

Rassegna

Mental health outcomes of the CoViD-19 pandemic

Gli esiti di salute mentale della pandemia di CoViD-19

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SUMMARY. The coronavirus disease 2019 (CoViD-19) caused by the novel Coronavirus strain SARS-CoV-2 is currently a pandemic. On January 30, 2020, the World Health Organization declared that the CoViD-19 outbreak is a public health emergency of international concern. The virus has already had a direct impact on the physical health of million people, and besides, it is supposed to pose a mental health threat of great magnitude globally. This review aims at synthesizing mounting evidence concerning the immediate psychological responses during the initial stage of the CoViD-19 pandemic among the general population, the health-care workers, and clinical populations. Experts point out the need to pay specific attention to other groups at risk of further distress that may need tailored interventions. Providing psychological first aid is an essential care component for populations that have been victims of emergencies and disasters, before, during and after the event. With the aim of dealing better with the urgent psychological problems of people involved in the CoViD-19 pandemic, a new psychological crisis intervention model is needed. Given the recommendation to minimize face-to-face interaction, online mental health services have been widely adopted in China and are urged in other countries.

KEY WORDS: CoViD-19, pandemic, mental health, psychological impact, stress, anxiety, depression.

RIASSUNTO. La malattia da coronavirus 2019 (CoViD-19) causata dal nuovo ceppo di coronavirus SARS-CoV-2 è attualmente una pandemia. Il 30 gennaio 2020, l'Organizzazione Mondiale della Sanità ha dichiarato che l'epidemia di CoViD-19 è un'emergenza di sanità pubblica di interesse internazionale. Il virus ha già avuto un impatto diretto sulla salute fisica di milioni di persone e si pensa che possa rappresentare una minaccia di grande portata per la salute mentale a livello globale. Questa revisione ha lo scopo di sintetizzare l'evidenza crescente relativa alle reazioni psicologiche immediate durante la fase iniziale della pandemia di CoViD-19 nella popolazione generale, negli operatori sanitari e nelle popolazioni cliniche. Gli esperti sottolineano la necessità di prestare particolare attenzione ad altri gruppi a rischio di ulteriore distress che potrebbero richiedere interventi mirati. Fornire il primo soccorso psicologico è una componente di assistenza essenziale per le popolazioni che sono state vittime di emergenze e disastri, prima, durante e dopo l'evento. È necessario un nuovo modello di intervento per la crisi psicologica allo scopo di affrontare meglio i problemi psicologici urgenti delle persone coinvolte nella pandemia di CoViD-19. I servizi di salute mentale online sono stati ampiamente adottati in Cina e sono sollecitati negli altri Paesi, data la raccomandazione di ridurre al minimo le interazioni faccia a faccia.

PAROLE CHIAVE: CoViD-19, pandemia, salute mentale, impatto psicologico, stress, ansia, depressione.

INTRODUCTION

The novel coronavirus disease pandemic originated from Wuhan, China, at the end of 2019 and has now rapidly spread over the world¹. The CoronaVirus Disease 2019 (CoViD-19) outbreak was declared a public health emergency of international concern on Jan 30, 2020, by the World Health Organization (WHO)².

Clinical features of CoViD-19 range from asymptomatic state to severe acute respiratory distress syndrome and multi organ dysfunction³. CoViD-19 not only threatens physical health: global public health and social systems are collapsing under coronavirus spread. Intensive care units are completely overwhelmed in some countries. Extremely strict pandemic prevention measures, the mandatory closure of schools and

the suspension of all nonessential productions and commercial activities are seriously affecting people daily life, working activity, and putting economic organizations in danger⁴.

Regardless of whether it succeeds in controlling the outbreak, the widespread contagion and lockdown will inevitably have a psychological effect^{5,6}. These effects might represent the mental health outcomes for people affected by CoViD-19⁶ or be associated with the prevention measures⁵ and the socio-economic impact⁴ for the general population. Furthermore, specific populations like the elderly⁷, the children⁸ and the health-care workers⁹ might report different level of psychological distress. Experts point out the need to pay specific attention to other groups at risk of further distress that may need tailored interventions, such as people with preexisting psychiatric conditions¹⁰, pregnant women¹¹, persons in detention¹², international migrant workers¹³, and international students¹⁴.

