



## Psychological Status of Healthcare Workers during COVID-19 Pandemic in Saudi Arabia

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### Authors' contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

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### ABSTRACT

**Background:** The 2019 Corona Virus Disease (COVID-19) is a global pandemic affecting the lower respiratory tract that is caused by Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-Cov2). It has caused psychological stress on people around the world, particularly those in the medical field. The purpose of this study is to determine the levels of anxiety, depression, burnout, and the sources of anxiety among healthcare workers (HCW) in Saudi Arabia during the

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COVID-19 pandemic. To determine the coping strategies of HCWs in dealing with mental health issues that may affect them during the pandemic.

**Methodology:** An observational cross-sectional study was carried out between May 2020 to November 2021 in Saudi Arabia. A Total of 260 HCW of both genders who are working in private and governmental hospitals were selected. However, non-healthcare workers such as technicians, administrators, clerical staff and maintenance workers were excluded.

**Results:** A total of 260 HCWs 98 (37.7%) doctors, 27 (10.4%) nurses, 6 (2.3%) pharmacists, 5(1.9%) physiotherapists, 113(43.5%) interns and 11 (4.2%) others, of whom 127 (48.8%) were male and 133 (51.2%) were female. The majority of participants aged from 20-29 years old 205 (78.5%), followed by 30-39 years old 26 (10%), 40-49 years old 18(6.9%), and 50-59 years old 10(3.8%), and 70-79 years old 1(0.4%). Around 42(16.2%) HCWs were working in ER, 82(31.5%) in wards, 83(31.9%) in outpatient clinics, 15(5.8%) were working in both wards and outpatient clinics, 6 (2.3%) in ICU and around 32(12.3%) in all demographics.

**Conclusion:** The results of this study illustrated the burden of psychological problems among different healthcare workers during the COVID-19 pandemic. The findings suggest that all health care workers (HCWs) were affected by varying degrees severity of anxiety and depression, insomnia and complaining from cardiovascular symptoms.

*Keywords: COVID-19 pandemic; healthcare workers; anxiety; depression.*

## 1. INTRODUCTION

The 2019 Corona Virus Disease (COVID-19) was first reported in December 2019 in Wuhan, China, which rapidly spread across the country [1]. It is a global pandemic affecting the lower respiratory tract that is caused by Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-Cov2) [2]. COVID-19 is more likely to affect old men who have comorbidities, diseases causing a severe and possibly fatal lower respiratory tract disease such as Acute Respiratory Distress Syndrome (ARDS) [3].

In March 2020, COVID-19 was announced to be a pandemic, making it a global emergency. Since then, governments all around the world have taken several actions and precautions to limit the spread of the virus, such as work and school closure, quarantines, as well as the limitation of different transportation means [4]. By the 8th of April 2020, WHO documented approximately 42,000 healthcare workers (HCW) were confirmed to have COVID-19 in China, and 22,073 cases in 52 countries [5].

In a cross-sectional study conducted in China that involved 2285 HCW, 56.59% were found to have insomnia, anxiety, and depression symptoms. Out of this, 38.47% had mild symptoms while 18.12% suffered from moderate/severe symptoms [5]. Additionally, a study carried out in Riyadh, Saudi Arabia, suggested that the source of anxiety for the majority of HCW was the possibility of transmitting COVID-19 to their families, rather

than themselves [6]. Other studies revealed that the persons at higher risk of developing psychological consequences due to COVID-19 were HCW. Furthermore, nurses were shown to have higher levels of anxiety than doctors [7]. Burnout, which is often characterized as multidimensional and includes emotional tiredness, depersonalization, and a weakened feeling of personal success [8], is another result of exposure to stresses. HCWs are particularly susceptible to job burnout, with the greatest levels of job burnout documented among HCWs working in the emergency and intensive care units (ICUs), where they are subjected to a high degree of job-related stress [9]. Furthermore, data shows that effective coping mechanisms can significantly minimize the risk of burnout. When compared to controls, a clinical experiment investigating the benefits of a 12-week incentive physical activity program among medical trainees found that burnout levels improved. Furthermore, a validated single-item linear self-assessment measure [8] revealed a substantial increase in quality of life in the research.

