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Research Article

Perceived Stress and Hopelessness in COVID-19 Contacts

Mert Kartal[1], Muhammet Bayraktar[2]

[1]Malatya Turgut Ozal University, Faculty of Health Sciences, Malatya, Türkiye
[2]Nigde Omer Halisdemir University Faculty of Medicine, Department of Public Health, Niğde, Türkiye

Abstract

Aim: We aimed to determine the perceived stress and hopelessness levels in COVID-19 patient contacts.

Materials and Methods: The study included all COVID-19 contacts who presented to a family health center in Niğde, Turkey between August and October 2020. The data were collected from contacts who were reached daily for a period of 14 days using the Beck Hopelessness Scale (BHS) and the Perceived Stress Scale (PSS). The data were analyzed using the SPSS package program, and $p<0.05$ was considered significant.

Results: While 55.8% of the participants were female, 71% were married, and 46.9% had a chronic disease. The mean age of the participants was 53.44 years. Their mean BHS and PSS scores were 4.40±3.33 and 25.07±5.98, respectively. A statistically significant relationship was found between the participants' places of residence and occupations and their mean BHS loss of motivation subscale scores ($p<0.05$). Among the participants, homemakers, those living in districts, towns, or villages, and those with chronic diseases had significantly higher PSS total scale and.stress-distress subscale mean scores than the others. A statistically significant positive correlation was found between the ages of the participants and their PSS total scale and stress-distress subscale scores ($p<0.05$).

Conclusion: Although the hopelessness levels of the participants were found low, their stress levels were determined to be high, and most of them thought the pandemic was exaggerated. Due to the psychological consequences of the COVID-19 pandemic such as shock, denial, anxiety, worry, and stress in people, it is important to strengthen crisis and stress management efforts and increase awareness, coping and social support resources by prioritizing high-risk groups such as healthcare workers, women, the elderly, those with chronic diseases, and COVID-19 contacts.

Keywords: COVID-19, contacts, hopelessness, stress

INTRODUCTION

The novel coronavirus disease 2019 (COVID-19), which is caused by the "Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2)" and spreads rapidly all around the world, still has widespread effects on the world's population, causing not only physiological but also psychological problems (1). Psychological problems caused by the COVID-19 pandemic have rapidly increased its public health burden. Pandemics can trigger depressive and bipolar disorders in people. Experience from previous pandemics has shown that depressive symptoms, varying degrees of anxiety disorders, and post-traumatic stress disorders can develop not only in people with anxiety disorders and panic attacks but also in people who have not had such complaints before (2). Therefore, health employees who are in contact with COVID-19 patients should be evaluated in this regard. Contact-tracing efforts made at the early stages of epidemic diseases in various regions have shown that most secondary infections occur in cases of contact inside the home, and the rate of secondary attacks is found to reach up to 10% (3,4). In a study that was conducted in the United States, the rate of secondary attacks among the 445 close contacts of 10 confirmed cases was found as 0.45%, while this rate was found 10.5% for contacts at home (3). A study carried out in the context of the COVID-19 pandemic showed that frontline healthcare workers, who are among people in contact with confirmed and suspected cases, experienced stress more intensely, while another study examining the psychological problems experienced by nurses revealed that nurses experienced stress and anxiety under intense

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Corresponding Author: Mert Kartal, Malatya Turgut Ozal University, Faculty of Health Sciences, Malatya, Türkiye
E-mail: akartal044@hotmail.com

pressure in this period (5,6). Bohlken et al. reported that healthcare workers and those with close contact with infected individuals experienced higher levels of stress (7).

As the COVID-19 pandemic causes both physical health issues and mental health problems such as anxiety, panic, and stress, it should be evaluated not only as a medical health crisis but also as a mental health emergency. Epidemic diseases affect not only people's physical and psychological health but also the well-being of the entire population. In the early days of the COVID-19 pandemic, mostly its physical consequences received attention, and therefore, its mental health consequences were not emphasized. However, even after the pandemic ends, its psychological effects will likely last for months or even years (8). It not only causes serious threats to the physical health and lives of many people around the world but also triggers the emergence of a wide variety of psychological problems, and the increase in perceived stress and hopelessness levels also facilitate the emergence of problems such as panic disorders, anxiety disorders, grief, loss, and depression (9).

In this study, within the scope of examining the effects of the COVID-19 pandemic on the psychological states of individuals, it was aimed to determine the perceived stress and hopelessness levels in the contacts of individuals infected in the pandemic period to understand and plan the necessary interventions.

