Addis Ababa University

College of Education and Behavioural Studies

School of Psychology

Anxiety, Depression and Coping Mechanisms during covid-19 among Staff of Amanuel Mental Specialized Hospital

By

Hayat Mekarim

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Advisor: Tigist Wuhib

This thesis is submitted to the School of psychology of AAU in partial fulfilment of the requirements for MA Degree in counselling psychology

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Table of Contents

List of Tables

Page No

List of Acronyms and abbreviations

AMSH: Amanuel Mental Specialized Hospital

ADAA: Anxiety, Depression, American Association

AOR: Adjusted odd ratio

COR: Crude odd ratio

CDC: Communicable Diseases Control

COVID-19: Corona Virus Disease 2019

HADS: Hospital Anxiety Depression Scale

HBM: Health belief model

HCW: Health Care Workers

MERS: Middle East respiratory distress syndrome

OECD: Organization Economic co-operation and development

SPSS: Statistical package for the social sciences

SD: Standard deviation

WHO: World Health Organization

Abstract

Corona virus diseases 2019 (COVID-19) is truly a public health problem and global pandemic. The diseases affect all segments of the population including healthcare workers in different facilities. There is the lack of research done inside the hospital community especially mental health center staffs so that the aim of the study was to assess anxiety and depression, and coping mechanism during the time of covid-19 pandemic among the staff of Amanuel mental specialized hospital. A cross-sectional study design and qualitative design were used. A total of 423 samples were selected using stratify sampling method. A self reported HADs and brief coping scale were used. A descriptive analysis was conducted to estimate the prevalence. Chi-square analysis was used to identify the association and a binary logistic regression was done to identify factors associated with outcome variables. Odds ratio with 95%CI was used to estimate the strength of association and P-value<0.05 and 14 participants participated in in-depth interview using purposive sampling method. The response rate was 94% (n=398). The result shows that the magnitude of anxiety obtained 44.5% and depression 33.4% and in coping mechanism scale depending upon magnitude two best results was selected. The first coping mechanism was the preventive measure including wearing mask, keeping distance, using sanitizer and washing of hands before and after touching the patient or materials and the second mechanism was Religion activities such as attending in religious place, reading regions books and prying during the pandemic. Binary logistic regression analysis indicated being female were statically significant association with anxiety and depression. Other socio-demographic characteristics had no statistically associated with anxiety and depression. In-depth-interview result showed that other psychological problems such as adjustment problem, lack of freedom, limited social life, discomfort, loneliness, sadness, and developing scared surrounding. The magnitude of anxiety and depression was high among staff members of Amanuel mental specialized hospital during COVID-19 pandemic. Adjustment problems, lack of freedom, limited social life, discomfort, loneliness, sadness, and developing scared surrounding were additional reported psychological problems. Preventive and religious coping mechanisms were used by most participants.

CHAPTER 1: INTRODUCTION

1.1 Background of the study

Novel Corona virus is caused by a new corona virus (COVID-19). SARS-CoV2 is a corona virus that causes severe acute respiratory syndrome. It was originally appeared in an outbreak of respiratory illness in Wuhan, China. Because of its pandemic nature, the COVID-19 outbreak was initially reported to the World Health Organization on December 31, 2019, and WHO declared the outbreak a global health emergency (WHO, 2020). COVID-19 is challenging because it's various symptoms, the most common one fever, dry cough, and exhaustion,lack of taste or smell, aches and pains, headache, sore throat, nasal congestion, red eyes, diarrhoea, or a skin rash are some of the less ordinary signs that may have an effect on some people (David,2021).

According to the World Health Organization, there have been 5,335,842deaths worldwide as of December, 2021. COVID-19 is primarily transmitted through droplets produced when an infected person coughs, sneezes, or exhales, according to experts. These droplets are too heavy to float through the air and instead fall to the earth or other surfaces and they can be infected by breathing it in or touching a contaminated surface and then infecting their eyes, nose, or mouth if they are in close proximity to the virus (WHO, 2021).

Anxiety and depression are two of our society's most common mental health issues. They're frequently described as a mix of emotional and functional difficulties. People who suffer from anxiety or depression can go through a wide range of emotions. Some people only have minor anxiety and depression symptoms, while others suffer devastating anxiety episodes or severe depression. Symptoms may also change over time, from from difficult episodes to periods of relief (ADAA, 2022).

Globally, due to, higher level of exposure hospital staffs are more prone to experience a wide range Anxiety, Depression and other psychological problems following an emergency or disaster. These Previous research, including the 2003 severe acute respiratory syndrome (SARS) epidemic, have found considerable emotional stress among hospital staff during or after infectious illness outbreaks (Tam, Pang & Lam , 2003). In addition to this, due to the severity of the COVID-19 outbreak and the psychological influence on hospital staffs, particularly those on the front lines, are currently experiencing high levels of mortality, unknown quarantine duration, insufficient medical supplies, fear of infection, stigma,

discrimination and other factors have a psychological problems such like Anxiety and depression during an outbreak of infectious illness (Brooks et al, 2020).As a result, hospital staffs were found to have a significant level of anxiety and depression in their daily lives (Pappa , 2008).

Besides, the strain of health infrastructure, human resource and equipment deficits put on health systems quality so hard. Due to these, associated problems have been exhibited during COVID-19 and other infectious disease and these have been linked to psychological concerns such as depression and anxiety, which have a negative impact on the population's overall health and well-being. As a result, hospital staffs are usually at the forefront in these epidemic crises and constitute are under, depression and fear(Stuijfzand , 2020).In regard to the COVID-19 pandemic, current studies including systematic reviews have found up to 46 %and50.4 % prevalence of anxiety and depression among healthcare staffs (Cabarkapa et al., 2020; Stuijfzand et al.,2020).

The first case of COVID-19 was confirmed in Ethiopia on March 13, 2020, and it was also the first case recorded since the outbreak began in China in December 2019 (WHO, 2020). Until Sep 14, 2021, Ethiopia had 325,000 COVID-19 recorded cases and 5,001 deaths, according to the ministry of health report in Ethiopia. The epidemic has consequences on both physical and mental health (Shigemura et al., 2020 &Brooks et al., 2020). Because of a higher level of self-exposure the consequences of the COVID-19 Pandemic may be particularly serious for hospital staffs (Fiorillo & Gorwood, 2020).In addition to this, a poorly known transmittable diseases outbreak, such as COVID-19, leads to unavoidable fear, and anxiety and depression. As a result of limited clinical knowledge about the virus, long working hours, risk of infection, insufficient provision of protective equipment, loneliness, physical fatigue, and separation from families, hospital staffs are at significant risk of adverse mental health outcomes during the pandemic (Kang Li Hu et al.,2020).

However global, continental and local coping mechanisms are the same, but they differ in terms of a country's economic capacity. Ethiopia is one of the developing countries, according to World Bank updated report.like, the rest of the world; Ethiopia has been experiencing the unprecedented social and economic impact of the COVID-19 pandemic. The COVID-19 shock is expected to be transitory with potential recovery possible in 2021, but the overall adverse economic impact on Ethiopia will be substantial. The economic impact of COVID-19 includes the increased price of basic foods, rising unemployment, slowdown in

growth, and increase in poverty. Staying at home and working from home is possible for well-developed countries due to technological availability, but it is difficult for developing countries(Worldbank,2021). Coping mechanisms are ways that people use to adjust to environmental stress in their surroundings. They are based on conscious or unconscious choices, and they help people gain control over their behavior or provide psychological comfort. Globally, the year 2020 will be an extraordinary year of transition, and many people's careers, social lives, and well-being will be negatively impacted (OECD, 2021).All over the globe, governments have asked citizens to follow proper precautionary measures.

Lazarus and folk Man coping theory can help us better understand the behaviors and responses. they define "coping strategies" as constantly changing cognitive and behavioral efforts, which are developed to handle specific demands that are valued as situations that exceed a person's resources.The coping principle implies that there are four levels we come upon while facing a crisis: (1) comparing the situation and our potential to address it, (2)Use of problem-solving skills, (3) Use of stress management approaches, and (4) Then if the issue is persistent and important, seeking sense and reason despite the circumstances (Stone,2020). To deal with this, it is important to carefully analyses the situation, and consider our capabilities. Additional measure will take if COVID-19 is spreading in our community; stay safe by taking some simple precautions, such as physical distancing, wearing a mask, keeping rooms well ventilated, Coughing into a bent elbow or tissue, avoiding crowds, and washing your hands and Check local advice where we live and work.

Individuals, communities, and organizations must adapt quickly to emerging threats in order to survive (Lai et al., 2020). People give self-care coping methods and chronic disease management to enhance resistance to viral risks, making it even more vital to remember and implement the basics like social distancing to limit the transmission of the disease. Some people would utilize emotion-based coping and some would use problem-focused coping strategies. During a pandemic, coping strategies can help mitigate the effects of a pandemic and increase resilience, but they won't completely remove the risk. It is important to model the coping strategies of individuals to design appropriate responses (Lai et al., 2020).