All except one previous study that measured the psychological impact of COVID-19 on HCW were conducted outside Saudi Arabia, mainly in China. The only study that was conducted in KSA was limited due to small sample size. It was also exposed to selection bias owing to the non-randomized selection of participants. Our study aims to identify the adverse psychological effects of COVID-19 on HCW, coping strategies with the use of a larger, more randomized sample, to

determine the levels of anxiety, depression and burnout among HCW in Saudi Arabia during COVID-19 pandemic, to identify the sources of anxiety in HCW during the COVID-19 pandemic and to determine the coping strategies of HCWs in dealing with mental health issues that may affect them during the pandemic.

## 2. MATERIALS AND METHODS

### 2.1 Study Design

This is cross-sectional observational research was carried out in Saudi Arabia.

### 2.2 Subject

Participants, recruitment and sampling procedure Study participants included are doctors, nurses, allied healthcare workers (pharmacists, physiotherapists, occupational therapists), ...etc. The sample was collected randomly.

### 2.3 Inclusion Criteria

- Health care workers: Private and governmental hospitals
- Male and Female
- Saudi and non-Saudi
- Agree to Participate

### 2.4 Exclusion Criteria

Not a healthcare worker: technicians, administrators, clerical staff and maintenance workers, ... etc.

### 2.5 Method for Data Collection and Instrument

A self-administered randomized anonymous questionnaire, written in English, was used as a study tool. The questionnaires were sent to participants via online (medical groups, E-mail) and also will be face to face in Hospital, PHC). The PHQ-9, a nine-item patient health questionnaire that has demonstrated high consistency with a diagnosis of severe depression based on organized interviews, was used to identify depressive symptoms during the past two weeks. Mild, moderate, and severe depression were characterized using cut-off values of 5, 10, and 15, respectively. The sensitivity and specificity of a PHQ-9 score of 10 for serious depression were previously reported to be 88 percent and 88 percent, respectively. In addition, we employed the 14-question Hamilton Anxiety Scale (HAMA) to assess anxiety levels.

There are five elements in each question. 0 (never), 1 (mild), 2 (moderate), 3 (severe), or 4 (extreme) are the possible responses (extremely serious). Overall, the HAMA total score is operationally classified as follows: no anxiety (scoring 0–6), mild and moderate anxiety (score 7–13), and severe anxiety (score 14–17). severe anxiety (score  $\geq 14$ ).

In addition, in order to analyze the causes of anxiety, we asked the HCW to select the most major source of anxiety that they were experiencing, which included eight sources of concern: (1) having access to appropriate personal protective equipment, (2) being exposed to COVID-19 at work and bringing the infection home to their family, (3) not having rapid access to testing if they develop COVID-19 symptoms and fear of spreading infection at work, (4) uncertainty that their organization will support/take care of their personal and family needs if they develop an infection, (5) access to child care during increased work hours and school closures, (6) (food, hydration, lodging, transportation), (7) being able to provide competent medical care if deployed to a new area (eg, non-ICU nurses having to function as ICU nurses), and (8) lack of access to up-to-date information and communication. The Copenhagen Burnout Inventory (CBI) scale was also included in our survey. Questions in this scale are divided into three parts: personal burnout, work-related burnout, and client related burnout. Responses are scored as 0 (Never), 25 (Seldom), 50 (Sometimes), 75 (Often), 100 (Always). Some other questions, however, have different response categories but with the same scoring system. Responses are: "to a very high degree", "to a high degree", "somewhat", "to a low degree", and "to a very low degree". One additional scale that we used is Brief COPE, a shortened version of the original COPE scale, which is designed to assess and spectate how individuals respond to stress and cope with certain situations. The Brief COPE scale includes a set of statements reflecting coping mechanisms, and responses were coded as follow: (1 = I usually don't do this at all, 2 = I usually do this a little bit, 3 = I usually do this a medium amount, 4 = I usually do this a lot).

### 2.6 Analyzes and Entry Method

The "Microsoft Office Excel Software" application (2016) for Windows was used to enter data on the computer. The data was then statistically evaluated using the Statistical Package of Social

Science Software (SPSS) software, version 20 (IBM SPSS Statistics for Windows, Version 20.0. Armonk, NY: IBM Corp.).

