



Anxiety and Fear Levels of Confirmed & Possible COVID-19 Cases Isolated at Home

Evde İzole Edilen COVID-19 Kesin & Olası Vakaların Anksiyete ve Korku Düzeyleri

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Abstract

Aim: This study aimed to determine anxiety and fear levels of confirmed and possible COVID-19 cases isolated at home and the influencing factors.

Methods: This descriptive study was conducted with 387 confirmed and possible cases in a province in southern Turkey between January-June 2021. The data were collected online via the snowball method using the Fear of COVID-19 Scale and the Coronavirus Anxiety Scale.

Results: Of the participants, 50.9% were “confirmed COVID-19 cases” and 49.1% were “possible COVID-19 cases”. It was determined that COVID-19 anxiety was low and fear of COVID-19 was high. COVID-19 anxiety was 2.57 times greater in women, 2.51 times greater in those whose educational level was primary school and below, 2.63 times greater in those living with others at home, and 1.93 times greater in those who had no room to go into isolation at home alone. Fear of COVID-19 was 2.62 times greater in those with low educational levels and 1.82 times greater in those who were married ($p<0.05$). Women’s fear of COVID-19 was on the statistical significance margin (OR=1.62; 95% CI:0.99-2.62, $p=0.051$).

Conclusion: Confirmed and possible COVID-19 cases have low anxiety and high fear. Disadvantaged groups like women, those with low educational levels and those with inappropriate home conditions for isolation have more apparent anxiety and fear. It is recommended that COVID-19 fear of confirmed and possible cases followed at home be brought to a realistic level.

Key words: Anxiety; COVID-19; fear; isolated at home; home care.

Özet

Amaç: Bu çalışmanın amacı, evde izole edilen COVID-19 kesin ve olası vakaların anksiyete ve korku düzeyleri ile ilişkili faktörlerin belirlenmesidir.

Yöntem: Tanımlayıcı olarak yapılan bu çalışma, 387 kesin veya olası vakanın katılımı ile gerçekleştirilmiştir. Çalışma Ocak-Haziran 2021 tarihleri arasında Türkiye’nin güneyinde yer alan bir ilde gerçekleştirilmiştir. Veriler kartopu yöntemi ile online olarak Koronavirüs Korku Ölçeği ve Koronavirüs Anksiyete Ölçeği ile toplanmıştır.

Bulgular: Katılımcıların %50,9’u COVID-19 “kesin vaka” %49,1’i “olası vaka”dır. COVID-19 anksiyetesinin düşük, COVID-19 korkusunun yüksek olduğu belirlenmiştir. COVID-19 anksiyetesi kadınlarda 2,57 kat, eğitim düzeyi ilköğretim ve altı olanlarda 2,51 kat, evde başkası ile yaşayanlarda 2,63 kat, evde tek başına izole olabileceği odası olmayanlarda 1,93 kat daha fazla bulunmuştur. COVID-19 korkusu ise eğitim seviyesi düşük olanlarda 2,62 kat, evli olanlarda 1,82 kat daha fazla saptanmıştır ($p<0.05$). Ayrıca kadınların COVID-19 korkusu istatistiksel anlamlılık sınırında bulunmuştur (OR=1,62; 95% CI: 0,99-2,62, $p=0,051$).

Sonuç: COVID-19 kesin ve olası vakaların anksiyetesi düşük olup korkusu yüksektir. Kadınlar, eğitim düzeyi düşük olanlar, ev koşulları izolasyon için uygun olmayanlar gibi dezavantajlı grupların anksiyete ve korkusu daha belirgindir. Evde takip edilen kesin ve olası vakaların COVID-19 korkusunun gerçekçi düzeye getirilmesi önerilmektedir.

Anahtar kelimeler: Anksiyete; COVID-19; korku; evde izolasyon; evde bakım.