The COVID-19 pandemic has had a significant influence on health systems around the world, including psychological problems such as anxiety, depression on hospital staffs. This study had looked at COVID-19 related anxiety and depression in Amanuel Hospital staffs, as well

as potential factors that could help them cope with the psychological problem of anxiety and depression during the time of pandemics.

1.2 Statement of the problem

As WHO reports, Corona virus diseases 2019 (COVID-19) is truly a public health problem and global pandemic. The diseases affect all segments of the population including healthcare workers in different facilities. Health care workers are on the front lines of COVID-19 pandemic defense and are exposed not just to COVID-19 infection due to their frequent contact with infected individuals, but also other diseases but also psychological distress, long working hours, fatigue, occupational stigma and physical violence(Billings et al, 2021).

In recent news, the WHO warned that within the first year of the pandemic, up to 44 million people in Africa might become infected with COVID-19, and that up to 190,000 Africans could die from COVID-19, depending on the intervention measures done to stop the spread (WHO, 2020).

As a result, bereavement, isolation, loss of money and fear are provoking mental health conditions or exacerbating existing ones. Many people may be facing increased levels of alcohol and drug use, as well as insomnia and anxiety. Currently, COVID-19 itself can lead to neurological and mental complications, such as delirium, agitation, and stroke and People who have pre-existing mental, neurological, or substance use disorders are more prone to SARS-CoV-2 infection, and they may have a higher risk of severe consequences, including death (WHO, 2021).

To sum up, assessing anxiety, depression and coping mechanisms helps to determine which psychological problem like anxiety and depression more affect the hospital employees. Also assist hospital administrator to take preventive strategies, apply effective treatment modalities to reduce the negative ongoing outcomes and to inform what kinds of coping mechanism will take during pandemic. The untreated psychological problem of COVID -19like Anxiety and depressions on hospital employees was affected at large their functioning to provide proper services to the society and it needs scientific study to bring changes.

A number of pervious researches of, journal article and others published and unpublished materials were reviewed. Majority of them focused on psychological impact under frontline, health workers, community and others. However, specifically studies on anxiety and depression inside the hospital community (staffs) were not addressed well enough related with covid-19. The investigators of this study have been working at Amanuel hospital at psychiatry department where, Anxiety and depression with different coping practice have been exhibiting among the whole hospital community or staffs and this warrants scientific study.

1.3Research Questions

- What are the prevalence of anxiety and depression during Covid-19 pandemic among staff members of AMSH
- Is there statistically significant association between socio demographic characteristics and working department with anxiety and depression among staff members AMSH during the time of covid-19
- What types of coping mechanisms used to reduce psychological problems during Covid-19 among the staff of AMSH?
- What are other psychological problems during the Covid-19 time among staff of AMSH?

1.4 Objectives

1.4.1 General objective:

The objective of this study was to find out the prevalence of anxiety and depression and coping mechanisms during the time of covid-19 pandemic among staff of AMSH

1.4.2 Specific objectives:

- To determine the prevalence of anxiety and depression during the time of covid-19 pandemic among staff of AMSH.
- To identify the factors associated with anxiety and depression during the time of Covid-19 among the staff of AMSH.
- Identify coping mechanisms to reduce psychological problems during the time of covid-19 among staff of AMSH.
- To explore other psychological problems during Covid-19 among staff of AMSH.

1.5 Significance of the study

There have been few studies on anxiety, depression and coping mechanisms of covid-19 pandemic in Ethiopia, especially on mental health center workers and this topic is not researched inAMSH so this study supposed to have two fold implications. Empirically, the finding of the study are hoped to fill the gap of addressing anxiety and depression and coping mechanism during the time of covid-19. particularly ,the finding would have contribution for the Amanuel hospital psychology department to open their office for the staff who needs counseling service .The study also provide further information for those who want to learn more about the COVID-19 related psychological problems like anxiety ,depression and also others psychological problems and coping mechanisms among staff of Amanuel hospital.

On the other side, the finding of the study shall also help the AMSH Admistrative body to take preventive strategies to reduce the negative ongoing outcome of covid-19 related psychological problems such as anxiety, depression and other mental health problems among the staff.

Finally it is hoped that the finding of the study will provide some important direction for conducting further research in the area for those who involved covid-19 related mental health problems on the mental health community staff.

1.6 Delimitation of the Study

The researcher was delimited at one hospital called AMSH. It was chosen because this hospital in Addis Ababa was the only one that provided mental health services for a long period so the staffs who are working at this institution may have additional burden with mental health services due to covid-19.

Though there are different variables that are taken as emotional or psychological problems during the time of covid-19, this study was mainly focus to measure the magnitude of as anxiety and depression among staff of Amanuel mental specialized hospital and also it examine the coping mechanisms they used.

1.7 Limitation of the study

In all research there are unavoidable problems. Likewise, in this research paper had encountered certain problems. During data collection was difficulty for security guards of the hospital due to the language difficulty they couldn't fill the Amharic version of the questionnaire.

1.8 Operational definition of Terms

Anxiety: -is defined as according to HADS-anxiety sub-scale score of >7.

Administrative staff: Employee at Amanuel hospital and their responsibility more of in Admistrative part such as employee at human resource office, faineance, leaders in difference office including higher Admistrative body such as CEO

Clinical workers: - include the job responsibility of hospital workers who deal directly with patients.

Coping Mechanisms:- responses to environmental stress that is based on conscious or unconscious choice and improves control over behavior or exploring strategies to reduce stresses related with covid-19 to gives psychological comfort such as preventive methods, religious activity, transference, denial, using substance….etc.

Depression: -is defined as according to HADS depression sub-scale score of >7.

Psychological problems: - The effects of covid-19 such as, depression and anxiety, and others mental health problems on staff of Amanuel mental specialized hospital within their day to day activities.

Socio-demographic characteristics: -Refers to the characteristics of Amanuel Hospital's employees such as, Age, sex, education level, marital status, leaving status, working department, working years, religion, job responsibility and occupational status are all common characteristics.

Supportive staff: Employee at Amanuel hospital and their responsibility such as cleaner, patient supporter, security guards runner, messengers and other supportive activities that support the hospital communities.

Working department: The staff who are working at Amanuel hospital and classified in to clinical staff, administrative staff and supportive staff.

WHO regions: refers to the six WHO world divisions (African region, Region of America, south-East region, European region, East Mediterranean region, Western pacific region) which are used for the purposes of reporting, analysis and administration.

CHAPTER TWO: RIVIEW OF LITRATURE

2.1 Review of Related Literature

2.2.1 What is Covid-19?

According to the WHO definition, Corona viruses (CoV2) are a large family of viruses that cause illness ranging from the common cold to more severe diseases. A novel corona virus (nCoV2) is a new strain that has not been previously identified in humans as well as a contagious disease caused by severe acute respiratory syndrome corona virus 2 (SARS-COV-2). COVID-19 affects different people in different ways. Most infected people will develop mild to moderate illness and recover without hospitalization. Most common symptoms are fever, cough, tiredness, loss of taste or smell and less common symptoms are sore throat headache aches and pains diarrhoea a rash on skin, or discolouration of fingers or toes red or irritated eyes (WHO, 2021).

2.1.2 Brief history of Covid-19

The COVID-19 Pandemic, also known as the Corona virus Pandemic, is a current Corona virus Disease 2019 pandemic caused by the Corona virus 2 severe acute respiratory syndromes (SARS-CoV-2). It was initially identified in December 2019 near Wuhan, China. In January 2020, the World Health Organization designated the outbreak an international public health emergency, and in March 2020, it was declared a pandemic. There were more than 83.9 million confirmed cases, with more than 1.82 million deaths attributed to COVID-19 As of January 2, 2021(Chaplin, 2020).

The World Health Organization (WHO) was officially alerted of a cluster of pneumonia cases in Wuhan, China's cultural and economic center, on December 31, 2019. Wuhan is home to 11 million people and is the cultural and economic center of downtown China. There had been 59 cases reported, none of which had resulted in death. The WHO received notification of 282 confirmed cases ten days later, four of which were in Japan, South Korea, and Thailand. Six people died in Wuhan, 51 people were extremely ill, and 12 people were in critical condition. On January 7, the causative virus was isolated, and on January 12, its genome was divided. A new corona virus, SARS-CoV-2, was the source of the severe acute respiratory syndrome that became known as COVID-19, and the rest is history that is constantly being rewritten. As of May 12, 2020, there have been 82,591 new cases of

COVID-19 confirmed daily worldwide and the daily death rate were over 4,200 (Chaplin, 2020).

