

Rates and correlates of post-traumatic stress disorder and symptoms during the immediate onset of COVID-19 pandemic in a sample of patients from an outpatient psychiatric clinic in Türkiye

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ABSTRACT

OBJECTIVE: This study was designed to investigate the traumatic stress levels, participants demonstrating higher than post-traumatic stress disorder (PTSD) cutoff, thus PTSD possibility, levels, and related factors of patients who felt the need to apply to the outpatient clinic for the 1st time during the first period of the outbreak of the pandemic as a traumatic event, when many psychiatry outpatient clinics were mostly closed to face-to-face admissions. In our research, we targeted three objectives. First, we evaluated PTSD as indicated with measure cutoff points and post-traumatic stress symptom (PTSS) rates among the individuals who were admitted to an outpatient psychiatric clinic for the 1st time, 3 months after the first COVID-19 case was reported in Türkiye. Second, we investigated the relationship between PTSS and PTSD cutoff with anxiety, stress, depression, hopelessness, fear of COVID-19, and disability levels. Third, we aimed to explore the sociodemographic data and risk factors related to PTSD cutoff and PTSS controlling levels of disability, hopelessness, fear of COVID-19, anxiety, depression, and stress.

METHODS: For our study, a total number of 85 cases were recruited. Post-traumatic Stress Diagnostic Scale (PDS), Beck Hopelessness Scale (BHS), Depression, Anxiety, and Stress Scale (DASS-21), Sheehan Disability Scale (SDS), and Fear of COVID-19 Scale (FCS) were administered to each patient.

RESULTS: The rates of possible PTSD and PTSSs were found to be 25.9% and 88.2%. The majority of participants were women (65.9%) who have been presenting complaints with anxiety symptoms (60.1%) and social media users (74.1%). The mean DASS-21 all subscales (anxiety, depression, and stress) ($p<0.01$), BHS ($p<0.01$), FCS ($p=0.03$), and SDS family life/home responsibilities subscale ($p<0.01$) scores of PTSD cutoff subgroup ($n=22$) were higher than non-PTSD group ($n=63$). We observed significant positive correlations between the FCS scores and DASS-21 anxiety subscale ($p<0.01$), SDS family life/home responsibilities and social life/leisure activities subscales ($p<0.05$), and PDS symptom severity subscale ($p<0.01$) scores.

CONCLUSION: These results demonstrate that a COVID-19 pandemic is a traumatic life event that causes high rates of possible PTSD, PTSS, anxiety, depression, hopelessness, and disability and leads to admissions to psychiatric outpatient clinics.

Keywords: Anxiety; depression; disability; hopelessness; social media.

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On March 11, 2020, the World Health Organization (WHO) announced that COVID-19 became a pandemic [1]. On March 10, 2020, the first case was confirmed in Türkiye. According to the WHO data, as of January 2022, the number of COVID-19 cases reported globally has exceeded 300 million, while the number of deaths due to COVID-19 has reached almost five and a half million [2]. Besides the physical health problems, this pandemic has also brought many psychological problems and led to mass trauma. According to the previous researches, infectious diseases are related to severe traumatic experiences and chronic psychological problems, and post-traumatic stress disorder (PTSD) due to psychological contagion, anxiety, infection fear, and stigmatization of infected individuals, health care workers [3–5].

It has been reported that individuals with PTSD have frequently psychiatric comorbidities such as depression, anxiety, and suicidality [6–8]. In the earlier researches; fear, depression, anxiety, and stress were frequently reported as natural and common reactions during uncertain outbreaks and they lead the individuals to confront the fragility of life. According to Mak et al. [5], post-traumatic stress symptom (PTSS) had been experienced among 40% of the severe acute respiratory syndrome (SARS) survivors. Being isolated or infected, the threat of being infected, working in places with high risk such as hospitals, and having friends or relatives who were infected with SARS were reported as the risk factors for developing PTSS [9].