### 3. RESULTS AND DISCUSSION

This study aimed to estimate the psychological effects of COVID-19 on HCW in Saudi Arabia. During this Cross-sectional study which was conducted during 2020-2021 a total of 260 HCWs 98 (37.7%) doctors, 27 (10.4%) nurses, 6 (2.3%) pharmacists, 5(1.9%) physiotherapists, 113(43.5%) interns and 11 (4.2%) others, of whom 127 (48.8%) were male and 133 (51.2%) were female. The majority of participants aged from 20-29 years old 205 (78.5%), followed by 30-39 years old 26 (10%), 40-49 years old 18(6.9%), and 50-59 years old 10(3.8%), and 70-79 years old 1(0.4%). Around 42(16.2%) HCWs were working in ER, 82(31.5%) in wards, 83(31.9%) in outpatient clinics, 15(5.8%) were working in both wards and outpatient clinics, 6 (2.3%) in ICU and around 32(12.3%) in all demographics.

Regarding the working place 26(10%) were working in the north region of Saudi Arabia, 23(8.8%) in the south, 151(58.1%) in the east, 52(20%) in the west and 8(3.1%) in Riyadh. As for working hours, 157(60.4%) were working less than 40 hours, 96(36.9%) from 40 to 60 hours and 7(2.7%) more than 60 hours. About 66(25.4%) were dealing directly with COVID-19 patients and 194(74.6%) of them were not. The most significant source of anxiety that affect HCWs is being exposed to COVID-19 at work and taking the infection home to your family 175(67.3%) followed by access to appropriate personal protective equipment 23(8.8%).

According to Hamilton Anxiety Rating Scale (HAM-A), 149(57.1%) were <17 which indicates mild anxiety, 35(13.4%) scored 18-24 which indicates mild to moderate anxiety, 29(11.1%) scored 25-30 which suggests moderate to severe anxiety and 47(18%) scored 31-56 which is very severe anxiety level. Furthermore, PHQ-9 total score for the nine items ranges from 0 to 27. In our study, the PHQ- 9 depression severity score were 34(13%), 74(28.4%), 88(33.7%), 38(14.6%) and 26(10%) which indicates minimal depression, mild, moderate, moderately severe and severe depression, respectively. The results of Copenhagen Burnout Inventory (CBI) were summarized in Table 1. Moreover, Table 2 shows brief COPE scale.

In studying the relationship between working hours and Hamilton anxiety scale the results showed that 66 of HCWs who work <40 hours are not complaining of insomnia, 39 have mild insomnia, 31 have moderate insomnia, 10 have severe insomnia, and 11 of them have very severe insomnia. While 20 of HCW who works 40-60 hours are not complaining of insomnia, 24 have mild insomnia, 30 have moderate insomnia, 14 have severe insomnia, and 8 of them have very severe insomnia. Also, 3 HCWs who work >60 hours are not complaining of insomnia, 0 have mild insomnia, 1 have moderate insomnia, 2 have severe insomnia, and 1 of them have very severe insomnia. Regarding feelings of tension, 52 HCWs who work <40 hours are not suffering of tension, 36 have mild tension, 39 have moderate tension, 15 have severe tension, and 15 have very severe tension. In addition, 12 HCWs who work 40-60 hours are not suffering of tension, 19 have mild tension, 39 have moderate tension, 18 have severe tension, and 8 have very severe tension. Furthermore, no one of HCWs who work >60 hours are suffering of tension, 2 have mild tension, 1 have moderate tension, 1 have severe tension, and 3 have very severe tension.

Additionally, 56 of HCWs who work <40 hours are not experiencing difficulties in concentration and poor memory, 40 HCWs have mild difficulty, 33 moderate, 21 severe, and 7 very severe difficulty. While 21 of HCWs who work from 40-60 hours are not experiencing difficulties in concentration and poor memory, 22 HCWs have mild difficulty, 24 moderate, 24 severe, and 5 very severe difficulty. Also, 3 of HCWs who work >60 hours are not experiencing difficulties in concentration and poor memory, 0 HCWs have mild difficulty, 1 moderate, 1 severe, and 2 very severe difficulty.

An additional point, 49 HCWs who work <40 hours are not complaining of depressed mood, 49 have mildly depressed mood, 27 have moderately depressed mood, 23 have severely depressed mood, 9 have very severely depressed mood. 18 HCWs who work 40-60 hours are not complaining of depressed mood, 14 have mildly depressed mood, 34 have moderately depressed mood, 21 have severely depressed mood, 9 have very severely depressed mood. 3 HCWs who work >60 hours are not complaining of depressed mood, 0 have mildly depressed mood, 2 have moderately depressed mood, 0 have severely depressed mood, 2 have very severely depressed mood.