Therefore, in addition to efforts at various levels to prevent the spread of the disease and other worrisome conditions, the psychological crisis intervention must be part of the public health response to the CoViD-19 outbreak¹⁵. With the aim of dealing better with the urgent psychological problems of people involved in the CoViD-19 pandemic, a new psychological crisis intervention model is needed. Given the recommendation to minimize face-to-face interaction, online mental health services have been widely adopted in China¹⁶ and are urged in other countries¹⁷⁻¹⁹.

To sum up, the mental health outcomes associated with a pandemic represent a complex and multi-layered issue.

Past literature reports that pandemic and measures to prevent it affect mental health of those who undergo them^{20,21}. Timely research reports concerning CoViD-19 outbreak are already reporting a substantial psychological impact of both the outbreak and the response, suggesting that the population may express high levels of psychopathological symptoms²².

Given the developing situation with coronavirus, evidence synthesis about mental health outcomes is needed to produce guidance for the health care institutions and the public.

The aim of this review is to summarize relevant literature about the psychological impact of the CoViD-19 pandemic in the affected populations. Potential critical implications for management of mental health outcomes will be discussed. Further, critical issues for future research will be suggested.

THE PSYCHOLOGICAL IMPACT OF A PANDEMIC AND ITS RESTRICTIVE MEASURES

Pandemics and epidemics have always been an essential part of human history and only in the last century, the Spanish flu (1918-1920), the Asiatic flu (1956-1957), the Severe acute respiratory syndrome (SARS, 2002-2003), the “Swine” flu (2009), the Ebola (2013-2014) and others affected people worldwide.

Several researches with different study design were conducted in the past with the aim to assess the psychological symptoms arising from these and other pandemics/epidemics^{5,20,21}. Literature suggests that restrictive measures such as quarantine, isolation, and social distancing, have an impact on psychological wellbeing of people as well as emotive reactions to pandemic itself^{5,20,21}. Nevertheless, methodological drawbacks and heterogeneity of studies could limit generalizability and conclusions of the impact of such sequelae.

Psychological reactions to pandemics include maladaptive behaviours, emotional distress and defensive responses²¹: anxiety, fear, frustration, loneliness, anger, boredom, depression, stress, avoidance behaviors. A peculiar syndrome known as “headline stress disorder” can be observed during modern pandemics: it is characterized by high emotional response, as stress and anxiety, to endless reports from the news media, that may cause physical symptoms including palpitation and insomnia; further progression to physical and mental disorders is possible²³.

SARS survivors (i.e., non-health care workers and health care workers) had higher stress levels during the outbreak compared with control subjects²⁴. One year after, they not only had elevated stress levels, but also high levels of depression, anxiety, and posttraumatic symptoms, and psychiatric morbidity. Health care workers had higher levels of

stress and psychological distress than non-health care workers survivors²⁴. General population reported negative affects in response to quarantine: fear, nervousness, sadness, guilt, confusion, anger, numbness, and anxiety-induced insomnia^{25,26}. Studies of hospital staff found that having been quarantined was the most predictive factor of acute stress disorder or of posttraumatic stress symptoms even three years later²⁷. Another study found that health-care workers who had been quarantined had more severe symptoms of posttraumatic stress than members of the general public who had been quarantined²⁵; moreover, health-care workers also felt greater stigmatization, exhibited more avoidance behaviours after quarantine, reported greater lost income, and were consistently more affected psychologically. They were also substantially more likely to think they had SARS and to be concerned about infecting others²⁵. Studies on long-term effects found that three years after the SARS pandemics, alcohol abuse or dependency symptoms were positively associated with having been quarantined in health-care workers²⁸.

During the 2009 H1N1 influenza outbreak (“swine flu”), avoidance behaviours, high levels of anxiety and worries about the infection were estimated among general populations^{29,30} and hospital staff³¹ with large regional differences. Family members of patients showed elevated levels of perceived stress and depression, compared to a control population, and moderate levels of death anxiety³². A study of mental health patients found that children and patients with neurotic and somatoform disorders were significantly over-represented among those expressing moderate or severe concerns about swine flu concerns³³.

Since 2012, an outbreak of Middle East respiratory syndrome (MERS) has affected several countries, primarily in its namesake, the Middle East. Studies on the psychological impact confirmed higher levels of anxiety, worries, social avoidance behaviours in the general population³⁴. MERS survivors of critical illness reported lower quality of life than survivors of less severe illness³⁵, showed psychiatric symptoms and received a psychiatric diagnosis and medication during their hospital stay³⁶. Stress, depression and stigma in front-line health care workers³⁷, and anxiety and anger in quarantined people having a history of mental disorder³⁸ were found as well.