The COVID-19 pandemic shows similar characteristics to the SARS epidemic and continues to spread globally. Every day, more people are being affected by COVID-19 and their social lives (e.g., economic losses, social isolation, and worries about the future) have deteriorated. According to a recent study in China, 7% of the 285 participants have met the criteria for COVID-19-related PTSD [10]. A recent survey in New York State which is one of the most infected regions in the world during this pandemic indicated that most of the New York City residents have reported anxiety symptoms (44%), hopelessness about the future (60%), and depressive symptoms (35%) [11].

Considering that PTSD is a chronic disorder and may lead to severe economic loss and comorbid mental health problems, early intervention and treatment of PTSD during the COVID-19 outbreak is important. We are unaware of the studies that have searched the rates of PTSD among patients from outpatient psy-

Highlight key points

- At the onset of COVID-19 pandemic PTSD and PTSS was higher and was correlated with anxiety, depression, hopelessness and disability at the psychiatric outpatients.
- Anxiety symptoms, traumatic symptom severity, and overall functional impairment, especially in the family settings are higher in the probable PTSD group.
- Exposure time to distressing COVID-19 related social media content was highly correlated with PTSD symptoms.

chiatric units at the very beginning of the COVID-19 outbreak. In this study, we aimed at three objectives. First, we wanted to determine possible PTSD levels and PTSS rates among the individuals who were admitted to an outpatient psychiatric clinic for the 1st time, 3 months after the first COVID-19 case was reported in Türkiye. Second, we aimed to determine the relationship between COVID-19-related possible PTSD levels and PTSS with levels of depression, anxiety, stress, hopelessness, fear of COVID-19, and disability. Third, we explored the sociodemographic and clinical risk factors related to emergence of PTSD possibility and PTSS which occurred in the aftermath of the COVID-19 outbreak. In addition, we assessed the levels of disability, hopelessness, depression, stress, fear of COVID-19, and anxiety.

MATERIALS AND METHODS

Sample

Our study included 85 patients who applied to a psychiatry outpatient clinic between July and August 2020, after the onset of the COVID-19 pandemic, after the first 3-month acute period when there were intense uncertainty and social life restrictions such as a lockdown. Inclusion criteria for this study required participants' being 18 years old or older, being literate and having the capacity to decide and provide written informed consent, admitting to psychiatry outpatients for the 1st time after the COVID-19 pandemic related to their concerns about the pandemic-related topics. Having a diagnosis of mental retardation, psychotic disorders, and currently having psychotic features during a mental disorder, dementia, and other neurodevelopmental disorders such as autism spectrum disorders, cognitive disturbances, mild cognitive impairment, or heavy social deficits that may interfere with providing an informed capacity were the exclusion criteria.

Ethical Approval

Ethical approval for this study was obtained on June 8, 2020, approval number: 18/June 08, 2020. The data collection process was performed accordingly with the rules of the Declaration of Helsinki.

Materials

The sociodemographic characteristics of our sample

The authors created a descriptive data form. Information regarding participants: Gender, educational status, age, marital and employment status, change in income, household size and employment status during the outbreak, presence of high-risk group individuals at home, history and family history of COVID-19, and duration of daily social media exposure.

Post-traumatic stress diagnostic scale (PDS)

The PDS consists of a 49-item self-report questionnaire. The scale evaluates six different DSM-IV diagnostic criteria used to diagnose PTSD [12]. Respondents rate 17 items for frequency of the symptoms included in DSM-IV criteria B, C, and D. The scale uses a 4-point scale (0 = not at all or only 1 time to 3 = 5 or more times a week/almost always). The PDS leads to a dichotomous PTSD diagnosis with a score of continuous severity. Isikli conveyed the validity and reliability study in Turkiye [13].

Sheehan disability scale (SDS)

The SDS is a disability or functional impairment scale. SDS is a discan metric. Thus using visual-spatial, numeric, and verbal descriptive anchors, SDS assesses disability or functional impairment across three life categories: Social life/leisure activities, work/school, and family life/home responsibilities. Each of the three domains is scored over 0–10, 10 being the most severe. Global SDS scores range between 0 (no impairment) and 30 (highly impaired) [14–16]. Global score of SDS can be directly achieved by adding the subdomain scores.