MATERIAL AND METHOD

Design and Sample

The sample of the study consisted of individuals who had been in contact with COVID-19 patients who were registered to the Kemerhisar Family Health Center No. 1 in Niğde, Turkey and monitored daily for a period of 14 days in line with the relevant guideline. After the COVID-19 contacts were asked about their symptoms and recommended social distancing, their answers to BHS and PSS were recorded on the data collection form, and their scale scores were evaluated by the researcher. Each interview lasted about ten to fifteen minutes. No sample selection was performed within the scope of the study, whereby all COVID-19 contacts who were over 18 years old and registered to the family health center between August and October 2020 were included in the study.

Data Collection Tools

The data were obtained using a 22-item questionnaire, including questions about the participants' sociodemographic characteristics, as well as the Beck Hopelessness Scale and the Perceived Stress Scale. Verbal consent was received via daily routine control phone calls from the participants after they were provided with the necessary information about the study.

Beck Hopelessness Scale (BHS): The scale was designed by Beck et al. and adapted into Turkish by Durak et al. The item-total correlation coefficients of the scale were reported to range from 0.39 to 0.76, and its reliability coefficient was 0.93. It consists of 20 true-false statements with 11 true and nine false answers. This is a self-reported scale, where one point is given for each compatible answer, and zero points are given for each incompatible answer. The arithmetic total scale score is considered the "hopelessness score", ranging from zero to 20. The scale consists of three subscales, namely feelings about the future, loss of motivation, and future expectations. The propositions include emotional, motivational, and cognitive factors (10).

Perceived Stress Scale (PSS): The scale was designed by Cohen Kamarck and Mermelstein, and its validity and reliability in Turkish were tested by Eskin et al. The item-total correlation coefficients of the scale were reported to range from 0.41 to 0.59. The scale consists of 14 items and is designed to measure how stressful individuals perceive certain situations in their lives to be. It has two subscales, namely perceived insufficient self-efficacy and perceived stress-distress. This is a five-point Likert-type scale on which the scoring options are in the range from zero points "never" to four points "very often". Seven items have positive statements and are inversely scored. Total scale score ranges from zero to 56. High scores indicate higher levels of stress. The internal consistency coefficient of the scale was reported as 0.84 (11).

Statistical analysis

The data were analyzed using the SPSS program. Descriptive statistics analyzed using frequency, percentage, and mean values. The Mann-Whitney U test and the Kruskal-Wallis test used to determine the relationships between descriptive statistics and scale scores for independent groups. To determine the distribution characteristics of the data, the Kolmogorov-Smirnov test was used, and $p<0.05$ was considered statistically significant.

Ethical considerations

For conducting the study, ethical approval (dated 23/07/2020 and numbered 27988) was obtained from the Ethics Committee of the Faculty of Medicine at Harran University, and institutional permission (dated 14/06/2020) was obtained from the family health center where the study would be carried out.

RESULTS

Table 1 shows the sociodemographic characteristics of the participants. While 55.8% of the participants were female, 71% were married, 23.9% were smokers, 41.6% were homemakers, 70.8% had detached houses, 88.5% lived outside the city center, 64.6% had primary or secondary education, and 46.9% had chronic diseases. The mean age of the participants was 53.44 years.

Table 2 shows the descriptive characteristics and BHS total and subscale scores of the participants. The mean total BHS

score of the participants was 4.40±3.33. The relationships between the genders, ages, marital statuses, educational levels, and chronic disease statuses of the participants and their mean BHS scores were not statistically significant (p>0.05). On the other hand, their mean loss of motivation subscale scores were significantly related to their places of residence and occupations (p<0.05). The participants who were single, those with bachelor's or higher degrees, those who were civil servants and tradespeople, those living in the city center, and those with no chronic diseases had higher hopelessness levels, while these differences were not statistically significant.

Table 3 shows the sociodemographic characteristics and PSS total and subscale scores of the participants. The mean total PSS score of the participants was 25.07±5.98. No significant relationship was determined between the mean PSS total and subscale scores of the participants and their marital statuses or educational levels (p>0.05). The female participants, those who were single, and those who were illiterate had higher mean total PSS scores than others, while these differences were not statistically significant (p>0.05). The participants who were homemakers, those living in districts, towns, or villages, and those with chronic disease had significantly higher PSS total and stress-distress subscale mean scores than others (p<0.05). The sociodemographic characteristics of the participants did not have a significant effect on their perceived insufficient self-efficacy subscale scores (p>0.05). A statistically significant positive relationship was determined between the ages of the participants and their mean PSS total and stress-distress subscale scores (p<0.05).