Researches on the psychological response to quarantine during Ebola outbreak confirmed previous findings: people reported fear, anger and anxiety-induced insomnia^{39,40}. Stigma from the others were found to be a major issue⁴¹. Depression, anxiety and post-traumatic stress were common sequelae in Ebola survivors⁴². Front-line health care providers reported profound sense of stigmatization, suffering, loneliness, isolation and sadness⁴³. Psychological distress, alcohol/drug misuse, post-traumatic stress disorder, depression, anxiety and insomnia were also found in military populations deployed in the emergency in west Africa⁴⁴.

SEARCH STRATEGY AND SELECTION CRITERIA

We searched MEDLINE, PsycINFO, and Web of Science through the combination of terms relating to CoViD-19 (eg, “coronavirus” and “CORonaVirus Disease 19”), restrictive measures (eg, “quarantine”, “isolation” and “social distancing”), psychological outcomes (eg, “psych”, “depression”, and

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“stress”), and guidelines (eg, “guide” and “managing”). In this review, we included only original researches. The studies had to be published in peer-reviewed journals or be available as preprints, be written in English or Chinese and included data on mental illness or psychological wellbeing, or on factors associated with mental illness or psychological wellbeing (i.e., any predictors of psychological wellbeing). The initial search took place from March 28 to April 3, 2020 and yielded 104 papers, of which 15 showed relevant data and were included in this Review. The characteristics of studies that met out inclusion criteria are presented in the tables (Table 1, Table 2 and Table 3).

MENTAL HEALTH OUTCOMES ASSOCIATED WITH THE COVID-19 PANDEMIC

Non-clinical populations

Among the papers included in this review, six were primary researches focused on mental health of general populations (Table 1). All of them were online surveys on Chinese population with a cross-sectional design^{22,45-49}. Convenience⁴⁹

and snowball sampling strategy were used^{22,49}. Four studies leveraged an online openly accessible platform to invite people to complete questionnaires^{22,46-48}, one study used a mobile phone app-based questionnaire and phone interviews⁴⁹, and the other study sampled and analyzed the Weibo posts from active Weibo users, using the approach of Online Ecological Recognition (OER)⁴⁵. Most of the studies started after the WHO declaration of the CoViD-19 outbreak as a public health emergency of international concern (30 January)^{22,46-48}. The studies investigated the emotive reactions of the last 7^{46,49}, 14 days²², or last month⁴⁵; data collection took place from few days^{22,46,47,49} to two weeks on average⁴⁵.

Another cross-sectional study investigated the mental health status of the subpopulation of medical students from a college in the Hubei province⁵⁰. The respondents in the target population were sampled by cluster sampling. The applied procedures have not been further described.

Globally, findings showed that the most of Chinese people, from 7% to 53.8%, experienced psychological distress during the initial stage of the CoViD-19 outbreak^{22,45-47,49}. A range of negative psychological responses were identified: besides anxiety, depression, and stress, which were the most explored conditions^{22,46-50}, insomnia⁴⁶, indignation⁴⁵, worries about their

Table 1. Original researches on general population.

	Country	Design	Population	Period	Measures
Li et al. ¹⁰	China	Online Ecological Recognition (OER)	17,865 active Weibo users	From 13 January to 26 January 2020	Emotional indicators (e.g., anxiety, depression, indignation, and Oxford happiness); cognitive indicators (e.g., social risk judgment and life satisfaction)
Zhang & Ma ⁴⁹	China	Cross-sectional (mobile phone app-based and phone interviews)	263 individuals	From 28 January to 5 February 2020	Impact of Event Scale (IES)
Liu et al. ⁴⁶	China	Cross-sectional (online survey)	285 residents in Wuhan and surrounding cities	From 30 January to 8 February 2020	PTSD Checklist for DSM-5 (PCL-5); items from the Pittsburgh Sleep Quality Index (PSQI)
Qiu et al. ⁴⁷	China	Cross-sectional (online survey)	52,730 individuals	From 31 January 2020	CoviD-19 Peritraumatic Distress Index (CPDI)
Wang et al. ²²	China	Cross-sectional (online survey)	1210 individuals	From 31 January to 2 February 2020	Impact of Event Scale-Revised (IES-R); Depression, Anxiety and Stress Scale (DASS-21)
Wang et al. ⁴⁸	China	Cross-sectional (online survey)	600 individuals	From 6 February to 9 February 2020	Self-Rating Anxiety Scale (SAS); Self-Rating Depression Scale (SDS)
Cao et al. ⁵⁰	China	Cross-sectional	7143 medical students living in Hubei province	Not specified	Generalized Anxiety Disorder Scale (GAD-7)

Table 2. Original researches on health-care workers.