Beck hopelessness scale (BHS)

Beck et al. [17] developed BHS in 1974. BHS has 20 items. Each item is scored between 0 and 1. High scores reflect higher scores of hopelessness. Thus, negative expectations for the future of an individual are aimed to be evaluated by this scale. Seber et al. [18] translated and conveyed the Turkish validity and reliability study.

The scale's validity, reliability, and factor structure later were reconsidered by Durak [19].

Depression, anxiety, and stress scale (DASS-21)

The DASS-21 is a self-rated scale. DASS-21 was developed to assess stress symptoms (1, 6, 8, 11, 12, 14, and 18), depression symptoms (items 3, 5, 10, 13, 16, 17, and 21), and anxiety (2, 4, 7, 9, 15, 19, and 20). Questions are addressed considering the past 7 days. Each subscale scores range between 0 and 7 [20]. Turkish validity and reliability were studied by Saricam [21].

Fear of COVID-19 scale (FCS)

Ahorsu developed FCS in 2020 [22] Satıcı et al. [23] conducted the Turkish validity and reliability study. FCS consists of 7 items which are individually scored between 1 (strongly disagree) and 5 (strongly agree). Fear of COVID-19 is assumed to be high with increasing scores.

Procedure

In this study, a cross-sectional research method was used. The objectives of this study were explained in detail to the participants, and their written consent was obtained. The sample size has been calculated through "www.e-picos.com," New York, NY. The minimum sample size was calculated as 85 to determine statistical significance at the maximum rate of 5% type I error and minimum power of 80% after a minimum 30% correlation was assessed in between the inventories.

Statistical Analysis

Statistical analyses were performed using the Statistical Package for the Social Sciences software package version 23.0 for Windows (SPSS Inc., Chicago, IL, USA). The independent samples t-test was used to compare the means of two normally distributed independent groups. The statistical test used to compare categorical variables was Pearson's Chi-square (χ^2). Correlation analysis was performed using the Pearson correlation coefficient. $P < 0.05$ was considered statistically significant.

RESULTS

The age range of participants was 19–67 years (mean age: 40.15 ± 12.053). The majority of participants were women (65.9%), not satisfied with their earnings during the COVID-19 pandemic (60%), who have been presenting complaints with anxiety symptoms (60.1%) and social media users (74.1%). Table 1 shows sociodemographic characteristics and descriptive data of our participants.

TABLE 1. Sociodemographic characteristics and descriptive data

	All cases (n=85) %	PTSD (n=22) %	Non-PTSD (n=63) %	p
Marriage status				
Married	50.6	50	50.8	0.54
Unmarried	32.9	36.4	31.2	
Divorced/widow	16.5	13.6	18	
Gender				
Female	65.9	68.2	65.1	0.79
Education				
No	3.5	0	4.8	0.67
5–8 years	34.1	27.3	36.5	
11 years or more	62.4	71.7	58.7	
Employment status				
Unemployment	15.3	18.2	14.3	0.45
Job loss due to pandemic	11.8	18.2	9.5	
Flexible/working from home due to pandemic, decreased payment	10.6	9.1	11.1	
Flexible/working from home due to pandemic, not decreased payment	9.4	4.5	11.1	
Working, no changes in job during pandemic	24.7	22.7	25.4	
Housewife, student, and retired	28.2	27.3	28.6	
Professional area				
Housewife	17.6	13.6	19.0	0.84
Student	5.9	9.1	3.2	
Retired	4.7	0	6.4	
Health employee	14.1	22.7	11.1	
Other	63.6	54.6	59.3	
Financial loss				
Yes	35.3	45.5	31.7	0.24
Satisfied with his financial situation				
Yes	40.0	27.3	44.4	0.15
Complaint of application				
Anxiety symptoms	60.0	77.3	76.0	0.36
Depressive symptoms	17.6	9.1	20.8	
Psychosomatic symptoms	3.5	4.5	3.2	
Other	2.4	9.1	0	
Additional medical illness				
Yes	30.6	31.8	30.2	0.88
Trauma history				
Yes	36.5	50.0	31.7	0.12
COVID symptoms during the pandemic				
Yes	20.0	36.4	14.3	0.02
Included in filiation				
Yes	18.8	27.3	15.9	0.23
Isolation				
Yes	10.6	18.2	7.9	0.17
Getting a positive diagnosis of COVID				
Yes	8.2	18.2	4.8	0.04
House members working in risky places for COVID				
Yes	14.1	18.2	12.7	0.52
Lost a relatives due to COVID				
Yes	9.4	13.6	7.9	0.43
Been stigmatized due to COVID				
Yes	11.8	22.7	7.99	0.06
Change a living place due to COVID				
Yes	8.2	4.5	9.5	0.46
Social media use				
Do not use	25.9	9.1	31.7	0.00
Less than an hour in a day	16.5	22.7	14.3	
1–2 h in a day	57.7	68.2	54.0	