Table 4 shows the distributions of the views of the participants about the COVID-19 pandemic. All participants reported that hand washing is important in preventing infections, 99.1% stated that they washed their hands whenever possible, social distancing is important for protection from the disease, the disease is transmitted even by shaking hands, and they cared about personal hygiene during isolation. Additionally, 61.9% of the participants thought that the pandemic was exaggerated, 97.3% stated that the disease is transmitted more in common living areas, and 96.5% reported that it was not difficult for them to follow the rules during isolation.

Table 1. Sociodemographic Characteristics of the Participants

Sociodemographic Characteristics		n	%	Sociodemographic Characteristics		n	%
Gender	Male	50	44.2	Occupation	Homemaker	47	41.6
					Retired	29	25.7
					Civil Servant, Tradesperson	11	9.7
	Female	63	55.8		Laborer	12	10.6
					Other (Self-employed, student, etc.)	14	12.4
Marital Status	Married	71	62.8	Housing Type	Apartment	33	29.2
					Detached house	80	70.8
	Single	19	16.8	Place of Residence	City center	13	11.5
					District, Town, Village	100	88.5
	Widowed / Divorced	23	20.4	Education status	Illiterate	11	9.7
					Literate with not formal degree	11	9.7
Smoking	Yes	27	23.9		Primary or secondary education	73	64.6
	No	86	76.1		University or above	18	15.9
Age	$\bar{X}$±SD	Min	Max	Has a Chronic Disease	Yes	53	46.9
	53.44±21.01	19.00	88.00		No	60	53.1

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Table 2. Comparisons of the BHS Total and Subscale Scores of the Participants