Moreover, 94 HCWs who work <40 hours have no cardiovascular symptoms, 30 have mild symptoms, 25 moderate, 7 severe, and 1 have very severe symptoms. In addition, 28 HCWs who work 40-60 hours have no cardiovascular symptoms, 23 have mild symptoms, 26 moderate, 13 severe, and 6 have very severe symptoms. 3 HCWs who work >60 hours have no cardiovascular symptoms, 1 have mild symptoms, 1 moderate, 2 severe, and 0 have very severe symptoms.

Furthermore, 106 HCWs who work <40 hours have no respiratory symptoms, 23 have mild symptoms, 19 moderate, 8 severe, and 1 have very severe symptoms. In addition, 38 HCWs who work 40-60 hours have no cardiovascular symptoms, 16 have mild symptoms, 21 moderate, 14 severe, and 7 have very severe symptoms. 3 HCWs who work >60 hours have no cardiovascular symptoms, 1 have mild symptoms, 1 moderate, 0 severe, and 2 have very severe symptoms.

Finally, 76 HCWs who work <40 hours have no gastrointestinal symptoms, 39 have mild symptoms, 27 moderate, 11 severe, and 4 have very severe symptoms. In addition, 29 HCWs who work 40-60 hours have no cardiovascular symptoms, 19 have mild symptoms, 21 moderate, 19 severe, and 8 have very severe symptoms. 5 HCWs who work >60 hours have no cardiovascular symptoms, 0 have mild symptoms, 0 moderate, 0 severe, and 2 have very severe symptoms.

The relationship between depression scale (PHQ-9) and dealing directly with COVID-19 patients is illustrated in Table 3.

Moreover, Table 4 shows the relationship between sources of anxiety and the demographics.

### 3.1 Discussion

The 2019 coronavirus pandemic is expected to have a significant psychological impact, according to experts. Because of the significant changes caused by SARS-CoV-2 in workplaces and the way people do their jobs, it's possible that some occupational and organizational elements have a role in employees' mental health and their capacity to cope with a new demanding working environment [9]. HCWs face emotional discomfort as the first line of defense in any epidemic, both during and after the

outbreak. Both the Ebola virus and the SARS outbreak had comparable outcomes. Concerns have also been made concerning HCWs' psychological well-being in the wake of the SARS-CoV-2 pandemic. The number of persons infected with COVID-19 is increasing at an alarming rate. This results in a greater workload in life-threatening situations, which has a negative impact on the psychological health of hospital staff. Controlling the infection is a serious challenge due to the virus's high transmission rate and the lack of any vaccine or medicine. SARS-high CoV-2's morbidity and mortality can exacerbate risk perception in healthcare workers. Furthermore, the rising number of patients and scarcity of protective equipment add to the strain on health-care systems [10].

In our study, 57.1 percent of individuals experienced mild anxiety, 13.4% had light to moderate anxiety, 11.1% had moderate to severe anxiety, and 18% had extremely severe anxiety. Minimal depression, mild depression, moderate depression, moderately severe depression, and severe depression were scored as (13%), (28.4%), (33.7%), (14.6%), and (10%), respectively. This was in line with prior research findings. According to a systematic review and meta-analysis of 54 observational studies, the prevalence of depression or depressed symptoms was roughly 28.8%, ranging from 20.9 percent to 43.2 percent in different studies depending on the scale employed [10]. Another study discovered significant levels of depression and anxiety symptoms in physicians, suggesting that immediate psychological intervention strategies are required to avoid physician burnout and suicide while also reducing the likelihood of medical mistakes [11]. According to the findings of a study, 10.0 percent of HCWs acquired moderate-to-severe anxiety disorder, and 237 (27.9%) experienced depression. In the depression group, anxiety and fear of infection and death, isolation and inappropriate treatment, motivation and departure from work were all higher than in the non-depression group [12]. According to a Chinese poll, 53.8 percent of respondents assessed the psychological effect as moderate-to-severe, 28.8% expressed moderate-to-severe anxiety, and 14.6% developed depressive symptoms [13, 14]. According to a recent study on SARS-CoV-2, there is a substantial asymmetry in favor of health professionals who are the most mentally impacted. Staff working in high-risk wards (direct and prolonged contact with SARS-CoV-2