PTSD: Post-traumatic stress disorder; Bold characters indicate statistical significance at the level of $p < 0.05$.

Twenty-two (25.9%) subjects met PTSD diagnosis according to PDS. The entire study population was divided into two subgroups: The PTSD group (n=22) and the non-PTSD group (n=63). There was no statistically significant difference between the subgroups for gender, marital and employment status, education, occupation, and income. The rates of those with COVID-19 symptoms ($p=0.02$), positive COVID-19 test ($p=0.04$), and social media users ($p<0.01$) in the PTSD subgroup were significantly higher than the non-PTSD group (Table 1).

The majority of subjects (88.2%) have COVID-19 pandemic-related PTSS according to PDS. There are 35 (41.1%) subjects with moderate-to-severe PTSS severity and 40 (47.1%) subjects with mild-to-moderate PTSS severity.

Table 2 shows PDS, DASS-21, SDS, BHS, and FCS scores. The mean scores of each of the DASS-21 subscales (anxiety, depression, and stress) ($p<0.01$), BHS ($p<0.01$), FCS ($p=0.03$), and SDS family life/home responsibilities subscale ($p<0.01$) scores of PTSD subgroup were higher than the non-PTSD group (Table 2).

There were significant positive correlations between the BHS scores and DASS-21 anxiety subscale ($r=0.423$, $p<0.01$), DASS-21 depression subscale ($r=0.588$, $p<0.01$), and DASS-21 stress subscale ($r=0.516$, $p<0.01$) scores. The BHS scores were significantly correlated with the PDS loss of function subscale ($r=0.423$, $p<0.01$), PDS symptom severity subscale ($r=0.470$, $p<0.01$), SDS work/school subscale ($r=0.242$, $p<0.05$), SDS social life/leisure activities subscale ($r=0.227$, $p<0.05$), and SDS family life/home responsibilities subscale ($r=0.238$, $p<0.05$) scores. The DASS-21 anxiety subscale scores were significantly correlated with the FCS ($r=0.316$, $p<0.01$), PDS loss of function subscale ($r=0.373$, $p<0.01$), PDS symptom severity subscale ($r=0.486$, $p<0.01$), SDS work/school subscale ($r=0.334$, $p<0.01$), SDS social life/leisure activities subscale ($r=0.493$, $p<0.01$), and SDS family life/home responsibilities subscale ($r=0.462$, $p<0.01$) scores. The DASS-21 depression subscale scores were significantly correlated with the PDS loss of function subscale ($r=0.466$, $p<0.01$), PDS symptom severity subscale ($r=0.508$, $p<0.01$), SDS work/school subscale ($r=0.384$, $p<0.01$), SDS social life/leisure activities subscale ($r=0.394$, $p<0.01$), and SDS family life/home responsibilities subscale ($r=0.418$, $p<0.01$) scores. The FCS scores were significantly correlated with the PDS symptom severity subscale ($r=0.351$, $p<0.01$), SDS so-

cial life/leisure activities subscale ($r=0.225$, $p<0.05$), and SDS family life/home responsibilities subscale ($r=0.244$, $p<0.05$) scores (Table 3).