			Beck Hopelessness Scale											
		n	Feelings about the future			Loss of motivation			Future expectations			BHS total scale score		
			$\bar{X}$±SD	Min-max	Median	$\bar{X}$±SD	Min-max	Median	$\bar{X}$±SD	Min-max	Median	$\bar{X}$±SD	Min-max	Median
Gender	Male	50	0.46±0.88	0.00-4.00	0.00	1.60±1.41	0.00-6.00	1.00	1.86±1.06	0.00-5.00	2.00	4.00±2.78	0.00-11.00	4.00
	Female	63	0.57±1.14	0.00-5.00	0.00	1.42±1.62	0.00-6.00	1.00	1.88±1.40	0.00-5.00	2.00	4.01±3.73	0.00-16.00	3.00
	Total	113	0.52±1.03	0.00-5.00	0.00	1.50±1.53	0.00-6.00	1.00	1.87±1.26	0.00-5.00	2.00	4.40±3.33	0.00-16.00	3.00
	p, Z		p=0.875, Z= -0.157			p=0.248, - Z=-1.154			p=0.785, Z=-0.272			p=0.411, Z=-0.823		
Marital Status	Single	71	0.47±0.96	0.00-5.00	0.00	1.59±1.52	0.00-6.00	1.00	1.95±1.26	0.00-5.00	2.00	4.12±3.26	0.00-16.00	3.00
	Married	19	0.42±0.83	0.00-3.00	0.00	1.36±1.21	0.00-3.00	1.00	1.78±1.08	0.00-4.00	2.00	3.68±2.60	0.00-9.00	3.00
	Divorced, Widowed	23	0.73±1.35	0.00-4.00	0.00	1.34±1.79	0.00-6.00	1.00	1.69±1.39	0.00-5.00	1.00	3.91±4.12	0.00-14.00	3.00
	p, KW		p=0.879, KW=0.258			p=0.473, KW=1.496			p=0.577, KW=1.100			p=0.625, KW=0.939		
Education status	Illiterate	11	0.36±0.92	0.00-3.00	0.00	1.36±1.74	0.00-6.00	1.00	1.63±1.20	0.00-4.00	1.00	3.54±3.83	0.00-14.00	3.00
	Literate	11	0.63±1.20	0.00-4.00	0.00	1.45±1.91	0.00-6.00	1.00	1.72±1.27	0.00-4.00	2.00	3.81±3.51	2.00-14.00	2.00
	Primary or secondary education	73	0.53±0.98	0.00-4.00	0.00	1.45±1.36	0.00-6.00	1.00	1.91±1.26	0.00-5.00	2.00	4.04±3.12	0.00-13.00	3.00
	University or above	18	0.50±1.24	0.00-5.00	0.00	1.83±1.85	0.00-6.00	2.00	1.94±1.34	0.00-5.00	2.00	4.27±3.96	0.00-16.00	4.00
	p, KW		p=0.679, KW=0.773			p=0.739, KW=0.604			p=0.714, KW=0.673			p=0.657, KW=0.839		
Occupation	Homemaker	47	0.53±0.99	0.00-4.00	0.00	1.06±1.30	0.00-6.00	1.00	1.72±1.36	0.00-5.00	1.00	3.46±3.38	0.00-14.00	3.00
	Retired	29	0.48±0.98	0.00-4.00	0.00	1.58±1.63	0.00-6.00	1.00	1.75±1.18	0.00-4.00	1.00	3.86±3.11	0.00-14.00	3.00
	Civil Servant, Tradesperson	11	0.90±1.81	0.00-5.00	0.00	2.72±1.84	0.00-6.00	3.00	2.63±1.20	1.00-5.00	3.00	6.36±4.34	1.00-16.00	6.00
	Laborer	12	0.25±0.22	0.00-2.00	0.00	2.16±1.58	0.00-6.00	2.00	2.25±1.05	1.00-5.00	2.00	4.75±2.73	1.00-11.00	4.00
	Other (self-employed, student, etc.)	14	0.50±0.75	0.00-2.00	0.00	1.28±1.06	0.00-3.00	1.00	1.71±1.13	0.00-4.00	2.00	3.64±2.67	0.00-8.00	3.50
	p, KW		p=0.887, KW=1.143			p=0.009, KW=13.630			p=0.111, KW=7.515			p=0.054, KW=9.313		
Place of Residence	City center	13	0.84±1.46	0.00-5.00	0.00	2.38±1.89	0.00-6.00	2.00	2.38±1.50	0.00-5.00	2.00	5.61±4.35	1.00-16.00	6.00
	District, Town, Village	100	0.48±0.96	0.00-4.00	0.00	1.39±1.44	0.00-6.00	1.00	1.81±1.22	0.00-5.00	2.00	3.80±3.14	0.00-14.00	3.00
	p, Z		p=0.329, Z=-0.977			p=0.049, Z=-1.968			p=0.165, Z=-1.388			p=0.106, Z=-1.617		
Has a Chronic Disease	Yes	53	0.56±1.08	0.00-4.00	0.00	1.37±1.54	0.00-6.00	1.00	1.79±1.21	0.00-5.00	2.00	3.83±3.38	0.00-14.00	3.00
	No	60	0.48±0.99	0.00-5.00	0.00	1.61±1.51	0.00-6.00	1.00	1.95±1.30	0.00-5.00	2.00	4.16±3.30	0.00-16.00	3.50
	p, Z		p=0.518, Z=-0.646			p=0.285, Z=-1.069			p=0.559, Z=-0.584			p=0.454, Z=-0.749		
Age		113	53.44±21.01	19.00-88.00	56.00	53.44±21.01	19.00-88.00	56.00	53.44±21.01	19.00-88.00	56.00	53.44±21.01	19.00-88.00	56.00
	p, r		p=0.669, r=0.037			p=0.414, r=0.78			p=0.901, r=0.012			p=0.730, r=0.033		