**Table 1. Copenhagen Burnout Inventory (CBI). Scales, items and response frequencies**

	<b>Always or To a very high degree (Scoring 100)%</b>	<b>Often or To a high degree (Scoring 75) %</b>	<b>Sometimes or Somewhat (Scoring 50)%</b>	<b>Seldom or To a low degree (Scoring 25)%</b>	<b>Never/ almost never or To a very low degree (Scoring 0)%</b>
<b>Personal burnout</b>					
How often do you feel tired?	12.6	26.4	33.3	20.3	6.9
How often are you physically exhausted?	11.9	18.8	44.4	16.5	8
How often are you emotionally exhausted?	12.6	28	30.3	18.8	10
How often do you think: "I can't take it anymore"?	9.2	20.3	34.9	19.5	15.7
How often do you feel worn out?	7.3	20.7	38.7	18.8	14.2
How often do you feel weak and susceptible to illness?	6.5	14.2	36	29.1	13.8
<b>Work-related burnout</b>					
Do you feel worn out at the end of the working day?	17.2	18.8	33.7	18	11.9
Are you exhausted in the morning at the thought of another day at work?	13.8	21.8	27.2	22.6	14.2
Do you feel that every working hour is tiring for you?	5.4	17.2	27.6	28.7	20.7
Do you have enough energy for family and friends during leisure time?	18.8	21.1	38.7	13.4	7.7
Is your work emotionally exhausting?	8.4	24.9	31.8	17.6	16.9
Does your work frustrate you?	10.3	13.8	31.8	21.8	21.8
Do you feel burnt out because of your work?	10.3	19.2	33.7	16.9	19.5
<b>Client-related burnout</b>					
Do you find it hard to work with clients?	3.1	16.1	28.7	32.2	19.5
Does it drain your energy to work with clients?	8.8	13.4	28	19.2	30.3
Do you find it frustrating to work with clients?	1.1	13.8	30.3	24.1	30.3
Do you feel that you give more than you get back when you work with clients?	5.4	15.7	29.1	19.9	29.5
Are you tired of working with clients?	3.1	9.2	32.2	30.7	24.5
Do you sometimes wonder how long you will be able to continue working with clients?	9.2	17.6	31	13.4	28.4

**Table 2. Brief COPE. Scale, items and response frequencies**

	<b>I have not been doing this at all</b>	<b>I have been doing this a little bit</b>	<b>I have been doing this a medium amount</b>	<b>I have been doing this a lot</b>
I've been turning to work or other activities to take my mind off things.	15.3	39.5	31	13
I've been concentrating my efforts on doing something about the situation I'm in.	19.2	31	33.3	16.1
I've been saying to myself "this isn't real."	36	33.3	17.6	12.6
I've been getting emotional support from others.	19.9	31.8	31.4	16.5
I've been giving up trying to deal with it.	39.5	29.1	21.5	9.6
I've been taking action to try to make the situation better.	19.9	33	28.4	18.4
I've been refusing to believe that it has happened.	36	33.3	17.6	12.6
I've been saying things to let my unpleasant feelings escape.	23.4	39.8	25.3	11.1
I've been getting help and advice from other people.	33.3	26.4	26.1	13.8
I've been using alcohol or other drugs to help me get through it.	54.8	24.5	8	12.3
I've been trying to see it in a different light, to make it seem more positive.	19.9	31.8	31.4	16.5
I've been criticizing myself.	23.8	40.6	21.1	14.2
I've been trying to come up with a strategy about what to do.	18.8	33.7	28.4	18.8
I've been getting comfort and understanding from someone.	24.9	33.7	26.8	14.2
I've been giving up the attempt to cope.	35.6	33	19.5	11.5
I've been looking for something good in what is happening.	20.3	30.3	21.8	27.2
I've been making jokes about it.	19.9	29.9	31.8	18
I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.	15.3	32.6	26.8	24.9
I've been accepting the reality of the fact that it has happened.	21.1	29.9	26.1	22.6
I've been expressing my negative feelings.	26.4	33.7	28.4	11.1
I've been trying to find comfort in my religion or spiritual beliefs.	14.2	28.4	35.2	21.8
I've been trying to get advice or help from other people about what to do.	23.4	28.4	35.2	12.6
I've been learning to live with it.	12.6	25.3	33.7	28
I've been thinking hard about what steps to take.	33.7	25.3	26.1	14.6
I've been blaming myself for things that happened.	30.7	33.3	21.8	13.8
I've been praying or meditating.	23	28.4	30.3	18
I've been making fun of the situation.	22.2	29.5	33	14.9