DISCUSSION

In this study, we found that one in four people met the criteria for PTSD diagnosis. COVID-19 pandemic-associated PTSD/probable PTSD rates in the general population are reported between 7% and 53.8% [10, 24–28]; and between 16.7% and 31.6% among health-care professionals [29, 30]. The differences in methodology and included population of the researches can cause the broad width of the rates in different researches. A meta-analysis, which assesses the researches that were reported in the 1st months of in the 4 months between February and May, reported that PTSS prevalence was 23.88% [31].

The previous studies that aimed to assess the consequences of the COVID-19 pandemic were in psychiatry which was conducted mostly through an online survey and with larger sample sizes. The participants of our study include the patients, who applied to an outpatient psychiatric clinic for the 1st time within 3 months of the COVID-19 pandemic, who were non-psychotic. More than half of the patients' (60.1%) main complaints were anxiety and the feeling of panic. The rest of the patients' complaints were depressive (e.g., sadness, crying, unwillingness, and malaise) and psychosomatic (e.g., shortness of breath and drowsiness) complaints.

Two studies that evaluated psychiatric outpatients population in the literature at the time demonstrated that the rates of "probable" PTSD were 31.6% and 32.6% [32, 33]. In the first online study, during the first peak of the epidemic with lockdown-in February-in China, compared the anxiety, depression, and PTSD symptom severity. Psychiatric outpatient subjects reported a more detrimental psychological (n = 76) outcome in this study [32]. Majority of the psychiatric patients reported mixed anxiety and depressive disorder (59%). The second most prominent psychiatric condition was anxiety disorders (25%). Major depressive disorder was found to be the third most psychiatric condition (16%) in this group. Psychiatric patients in this study demonstrated a higher tendency to meet the criteria for PTSD in contrast to healthy controls (31.6% vs. 13.8%). In that study [32], the Impact of Event Scale Revised (IES-R) was used to assess the psychological impact of the COVID-19 epidemic. Clinically significant PTSD

TABLE 2. Age and PDS, DASS-21, SDS, BHS, and FCS scores of the study subjects

	All cases (n=85)		PTSD (n=63) (74.1%)		Non-PTSD (n=63) (74.1%)		p
	Mean	SD	Mean	SD	Mean	SD	
Age	40.15	12.05	36.91	11.10	41.29	12.24	0.14
BHS	7.82	5.32	10.77	5.83	6.79	4.76	0.00
FCS	19.95	8.73	23.27	9.11	18.79	8.35	0.03
SDS work	4.28	4.44	5.14	4.33	3.98	4.47	0.29
SDS social	6.35	3.40	6.27	3.52	6.37	3.39	0.90
SDS family	5.09	3.64	7.00	2.33	4.43	3.80	0.00
DASS-21 anxiety	7.86	5.08	10.27	4.63	7.02	4.99	0.00
DASS-21 depression	8.71	5.80	12.00	5.22	7.56	5.27	0.00
DASS-21 stress	9.47	4.66	11.73	5.46	8.68	4.11	0.00
	n	%	n	%	n	%	p
DASS-21 (anxiety)							
No (0–7)	41	48.2	6	27.3	35	55.6	0.16
Mild (8–9)	11	12.9	3	13.6	8	12.7	
Moderate (10–14)	24	28.2	10	45.5	14	22.2	
Severe (15–19)	7	8.2	2	9.1	5	7.9	
Extremely severe (20+)	2	2.4	1	4.5	1	1.6	
DASS-21 (depression)							
No (0–9)	48	56.5	8	36.4	40	63.5	0.03
Mild (10–13)	18	21.2	5	22.7	13	20.6	
Moderate (14–20)	19	22.4	9	40.9	10	15.9	
DASS-21 (stress)							
No (0–14)	76	89.4	16	72.7	60	89.4	0.01
Mild (15–18)	5	5.9	3	13.6	2	5.9	
Moderate (19–24)	4	4.7	3	13.6	1	4.7	
PDS loss of function							
No (0)	22	25.9	0	0	22	34.9	0.00
Mild (1–2)	10	11.8	1	4.5	9	14.3	
Moderate (3–6)	50	58.8	20	90.9	30	47.6	
PDS symptom severity							
No symptom (0)	10	11.8	0	0	10	15.9	0.00
Mild (1–10)	19	22.4	0	0	19	30.2	
Moderate (11–20)	21	24.7	3	13.6	18	28.6	
Moderate-severe (21–35)	24	28.2	10	45.5	14	22.2	
Severe (36–51)	11	12.9	9	40.9	2	3.2	

