

The Mental Burden of COVID-19 in Pulmonary Patients: An Investigation of Fear, Anxiety, and Quality of Life

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Abstract

Introduction: The coronavirus disease 2019 (COVID-19) pandemic has significantly impacted various aspects of life, particularly mental health and quality of life.

Purpose: This study aims to assess the levels of anxiety and fear experienced during the coronavirus disease 2019 (COVID-19) pandemic, examine how these factors vary according to sociodemographic and individual characteristics, and explore their impact on the quality of life of individuals attending private pulmonology clinics.

Methodology: A descriptive cross-sectional study was conducted with 112 patients who visited a private pulmonology clinic in Greece during the COVID-19 pandemic. Data were collected via a questionnaire that included six sections, covering demographics, stigma, fear, quality of life, coping strategies, and mental health. Statistical analysis was performed via SPSS 25.

Results: The survey revealed high rates of COVID-19-related stigma, especially for foreigners (50.9%) and health workers (29.5%), with half of the participants believing that people were ill due to irresponsible behaviour. Fear of COVID-19 appears to be significantly high ($m = 15.7$), with gender (women) being among the determinants of the highest levels of fear. Anxiety occurs at normal levels ($m = 5.6$), although higher levels of fear have been shown to lead to higher levels of anxiety. Finally, both fear ($p = 0.000$) and anxiety ($p = 0.003$) are negatively correlated with most dimensions of quality of life.

Conclusions: The present research highlights the stigma created by COVID-19, especially for specific groups of people. In addition, increased levels of fear and anxiety affect the quality of life of individuals.

Keywords

Mental Health, anxiety, COVID-19, fear, pandemic, quality of life, stigma

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Introduction

The effects of the COVID-19 pandemic on social cohesion, the economy, and individual lives remain incalculable. In addition to infections, the psychological burden has significantly increased, as evidenced by heightened levels of generalized anxiety and persistent fear, which adversely affect quality of life (Shereen 2020, Taylor 2020). Numerous studies have linked the COVID-19 outbreak to emotional responses such as increased anxiety, depression, posttraumatic stress disorder, psychological distress, and stress, as well as the prevalence of physical and psychological symptoms (Chew 2020, Kapteyn 2020). Similar trends were observed during previous pandemics, such as H1N1, bird flu, Ebola, and SARS (Secor 2020, Sim 2010). Thus, it is unsurprising that stress, fear, and anxiety escalate when deadly diseases spread.

Fear and worry are natural responses in humans and animals during challenging times. Fear, however, can also have positive effects. Recent research has indicated that fear of contracting COVID-19 is correlated with adherence to health guidelines (Pakpour 2020). This aligns with broader findings suggesting that fear drives safety behaviours such as hand washing and mask wearing. These negative emotions can impact quality of life (Harper 2021).

Purpose

This study aims to evaluate anxiety and fear levels during the COVID-19 pandemic, their sociodemographic variations, and their effects on the quality of life of patients visiting private pulmonology clinics.

Methodology

Study Settings and Participants

A descriptive, cross-sectional study was conducted from 1st September to 28th February 2021 in a private pulmonology clinic in Greece. The sample included 112 patients who visited the clinic during the pandemic. The inclusion criteria were as follows: (1) aged 18 years or older; (2) proficiency in Greek and capable of communication; and (3) consent to participate. The study's purpose was explained to all participants, who then signed an informed consent form.

Assessment instruments

The data for the implementation of the research were collected via a questionnaire consisting of 6 separate sections. For each of the tools used, the relevant permission was obtained from the manufacturers. The sections of the survey questionnaire are analysed as follows:

1. Demographic and Occupational Characteristics Questionnaire:

Sociodemographic (age, residence, marital status, number of children, education, religion) and occupational/clinical data (COVID-19 infection, vaccination) were collected.

2. COVID-19 Stigma-Discrimination Toward Health Workers Scale:

Compared with 18 yes–no questions, this scale measures stigma and discrimination levels among health workers due to COVID-19. Each question individually assesses the severity of COVID-19-related stigma (Campo-Arias 2021, Saridi 2022).

3. Fear of COVID-19 Scale Questionnaire:

A self-report tool with 7 items measuring fear of contracting COVID-19. Participants indicate agreement on a five-point Likert scale ranging from 'strongly disagree' to 'strongly agree', with scores ranging from 1 to 5 per question (Ahorsu 2022, Tsiropoulou 2021).

4. Missoula – VITAS Quality of Life Index 15 (MVQOLI-15):

Quality of life was evaluated across five domains: symptoms, functionality, interpersonal relationships, prosperity, and spirituality. It uses a five-point Likert scale, where lower scores indicate less desirable states (Byock 1998, Theofilou 2013).