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Introduction

The increase in the number of COVID-19 cases continues in all countries. In many countries, epidemic management guidelines have been prepared to combat the COVID-19 epidemic. It is stated in the guidelines that certain and probable cases with mild clinical course and no risk factors for serious diseases should be isolated at home if there is no indication for hospitalization.^{1,2} In Turkey, most confirmed and possible COVID-19 cases are followed at home. Confirmed and possible COVID-19 cases are followed at home by filiation teams and family practitioners.³

Increased rate of prevalence of COVID-19, inability to take the virus under control, the emergence of variant strains, continuation of the pandemic, and increase of restrictions during this period increase the fear and anxiety levels of individuals.^{4,5} This is even more apparent for individuals who have been infected with COVID-19 and those who are in close contact and contact with individuals infected. Since possible cases have a higher potential of testing positive for COVID-19 compared to other people, their anxiety and fear levels may increase. People may experience emotions like depression, anxiety, and fear due to the thought of being infected. Also when confirmed COVID-19 cases and close contacts go into isolation or quarantine, they may face problems like loneliness, social isolation, stress, and stigma besides the aforementioned problems. The World Health Organization has made suggestions for people isolated during the pandemic. These suggestions are maintaining communication via social networks (using social media and telephone, doing video conferences), healthy nutrition, adequate sleep, regular exercise, and keeping away from rumors and news discomfoting the individual.²

In the literature, it is stated that psychological problems are common in confirmed cases. It was found that anxiety and depressive symptoms were more common among confirmed COVID-19 cases in China. Also, low sleep quality and the presence of two or more physical symptoms are risk factors for anxiety.⁶ In another study, it was indicated that COVID-19 patients have developmental problems due to anxiety, fear, and isolation and these problems are intertwined with physical symptoms and this was the most important problem.⁷ In the study by Chen et al., people had experiences like fear of being infected with COVID-19, a sense of stigma; impatience and irritability, and tranquility.⁸

Besides anxiety and fear experienced by confirmed and possible cases, their experiences during the pandemic are also noteworthy. How these people feel, from whom they obtain information to manage the process, and what kind of interventions they make to overcome the disease should be determined. In the studies conducted, the frequency of anxiety and depression in hospitalized patients was examined, but no study was found that investigated the anxiety, and depression levels of probable and definite cases at home and their experiences at home in this process. This study may not only guide people currently experiencing the process of planning the interventions but also prepare people for future crises. The study aimed to determine the anxiety and fear levels of confirmed and possible COVID-19 cases isolated at home and the influencing factors. The research questions were as follows:

What are the anxiety and fear levels of confirmed and possible COVID-19 cases receiving home treatment?

What are the factors affecting the anxiety and fear levels of individuals concerning COVID-19?

What are the experiences of individuals in the home environment during the isolation?

Methods

Design and setting

The method of the study was prepared according to the STROBE Checklist (STrengthening the Reporting of OBservational studies in Epidemiology).⁹ The study was conducted in XXX between January-June 2021.

Participants

The population of the study consisted of confirmed and possible COVID-19 cases in central four districts of Antalya. According to the “infinite population formula” with unknown prevalence (50%), the target sample size was calculated to be 384 individuals.¹⁰ At the end of the study, 387 confirmed and possible cases were reached. In the study, the snowball method which is among the improbable sampling methods was used.^{10,11}

Inclusion criteria

Confirmed and possible COVID-19 cases isolated at home

Being a confirmed COVID-19 case (being diagnosed by the PCR test in healthcare organizations)

Being a possible COVID-19 case (being in close contact/contact with individuals testing positive)

Being able to complete the online survey

Measurements

The data were collected based on the self-report of the individuals by sending the link of a survey created via Google forms to their phones. The instrument consists of two parts. First, the descriptive characteristics were collected from the questionnaire with 20 items, such as the presence of confirmed and possible cases, age, gender, education, financial and educational status, with whom they live at home and with how many people, smoking

status and presence of a chronic illness. Besides the day of the COVID-19 isolation, COVID-19 symptoms, infection way of COVID-19, medications used outside the prescribed treatment for COVID-19, presence of a room to go into isolation at home alone, special methods used for managing this process at home outside the treatment and physiological and psychological problems experienced at home during the isolation were questioned. Second, COVID-19 anxiety and fear were measured using the Fear of COVID-19 Scale and the Coronavirus Anxiety Scale.