SD: Standard deviation; PTSD: Post-traumatic stress disorder; BHS: Beck Hopelessness Scale; FCS: Fear of COVID-19 Scale; SDS: Sheehan Disability Scale; Bold characters indicate statistical significance at the level of $p < 0.05$.

was diagnosed over the cutoff score of 24. Furthermore, high frequencies of clinically significant PTSD-like symptoms (43.4%, IES-R score > 18), moderate-to-severe depressive symptoms (22.4%, DAS-21 depression

subscale score > 14) in psychiatric patients, and moderate-to-severe anxiety symptoms (23.6%, DAS-21 anxiety subscale score > 10) were reported. In our study, we found similar rates with the previous study [32] that

TABLE 3. The correlations among the study variables

Age	Age 1	SDS work	SDS social life	SDS family life	BHS FCS	DASS-21 A	DASS-21 D	DASS-21 S	PDS loss of function	PDS symptom severity
SDS work	-0.142	1								
SDS social life	-0.008	0.305**	1							
SDS family life	-0.024	0.263*	0.486**	1						
BHS	-0.055	0.242*	0.227*	0.238*	1					
FCS	0.164	0.130	0.225*	0.244*	0.157	1				
DASS-21 A	-0.113	0.334**	0.493**	0.462**	0.423**	0.316**	1			
DASS-21 D	-0.157	0.384**	0.394**	0.418**	0.588**	0.139	0.666**	1		
DASS-21 S	-0.158	0.297**	0.385**	0.366**	0.516**	0.074	0.731**	0.793**	1	
PDS loss of function	-0.169	0.276*	0.165	0.247*	0.423**	0.209	0.373**	0.466**	0.433**	1
PDS symptom severity	0.014	0.146	0.140	0.360**	0.470**	0.351**	0.486**	0.508**	0.472**	0.521**

BHS: Beck Hopelessness Scale; FCS: Fear of COVID-19 Scale; SDS: Sheehan Disability Scale; DASS-21: Depression, Anxiety, and Stress Scale; PDS: Post-traumatic Stress Diagnostic Scale; *: Correlation is significant at the 0.05 level; **: Correlation is significant at the 0.01 level.

41.1% of cases with moderate-to-severe PTSS severity (in other words clinically significant of PTSD-like symptoms), moderate-to-severe anxiety symptoms (38.8%, DAS-21 anxiety subscale score >10), and moderate-to-severe depressive symptoms (22.4%, DAS-21 depression subscale score >14).

Traumatic experiences, life events leading to stress, anxiety, and depressive feelings can increase the levels of the hopelessness of individuals [34–36]. In our study, the level of hopelessness was significantly correlated with the level of PTSS severity and disability. In addition, the level of hopelessness was found higher among the possible PTSD subgroup than the non-PTSD group ($p < 0.01$).

In the other study conducted in our country, health care workers and non-health care workers were compared based on hopelessness and anxiety levels. This study demonstrated that there is a strong correlation between two emotional states. Besides, anxiety levels were suggested to be a predictor of hopelessness [37]. As expected, health care workers who possess higher COVID risk showed more negative psychological outcomes, respectively, increasing with the number of active working hours. Accordingly, change and uncertainty in working hours were inevitably related to higher anxiety levels. Similarly, this study was conducted within the 1st month of the pandemic. The uncertainty in individuals at the time probably had a significant effect on the outcome of this study. The hopelessness level of the sample of our study was higher, although it was close to the highest level of hopelessness (7.15 ± 5.42) obtained in the previous study. At the time, our study was conducted, it was 3 months after the beginning of the pandemic, the COVID-19 case numbers were taken under control and the measures have started to be loosened, however, the traumatic consequences of the outbreak for the public health, due to the long-lasting partial quarantine measures, changes in working conditions, and deaths caused by COVID-19 may be the explanations for the increased hopelessness observed in our study. Just over a quarter of our sample was unemployed, just over a fifth has experienced a negative change in their working conditions, just over a third reported a financial loss because of the pandemic, one-fifth has experienced COVID-19-related symptoms, most of them (78.2%) has felt anxious to be infected with the virus and anxious about the risk of infecting someone else.