	Country	Design	Population	Period	Measures
Lai et al. ⁵¹	China	Cross-sectional	1257 health-care workers: 493 physicians and 764 nurses	From 29 January to 3 February 2020	Patient Health Questionnaire (PHQ-9); Generalized Anxiety Disorder scale (GAD-7); Insomnia Severity Index (ISI-7); Impact of Event Scale-Revised (IES-R)
Kang et al. ⁵³	China	Cross-sectional (online survey)	994 health-care professionals working in Wuhan: 183 doctors and 811 nurses	From 29 January to 4 February 2020	Patient Health Questionnaire (PHQ-9); Generalized Anxiety Disorder (GAD-7); Insomnia Severity Index (ISI); Impact of Event Scale-Revised (IES-R)
Huang et al. ⁵²	China	Cross-sectional	230 health-care professionals working in a tertiary infectious disease hospital: 70 doctors and 160 nurses	From 7 February to 14 February 2020	Self-rating Anxiety Scale (SAS); Post-Traumatic Stress Disorder Self-rating scale (PTSD-SS)
Li et al. ⁵⁴	China	Cross-sectional (mobile phone app-based)	740 individuals: 214 general public, 234 front-line nurses and 292 non-front-line nurses	From 17 February to 21 February 2020	Chinese version of the vicarious traumatization questionnaire
Cao et al. ⁵⁵	China	qualitative-quantitative – letter to the Editor	37 health-care professionals working in a fever clinic for CoViD-19: 16 doctors, 19 nurses and 2 clinical technicians	February 2020	Patient Health Questionnaire (PHQ-9); Maslach Burn-out Inventory (MBI)

Table 3. Original researches on patients with CoViD-19.

	Country	Design	Population	Period	Measures
Zhao et al. ⁵⁶	China	Cross-sectional (online survey)	106 CoViD-19 patients during isolation treatment from Tongji Hospital in Wuhan	From 2 February to 16 February 2020	Patient Health Questionnaire-9 (PHQ-9); Generalized Anxiety Disorder Scale-7 (GAD-7); Patient Health Questionnaire-15 (PHQ-15)
Nguyen et al. ⁵⁷	Vietnam	Cross-sectional	3947 outpatients from departments of nine hospitals and health centers across Vietnam: 1387 with suspected CoViD-19 and 2560 without suspected CoViD-19	From 14 February to 2 March 2020	Patient health questionnaire (PHQ-9); 36-Item Short Form Survey (SF-36); International Physical Activity Questionnaire (IPAQ); Short form of the health literacy questionnaire (HLS-SF12)
Bo et al. ⁵⁸	China	Cross-sectional (online survey)	714 clinically stable CoViD-19 patients prior to their discharge from “Fang Cang” hospitals in Wuhan	March 2020	PTSD Checklist (PCL-C)

own health and family⁴⁵, sensitivity to social risks⁴⁵, life dissatisfaction⁴⁵, phobias⁴⁷, avoidance⁴⁷, compulsive behaviour⁴⁷, physical symptoms^{22,47}, and social functioning impairment⁴⁷ were explored as well. The levels of stress^{22,47,49}, anxiety²² and depression²² ranged from mild to moderate-severe. In the college student’s population, rates of mild, moderate, and severe

anxiety were 21.3%, 2.7%, and 0.9%, respectively⁵⁰. Only one study found that people were psychologically stable, with just the 6.33% and 17.17% of the participant reporting respectively anxiety and depression⁴⁸. With regard to factors associated with higher level of psychological distress, consistent findings were shown, except for education level: female gender^{22,46-48},

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young adults (aged 18-40)^{47,48} experienced a major negative impact. Occupation (e.g. migrant workers⁴⁷, student status²², professionals⁴⁸), place of residence (hit hardest or not by epidemics)⁴⁷, specific physical symptoms²², poor self-rated health status²², and having relatives or acquaintances infected with CoViD-19⁴⁹ were also suggested as risk factors. High^{47,48} and low²² education level were both found as risk factors for negative psychological outcomes.