The Coronavirus Anxiety Scale: The scale was developed by Lee (2020) and adapted into Turkish by two groups.^{12,13} It measures the frequency of individuals experiencing anxiety related to coronavirus within the past two weeks. The scale is a five-point likert scale with five items. The items comprise statements as; ‘0’= *Never*, ‘1’= *Rare, one or two*, ‘2’= *A few days*, ‘3’= *More than 7 days*, ‘4’= *Less than a day nearly every day within the past two weeks*. Each item score is summed (0-20 points). As the score increases, the anxiety related to coronavirus-19 increases.

The Fear of COVID-19 Scale: The scale was developed by Ahorsu et al., (2020) and adapted into Turkish by Bakioğlu et al., (2020). It measures the fear experienced by individuals related to the coronavirus.¹⁴ The scale is a five-point likert scale with seven items. The items comprise of statements as; ‘1’= *Strongly disagree*, ‘2’= *Disagree*, ‘3’= *Undecided*, ‘4’= *Agree*, ‘5’= *Strongly agree*. Items are not rated reversely. The lowest and highest scores on the scale are 5 and 35, respectively. Higher scores signify that the fear related to coronavirus-19 increases.

Bias

As the snowball method was used in collecting the data for the study, the presence of bias can be considered. On the other hand, the surveys were completed in online forms based on the self-report of the individuals. Therefore, the individuals were not under any influence when completing the surveys.

Ethical considerations

For the study, the ethics committee approval (Number: 70904504/37, Date: 29.01.2021) and informed consent of the individuals were received. Before completing the data collection tools, information about the study was given on the first page of the online form. Participation was voluntary. In case the individuals agreed to participate, they were asked to mark “I agree to participate in the study”. Other questions opened following this approval marking. A "thank you for your time" message was automatically sent by google forms to the participants who chose the "I disagree" option. The individuals were ensured that they were not to be charged any fee.

Statistical analysis

Statistical analyses were conducted using IBM SPSS Statistics 23.0. The descriptive data were given with numbers, percentages, mean, standard deviation, median, minimum, and maximum values. Whether the dependent variables (anxiety and fear of COVID-19) were normally distributed or not was evaluated using the Kolmogorov-Smirnov test and it was found that they were not normally distributed. The correlation between anxiety and fear of COVID-19 was analyzed using Spearman’s correlation test. The factors affecting the scores obtained from the COVID-19 anxiety and fear scales were analyzed using the Mann-Whitney U and the Kruskal-Wallis tests. In these analyses, the significant variables were included in the logistic regression analysis. In the univariate analyses, the variables with significant values were included in the logistic regression. Since there was no difference between the anxiety and fear scores of the confirmed and possible COVID-19 cases, the logistic regression analysis was conducted based on all participants. In the logistic regression analysis, the COVID-19 anxiety and fear variable was coded according to the median value of the scale. The statistical significance value was taken as 0.05.

Results

It was determined that 68.5% of the participants were female, 96.9% were under the age of 60, 91.5% were secondary school graduates and above, 52.5% were married and 89.1% had a middle and high-income level. 76.5% of the participants did not smoke, 77.5% had no chronic illness, 91.7% did not live alone and 85.3% had room to go into isolation alone in case of COVID-19 (Table 1).

Table 1. Characteristics of sociodemographic the participants (n= 387)

Characteristic		n	%
Gender	Female	265	68.5
	Male	122	31.5
Age (year)	18-29	172	44.4
	30-59	203	52.5
	60 +	12	3.1
Educational level	Primary school or less	33	8.5
	Secondary school or higher	354	91.5
Marital status	Married	203	52.5
	Single	184	47.5
Economic status	Bad	42	10.9
	Moderate	244	63.0
	Good	101	26.1
Smoking status	Yes	91	23.5
	No	296	76.5
Number of cigarettes consumed in a day	1-10	39	42.9
	11-20	35	38.5
	21-30	13	14.3
	31 or more	4	4.3
Presence of chronic disease *	Yes	87	22.5
	No	300	77.5
Chronic disease (n=87)*	Diabetes Mellitus	25	28.7
	Hypertension	20	22.9
	Asthma	11	12.6
	Cancer	5	5.7
	Chronic heart disease	4	4.6
Who does she/he live with at home?	Alone	32	8.3
	With others	355	91.7
The presence of a room in the house where it can be isolated alone	Yes	330	85.3
	No	57	14.7

It was found that 50.9% of the participants were “confirmed cases” testing COVID-19 positive and 49.1% were “possible cases” in close contact and contact. 52.5% of them took supplementary nutrients and vitamins outside the prescribed medications, 91.5% had practices (such as ventilating the house, attaching importance to cleaning, having a regular and balanced diet) to manage the process at home outside the medical treatment, 40.1% had lost their friends and relatives due to COVID-19 and 45.7% had relatives/friends hospitalized (Table 2).