Table 3. Comparisons of the PSS Total and Subscale Scores of the Participants

			Perceived Stress Scale								
		n	Perceived insufficient self-efficacy			Perceived stress/distress			PSS total scale score		
			$\bar{X}$±SD	Min-max	Median	$\bar{X}$±SD	Min-max	Median	$\bar{X}$±SD	Min-max	Median
Gender	Male	50	13.48±3.40	4.00-19.00	14.00	10.76±5.27	1.00-24.00	10.00	24.24±5.21	12.00-34.00	25.00
	Female	63	14.31±3.66	6.00-21.00	15.00	11.42±5.43	1.00-26.00	12.00	25.74±6.48	12.00-41.00	27.00
	Total	113	13.94±3.55	4.00-21.00	15.00	11.13±5.35	1.00-26.00	11.00	25.07±5.98	12.00-41.00	26.00
	p, Z		p=0.216, Z=-1.237			p=0.436, Z=-0.780			p=0.175, Z=-1.355		
Marital Status	Single	71	14.05±3.47	7.00-21.00	14.00	11.25±5.24	1.00-24.00	11.00	25.30±5.84	12.00-41.00	26.00
	Married	19	14.15±3.05	8.00-18.00	15.00	8.57±4.75	1.00-16.00	9.00	22.73±5.63	12.00-32.00	22.00
	Divorced, Widowed	23	13.43±4.25	4.00-20.00	14.00	12.86±5.57	5.00-26.00	13.00	26.30±6.38	14.00-35.00	27.00
	p, KW		p=0.895, KW=0.222			p=0.075, KW=5.193			p=0.120, KW=4.237		
Education status	Illiterate	11	14.63±3.88	9.00-20.00	16.00	13.63±5.74	6.00-26.00	13.00	28.57±5.53	19.00-35.00	28.00
	Literate	11	12.45±3.23	8.00-18.00	12.00	13.54±4.36	7.00-21.00	13.00	26.00±4.75	15.00-32.00	27.00
	Primary or secondary education	73	14.20±3.57	4.00-21.00	15.00	10.78±5.43	1.00-24.00	11.00	24.98±6.19	12.00-41.00	26.00
	University or above	18	13.38±3.44	7.00-18.00	14.50	9.55±4.68	1.00-20.00	9.00	22.94±5.46	14.00-33.00	24.00
	p, KW		p=0.367, KW=3.168			p=0.113, KW=5.964			p=0.126, KW=5.724		
Occupation	Homemaker	47	14.65±3.65	6.00-21.00	16.00	11.70±4.56	2.00-21.00	12.00	26.36±5.99	13.00-41.00	28.00
	Retired	29	13.20±3.64	4.00-19.00	14.00	13.20±5.67	2.00-26.00	13.00	26.41±5.36	14.00-35.00	27.00
	Civil Servant, Tradesperson	11	13.63±3.80	7.00-18.00	15.00	9.90±6.25	1.00-20.00	9.00	23.54±6.71	16.00-36.00	24.00
	Laborer	12	14.41±2.90	9.00-20.00	14.50	7.91±5.96	1.00-19.00	7.00	22.33±5.89	12.00-30.00	22.00
	Other (Self-employed, student, etc.)	14	12.92±3.22	8.00-18.00	14.00	8.64±3.91	1.00-15.00	9.50	21.57±4.76	12.00-29.00	21.50
	p, KW		p=0.352, KW=4.419			p=0.019, KW=11.819			p=0.014, KW=12.561		
Place of Residence	City center	13	12.76±3.70	7.00-17.00	15.00	8.07±4.64	1.00-17.00	9.00	20.84±5.11	14.00-29.00	21.00
	District, Town, Village	100	14.10±3.52	4.00-21.00	14.50	11.53±5.33	1.00-26.00	11.50	25.63±5.88	12.00-41.00	26.00
	p, Z		p=0.345, Z=-0.945			p=0.027, Z=-2.206			p=0.006, Z=-2.762		
Has a Chronic Disease	Yes	53	14.30±3.94	4.00-21.00	15.00	12.98±5.39	2.00-26.00	13.00	27.28±5.85	14.00-41.00	29.00
	No	60	13.63±3.17	7.00-20.00	14.50	9.50±4.79	1.00-20.00	10.00	23.13±5.43	12.00-36.00	24.00
	p, Z		p=0.298, Z=-1.040			p=0.002, Z=-3.101			p=0.000, Z=-3.881		
Age		113	53.44±21.01	19.00-88.00	56.00	53.44±21.01	19.00-88.00	56.00	53.44±21.01	19.00-88.00	56.00
	p, r		p=0.770, r=0.028			p=0.01, r=0.320			p=0.000, r=0.730		

Table 4. Thoughts of the Participants on the Pandemic

Thoughts on the COVID-19 pandemic	Yes		No	
	n	%	n	%
Hand washing is important in preventing the disease	113	100	0	0
I wash my hands whenever possible	112	99.1	1	0.9
I think the pandemic is exaggerated	70	61.9	43	38.1
Social distancing is important for protection from the disease	112	99.1	1	0.9
The disease is transmitted even by shaking hands	112	99.1	1	0.9
The disease is transmitted more in common living areas	110	97.3	3	2.7
It is not difficult for me to follow the rules during isolation	109	96.5	4	3.5
I care about my personal hygiene during isolation	112	99.1	1	0.9