Although the above-mentioned findings are consistent with previous literature^{20,21,24-44}, they should be interpreted carefully given the inherent methodological shortcomings of these studies: study design, sampling methods, the use of self-report questionnaires or not validated questionnaires, and machine-learning predictive models may have biased results to some extent.

Health-care workers

Previous literature showed that health-care providers are at particular risk of negative psychological impact during pandemics, especially if they were front-line workers^{24,27,28,31,37,43}.

To date, five original researches on the psychological conditions of health-care workers during CoViD-19 pandemics have been published⁵¹⁻⁵⁵ (Tab. 2). One study has been published as a "Letter to the Editor"⁵⁵. They were all carried out in China over six consecutive days on average, in a period ranged from the end of January to the end of February⁵¹⁻⁵⁵.

As the studies on the general public, these researches were all cross-sectional, though some differences in methods exist (Table 2). Moreover, the variables explored were not the same. In fact, four studies explored the mental health outcomes among health-care workers exposed to CoViD-19, that is, anxiety, depression and psychological distress^{51-53,55}, whereas the fifth study compared the severity of vicarious traumatization in front-line nurses, non-front-line nurses, and the general public⁵⁴.

Lai et al.⁵¹ recently published a well-designed hospital-based survey, conducted via a region-stratified, 2-stage cluster sampling. Samples were stratified by their geographic location. Since Wuhan was most severely affected, more hospitals of the city were sampled. Then, one clinical department was randomly sampled from each selected hospital. Both secondary and tertiary hospitals were involved. The target sample size of participants was mathematically determined before starting the survey. The final sample consisted of 1257 respondents (response rate=68.7%), 493 medical doctors and 764 nurses, who completed well-known, internationally validated questionnaires. Another research⁵² was published in Chinese language. It involved 230 members of medical staffs, 70 doctors and 160 nurses, in a tertiary infectious disease hospital for CoViD-19 of Fuyang, next to Wuhan (response rate= 93.5%). They were enrolled using a cluster sampling and were asked to complete two Chinese questionnaires. The method of administration of the questionnaires was not specified in both researches, albeit a web-based method is hinted.

Kang et al.⁵³ conducted a study using an online survey tool. The sample included 183 medical doctors and 811 nurses (N=994). A total of 31.1% worked in high-risk departments in Wuhan. Cao et al.⁵⁵ made qualitative and quantitative evaluations on health-care providers working in a 24-h

fever clinic set up in an Emergency Department, in the framework of the psychological support provided through a hotline service. Interviews were conducted whenever the medical workers were free. Each medical worker was interviewed several times during their 2- to 3-week work time rotation. The research on vicarious traumatization was a mobile phone app-based questionnaire survey⁵⁴. 214 general public and 526 nurses (i.e., 234 front-line nurses and 292 non-front-line nurses), were enrolled and assessed by the Chinese version of the vicarious traumatization evaluation scale.

Findings showed that health-care workers have been exposed to high levels of stressful or traumatic events and expressed substantial negative mental health outcomes^{51-53,55}, including stress-related symptoms⁵¹⁻⁵³, depression^{51,53,55}, anxiety⁵¹⁻⁵³ and insomnia^{51,53}. Depression rate was of 50.4%⁵¹, anxiety rate ranged from 23.04%⁵² to 44.6%⁵¹, insomnia rate was of 34.0%⁵¹, and stress rate ranged from 27.39%⁵² to 71.5%⁵¹. Most of health-care workers suffered from mild-moderate disturbances^{51,52,53,55}.

Nurses^{51,52}, women⁵¹⁻⁵³, young age⁵³, front-line health-care workers⁵¹, and those working in Wuhan⁵¹, intermediate professionals⁵² reported more severe degrees of mental health symptoms than other health-care workers⁵¹. Front-line health-care workers were associated with a higher risk of psychological symptoms during the CoViD-19 outbreak⁵¹. Compared with working in second-line positions, working in the front-line directly treating patients with CoViD-19 appeared to be an independent risk factor for all psychiatric symptoms after adjustment⁵¹. Compared with those working in tertiary hospitals, participants working in secondary hospitals were more likely to report severe psychopathological symptoms⁵¹. No differences were found based on others demographic data^{51,52}, that is, marital status, educational level, place of residence. However, limitations of these studies may reduce the generalizability of their findings, as the cross-sectional nature of the study design, the administration of self-report questionnaires or not widely used questionnaires.