The symptoms of COVID-19 range from minimal symptoms to severe illness. When humans are close by, the virus primarily spreads through the air. It permits an infected individual to infect another person through their mouth, nose, or eyes by breathing, coughing, sneezing, or speaking. It can also spread through surfaces that have been polluted. Even if they don't show symptoms, people can stay infectious for up to two weeks and spread the infection (Medical news today, 2020).

To put the COVID 19 pandemic in historical context, it has been compared to global influenza epidemics. Seasonal influenza causes three to five million cases of serious illness and 290,000 to 650,000 deaths from respiratory infections each year, according to the World Health Organization. The virus that caused the swine flu pandemic in 2009/10 infected between 11% and 21% of the world's population (between 750 million and 1.4 billion people) and killed roughly 280,000 individuals due to respiratory and cardiovascular problems. Two-thirds of those who died were between the ages of 18 and 64. COVID-19 has already claimed the lives of almost 280,000 people globally as of May 12th (Chaplin, 2020).

The first European country affected by the corona virus was Italy. COVID-19 quickly moved worldwide after the epidemic in Wuhan, reaching a small village in northern Italy on February 18, 2020, when the first positive patient was diagnosed. The virus spread across the country for a few weeks due to politicians' reluctance to implement appropriate counter measures and limited / disputed information regarding the pandemic. The government prolonged the Anywhere Bans after the initial illusion of stopping the epidemic on March 11, 2020.However, due to increased demands on hospital stays, the pandemic's morbidity and mortality increased, and also a challenge to the public health system (Marazziti, 2020).

2.1.3 Current Status of Covid-19 worldwide

COVID-19 represents a massive worldwide challenge that has required exceptional levels of intervention. In some ways, it's a new threat: SARS-CoV-2 arose as a novel virus against which humans had no immunity; it spreads rapidly, has a high mortality rate, and can overwhelm health-care systems' ability to treat the serious ill patients. However, it is not incomparable: because it is related to other corona viruses and recent epidemics, infection control methods are well-practiced, and existing technology can be used to accelerate the

development of new vaccines and therapies (McIntosh, 2021). The worldwide effort to develop a COVID-19 vaccination that is both safe and effective is bearing fruit. More than a dozen vaccines have already been approved around the world, with many more in the works (Mohan, 2021)

2.1.4 Current Status of Covid-19 in East Africa and Ethiopia

According to the BBC news in Africa reported on July 1, 2021, the total number of corona virus (COVID-19) cases in East Africa was 687,379. Ethiopia and Kenya, with 276.3 thousand and 184.5 thousand cases, respectively, were the most affected countries in the African continent's eastern region and The World Health Organization (WHO) has warned that new and faster spreading variants could mean Africa's third wave is worse than previous surges**(**Saifaddin Galal, 2021)

The Ethiopian Ministry of Health introduced the COVID-19 vaccine at a high-level national event held at EkaKotebe COVID-19 Hospital on March 13, 2021, when frontline health workers were immunized to mark the start of the immunization campaign. EkaKotebe Hospital's doctors, nurses, and support staffs were vaccinated, marking the start of the vaccine campaign across the country. In simultaneous high-level events; the vaccination campaign was started nationally as well as in all regions. Frontline health workers and support staffs, the elderly with underlying diseases, and other high-risk populations would be prioritized for vaccination, according to the National Deployment and Vaccination Plan (NDVP) developed in accordance with the WHO Prioritizing Roadmap to make the most use of the limited vaccine supplies, this prioritized strategy is required (World Health Organization, 2021).

In Ethiopia, 11,089 new active cases were reported in July 04 2021, bringing the overall number of confirmed cases to 276,368. The death toll has risen to 4,330 people and serious critical 135. At the end of the month, the number of recovered patients had risen to 260,949; serious critical 167 cases were hospitalized (World Health Organization, 2021).

2.1.5 Covid-19 and Mental health profession

As the corona virus pandemic spreads around the globe, it is causing widespread concern, worry, and concern among the general public, as well as specific groups such as frontline health worker, older, caregivers, and those with underlying health concerns. Increased levels of stress or concern have been the most significant psychological impact on public mental

health too far. However, once new policies and consequences are implemented, such as quarantine and its influence on many people's daily activities, routines, or livelihoods, levels of loneliness, sadness, excessive alcohol and drug use, and self-harm or suicide behaviour are predicted to rise. Issues of service access and continuity for people with emerging or current mental health illnesses, as well as the mental health and well-being of frontline workers, are becoming a significant issue of concern in places that have already been severely impacted, such as Lombardy in Italy. WHO collaborated with partners to develop a set of new resources on mental health and psychiatry as part of its public health response .WHO collaborated with partners to create a set of new COVID-19 mental health and psychosocial support services (WHO news, 2021).

2.2 Psychological problems during the time of Covid-19

Individuals' psychological well-being has a significant impact on their performance. COVID-19 has been shown to have a negative influence on mental health in a variety of demographics, including health professionals, in a number of nations. Despite the fact that the consequences of a disease epidemic are costly, the mental health impact of a pandemic is often overlooked during pandemic management (Pedrosa, 2020).

Hopelessness, loss of interest, anger, fear of death, difficulty sleeping, loss of appetite, and anxiety were the most frequent mental and psychosocial illnesses that occurred in other parts of the world during prior outbreaks. Suicide, stress, anxiety, frustration, confusion anger, boredom, financial loss, and stigma are all symptoms of the current pandemic (kassaw, 2020)

The pandemic and quarantine had immediate devastating psychological problem like Depression, anxiety on the Italian people. Medical staffs worked in emergency circumstances and had to cope with critically ill patients, as well as the fear of being infected and infecting their families, were the first to be impacted. The most vulnerable member of the society was affected, including psychiatric patients and their caregivers (Marazziti& Stahl, 2020).

Women and people under the age of 30 who had high levels of exposure were more likely to have clinically significant post-traumatic symptoms, and roughly 30% of the participants had clinically significant post-traumatic symptoms. Positive case closeness, prolonged incarceration, relocation, and limited defensive functioning were all risk factors for severe distress and traumatic symptoms (Giuseppe&Zilcha-Mano, 2020).

The prevalence of the psychological impact of covid-19 was different in different countries, according to the study. In Italy, 38 % of the respondents developed mild to moderate psychological distress, including anxiety, and depression. In China, 53.8 % of the respondents developed mild to moderate psychological distress, including anxiety and depression. In Australia, 78 %of the respondents developed mild to moderate psychological distress, including anxiety and depression. In France, 38.6% and in India 25.3 %of the respondents developed mild to moderate psychological distress, including anxiety, Depression. The study conducted in an Addis Ababa community, the extent of the psychological disturbance ranged from mild to severe was 66.4%.(Bonati , 2021;Wang ,2020; Kassaw ,2020).

The study conducted in China during the corona outbreak, 53.8% of respondents experienced psychological problems, 16.5% depressive symptoms, 28.8% anxiety symptoms, (Lai J, Ma S, Wang Y, et al,2020).Similarly, 11% of nurses in Taiwan who worked during the SARS pandemic suffered anxiety, sadness, and somatization, according to a research (Zheng , Zhou, Qiu, 2021).

Evidence from previous outbreaks revealed that levels of moderate anxiety ranged from 22.6 % to 44.6 %, and severe anxiety ranged from 2.9 % to 5.3 %, according to a systematic review of the potential impact of COVID-19 on mental health outcomes of health-care providers and the implications for service solutions. Furthermore, 50.4% had severe depression while 34% of health-care workers had mild disturbances, 22% had moderate disturbances, and 6.2% had severe disturbances (Pappa, 2020).

Likewise, in a study done on mental health and psychosocial problems between medical and nonmedical health workers, in China, medical health workers had a higher prevalence of anxiety 13.0% vs. 8.5%, depression 12.2% vs. 9.5% as compared with non-medical health workers (Zhang, Wang, Yin, 2020). An umbrella review of meta-analyses revealed that the magnitude of depression and anxiety were 24.94% and 24.83% respectively (Sahebi, 2021). The prevalence with 95% confidence intervals of anxiety among health professionals in Ethiopia during an early stage of COVID-19 pandemic was 26.8% (Dagen, 2021).

According to the findings of a study conducted in Turkey, health-care staff's anxiety levels in pandemic situations were higher than in studies conducted prior to the pandemic. Anxiety levels were shown to differ depending on a variety of socio-demographic factors. Anxiety levels among those in the 20–29 age groups, those in the 40 and beyond age groups, females, and those with an associate's degree were studied in this study (Damla, AylinAkça, Enes al, 2021).

According to a recent survey of Chinese health-care employees, 44.6 %had anxiety symptoms, while 50.4 % have depression symptoms .The research done in India during the second phase of covid time from 1124 health care workers approximately one-third respondents having anxiety and depressive symptoms. However, because this study was conducted during the peak of the COVID-19 pandemic, the increase of anxiety and depressive symptoms in the population, During the H1N1 flu pandemic in Singapore, a comparable study found that 25.3% of HCWs at a screening centre experienced psychological morbidity (Gupta, 2020).