**Table 3. Relationship between depression scale (PHQ-9) and dealing directly with COVID-19 patients**

Depression PHQ	Not at all		Several days		More than half the days		Nearly every day	
	Dealing directly with COVID-19 patients	Not dealing directly with COVID-19 patients	Dealing directly with COVID-19 patients	Not dealing directly with COVID-19 patients	Dealing directly with COVID-19 patients	Not dealing directly with COVID-19 patients	Dealing directly with COVID-19 patients	Not dealing directly with COVID-19 patients
Little interest or pleasure in doing things	10	75	23	63	25	37	8	19
Feeling down, depressed	11	69	24	68	23	34	8	23
Trouble falling or staying asleep, or sleeping too much, or hopeless	8	71	27	55	26	43	5	25
Feeling tired or having little energy	7	50	22	75	30	38	7	31
Poor appetite or overeating	17	61	19	55	15	55	15	23
Feeling bad about yourself or that you are a failure or have let your self or your family down	16	73	22	50	19	51	9	20
Trouble concentrating on things, such as reading the newspaper or watching television	23	74	21	55	11	47	11	18
Moving or speaking so slowly that other people could have noticed. Or the opposite being so figety or restless that you have been moving around a lot more than usual	35	105	17	42	12	35	2	12
Thoughts that you would be better off dead, or of hurting yourself	35	103	14	39	10	37	7	15

**Table 4. Relationship between sources of anxiety and the demographics**

	ER	ward	outpatient	Ward+outpatient	ICU	All
access to appropriate personal protective equipment	5	12	5	0	1	0
being exposed to COVID-19 at work and taking the infection home to their family	26	51	54	10	4	30
not having rapid access to testing if they develop COVID-19 symptoms and concomitant fear of propagating infection at work	3	2	6	0	0	0
uncertainty that their organization will support/take care of their personal and family needs if they develop infection	5	5	4	2	0	0
access to childcare during increased work hours and school closures	0	4	7	0	0	0
support for other personal and family needs as work hours and demands increase (food, hydration, lodging, transportation)	2	3	2	2	1	0
being able to provide competent medical care if deployed to a new area (eg, non-ICU nurses having to function as ICU nurses)	1	5	5	1	0	2

infected patients) reported significantly higher levels of fear ( $p = 0.024$ ), anxiety ( $p = 0.005$ ), and depression ( $p = 0.007$ ) than non-clinical staff, and obviously higher levels of anxiety ( $p = 0.026$ ) than low-risk medical staff. In any event, the effects of stress in the workplace should not be overlooked [15].

Anxiety (44.6 percent), despair (50.4 percent), and sleeplessness (34.0 percent) were all observed to be high in a study of healthcare professionals [16]. Another research found that 68.7%, 53.3, 52.2, and 40.3 percent of all individuals had mild to severely severe insomnia, depression, anxiety, and stress symptoms, respectively [17].

Another study [18] found that 35.6 percent of healthcare professionals in China during the COVID-19 epidemic had generalized anxiety disorder using the Generalized Anxiety Disorder-7 scale. According to research utilizing the Hamilton Anxiety Scale [19], 22.6 percent of healthcare professionals reported mild to moderate anxiety during the COVID-19 epidemic, whereas just 2.9 percent had severe anxiety.

In comparison to prior findings, a research indicated a significant degree of anxiety; nevertheless, there is no mental health care for doctors who are on the frontlines of both COVID-19 and the civil war, risking their lives for patients. As a result, these healthcare professionals require an effective mental health support system and intervention programs, such as online meetings or telephone counseling, to enable them to share their issues and perform more successfully [20]. Zhang et al. [21] observed that medical HCWs had considerably greater levels of sleeplessness, anxiety, depression, somatization, and OCD symptoms than non-medical HCWs.