The vicarious traumatization of front-line nurses was found to be less serious than that of non-front-line medical staff and of the general public⁵⁴. There was no significant difference between the general population and non-front-line nurses. Among nurses, being married, divorced or widowed was associated with a higher level of vicarious traumatization⁵⁴. Nevertheless, the results may be biased by the heterogeneity of the sample.

Patients affected by CoViD-19

Previous researches focusing on pandemics confirmed that individuals who have experienced public health emergencies reported varying degrees of psychological disorders^{24,35,36,42}. Hence, the outbreak of the CoViD-19 is supposed to cause huge psychological problems and psychiatric morbidities in the sub-population of patients with confirmed and suspected infections. It is hypothesized that patients affected by CoViD-19 may experience psychopathological symptoms due to several reasons: clinical symptoms or disease progression, medication side effects, perceived danger, fear of virus transmission to others or social isolation, uncertainty, physical discomfort, and overwhelming negative news portrayal in mass media coverage^{15,17}.

At present, the mental health problems of the patients infected with CoViD-19 have been reported in three cross-sectional studies (Table 3), of which two were carried out in Wuhan, China^{56,58}, and the other in Vietnam⁵⁷. The observation period was 14 days on average. These researches were heterogeneous in methods: Bo et al.⁵⁸ made an online assessment of stress symptoms and patients' attitude toward crisis mental health services as part of the crisis psychological interventions for clinically stable CoViD-19 patients; Zhao et al.⁵⁶ recruited CoViD-19 patients during isolation treatment through an online questionnaire measuring anxiety, depression and somatic symptoms, whereas the Vietnamese study⁵⁷ enrolled CoViD-19 and no-CoViD-19 outpatients and interviewed them using printed questionnaires on depression and related factors.

Findings suggest that the psychological impact on CoViD-19 patients is relevant: the 96.2% of clinically stable patients reported significant post-traumatic stress symptoms prior to discharge⁵⁸, likely leading to lower quality of life and impaired working performance. The remarkable prevalence of stress could be attributed to the particular illness phases (i.e., clinically stable CoViD-19 inpatients). Only half of the patients hold positive attitudes towards crisis mental health services⁵⁸: this result could be due to the difficulties of specific patients (i.e., older patients) in accessing online mental health services. Nearly 50% of people diagnosed with CoViD-19 in the other Chinese study⁵⁶ had depressive symptoms, over 55% had anxiety and almost 70% had somatic symptoms. Among these patients, 9%, 15% and 21% were severe cases, respectively. Patients who were married and nucleic-acid-positive had more severe depression than their counterparts, whereas patients who were married and nucleic-acid-negative had more somatic symptoms⁵⁶. In this study people reported also insomnia (67,92%) and self-mutilating or suicidal thoughts (25%). The Vietnamese study⁵⁷ found that out of all participants, 7.4% were depressed: the prevalence of depression was significantly higher in people with CoViD-19 (64.3%) than in people non-affected (35.7%). The health-related quality of life score was significantly lower in the people with CoViD-19. Some demographic data were associated with higher degree of depression⁵⁷, such as older age (i.e., 60 years old or above), comorbidities, lower education attainment, lower physical activity. Health literacy was found to be a protective factor for improving depression and health-related quality of life during the CoViD-19 epidemic⁵⁷.

Findings in these studies should be interpreted carefully given their inherent methodological shortcomings.

Patients with mental disorders

Up until now, no observational studies aiming at exploring the psychological impact of the CoViD-19 pandemic of the patients with mental disorders were conducted.