In India, health care workers with an unmarried status and a young age group of 20 to 30 had higher anxiety symptoms, and unmarried health workers have 3.6 times the chance of having anxiety symptoms than separated and married workers. Female gender, young age group, and nurse work profile are all risk factors for anxiety symptoms, while younger age and the working place of the primary care hospital is a risk factor for depressive symptoms (Gupta , 2020).

A study of 250 health care professionals in Pakistan found that while they did their tasks properly during the outbreak, they were concerned about their safety and worried about infecting themselves and their family members. The lack of evidence-based standards for patient management, as well as media reports about the pandemic crisis and dealing with difficult patients who refused to be quarantined, added to their anxiety , Receiving recognition and respect from the general population in exchange for services, monetary compensation, and proper training to treat patients (Noreen, 2020)

The study conducted in Iran, 1498 people out of a total of 1498 responded to the question, and the majority of the participants had normal or mild levels. 57.9% of participants report a typical degree of anxiety, 12.4% have anxiety that is more than moderate. In addition, roughly 15% of the individuals suffer from severe or extremely severe depression (Khademian, Delavari, Koohjani, 2021).

Also the same finding showed that Being female, living with a high-risk family member, health status, economic status, social capital, disease risk, and following COVID-19 news are all linked to stress, Anxiety is related to education level, living with a high-risk family member, health status, social capital, infection risk, and following COVID-19 news. Education level, having a high-risk family member, health status, social capital, disease risk, and following Covid-19 news are all associated to depression scores. As a result, people's mental health during pandemics, as well as suitable and timely interventions to decrease problems, particularly for vulnerable groups, are important considerations (Khademian, Delavari, Koohjani, 2021).

The study done in Jima university among medical center visitors during the first time of the outbreak of pandemic ,From March 22 to March 28, 17.4 %, 8.5 %, of hospital visitors reported mild psychological impact including Anxiety, depression, moderate psychological impact, and severe psychological impact, respectively, during the early phases of the COVID-19 outbreak (Yitayih , 2020).

According to the survey, 69.6% and 55.3 % of respondents in Ethiopia's North West Amhara area were experiencing anxiety and depression in response to the epidemic, respectively and In comparison to other county studies, the anxiety level was higher, and the researcher suggested that the difference could be due to differences in socioeconomic, cultural, and environmental factors such as attitudes, a lack of adequate equipment such as personal protective equipment, and resources that contribute to coping with the pandemic's psychological crisis(Mekonen, 2020).

2.3 Coping mechanisms of covid-19

Global, continental and local coping mechanisms are same but it differs in respect to the economical capacity of the country. Staying at home and working from home for well-developed nation due to technological availability, it is possible but for those under developing countries has been challenging (Oran&young, 2009).

According to a study conducted on health workers in Alabama last year, half of the respondents believe that relying on an avoidance strategy for nurses could significantly limit their access to updated risk information, such as improved studies or additional protective measures, and two-thirds of respondents report that they follow strict protective measures such as wearing gloves hand-washing, face masks, protective gear to reduce their risk of infection.While one-third of respondents did not believe that protective measures were the most effective way to minimize their COVID-19 risk, 41.2 % (45 samples) of respondent nurses are using transference strategies such as prayer, meditation, and reading, around 73 %(80 samples) of the nurses said they talked to friends to relieve stress before seeking treatment, and none of the respondents said they didn't seek help from a psychologist(Ali, 2020).

In the same survey, 10% of nurses used a coping mechanism that wasn't included above.Seven nurses said spending time with their children helped them cope during the pandemic, with 4.6 %saying they did general activities with their kids and 1.8 %saying they did arts and crafts with them. Around 5.5 %of nurses said they use alcohol as a coping method (Ali , 2020).

According to a study in China, and health care workers who used more coping humor and approaching coping strategies rather than avoidant coping strategies perceived less COVID-19-related stress. In terms of the latter, avoidant coping and humor coping techniques were found to be connected with perceived stress in distinct ways. However, no link was discovered between adopting coping humor to deal with stress and risk exposure. A good place to start is to develop a sense of humor about life's obstacles. A sense of humor can help you cope with stress and improve your physical and mental well-being. It will also allow you to bond with others, see things from a different perspective, normalize your experience, and maintain a healthy relationship, As a result, the use of humor to cope with stress was found to be independent of HCWs' exposure to COVID-19 (Canestrari, 2020).

The nurses caring for Covid-19 patients in Turkey were negatively affected by the pandemic both psychologically and socially, according to a study conducted in Istanbul in 2020. They used short-term coping strategies and needed psychosocial support and resource management, which support this idea, as we discovered that seeking social support was the most common coping method used by health workers (Kackin, 2020).

A cross-sectional study of mental health status and self-psychological adjustment among Chinese nurses who work with Covid-19 the findings reveal that frontline nurses working in isolation wards have mental health issues during the COVID-19 outbreak. Administrators should pay close attention to nurses' mental health, identify high-risk individuals with a general screening tool, provide psychological support and counseling based on their stressors, and collaborate with expert teams to provide professional psychological service when necessary, all under the guidance of national policies so these actions will strengthen their mental resilience and ability to self-adjust, resulting in increased nurse efficiency and clinical safety (Chen, 2020).

2.4 Review of the theory

2.4.1 Lazarus and Folk man theory of stress and coping

Lazarus and Folk man (1986) defined these "coping strategies" as constantly changing cognitive and behavioral efforts, which are developed to handle specific demands that are valued as situations that exceed a person's resources. According to Lazarus and Folk man (1984), there are two types of coping responses: emotional and problem-focused.

Emotion-Focused coping

Emotion-focused coping is a type of stress management that attempts to reduce negative emotional responses associated with stress. Individuals use a variety of coping mechanisms to lessen or eliminate negative feelings such as shame, fear, worry, depression, excitement, and frustration. Emotion-focused coping is not a long-term solution and may have negative consequences because it causes the person to avoid dealing with the situation. However, they can be a good choice if the source of stress is outside the person's control (e.g. pandemics) and gender differences have also been reported: women tend to use more emotion-focused strategies than men (Billings & Moos, 1981).

Emotion-focused coping is one of the key coping styles, which works to manage (tolerate, minimize, or eliminate) the physiological, emotional, cognitive, and behavioral reactions that come with stressful interactions. Lazarus and Folk man (1984) first proposed the concept of emotion-focused coping as part of their cognitive model of stress and coping. According to this paradigm, people develop coping techniques in response to stressful situations such as

daily problems (for example, discovering a flat tire in one's car or being treated harshly by a government official), life events,(for example, a spouse's illness or a job loss), or big-scale dangerous occurrences involving a significant number of individuals e.g. natural disasters and terror attacks(Billings & Moos, 1981).

The experience is appraised as a threat and/or loss when stressful interactions generate demands that drain or exceed a person's resources, resulting in these assessments. Given that the pandemic is a natural occurrence and Emotion-focused coping approaches were more extensively adopted, which could influence emotional state and choice of coping strategy in the face of the pandemic (Billings & Moos, 1981).

When a challenge comes up with us, we have probably had a handful of go-to strategies to help you deal with it. Even though your strategy differs slightly from problem to problem, you most often handle most challenges in the same way. For example, be a problem solver. When navigating a challenge or stressful event, you go straight to the source and work at it until you've either fixed what's wrong or brought your stress down to a more manageable level. These two approaches represent two distinct coping strategies: Problem-focused coping is confronting stress head-on and taking steps to address the underlying cause Rather than addressing the problem, emotion-focused coping entails managing your feelings and your response to it. Both strategies have advantages (Billings & Moos, 1981)

Problem-focused coping methods

Problem-focused coping targets the causes of stress in practical ways which tackles the problem or stressful situation that is causing stress, consequently directly reducing the stress. Those who perceive themselves to have a better academic self-concept, social skills, and emotional intelligence are more likely to adopt problem-focused coping techniques including active solution, optimistic attitude, and seeking information and guidance. In general problem-focused coping is best, as it removes the stressor, so deals with the root cause of the problem, providing a long term solution (McLeod, 2015).

