequate information about the protective gears. HCWs have faced stigma in previous pandemics and the situation prevails in the current pandemic.¹³⁻¹⁵ However, most of our sample did not worry about stigma, which probably reflects their mature coping skills.

Stress in HCW has been seen in previous pandemics.^{12,16} When the HCWs from China were assessed during the pandemic, symptoms of depression were found.¹⁷ An Indian online survey exploring the knowledge, attitude, and behavior of 152 doctors in relation to COVID-19 using Depression Anxiety Stress Scale-21 found that 34.9% were depressed, 39.5% were anxious, and 32.9% had stress.¹⁸ Similarly, de-

pressive and anxiety symptoms were also found in our study, numerically more in the JR group. Overall tiredness (45.1%) was the most common depressive symptom and worrying too much (47.5%) was the most common anxiety symptom. Moreover, we found higher levels of sleep disturbances as an individual symptom. Sleep was specifically evaluated in previous studies and found to be disturbed in HCWs and often it has a negative outcome for psychological well-being.¹⁹⁻²¹ We suppose the increased level of symptoms in JRs may be related to their lesser experience with working under stressful situations, something that consultants have probably been through.

We found that overall 77.1% of the consultants and 58% of the JRs were worried about getting infected with COVID-19. Worries were more related to family getting infected as well as doctors themselves spreading the infection to family members. It is hypothesized that the JRs were more worried about family members getting affected because either they are elderly or they live away from home causing a subjective sense of helplessness for any untoward event.²²⁻²⁴ Thus, worries regarding these features probably cannot be decreased until the national situation regarding COVID-19 improves. These worries have not caused dysfunction in various spheres of life. Probably, these also contribute to be vigilant and use protective measures in the pandemic of 9 months now.

To reduce burnout, positive coping skills are required. Also, positive lifestyle behaviors like eating healthy food, physical exercises, practicing good sleep hygiene, and avoiding alcohol/drugs are essential.^{11,25} Our sample participants used mostly positive coping strategies to deal with the stress (► **Table 5**). Physical exercise was most commonly used by consultants, but not so much by the JRs. Negative coping skills like using alcohol or smoking was seen in 9.09% of JRs and none in consultants. According to our study only 2.4% of the whole sample struggled to cope. In another study when

595 HCWs were evaluated for stress and coping styles using scales, a positive attitude towards stressful situations was a protective factor and avoidance strategies were a risk factor for increased stress.²⁶ Altruistic coping was found to be related to psychological distress.¹⁸ We found that most participants used multiple coping skills (consultants = 76.3%, JRs = 80.7%) that are optimal for a large-scale pandemic. However, avoidance of thinking about COVID-19 was used as a coping mechanism by 43.3% of our sample that may be helpful during acute stressful condition, but may become problematic if the stress is prolonged, especially over months, such as the current pandemic.

Frontline doctors have to work under more stress and their psychological well-being needs to be taken care of. This can be handled at an organizational level and also at an individual level.²⁷ Adequate, updated, and correct information and protocols provided from reliable sources can help to minimize misinformation and needless rumors. Symptoms of anxiety and depression should be individually assessed and not sidelined as an inevitable occurrence. Such disturbances may ultimately impact the care provided to the patients negatively. Adequate time gap should be provided between duties, although it may not be feasible to give recommended rest days due to a shortage of HCWs. However, a lesser duration of the rest period may have a positive impact. Psychological help teams, mainly consisting of psychiatrists, had been formed in hospitals of Wuhan to help the frontline doctors that helped in improving the psychological state of the HCWs.^{16,28} Well-informed, well-rested, energetic, and optimistic HCWs have always remained as the best resource in our fight against the COVID-19 pandemic.

As COVID-19 is still an ongoing pandemic, there is a continuous flow of new data regarding our subject of enquiry. In a qualitative study done on the nurses working in intensive care units in Denmark, the usual worries comprised of lack of PPE, transmission of infection to their own families, increased workload, along with the isolation rules, and being forced to do the stressful work.²⁹ In a systematic review done by Danet in 2021, it was seen that the percentage of healthcare personnel who suffered from stress ranged from 37 to 78%. When comparing the HCW with general population, greater anxiety was seen in the HCW, along with signs of depression and sleep disturbances. Significant levels of emotional exhaustion, burnout, and depersonalization were observed in the HCW, highlighting the need and utilization of the positive coping strategies.³⁰ For the aftermath of COVID-19, it has been observed that many frontline workers experienced the burnout, posttraumatic stress disorder, and even suicidal ideation with higher levels being in younger age group, residents, kind of work, and females emphasizing the need to focus on mental health along with physical health following a pandemic.³¹⁻³³

The strength of our study lies in its comprehensive assessment of knowledge, beliefs, myths regarding COVID-19, and coping skills used. We have separately listed out common myths and evaluated worries specifically related to sleep, family, and PPE. We consider symptom-wise assess-

ment of anxiety and depression, as done in our study, as a better approach than using scales. To the best of our knowledge, this is the first Indian study to compare the postgraduates and consultants regarding COVID-19-related psychological issues. The limitation of our study is that it was Internet-based self-reported study that can have biases in the participants we recruit and also in the nature of response we get. We understand that the poor response may be due to many questionnaires being circulated through social media during this pandemic.

Conclusion

In conclusion, this study reveals that adequate and reliable information about the COVID-19 pandemic should be made available to and practiced by the HCWs. Specific symptom-based screening for the mental health state of the front-liners should be done frequently as it may affect their patient service.¹¹ Positive coping skills may add to the better functioning of the HCWs.¹⁸ A doctor with a sound mind, body, and soul is the current need of the hour to deal with a natural calamity like the pandemic.

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Conflict of Interest

None declared.

Presentation at a Meeting

1. Organisation: KANCIPS by IPS-KC
Place: Online platform in Webinar
Date: October 11, 2020
Status: Won the Dr. H.S. Subrahmanyam Award paper 2020
2. Organisation: IPSOCON (South Zone) by IPS-KC
Place: Online platform in Webinar
Date: October 31, 2020

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