5. Coping Orientations to Problems Experienced Inventory (COPE), Brief-Cope:

Twenty-eight questions were divided into problem-focused, emotion-focused, and avoidance coping categories and were answered on a four-point Likert scale from 1 (not at all) to 4 (a lot) (Charles 1997, Kapsou 2010).

6. Depression Anxiety Stress Scale-21 (DASS 21):

The scale consists of 21 items grouped into depression, anxiety, and stress subcategories. The participants rated each statement on a four-point Likert scale (0=Not at all true to 3=True most of the time). Scores are summed for a total negative emotional state value, with higher scores indicating higher anxiety and depression levels (Antony 1998, Lurakos, 2011).

Statistical analysis

The data were analyzed via IBM SPSS Statistics Version 25. Descriptive statistics (frequency, percentage distribution, mean, and standard deviation) were used, along with inductive statistical methods to examine variable correlations. Specifically, the χ^2 test, Student's t test, Mann–Whitney test, Kruskal–Wallis test, Pearson correlation, and Spearman correlation were employed. All tests were conducted with a significance level of $p=0.05$, indicating a 5% probability of error (95% confidence level).

Ethical considerations

The study adhered to the ethical standards of the Declaration of Helsinki. The participants were fully informed of the study's purpose, procedures, risks, and benefits before providing written informed consent. The research protocol received approval from the Department of Social and Educational Policy of the University of Peloponnese.

Results

Sociodemographic and occupational characteristics of the sample

The sample included 112 patients from a private pulmonology clinic during the COVID-19 pandemic. Table 1 shows their sociodemographic and occupational characteristics: 76.1% were female ($n=83$), 23.9% were male ($n=26$), 52.7% were aged 40-59, and 40.2% held a university or technological institute degree. During the pandemic, 61.2% of the respondents continued working at their workplace.

Stigma and COVID-19

Key topics included xenophobia, mass media effects on mental health, individual responsibility for COVID-19, and perspectives on healthcare workers. The important characteristics were sex, age, chronic illness, and COVID-19 infection. Most participants viewed foreigners as having greater transmission risk and blamed irresponsible behavior for the illness (50.9% and 49.5%, respectively). Approximately one-third believed that healthcare workers should avoid public transport. Gender influenced xenophobia, with men being more likely to see foreigners as higher risk (73.1%) and to blame illness for irresponsibility (61.4%). Age also influenced xenophobia; those over 40 years of age saw foreigners as having greater risk (72.7%) and felt more anxious due to media (40.9%). People with chronic illnesses were less accepting of healthcare workers in contact with COVID-19

patients, believing that they should be isolated (16.7%), as were those who had COVID-19 (33.3%).

The correlations between the questionnaire items on COVID-19 stigma and the fear scale scores are shown in Table 2. Half of the stigma-related items (9 out of 18) correlated with the total fear scale score, indicating a positive correlation between greater COVID-19 stigma and fear.

Quality of Life

The calculation of scores in its five individual dimensions questionnaire is complex. Each dimension provides information about that dimension's impact on the patient's quality of life. The final score for each dimension reflects its overall effect on the patient's quality of life. Negative dimensions reduce quality of life, whereas positive dimensions enhance it, and the score reflects the dimension's impact size, acting as a weighting factor.

Three dimensions improve quality of life, and two dimensions reduce it. Specifically, the positive dimensions, in order of importance, are spirituality (mean=2.85), well-being (mean=1.04), and functionality (mean=0.95). Conversely, the dimensions that reduce quality of life during the pandemic are interpersonal relationships (mean=-3.21) and symptoms (mean=-0.47) (Table 3).

Fear of COVID-19, anxiety, and quality of life

A significant portion of the sample fears COVID-19 (mean=2.99), feels unsafe (mean=2.76), and becomes nervous and anxious when watching related news (mean=2.38).

Factors influencing COVID-19 fear include gender (higher in women), occupation (private employees and freelancers), work status during restrictive measures (higher fear in those suspended or working normally), chronic disease presence (higher in those with chronic conditions), vaccination status (higher fear in the unvaccinated), trust in the health system (positive correlation with fear), and beliefs about the pandemic's end.

No significant differences were found in the scales for depression, anxiety, or stress. Stress is influenced by family situation, area of residence, chronic illness, regular medication, exercise, computer and mobile phone use, trust in the health system, and medical and nursing personnel.