Table 2. Data of participants on COVID-19

		n	%
Situation regarding COVID-19 (Possible/confirmed)	Confirmed COVID-19	197	50.9
	Possible Case		
	Close contact (high-risk)	92	23.8
	Contacted (low-risk)	98	25.3
Presence of symptoms related to COVID-19	Yes	281	72.6
	No	106	27.4
Symptoms related to COVID-19 (n=281)	Fever	96	34.2
	Cough	127	45.2
	Throat ache	130	46.3
	Dyspnea	70	24.9
	Weakness	184	65.5
	Headache	149	53.0
	Vomiting	9	3.2
	Diarrhea	21	7.5
	Stomach ache	15	5.3
	Joint pain	5	1.8
	Back pain	7	2.5
	Inability to smell	9	3.2
COVID-19 transmission cause (n=197)	Other	14	4.9
	Not using the mask regularly	14	7.1
	Disobeying the distance rule	155	78.7
	Other	28	14.2
Use of supplements and vitamins except for prescription drugs	Yes	203	52.5
	No	184	47.5
Existence of applications to manage the process at home other than medical treatment	Yes	354	91.5
	No	33	8.5
Applications to manage the process at home other than medical treatment (n=354) *	Paying attention to nutrition	300	84.7
	Sleep regularly	196	55.4
	Ventilate the house	289	81.6
	Paying more attention to cleanliness	270	76.3
	Using a double mask at home	97	27.4
	Talking to relatives on the phone	155	43.8
	Other	7	1.9
Situation in friends and relatives due to COVID-19 *	Death	155	40.1
	Hospitalization in intensive care	114	29.5
	Hospitalization in the clinics	177	45.7
	Spend the process at home	121	31.3

* There are those who have more than one chronic disease. More than one option is ticked.

The participants' mean scores were 2.98 ± 3.69 on the Coronavirus Anxiety Scale and 19.48 ± 6.58 on the Fear of COVID-19 Scale. There was no difference between the anxiety and fear scores of the confirmed and possible (in contact or close contact) COVID-19 cases ($p > 0.05$) (Table 3). There was a positive moderate significant correlation between coronavirus anxiety and fear ($r = 0.521$, $p < 0.01$).

Table 3. Coronavirus anxiety and fear scale scores

	Mean (sd)	Median (min-max)	Confirmed COVID-19	Possible COVID-19	Z*	p
Coronavirus Anxiety Scale (0-20 points)	2.98 (3.69)	2.00 (0.00-20.00)	3.07(3.63)	2.88(3.76)	-0.73	0.462
Fear of COVID-19 Scale (5-35 points)	19.48(6.58)	20.00 (7.00-35.00)	19.86(6.70)	19.06(6.44)	-1.16	0.243

*Mann Whitney U test

In the univariate analyses, the COVID-19 anxiety scores were found to be statistically significantly higher in the participants who were female, were aged 60 years and older, were primary school graduates and below, did not smoke, had a chronic illness, did not live alone and had no room to go into isolation alone ($p < 0.05$). Marital status, financial status, and presence of COVID-19 symptoms did not affect anxiety ($p > 0.05$). For the confirmed COVID-19 cases; gender, age, educational level, marital status, presence of a chronic illness, living with others, having room to go into isolation alone, and presence of COVID-19 symptoms affected anxiety. In the confirmed COVID-19 cases, financial status, and smoking status did not affect anxiety. In the possible cases, variables outside the gender variable did not affect COVID-19 anxiety (Table 4).