DISCUSSION

In addition to the evaluation of the societal impact of the pandemic on mental health among infected individuals, it is also important to evaluate people at risk of COVID-19 infection. The psychological evaluation of COVID-19 contacts is neglected as the treatment of COVID-19 patients is prioritized. We aimed to determine the perceived stress and hopelessness levels in individuals who had had contact with COVID-19 patients. The mean BHS and PSS scores of the participants of our study were 4.40±3.33 and 25.07±5.98, respectively. Studies have reported that both family members and contacts of COVID-19 patients have mental issues as they are isolated or quarantined, and these individuals feel shame, guilt, or stigma. Studies have also reported that the frequency of post-traumatic stress disorder and depression increases in the family and close contacts of COVID-19 patients (12,13,14). Although the stress levels of the COVID-19 contacts in our study were in parallel with those reported in the literature, the hopelessness levels of our participants were not very high. This may be because of the possibility that the participants of this study considered that their personal protective measures would protect them from the disease. Additionally, 61.9% of the participants thought that the pandemic was exaggerated, and 96.5% stated that it was not difficult for them to abide by the rules, which may have reduced their hopelessness levels. Although the hopelessness and stress levels of the female participants were higher than those of the male participants, the differences between them were not statistically significant. Furthermore, almost all participants were aware of the importance of washing hands and social distancing during the pandemic period, the risks of commonly shared areas, and the value of personal hygiene. Göksu and Kumcagiz conducted a study on perceived stress and anxiety in individuals during the COVID-19 pandemic period and found higher anxiety and stress levels in female participants (15). One study on psychological reactions and related factors in the first phase of the COVID-19 pandemic revealed that women had higher anxiety levels than men did (12). Another study of healthcare workers found higher stress and anxiety levels in female workers during the pandemic (5). This may be because the working life requirements and social and domestic roles imposed on women lead them to have higher stress levels than men.

Although the participants of our study who were single were more stressed and hopeless than those who were married, the difference between them was not statistically significant. Göksu and Kumcağiz found higher stress levels in single individuals (15). This may be because family support reduces hopelessness and stress levels among married people. The results of our study revealed that occupation did not affect hopelessness, but the retired participants had a significantly higher mean total PSS score than others. Likewise, there was a significant positive relationship between the ages of the participants and their perceived stress levels. Our result was supported by one study about the effects of COVID-19 on mental health (16). Tian et al. determined that people aged 50 and over in China had phobic anxiety, more obsessive-compulsive symptoms, psychotic symptoms, and interpersonal sensitivity during the pandemic (17). Another study emphasized psychological problems in the elderly during the pandemic as they had a higher level of fear of becoming infected and dying (18). Stress increases by age as older people stay at home more than other age groups do during the pandemic, and the disease causes more deaths in the elderly. Studies in the literature have stated that isolation at home increases depression, health anxiety, financial anxiety, and feelings of loneliness (19,20). The results of the present study showed higher perceived stress levels in the participants who lived outside the city center (district, village, town) and those had chronic diseases. Although the COVID-19 pandemic has caused unemployment and loss of welfare in all segments of society, it had a greater impact on some risk groups (21,22). Wilner et al. reported that the pandemic affected people with chronic diseases more, causing them to have higher stress levels (23). Cao et al. also emphasized that staying in an urban area instead of a rural area has a protective effect during the

pandemic (24). People living outside the city center and those with chronic diseases have higher perceived stress levels due to their inability to access health services, the need for private or rental cars for hospital transportation, and the emergence of additional nutritional needs to keep immunity strong.

CONCLUSION

The COVID-19 pandemic has caused unemployment and loss of welfare in all social segments, but it has had more severe impact on some risk groups such as COVID-19 contacts. In our study, the mean BHS and PSS scores of the COVID-19 contacts were 4.40±3.33 and 25.07±5.98, respectively. Moreover, 61.9% of the participants thought that the pandemic was exaggerated, and 96.5% stated that it was not difficult for them to obey the rules in place. Furthermore, almost all participants were aware of the importance of washing hands and social distancing during the pandemic period, the risks of commonly shared areas, and the value of personal hygiene.

Due to the psychological consequences of the COVID-19 pandemic like shock, denial, anxiety, worry, and stress in people, it is important to strengthen crisis and stress management and increase awareness, coping, and social support resources by prioritizing high-risk groups like the aged, women, health employees, those with chronic diseases, and COVID-19 contacts.

Social workers should increase the awareness of these risk groups regarding pandemic-related problems, identify their needs, evaluate the effects of these problems on individuals, and help them develop rational coping strategies.

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