In our study, level of hopelessness levels demonstrated an obvious positive correlation with anxiety, stress, PTSD-associated function loss, depression, symptom severity, and pandemic related disability of work/school, social life/leisure activities, and family life/home responsibilities. In a previous study, state anxiety was observed to have a crucial correlation with hopelessness [37]. In-nate construct of anxiety was as well suggested to include hopelessness in its natural course by the authors [38]. Hopelessness and anxiety levels showed a direct linear relationship [39, 40].

As a traumatic experience, the COVID-19 pandemic has characteristics in common with critical and catastrophic life events, on the one hand, with the limited coping resources and the effects of the consequences of the disease, on the other hand, with strong feelings of threat that people may associate with fear of the virus regardless of preventive measures that could be taken care of. As a result, there is an increase in anxiety, insecure reactions, which can lead to tension, stress, hyperarousal, and impaired concentration [41]. The experience of COVID-19 symptoms per se is a sufficient factor for the development of feelings of strong fear and helplessness, due to the awareness of the possibility of death as a result of illness, which may lead to the development of PTSS [42]. In our study, fear of COVID-19 positively correlated with depression, stress, disability of work/school, social life/leisure activities, the family life/home responsibilities, and levels of anxiety, symptom severity, and PTSD-related loss of function.

Watching COVID-19 news on social or the mainstream media was previously observed to be related to anxiety, negative affect, depression, and stress [43–45]. In our study, most subjects (57.7%) reported visiting social media over an hour daily, and the rate of exposure time to social media was found higher in the possible PTSD group than the non-PTSD group. According to the previous study's results, higher severity of post-traumatic stress was found to be correlated with the daily media exposure levels of the outpatient visitors. Anxiety and depression were other outcomes of this study [33]. Exposure time to distressing presentations of COVID-19 in the media was found to be highly associated with PTSD symptoms. Misinformation on social media was also reported to be a detrimental factor for vulnerable people [33].

In our study, there was no difference between the possible PTSD group and the non-PTSD group in terms of age, education level, gender, marital status, occupation,

additional medical illness, and trauma history indicates that all segments of the society were adversely affected by the COVID-19 pandemic. As expected, compared to the non-PTSD group, the rate of those with COVID-19 symptoms and a diagnosis of COVID-19 were significantly higher in the possible PTSD group, and the rate of those experiencing stigma due to COVID-19 tended to be statistically higher ($p=0.06$).

In the present study, there are some limitations. First of all, it is a small sample size. In addition, there is difficulty in generalizing a sample recruited in an outpatient clinic. Another limitation is the traumatic event was not specified with PDS. In addition, in this study, we could not further exclude the effects of other types of previous and current traumatic events in detail. Despite the limitations, as far as we know, this is one of the first studies examining the psychological impact of the pandemic outbreak at the very first moment on people who applied to the psychiatric outpatient clinic for the 1st time, in a city affected dreadfully by the COVID-19 pandemic with strict lockdown measures, just about 3 months after the pandemic has been declared by the WHO and in a time when restrictions were loosened in Türkiye. We tried to overcome these limitations by conducting the surveys, which we see as the advantage of this study, through face-to-face interviews instead of online survey.

Conclusion

As a result, this study suggests that the COVID-19 pandemic is a traumatic event that causes high rates of PTSD possibility, anxiety, depression, hopelessness, and disability and leads to admissions to psychiatric outpatient clinics. Psychological interventions are required for medium- and long-term psychopathological effects as a negative outcome of the COVID-19 pandemic. Mental health experts should be conscious that all people have the potential to develop PTSD during this pandemic. Careful attention should be paid to individuals at risk, that is, survivors with complications from COVID-19, WHCs, employees of nursing homes, those who were stigmatized because of the disease, and individuals who have additional mental health conditions.

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