Table 1: Sociodemographic characteristics and health conditions of the sample (n=112)

Characteristics	N(%)
Gender:	
Male	26 (23.9%)
Female	83 (76.1%)
Age:	
19-28	12 (10%)
30-40	34 (30.4%)
41-59	59 (52.7%)
60-70	5 (4.7%)
71 +	2 (1.8%)
Education level:	
Elementary/Junior High	16 (14.3%)
High School	42 (37.5%)
University/Technological Institute	45 (40.2%)
Postgraduate	9 (8%)
Work situation:	
Unemployed	4 (3.8%)
Private employee	37 (35.2%)
Civil servant	28 (26.7%)
Freelancer	11 (10.5%)
Retired	12 (11.4%)
Other	13 (12.4%)
Work during the period of restrictive measures:	
Suspended	13 (12.6%)
Telecommunity	20 (19.4%)
Normally in the workplace	63 (61.2%)
Complete stoppage of work	7 (6.8%)
Chronic illness:	
Yes	30 (26.8%)
No	82 (73.2%)
Chronic mental health:	
Yes	4 (3.6%)
No	107 (95.5%)
Covid-19 Infection:	
Yes	15 (13.4%)
No	97 (86.6%)
Covid-19 vaccination	
Yes	83(74.1%)
No	29 (25.9%)

The Pearson correlation coefficient was used to examine the relationships between the fear of COVID-19, anxiety, and quality of life dimensions, as shown in Table 4. Fear of COVID-19 is correlated with all quality-of-life dimensions (except symptoms) and overall quality of life. Functionalism has a moderate negative correlation with fear; less functional individuals exhibit greater fear. Interpersonal relationships are moderately positively correlated with fear. Both well-being and spirituality have moderate negative correlations with fear; lower levels of well-being and spirituality correspond to greater fear. Overall quality of life also has a moderate negative correlation with fear; lower quality of life

corresponds to greater fear. All these correlations are bidirectional.

The stress level is correlated with several quality-of-life dimensions. Specifically, stress level has a moderately negative relationship with functionality (-0.352), well-being (-0.248), and spirituality (-0.330); higher levels of these dimensions correspond to lower stress levels. Overall quality of life has a moderate negative correlation with stress levels (-2.82); better quality of life corresponds to lower stress. Finally, both fear ($p=0.000$) and anxiety ($p=0.003$) negatively correlate with most quality-of-life dimensions.

Table 2. Correlations between evidence of COVID-19 stigma and fear of COVID-19

Evidence from the Covid-19 stigma	Mean score	fear	P Value
	Yes	No	
Should people be afraid of those with Covid-19?	18,1	15,1	0,001
When I see news and hear stories about Covid-19 on TV, in the press or on social media, I feel nervous or anxious.	17,7	14,7	0,000
People who work in health services and meet Covid-19 patients must isolate themselves from society.	20,1	15,4	0,001
Patients with Covid-19 must be isolated from society.	17,5	14,9	0,002
I am afraid of being infected by the health personnel I meet on public transport, on the street or even at home.	18,6	15,0	0,000
People with Covid-19 are guilty.	19,7	15,3	0,005
Should people who have recovered from Covid-19 stay away from their workplaces for a long time.	16,9	15,3	0,029
Health care workers should avoid returning home to avoid infecting their families.	19,9	15,2	0,000
Health care workers should avoid going out to avoid infecting other populations	20,6	15,3	0,000

Table 3. Basic descriptive measures for the dimensions of quality of life

	Mean	Median	Std deviation	Min	Max
Symptoms	-.4732	-3.0000	8.36333	-12.00	30.00
Functionality	.9554	.0000	6.66764	-9.00	30.00
Interpersonal relationships	-3.2143	-3.0000	5.39841	-30.00	12.00
Well-being	1.0455	.0000	4.70484	-6.00	15.00
Spirituality	2.8482	2.000	8.98568	-30.00	30.00

Table 4. Pearson's (r) correlation of fear of COVID-19, anxiety and dimensions of quality of life.

Dimensions of quality of life	Fear		Anxiety	
	Coefficient correlation (Pearson Correlation)	P Value	Coefficient correlation (Pearson Correlation)	P Value
Quality of life - Symptoms	-0.094	0,325	-0.160	0,097
Quality of life - Functionality	-0.493	0,000	-0.352	0,000
Quality of life - Interpersonal relationships	0.374	0,000	0.168	0,081
Quality of life - Well-being	-0.364	0,000	-0.248	0,010
Quality of life - Spirituality	-0.472	0,000	-0.330	0,000
Overall quality of life	-0.458*	0,000	-0.282*	0,003

*Spearman correlation

Discussion

Interpretation of findings

Diseases that cause pandemics, such as COVID-19, affect both the medical and mental health of individuals. During a pandemic, people may experience anxiety, discrimination, stigma, fear, guilt, and shame, which affect their mental state and cause serious problems in their quality of life. The main purpose of this research was to investigate the levels of anxiety and fear caused by the pandemic and their relationships with the quality of life of people who visit private pulmonology clinics during the COVID-19 pandemic.