Table 4. Factors affecting COVID-19 anxiety and fear according to logistic regression analysis

Anxiety of COVID-19*			
	Odds Ratio	95% CI	p
Gender (Female:1, male:0)	2.57	1.54-4.27	<0.01
Educational level (Primary school or less:1, secondary school or higher:0)	2.51	1.08-5.81	0.032
Who does she/he live with at home? (Alone:0, with others:1)	2.63	1.04-6.57	0.039
The presence of a room in the house where it can be isolated alone (yes:0, no:1)	1.93	1.04-3.53	0.034
Constant	-2.38	-	<0.01
Omnibus test: Chi-square=42.57, df=7, $p < 0.01$; Hosmer Lemeshow test: Chi-square=3.86, $p > 0.05$			
Fear of COVID-19**			
	Odds Ratio	95% CI	p
Educational level (Primary school or less:1, secondary school or higher:0)	2.62	1.11-6.15	0.027
Marital status (Married:1, single:0)	1.82	1.17-2.82	0.008
Constant	-1.31	-	<0.01
Omnibus test: Chi-square=31.03, df=6, $p < 0.01$; Hosmer Lemeshow test: Chi-square=8.26, $p > 0.05$			

* Dependent variable: Anxiety of COVID-19; According to the median value, 0-2 points were coded as 0 (no anxiety), and 3-20 points were coded as 1 (having anxiety). Independent variables: sex, age, educational level, smoking status, presence of chronic disease, Who does she/he live with at home? The presence of a room in the house where it can be isolated alone.

** Dependent variable: Fear of COVID-19; According to the median value, 5-20 points were coded as 0 (no fear), and 21-35 points were coded as 1 (having fear). Independent variables: sex, age, educational level, marital status, smoking status, and presence of chronic disease.

It was found that among all participants, those who were female, were aged 60 years and older, were primary school graduates and below, were married, did not smoke, had a chronic illness, and did not live alone had higher COVID-19 fear scores ($p < 0.05$). Financial status, having room to go into isolation alone, and the presence of COVID-19 symptoms did not affect fear ($p > 0.05$). In confirmed COVID-19 cases, educational level, marital status, smoking status, and presence of a chronic illness were variables affecting fear. In possible cases, gender, educational level, marital status, and living with others were variables affecting fear. Age, financial status, smoking status, presence of a chronic illness, having room to go into isolation alone, and presence of COVID-19 symptoms did not affect fear in possible cases ($p > 0.05$) (Table 4). According to the logistic regression analysis, anxiety about COVID-19 was found to be 2.57 times greater in women, 2.51 times greater in those whose educational level was a primary school and below, 2.63 times greater in those living with others at home and 1.93 times greater in those who had no room to go into isolation at home alone ($p < 0.05$). Fear of COVID-19 was 2.62 times greater in those with low educational levels and 1.82 times greater in those who were married ($p < 0.05$). Also, women's COVID-19 fear was on the statistical significance margin (OR=1.62; 95% CI:0.99-2.62, $p = 0.051$). The other independent variables did not affect COVID-19 anxiety and fear ($p > 0.05$, Table 4).

Discussion

Besides being a pandemic threatening the lives of people worldwide, COVID-19 has brought a state of uncertainty affecting their whole life. Together with this state of uncertainty, negative feelings such as being diagnosed with COVID-19 or having a suspicion of the diagnosis, anxiety about infecting others, isolation at home and unemployment have caused individuals to experience fear and anxiety.¹⁵ Anxiety and fear levels of individuals who are diagnosed with COVID-19 or have a high risk of being a possible case due to contact and are treated and followed isolated at home in this process, their experiences, and the influencing factors comprised the aim of this study.

In the study, it was determined that the confirmed and possible cases had low COVID-19 anxiety and high COVID-19 fear. There was a directly proportional and moderate correlation between fear and anxiety of the individuals. In the individuals who were confirmed to have COVID-19 and contact, the sense of anxiety might have been replaced by fears related to the disease. A high fear level may be associated with the high fatality of the disease and being far from the full surveillance of healthcare professionals at home.¹⁶ Low anxiety levels in the confirmed and possible COVID-19 cases may be associated with the removal of uncertainty. This can explain the lack of anxiety related to obscurity in the individuals who had a test, had an established final diagnosis, or were confirmed to be a possible case due to being in contact. The mobile application of “Hayat Eve Sığar”, which is defined as the identity number of every citizen in Turkey, provides the risk condition of the individual concerning COVID-19 and a risk map of their region, detects those in contact and has interfaces directed to family practitioners and filiation teams, might have prevented anxiety by providing confidence in the confirmed and possible cases. Family physicians and nurses working in the Family Health Centers can also deliver health information to society online to reduce the anxiety and fear of society. They can often follow individuals with mental sensitivity frequently during times of crisis such as COVID-19.