There seems to be relatively stronger evidence that problem-focused coping strategies would promote better mental health outcomes and well-being (Aebi, Giger, Plattner, Metzke, &Steinhausen,2014).whereas emotion-focused coping strategies were regarded as dysfunctional (Taylor & Stanton, 2007) and might result in mental health problems. Individuals who use this technique feel they will be able to face or modify stressful situations

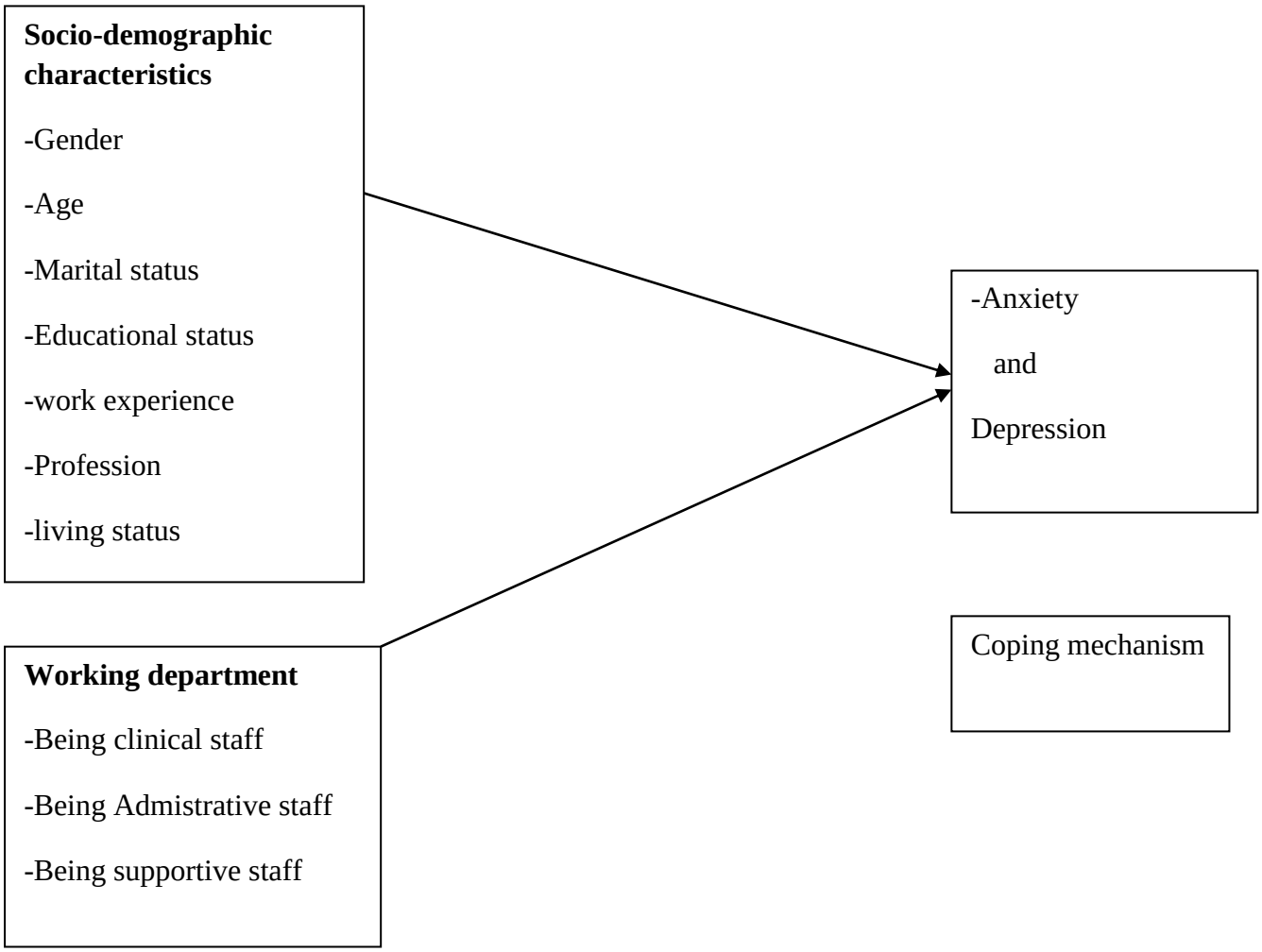
or conditions. Problem focused coping is a type of coping that focuses on problems and strives to address current difficulties. Coping, particularly problem-focused (PF) and disengaged (DS) behaviors, offers one plausible pathway by which service members' subclinical trauma symptoms might predict civilian partners' psychological distress(Lovell &Gaszka, 2018).

Meta-analysis revealed emotion-focused strategies are often less effective than using problem-focused methods in relation to health outcomes, People who utilized emotion-focused techniques like eating, drinking, or using drugs had poorer health outcomes in general. Such strategies are unproductive because they disregard the source of the stress (McLeod, 2015).

2.5 Research gap

Thus, based on the above literatures several studies conducted and showed different psychological consequences like Anxiety and Depression among health Professional especially nurses; impact of on community and health center visitors in the world and in Ethiopia some research done with psychological impact on community, psychological impact on nurses in southern and northern area of Ethiopia. But there is a gap in assessing on specifically psychological problems like anxiety depression among whole staffs in the hospital center especially staffs on mental health center area. Furthermore, there is the absence of adequate research conducted to coping mechanisms occurred in the staff for the pandemic. Therefore; there is a gap of assessing anxiety and depression and coping mechanisms among the whole staffs, So that, this study was tried to fill the gap and came up with some evidences.

2.6 Conceptual frame work



CHAPTER THEREE: METHODS AND PROCEDURE

This section provides an overview about research methods. The following specific issues are addressed: study design, study area, study population, sampling procedures, instrument of data collection, pilot study, method of data analysis and ethical consideration.

3.1 Study Design

A cross-sectional study design and mixed research methods were used in this study; the methods were used to find out the prevalence of anxiety and depression and explore what are other psychological problems during the time of covid-19.The quantitative part focus on Anxiety, depression and coping mechanism. Whereas the qualitative part was explored other psychological problems that are not explained by quantitative by using an in-depth interviews (IDIs). The mixed research approach was employed to conduct this study to provide better understanding which psychological problem was affected by the hospital employee, which is generally known to contain both quantitative and qualitative methods (Creswell, 2014).

Mixed-method research, according to Creswell and Plano-Clark (2011), is defined as studies that include at least one quantitative and one qualitative component: Quantitative approach research is usually done in the social sciences, and it applies the statistical methodology mentioned above to acquire quantitative data from the study.

3.2 Study area

The research was conducted at Amanuel Mental Specialized Hospital which located in Addis Ababa, Amanuel Mental Specialized Hospital is the only specialized mental health federal hospital in Ethiopia under ministry of health (MoH),which is offering both outpatient and impatient services for an individuals who are suffering from mental illness. The hospital has 370 beds, the majority of which are dedicated to therapy, and offers comprehensive outpatient and limited inpatient services. Currently there are 11 wards namely psychotic ward with five case teams, three case team of mood ward, also substance abuse ward, emergency ward and forensic ward and Amanuel Mental Specialized Hospital in Addis Ababa was once the country's only psychiatric center for long period of time (Alemayhu, 2004).

3.3 Study population &Sampling Procedure

The study populations were the entire employee in Amanuel mental specialized hospital and Stratifying sampling method had used to assess anxiety and depression and coping mechanisms during the time of covid-19.it took 50% to determine the sample size

Sample size *(n) =z2 p q/d2* The source population (N= 823)

Where n =is sample size,

Z = reliability coefficient with 95% of CI=1.96

P= Population variance a available from pervious data(q=1-p) , p=0.5 and q=1-0.5

d = degree of precision or margin of error=0.05

Therefore proportion is not known in this case

$n= (1.96)^2 (0.5)^2 \frac{o.5^{\ 2}}{(0.05)^2}$=384,

Adding 10% non-response rate, the final sample size is 423.

The total number of the staffs at Amanuel mental specialized hospital is 823 including clinical and administrative staffs so 423 sample sizes were determined during data collection and 398 were responded for the questioner. 14 staffs were participated for in depth interview. Therefore, according to single population formula 423 staffs had selected out of 823 staffs. The selected sample was stratifying with both clinical and administrative staffs so 187 clinical and 236 administrative staffs were selected. Then the first sample from clinical and administrative (supportive) staff selected by lottery method then the rest of the sample was used systematic sampling method. For qualitative study a total of 14 participants were participated from the staffs' different job responsibility, including supportive staffs working in this area so purposive sampling method had used for qualitative study.

3.4 Instruments for data collection

In this research study self reported questionnaires of HADS scale and Brief coping scale and also interviews were used data collection. The demographic characteristics information which included gender, age, Religion, working department, work experience, educational status, marital status, living status and their profession and also interview guide questions was adopted and customized by the researcher.

A standardized scale was used to obtain quantitative data. The Hospital Anxiety Depression Scale (HADS) and Brief Coping Scale both adapted and customized with covid-19. The HADS was created as a self-assessment instrument, according to Zigmond and Snaith

(1983). The Hospital Anxiety and Depression Scale (HADS) can be used in a variety of settings, including general care, community settings, prenatal clinics, psychiatric patients, and screening normal and above-normal people. There are 14 items on the HADS scale (seven items for the anxiety sub-scale customized with covid-19 and seven items for depression sub-scale also customized with the pandemic). Each item's value on the scale ranges from zero to three: zero means not at all, one means sometimes, two means a lot of the time, and three means most of the time. The overall score for each subscale, which ranges from 0 to 21, indicates the severity of anxiety and depression (0-7=normal, 8-10=mild, 11-14=moderate, and 15-21=severe) and The greater than seven of the total score, the more anxiety and depression there is.