A systematic review of 22 studies found that the percentage of healthcare workers experiencing anxiety ranged from 9% to 90%, with a median of 24%. There was information from 19 studies on depression [22]. The proportion of people suffering from depression ranged from 5% to 51%, with a median of 21% [23].

In terms of insomnia symptoms, our findings show that 66 percent of HCWs working 40 hours or more do not have insomnia, 39 percent have mild insomnia, 31 percent have moderate insomnia, 10 percent have severe insomnia, and 11 percent have extremely severe insomnia.

While 20 of the 40-60 hour working HCWs do not have insomnia, 24 have mild insomnia, 30 have moderate insomnia, 14 have severe insomnia, and 8 have very severe insomnia. In addition, three HCWs who work more than 60 hours a week do not have insomnia; one has light insomnia, one has moderate insomnia, two have severe insomnia, and one has very severe insomnia. A study reported that the mean symptom score has been increasing by 20% in the overall sample. However, this finding did not result in a corresponding increase in the prevalence of clinically relevant insomnia symptoms, suggesting an overall worsening of insomnia in the sample, although below the limits of clinical relevance [24]. Another study reported that 6% of all participants presented severe symptoms of insomnia, and 10.4, 19.9, and 11% of all participants presented severe to extremely severe symptoms of depression, anxiety, and stress, respectively [25]. According to data from six studies, the percentage of persons who have sleeping disorders ranges from 34% to 65%, with a median of 37%. Data on distress was gathered from 13 different research. The percentage of patients in distress ranged from 7% to 97 percent [26], with a median of 37%. 34.0 percent of participants in one trial had insomnia [27]. Sleep quality and social support were shown to be mediated by anxiety, stress, and self-efficacy. Anxiety levels were linked to poor sleep quality [18]. Social support, on the other hand, was shown to be favorably linked with self-efficacy and sleep quality while being adversely connected with anxiety and stress among HCWs [28].

During the COVID-19 epidemic, major psychological difficulties were noted in healthcare staff caring for high-risk patients. It's worth noting that the majority of healthcare personnel work in isolation units, which, when paired with low resources and inadequate training, can lead to increased stress and psychological impacts. Psychological intervention and smart resource use are essential to ameliorate the psychological impacts of this worldwide epidemic. In order to minimize catastrophic results, it is also necessary to expand monitoring and improve detection of early cases of depression and anxious symptoms [10].

Avoiding intense exposure to COVID-19 media coverage (a phenomena that has expanded globally) and keeping a caring and happy lifestyle by helping others are two acts that may be

performed to lessen the intensity of the psychological repercussions. Resilience training programs for healthcare professionals, law enforcement, and the general public should be implemented to deal with the pandemic's side effects, including (a) balancing family life and work; (b) clear and timely information on the disease and its effects on psychological well-being; (c) education and preparation of societies for future pandemics and epidemics; and (d) validation and evaluation of frontline healthcare personnel's contribution [23].

#### 4. CONCLUSION

The results of this study illustrated the burden of psychological problems among different healthcare workers during the COVID-19 pandemic. The findings suggest that all health care workers (HCWs) were affected by varying degrees severity of anxiety and depression, insomnia and complaining from cardiovascular symptoms. The most significant source of anxiety that affect HCWs is being exposed to COVID-19 at work and taking the infection home to their families followed by access to appropriate personal protective equipment and dealing directly with COVID-19 patients. Severity of Insomnia and cardiovascular symptoms were significantly related to the number of working hours. These findings will help us to improve our understanding of the impact of the epidemic on the mental health of medical personnel and recommend measures that go beyond saving the lives of COVID19 patients; Psychosocial intervention and support for medical personnel should be included to respond to the COVID19 pandemic. Intervention and support of HCWs are needed for short-term psychological problems such as anxiety, depression, and insomnia. In addition, emphasis should be placed on self-relaxation training, regular exercise, and a healthy lifestyle. More research on medical personnel needs to be done to explore the long-term effects of the COVID19 pandemic (such as depression and stress disorder) and psychosocial interventions to improve mental health of the vulnerable groups of HCW.

#### CONSENT

Informed consent was obtained from all participants included in the study

#### ETHICAL APPROVAL

The research proposal was approved by the Regional Research and Ethics committee of

Imam Abdulrahman Bin Faisal University with Ethical approval number (IEB-UGS-2021-01-259).

#### COMPETING INTERESTS

Authors have declared that no competing interests exist.

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