COVID-19 anxiety was found to be 2.57 times greater in women, 2.51 times greater in those whose educational level was a primary school and below, 2.63 times greater in those living with others at home, and 1.93 times greater in those who had no room to go into isolation at home alone. This is compatible with the previous studies suggesting that COVID-19 anxiety is higher among women.¹⁷ Female gender is an effective sociodemographic characteristic in studies investigating anxiety and fear related to COVID-19.¹⁸⁻²² This finding is compatible with the results of other studies suggesting that women experience psychological problems more often than men.²³

It was determined that low educational level was an important variable predicting both COVID-19 anxiety and COVID-19 fear. This can be explained by the fact that people with low educational levels have low health literacy and weaker coping capacity.^{24,25} Previous studies also reported that people with low educational levels had higher COVID-19 anxiety and fear.^{26,27}

The fact that people living with others at home and having no room to go into isolation alone had higher COVID-19 anxiety indicated that they had anxiety about infecting others. Also, the fact that COVID-19 fear was higher in married ones indicates that they have anxiety that the home environment and environmental area will increase the risk of infection. This may indicate that confirmed and possible cases cared about the health of the people they lived with.

Besides physiological and psychological problems experienced by confirmed and possible COVID-19 cases during the isolation at home; social and financial consequences of issues related to the pandemic such as uncertainty, social distancing, isolation and lockdown, and staying at home for a long time may affect the mental health of individuals negatively. In a study conducted to investigate the effects of COVID-19 on the mental health of individuals, it was determined that negative emotions (such as anxiety, depression, and anger) and social risks increased.

When examining the experiences of the participants in the home environment during the isolation, it was determined that the participants cared about nutrition, slept regularly, ventilated their house, attached more importance to cleaning, and used double masks at home to promote and regain their health at home. These behaviors and experiences are in agreement with the guidelines written for COVID-19 and measure suggestions made by health authorities.^{2,28,29} In infectious diseases, an adaptation of the participants to healthy nutrition, regular sleep, ventilating the home environment, and home hygiene rules, which accelerate the recovery process indicates their active and correct participation in the recovery process.

The isolation at home signifies getting out of the routine. Telephone interview of participants with their relatives and friends during the 14-day isolation related to COVID-19 is among other home experiences. Online interviews via social networks during the isolation are consistent with both recommendations for the COVID-19 pandemic period and the important place of visitation in Turkish culture.²⁸

Limitations

It is possible to mention two limitations of the study. The first one is that the data were collected in only one province. Therefore, they cannot be generalized to the whole country. The second one is that the advanced age group with low technology literacy could not be reached because the data were collected online.

Conclusion

COVID-19 is a state of uncertainty that affects the whole life, negative emotions such as being diagnosed with COVID-19 or being a possible case, anxiety about infecting others, and isolation at home have affected the level of fear and anxiety of individuals. In the second year of the COVID-19 pandemic, the individuals who are treated and followed at home due to being confirmed and possible cases have low anxiety and high fear of COVID-19 during the isolation. Those who were female, had a low educational level, had no room to go into isolation at home and were living with others at home experienced higher anxiety and fear. Family health workers (physicians and nurses) working in primary care centers such as Family Health Centers and Community Health Centers must inform/raise awareness of the public with evidence-based information. In addition, they should evaluate the fear and anxiety levels of the individuals they provide health care services and identify individuals who may be at risk in terms of mental problems in the early period. It should be taken into consideration that confirmed and possible COVID-19 cases who are treated and followed during isolation at home may have fears due to being away from the health authority and this may affect the recovery process negatively. To reduce fears during isolation at home, applications making individuals feel safe should be conducted.

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