The stigma created by COVID-19 for individuals and society was investigated, revealing elevated stigma levels in most of the assessed situations. The survey revealed a link between high fear of COVID-19 and increased stigmatization across multiple questions. The sample perceived a greater transmission risk from foreigners (OR = 1.49, Std. Dev=0.502), aligning with previous studies on other epidemics or pandemics (e.g., H1N1, bubonic plague, Asian flu, cholera, Ebola, Zika, HIV, tuberculosis, SARS, MERS), which reported connections between weight stigma, discrimination, and virus fear (Fischer 2019). Consequently, high levels of fear and stigma in these groups could hinder transmission prevention practices. These situations indicate that preexisting stigmas were reinforced and found new spaces to grow during the COVID-19 pandemic (Turner-Musa 2020).

Healthcare workers in COVID-19 care units face significant stigma, discrimination, and social stigmatization, which also extends to their family and friends as "secondary" or "associative" stigma. This study highlighted considerable stigma against health workers, which is strongly correlated with heightened fear of the disease. The "infodemic," or the spread of misinformation about COVID-19, exacerbates both stigmatization and fear (Hudson 2020). This study revealed a positive association between misinformation and fear of COVID-19 (OR = 1.67, Std. Dev=0.472).

The link between fear and stigma underscores the pandemic's severe public health impact. Fear can lead to concealment of the disease, hindering pandemic control activities such as contact tracing and delaying medical care for symptomatic individuals (Ornell 2020). A moderate positive correlation was also noted between fear, depression, and anxiety, which aligns with the findings of Ahorsu et al. (2020), who reported that fear of COVID-19 adversely affects

mental health (Ahorsu 2020). Fear may stem from catastrophizing, a cognitive error linked to anxiety and depression, exacerbated by the pandemic's negative outlook and containment measures. This negative feedback loop heightens fear and, consequently, depressive and anxiety symptoms.

However, the impact of the pandemic on this sample was not significant. The average anxiety (5.6), depression (8.2), and stress (11.4) levels were within normal ranges, although 25% exceeded normal stress limits, with 6.4% experiencing severe or extremely severe anxiety disorders. This finding is similar to the prevalence of anxiety disorders worldwide, which is estimated to be approximately 7.3% (95% CI: 4.8% to 10.9%) before the onset of the pandemic (Stein 2017).

The sample exhibited high levels of problem-focused and emotion-focused coping but moderate levels of avoidant coping. Notably, problem-focused coping was negatively correlated with anxiety, whereas avoidant coping was positively correlated with anxiety. Thus, anxiety levels are influenced by coping strategies, with greater anxiety linked to increased use of avoidant coping, supporting previous findings (Satija 1998).

This research underscores the significant impact of spirituality on quality of life and well-being during the COVID-19 pandemic. Well-being, which affects multiple life sectors, is crucial, as highlighted by Hodge et al. (2020), who emphasized considering the complex intersections of various life aspects during the pandemic. Functionality also emerged as a crucial positive factor during this period. Conversely, interpersonal relationships and symptoms are factors that diminish quality of life. COVID-19 has significantly affected social connections and interpersonal relationship quality.

Strengths and Limitations

The strengths of this study include the comprehensive approach of combining validated instruments such as the Fear of COVID-19 Scale, Depression Anxiety Stress Scale (DASS-21), and Missoula-VITAS Quality of Life Index (MVQOLI-15). This allows for nuanced insights into fear, anxiety, and their effects on quality of life during the COVID-19 pandemic. Its focus on a specific patient demographic (those visiting pulmonology clinics) offers targeted relevance, whereas the use of descriptive cross-sectional methodology provides a snapshot of psychological and social impacts during a critical period. Statistical rigor with a variety of tests enhances the reliability of the analysis. Limitations

are limited by its sample size (112 participants), which may reduce the generalizability of the findings. Self-reported measures introduce the possibility of response bias, and the cross-sectional design precludes the establishment of causal relationships. Moreover, the reliance on patients from private pulmonology clinics might skew results towards a subset of the population with better health care access.

Conclusions

Overall, quality of life decreases as fear of COVID-19 increases across all associated dimensions. Functionality and spirituality are key factors in reducing fear, whereas frequent interpersonal interactions can significantly increase it.

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Conflict of interest

The authors declare no conflicts of interest.

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