The other scales that were used in this research paper were brief Coping Scale. These coping scales have 14 item of self-report questionnaires designed to measure effective and ineffective ways to cope with a stressful life event. The scale was often used in health-care settings to ascertain how patients were emotionally responding to a serious circumstance. It can be used to assess how someone is dealing with a variety of challenges, such as cancer, heart failure, injuries, assaults, natural disasters, pandemics, financial difficulties, or mental illness. The scale can determine a person's main coping styles. The following aspects of coping were also mentioned: Self-distraction, Denial, Substance Use, Behavioral disengagement, Emotional Support, Venting, Humor, Acceptance, Self-Blame, Religion, Active Coping, Use of Instrumental Support, Positive Reframing, Planning and the scale was customized with the current pandemic.

The qualitative data was collected using an in-depth interview. The research guides with 10 questions was developed and have been customized with covid-19 issue. Fourteen (14) professionals were selected from different department workers such like, emergency, cleaner, outpatient ,impatient, rehabilitation ,forensic, driver, patient supporter in order to better understand and explored what are other psychological problems not explained in the quantitative study and coping mechanisms during the time of covid-19 among staff of Amanuel mental specialized hospital staff.

According to Ambaw's (2011) study on orphans, the Cronbach alpha values for the anxiety and depression sub-scales of the Hospital Anxiety Depression Scale (HADS) in Amharic were 0.81 and 0.76, respectively. The other study that was conducted by Mekonnen (2017) indicated that the results for the HADS Cronbach alpha values were 0.80 and 0.78

respectively. Therefore, the items in the scale have consistency with each other and the reliability of the scale was good.

Baumstarck, et al. (2017) indicated Cronbach alpha for the brief coping scale to be 0.82.

3.5 Pilot Study

A pilot study was conducted to check the clarity, appropriateness and reliability of the instruments. Before collecting the data, the reliability of HADS and Brief coping scale were checked for internal consistency. The instruments which were prepared in English were translated in to Amharic and again back to English .For the purpose of the pilot study, 36 participants were selected randomly from different staff of AMSH However; those respondents who participated in pilot study were excluded from the main study.

The collected data were entered and analyzed using SPSS version 21 to identify the reliability of HADS and Brief Cope Scale. Cranach alpha of 0.72 for both of depression and anxiety (HADS), Cronbach alpha for the Brief Cope Scale were calculated 0.71. The Cronbach alpha results of these measures in the main study were 0.86 for HADS scale and 0.72 for Brief Cope Scale.

3.6 Procedure of Data Collection

The standardized scale was adopted and adjusted for this study in English language and then translated to Amharic language and oromic language. The Amharic versions of the Hospital Anxiety Depression Scale (HADS) and the Brief Cope Scale had used with context of covid-19. First, the researcher obtained a letter of approval from the hospital's director, as well as the informed consent obtained from each study participant from Amanuel hospital workers before the data collection. The researcher then looked into the anxiety and depression and coping mechanisms of hospital employees. After collected the data, the researcher had double-checked that all of the questions had been answered.

During data collection the security guards were on difficulty to filled Amharic questioner so it was changed to oromic language then they were easily collected with the supporter of data collectors. The interview was in Amharic, and translations were afterwards completed in English and Data was collected from Aug to Sep 2021 for 5 consecutive weeks.

3.7Data analysis

After completion of data collection, all data filled was checked for completeness. If somehow it was found incomplete it was considered as a non-response, to answer the research questions and meet the study's objectives, descriptive statistics had utilized in this study. The quantitative data in this research were described, analyzed, summarized, and interpreted using the Statistical Package for Social Science (SPSS) window version 21. The researcher used descriptive statistical approaches used to such as frequency count was done for socio demographic characteristics for 398 participants, means and standard deviation to analyze age and work experiences of 398 participants. A particular response for an individual questions and percentage was done.

Cross-tabulation were used to calculate the prevalence anxiety and depression with socio demographic characteristics and also prevalence of anxiety and depression with the coping mechanisms of the 398 participants in the study

Chi-square analysis was conducted to assess the association between anxiety and depression with socio-demography and working department and Logistic regression was conducted to identify the independent predictor of anxiety and depression and declared at p-value <0.05 cut off point and the strength of association was assessed using AOR(Adjusted odd ratio) with their corresponding at 95% confidence level

The qualitative data was gathered through audio-recorder and using some hand note. The original expressions of the participants were well organized without any change. The transcripts were sorted with codes and all the interview guide questions collected in Amharic language, were directly translated into English by the researcher. After reading the materials, the researcher wrote some sort of summaries from each transcript to identify the issue mentioned frequently by the participants. Then the transcribed data really helped the researcher to see an overall sense of labeling of key topics, phrase, feelings and activities as well. Finally the researchers created the general themes were identified through notifying similar and frequent statements across the code available. The interpretations of these themes were integrated into the interpretation of the result of the study

3.8 Ethical considerations

The study was conducted after acquiring the appropriate ethical approval. Ethical approval obtained from school of psychology ethical review committee and Amanuel mental

specialized hospital ethical review committee. Prior to administering questionnaire and doing of interviews, verbal informed consent had elicited from research participants to complete the questionnaire and record their voices. Necessary precaution was made to ensure confidentiality. Participants thoroughly had explained on their rights and the purpose of the research. Care was taken to ensure participants know their responses were kept anonymous and confidential. In my conduct all respondents in Amanuel mental specialized hospital staffs as individual had protected their dignity, rights and welfare as participants.

CHAPTER FOUR: RESULTS

The purpose of the study was to find out anxiety, depression and coping mechanism during the time of covid-19 among staffs of Amanuel mental specialized hospital. This chapter presents data collected through self-report questionnaires and in-depth interviews. The analysis was presented in line with the research questions raised in the study. Four hundred twenty three (423) staffs from AMSH were invited to participate in the study and 398 (94%) respond to complete the survey and HADS Scale and Brief coping scale were used for quantitative data, and in-depth interviews were included for qualitative study. The data was collected from August 02 to Sep 10,2021and it took 5 consecutive weeks. The in-depth interviews were employed with fourteen (14) staffs from different department, in average 10mints for individual were taken. More than half of the participants were females232 (58.3%) and administrative and supportive were 210(52.8%).

4.1 Result of the study

Socio-Demographic Characteristics of the participants

Among 398 participants 232(58.3%) were female and 166(41.7%) were male. Administrative and supportive staffs 210(52.8%) are more than the clinical staff 188(47.2%). The mean age of the participants was 33.5 (±8.54) years and the mean of work experiences of the participants was 6.25 (±5.57). With regard to their educational level 110(27.6%) of them were first degree holders. 305(76.6%) were living with their family and the supportive were 112,(28.1%)of the total participants and 341(85.7%) staffs were worked between one and ten years. These indicate the majority of the staff were female and worked as administrative and supportive, and they were living with family.

Table 1: Socio-Demographic Characteristics of the Participants (N=398)

Socio-demographic		Mean(±SD)	Frequency	Percent
Gender	Male		166	41.7
	Female		232	58.3
Working department	Clinical staffs		188	47.2
	Administrative and supportive staffs		210	52.8
Age in years		33.5 (8.54)		
	Orthodox Christian		259	70.1
Religion	Catholic		7	1.8
	Protestant		65	16.3
	Muslim		40	10.1
	Others		7	1.8
	Specialist		9	2.3
Educational level	Masters degree		44	11.1
	Bachelor Degree		110	27.6
	Diploma		105	26.4
	Certificate		83	20.9
	Below certificate		47	11.8
Work experience in years		6.27(5.57)		
	Married		174	43.7
Marital status	Single		189	47.5
	Divorce		14	3.5
	Separated		8	2
	Widowed		13	3.3
	Live alone		77	19.3
Living status	Live with family		305	76.6
	Live with Friends		13	3.3
	Others		3	0.8
	Nurses		85	21.4
	Mental health professional		30	7.5
Profession	specialists (MSc)		27	6.8
	Psychiatry officers (BSc)		27	6.8
	Pharmacy and laboratory		19	4.8
	Psychiatrists and General		96	24.1
	practioners		114	28.6
	Administrative staffs			
	Supportive staffs			

- **Administrative staffs** include human resource, finance, office worker**, secretary**
- **Supportive staffs** include staffs such as cleaner, runner, patient supporter, massagers, garden, and security

4. 1. 1The prevalence of Anxiety among the staff of AMSH

Table 2: Summary table of Anxiety measured by HADS

Level of Anxiety	Frequency	Percent
Normal	221	55.5
Anxiety	177	44.5
Total	398	100

As indicated in the above table the total prevalence of anxiety was 177(44.5%).