There is a need for research on this field since this population is a vulnerable group for several reasons¹⁰. First, even in normal conditions, people with established mental illness have a lower life expectancy and poorer physical health outcomes than the general population⁵⁹. When epidemics arise, these people are generally more susceptible to infections due to cognitive impairment, little awareness of risk, and diminished efforts regarding personal protection⁶⁰. Second, they

can be exposed to more barriers in accessing timely health services, because of discrimination associated with mental illness in health-care settings⁶⁰. Additionally, mental health disorder comorbidities to CoViD-19 will make the treatment more challenging and potentially less effective⁶⁰. Third, people with mental health conditions could be more substantially influenced by the emotional responses brought on by the CoViD-19 pandemic, resulting in relapses or worsening of an already existing mental health condition because of high susceptibility to stress compared with the general population⁶⁰. Compared with patients from other departments, psychiatric patients encountered more barriers and problems¹⁰. For instance, they were often confined to crowded living conditions in hospitals where they share common dining and bathroom spaces; their family visiting was cancelled due to fear of transmission of the novel coronavirus; smartphones and other electronic equipment were not permitted in the ward and no online information was made available¹⁰.

As a result, they might be at increased risk of infection with CoViD-19, increased risk of having problems accessing testing and treatment, and increased risk of negative physical and psychological effects stemming from the pandemic⁵⁹.

Evidence derived from scientific research could represent a valid support for mental health-care workers and authorities to offer effective, tailored and timely psychological services for psychiatric patients.

CONCLUSIONS AND FUTURE DIRECTIONS

Taken together, evidence accumulated so far confirms that the on-going CoViD-19 pandemic is having a huge psychological impact on individuals. People experienced considerable psychological distress during the initial stage of the CoViD-19 outbreak in terms of anxiety, depression and post-traumatic symptoms. Globally, findings were relatively consistent in terms of severity: most of individuals suffered from mild-moderate disturbances, whereas subjects reporting severe symptoms were a minority. Conversely, the observed prevalence was not homogenous: this inconsistency could be due, among other things, to differences in methodology, in administered assessment tools or examined populations. Some categories have proven to be more vulnerable, that is, health workers and patients affected by CoViD-19. Furthermore, some variables were associated with higher psychological impact, such as female gender and young age. Preliminary findings from our research project are in line with the Chinese studies. We found high rates of negative mental health outcomes, including post-traumatic stress symptoms and anxiety, in the Italian general population⁶¹ and in health-care professionals⁶² three weeks into the CoViD-19 lockdown measures, associated with different CoViD-19 related risk factors: female gender and younger age were associated with higher risk for mental health outcomes.

These findings support the notion that public mental health interventions should be formally integrated into public health preparedness and emergency response plans. Xi-ang et al.¹⁵ suggested three important steps: institution of multidisciplinary mental health teams, clear communication with appropriate updates about the CoViD-19 outbreak, and establishment of secure services to provide psychological

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counseling through telemedicine (e.g., electronic devices, application, online mental health services), with improved access for disadvantaged people like older adults or psychiatric patients. Particular effort must be directed to vulnerable populations with the provision of targeted psychological interventions. For example, health workers could benefit from a continuous monitoring of psychological status, from a pre-job training on how to relax properly and on how to deal with uncooperative patients, or from the presence in hospitals of a place for rest where temporarily isolate themselves from their family if they get infected⁶⁵. As regards people affected by CoViD-19, interventions should be based on a comprehensive assessment of risk factors leading to psychological issues, including poor mental health before a crisis, bereavement, injury to self or family members, life-threatening circumstances, panic, separation from family and low household income⁶. These measures can help diminish or prevent future psychiatric morbidity.

Mental health-care organizations and public health institutions are releasing practical guidelines on taking care of mental health and well-being. The American Psychiatric Association (APA)⁶⁴, the National Alliance On Mental Illness (NAMI)⁶⁵, and the Substance Abuse and Mental Health Services Administration (SAMHSA)⁶⁶ provide general tips for the community on how to organize their own time and manage their physical and mental health. The Centers for Disease Control and Prevention (CDC)⁶⁷ and the WHO⁶⁸ supply further information specific for the high-risk groups.

Although some crucial aspects of these interactions need further clarification, convincing evidence now suggests a relation between CoViD-19 pandemic, lockdown, socio-economic impact and mental illness. Potential risk and protective factors have to be further investigated. Furthermore, future studies investigating the long-term psychological consequences that affect people facing the CoViD-19 outbreak are needed. Future research should also be dedicated to addressing the development of proper prevention, treatment and rehabilitation strategies against a world public health emergency such a pandemic. Another challenge will be tailoring targeted intervention for most affected categories.

Conflict of interests: the authors have no conflict of interests to declare.

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