4.1.2 Cross tabulation of anxiety and socio demography

The level of anxiety is higher among females 122(52.5 %) than males 55 (33.1 %) in the mild to severe ranges, as shown in table below. The administrative and supportive staffs (106, 50.5 %) were more anxious than clinical staffs (71, 37.7 %). The level of anxiety among employees with a certificate (48, 57.8%) or a diploma (48, 57.8%) was higher than among those with a master's (14, 36.3%) or a bachelor's degree (40, 36.2 %). The unmarried status of the staff was observed to have a higher percentage anxiety level, as seen in the table above (87, 46 %). When compared to other living arrangements, employees who lived with their families had a higher level of anxiety (129, 42.3%). The supportive staffs such as cleaners, patient supporters, runner, security, and messengers were greater anxiety (58, 50%) from mild to severe range of anxiety level,

Table3: Cross-tabulation between Anxiety and socio-demography characteristics

Variables		Anxiety				Total
		No	Yes			
		Normal	Mild	Moderate	Severe	
Gender	Male	111(66.9%)	34(20.5%)	15(9.0%)	6(3.6%)	166(41.7%)
	Female	110(47.4%)	49(21.1%)	43(18.5%)	30(12.9 %)	232(58.3%)
	Total	221(55.5%)	83(20.9%)	58(14.6%)	36(9.0%)	398(100%)
Working department	Clinical	117(62.2%)	34(18.1%)	23(12.2%)	14(7.4%)	188(47.2%)
	Administrative (Supportive staff)	104(49.5%)	49(23.3%)	35(16.7%)	22(10.5 %)	210(52.8%)
	Total	221(55.5%)	83(20.9%)	58(14.6%)	36(9.0%)	398(100%)
Educational status	Specialist	5(55.6%)	4(44.4%)	0(0%)	0(0%)	9(2.3%)
	Masters	28(63.6%)	6(13.6%)	6(13.6%)	4(9.1%)	44(11.1%)
	Degree	70(63.6%)	20(18.2%)	8(7.3%)	12(10.7 %)	110(27.6%)
	Diploma	57(54.3%)	22(21.0%)	19(18.1%)	7(6.7%)	105(26.4%)
	Certificate	35(42.2%)	23(27.7%)	18(21.7%)	7(8.4%)	83(20.9%)
	Below	26(55.5%)	8(17.0%)	7(14.9%)	6(12.8%)	47(11.8%)
	Total	221(55.5%)	83(20.8%)	58(14.6%)	36(9.0%)	398(100%)
Marital status	Married	104(59.9%)	36(20.7%)	21(12.1%)	13(7.5%)	174(43.7%)
	Single	102(54.0%)	38(20.1%)	31(16.4%)	18(9.5%)	189(47.5%)
	Divorce	5(35.7%)	5(35.7%)	1(7.7%)	3(21.4%)	14(3.5%)
	Separated	3(37.5%)	1(12.5%)	4(50.0%)	0(0%)	8(2.0%)
	Widowed	7(53.8%)	3(23.1%)	1(7.7%)	2(15.4%)	13(3.3%)
	Total	221(55.5%)	83(20.9%)	58(14.6%)	36(9.0%)	398(100%)
Living status	Live Alone	39(50.6%)	24(31.2%)	11(14.3%)	3(3.9%)	77(19.3%)
	Live With family	176(57.7%)	57(18.7%)	43(14.1%)	29(9.5%)	305(76.6%)
	Live With friends	5(38.5%)	1(7.7%)	3(23.1%)	4(9.5%)	13(3.7%)
	Other	1(33.3%)	1(33.3%)	1(33.3%)	0(0%)	3(0.8%)
	Total	221(55.5%	83(20.9%)	58(14.6%)	36(9.0%)	398(100%)
Profession	Clinical/BSC nurse	46(54.1%)	18(21%)	14(16.5%)	7(8.0%)	85(21.4%)

	Psychiatry specialist(masters)	15(50.0%)	8(26.7%)	4(13.3%)	3(10.0%)	30(7.5%)
	Psychiatry officer (degree)	21(77.8%)	2(7.7%)	2(7.7%)	2(7.7%)	27(6.9%)
	Specialist and doctors	9(47.4%)	5(26.3%)	2(10.5%)	3(15.8%)	19(4.8%)
	Pharmacy and lap professional	18(66.7%)	7(22.6%)	1(3.2%)	1(3.2%)	27(6.8%)
	Administrative staff	54(56.3%)	17(18.1%)	17(18.1%)	8(8.5%)	96(24.1%)
	Supportive staffs	58(50.9%)	26(23.2%)	18(16.1%)	12(10.7 %)	114(28.6%)
	Total	221(55.5%)	83(20.9%)	58(14.6%)	36(9.0%)	398(100%)

Table 4: Summary of chi-square for anxiety as measured by HADS

Variable		Anxiety		Df	Calχ2.	p-value
		No	Yes			
Gender	Male	111(66.9%)	55(33.1%)			
	Female	110(47.4%)	122(52.5%)	3	21.89	.00
	Total	221(55.5%)	177(44.5%)			
Working department	Clinical	117(62.2%)	71(37.7%)	3	6.54	.02
	Administrative (supportive) staff	104(49.5%)	106(50.5%)			
	Total	221(55.5%)	177(44.5%)			
Educational status	Specialist	5(55.6%)	4(44.5%)	15	22.39	.04
	Masters	28(63.6%)	16(36.3%)			
	Degree	70(63.6%	40(36.2%)			
	Diploma	57(54.3%)	48(45.8%)			
	Certificate	35(42.2%)	48(57.8%)			
	Below	26(55.5%)	21(44.7%)			
	Total	221(55.5%)	102(44.5%)			

The above chi-square test was performed to assesses the relationship between anxiety with the socio demographic characteristics like gender, working department, age, educational status, working year, marital status, living status, and job responsibility, then there were significant relationship between anxiety with three variables such as gender, $\chi 2$ (3,398) =21.89, p=.00, working department $\chi 2$ (3,398) =6.54, p=.02, and educational status $\chi 2$ (15,398) =22.39, p=.04. Other demographic characteristics were not significant relationship with anxiety related with covid-19.

Table 5: Summary of Binary Regression factor associated with Anxiety during time of covid-19 pandemic among the staff of AMSH (N=398)

Variable	**Category**	**Crosstab with Anxiety**		**COR(95%CI)**	**AOR(95%CI)**	**P-Value**
		No	**Yes**			
Gender	Male	111	55	Ref(1.00)	Ref(1.00)	.001
	Female	110	122	2.24(1.98, 3.38)	2.28(1.48, 3.51)	
Educational status	Specialist/Msc /doctors	33	20	Ref(1.00)	Ref(1.00)	
	Degree	70	40	0.94(0.48, 1.86)	0.92(0.45, 1,86)	
	Diploma	57	48	1.39(0.71, 2.73)	1.21(0.56, 2.62)	
	Certificate /below	61	69	1.86(0.97, 3.59)	1,37(0.62, 3.03)	
Working department	Clinical	117	71	Ref(1.00)	Ref(1.00)	
	Admistrative /supportive staff	104	106	1.68(1.13, 2.51)	1.30(0.77, 2.22)	

The above regression table has shown that the relative OR(odd ratio) of the female having anxiety 2.3 times [AOR: 2.28, 95% CI: (1.48-3.51)].higher risk of developing anxiety as compared with male and also the relative odds of the staff who live without family 2 times[AOR:1.97, 95%CI: (1.19-3.26)] higher risk of developing anxiety as compared the staff who live with family therefore, therefore in socio demographic characteristic gender and living status have significant association with anxiety during the time of covid-19 pandemics.

4. 1. 3 The prevalence of Depression among the staff of AMSH

Table 6: Summary table of Depression measured by HADS

Level	Frequency	Percent
Normal	265	66.6
Depressions	133	33.4
Total	398	100

As indicated in the above table the magnitude of depression was 133(33.4%).

Table 7: Cross-tabulation between Depression and socio-demography characteristics

Variables		Depression				Total
		No	Yes			
		Normal	Mild	Moderate	Severe	
Gender	Male	125(75.3%)	32(19.3%)	8(4.8%)	1(0.6%)	166(41.7%)
	Female	140(60.3%)	60(25.9%)	24(10.3%)	8(3.4%)	232(58.3%)
	Total	265(66.6%)	92(23.1%)	32(5.8%)	9(2.3%)	398(100%)
Working department	Clinical	137(72.9%)	35(18.9%)	10(5.3%)	6(3.2%)	188(47.2%)
	Administrative (Supportive staff)	128(61.0%)	57(27.1%)	22(10.5%)	3(1.4%)	210(52.8%)
	Total	265(66.6%)	92(23.1%)	32(8.0%)	9(2.3%)	398(100%)
Educational status	Specialist	6(66.6%)	3(33.3%)	0(0%)	0(0%)	9(2.3%)
	Masters	33(75%)	9(20.5%)	1(2.3%)	1(2.3%)	44(11.1%)
	Degree	79(71.8%)	18(16.4%)	10(9.1%)	3(2.7%)	110(27.6%)
	Diploma	71(67.6%)	22(21.0%)	8(7.6%)	4(3.8%)	105(26.4%)
	Certificate	41(49.4%)	31(37.3%)	10(12.0%)	1(1.2%)	83(20.9%)
	Below	35(74.5%)	9(19.1%)	3(6.3%)	0(0%)	47(11.8%)
	Total	221(55.5%)	92(23.1%)	32(8.0%)	9(2.3%)	398(100%)
Marital status	Married	119(68.4%)	38(21.8%)	13(7.5%)	4(2.3%)	174(43.7%)
	Single	127(67.2%)	43(22.8%)	15(7.9%)	4(2.1%)	189(47.5%)

	Divorce	6(42.9%)	4(28.6%)	3(21.4%)	1(7.1%)	14(3.5%)
	Separated	5(62.5%)	2(25.0%)	1(12.5%)	0(0%)	8(2.0%)
	Widowed	8(61.5%)	5(38.5%)	0(0%)	0(0%)	13(3.3%)
	Total	265(91.7%)	92(23.1%)	32(8.0%)	9(2.3%)	398(100%)
Living status	Live Alone	48(62.3%)	23(29.2%)	6(7.8%)	0(0%)	77(19.3%)
	Live With family	211(69.2%)	65(21.3%)	21(6.9%)	8(2.6%)	305(76.6%)
	Live With friends	5(38.5%)	2(15.4%)	5(38.5%)	1(7.7%)	13(3.7%)
	Other	1(33.3%)	2(66.6%)	0(0%)	0(0%)	3(0.8%)
	Total	265(91.7%)	92(23.1%)	32(8.0%)	9(2.3%)	398(100%)
Profession	Clinical/BSC nurse	64(75.3%)	13(15.3%)	5(5.9%)	3(3.5%)	85(21.4%)
	Psychiatry specialist(masters)	16(53.3%)	11(36.7%)	3(10%)	0(0%)	30(7.5%)
	Psychiatry officer (degree)	20(74.1%)	5(18.5%)	1(3.7%)	1(3.7%)	27(6.9%)
	Psychiatry specialist and doctors	11(57.9%)	6(31.6%)	0(0%)	2(10.5%)	19(4.8%)
	Pharmacy and lap professional	22(81.4%)	1(3.2%)	4(12.9%)	0(0%)	27(6.7%)
	Administrative staff	56(58.3%)	26(27.7%)	12(12.8%)	2(20.1%)	96(24.1%)
	Supportive staffs	76(66.7%)	30(26.8%)	7(6.3%)	1(0.9%)	114(28.6%)
	Total	265(91.7%)	92(23.1%)	32(8.0%)	9(2.3%)	398(100%)

4.1.4 Cross tabulation of depression and socio demography

As shown in the above table, females 92(39.6%) have a higher rate of depression than males 41(24.7%), ranging from mild to severe. Administrative and supportive staff had a higher level of depression 82(39%) than clinical staff 51(27.4%). When compared to other educational statuses, the level of depression among the participants was estimated to be higher 42(50.5 %). Unmarried staff at Amanuel Hospital had a greater depression 43(22.8 %), but separated and widowed staff had no severe depression. According to the above table, the level of depression was greater in employees who live with their families9 4(30.8 %), ranging from mild to severe. In comparison to other professions, administrative staffs such as human power, fiancé, office worker, and secretary had greater depression levels (40, 60.6 %).

Table8: Summary table of chi-square for depression as measured by HADS

Variable		Depression		Df	Calχ2	P-value
		No	**Yes**			
Gender	Male	125(75.3%	41(24.7%)	3	12.206	.00
	Female	140(60.3%)	92(39.6%)			
	Total	265(66.6%)	133(33.4%			
Age group	20-30	140(72.5%)	53(27.4)	12	13.406	.05
	31-40	85(62.5%)	51(37.4%)			
	41-50	28(57.1%)	21(43%)			
	51-60	11(61.1%)	7(38.9%)			
	>61	1(50%)	1(50%)			
	Total	265(66.5%)	133(33.4%			

The above chi-square test was performed to assesses the relationship between depression with the socio demographic characteristics like gender, working department, age, educational status, working year, marital status, living status, and job responsibility, then there were significant relationship between depression with two variables such as gender, $\chi 2$ (3,398) =12.21, p=.00, age group $\chi 2$ (12,398)=13.37, p=.05.Other demographic characteristics were not significant relationship with depression related with covid-19.

Table 9: Summary of Binary Regression of factor associated with Depression during covid-19among staff of AMSH (N=398)

Variable	Category	Crosstab of depression		COR(95%CI)	AOR(95%CI)	P-Value
		No	Yes			
Gender	Male	125	41	Ref(1.00)	Ref(1.00)	.002
	Female	140	92	0.49(0.32, 0.78)	2.06(1.29-3.29)	
Age	20-29	123	44	0.46(0.27, 0.79)	0,49(0.27, 0,87)	
	30-39	92	50	0.69(0.41, 1.19)	0.83(0.47, 1.47)	
	>=40	50	39	Ref(1.00)	Ref(1.00)	

The above regression table 9 has shown that the relative OR(odds ratio) of the female 2 times [AOR: 2.06, 95%CI: (1.29-3.29)] higher risk of developing depression as compared with male and odd ratio living status 2times [AOR:2.21, 95%CI: (1.32,3.72)higher risk of developing depression as compared with living status with family, therefore; other the socio demographic characteristic such as age, educational status, marital status, working department and work experience have no significant association with the presence of depression during the time of covid-19 pandemics.

Table10: Frequency and Percentage among participants as measured by Brief Coping Scale

No	Coping mechanisms	0 Not used F %	1 Used to small amount F %	2 Used in a medium F %	3 Used a lot F %
1	I have been taking steps to improve the situation following the epidemic (such as staying a safe distance, washing my hands, using sanitizer and wearing mask).	53(13.3%)	33(8.3%)	46(11.6%)	**266(66.8%)**
2	When I'm suffering bad feeling from covid-19, Ive tried to find comfort in my religion or spiritual believes attend a regions site, pray to God, and read religious book.	59(14.8%)	89(22.4%)	63(15.8%)	**189(47%)**
3	I've been thinking hard about what steps to take during covid-19.	63(15.8%)	83(20.9%)	86(21.6%)	**166(41.7%)**
4	I've been thinking for something good in the pandemic is happening.	81(20.4%)	120(30.2%)	95(23.9%)	**102(25.6%)**
5	I.ve been turning to work or other activities to take my mind off things when I want to escape the bad of feeling covid-19	131(32.9%)	107(26.9%)	64(161%)	**96(24.1%)**
6	I've been trying to get a advice or help from other people about what to do during covid-19	128(32.2%)	88(22.1%)	87(21.9%)	**95(23.9%)**
7	I have been making fun of the situation when I feel not good due to pandemic	84(21.1%)	130(32.7%)	101(25.4%)	**83(20.9%)**
8	I've been getting emotional support from others when I became disturbed with pandemic I try to connect myself with psychologist.	147(36.9%)	108(27.1%	63(15. %)	**80(20.1%)**
9	I've been doing something to think about it is less such as going to movies, watching tv, reading, day	148(37.2%)	95(23.2%)	82(20.6%)	**73(18.3%)**
10	Due to covid-19, Ive started expressing my negative feeling.	87(21.9%)	154(38.7%)	96(24.1%)	**61(15.3%)**
11	I've been refusing whether or not covid-19 has occurred, for example avoiding news about pandemics.	203(51.0%)	83(20.9%)	74(18.6%)	**38(9.5%)**
12	When I've been having unpleasant feeling due to covid-19 I have been utilizing alcohol or other medication to make myself feel better.	341(78.9%)	32 (8.0%)	31(7.8%)	**21(5.8%)**
13	Covid-19 is not real I have been telling myself.	272(68.3%)	80 (20.1%)	31(7.8%)	**15(3.8%)**

As presented on the above table of coping mechanism, out of 398 participants ,266(66.8%) with (M=3.32, SD=1.09) first highest coping mechanism (66.8%) reported the staff taking steps to improve the situation following the epidemics such as staying a safe distance, washing hands and wearing mask and the second highest coping mechanism was189(47%) with(M=2.95,SD=1.14 reported that religious and spiritual activities are their most common coping mechanism next to preventive methods for Amanuel hospital staffs. And also Out of 398 participants, 41.7%were thinking hard about what steps to take during the pandemic ,25.6 % believe the pandemic will happen a good thing in the future , 24.1 % use transference, turning to work or other activities to take their mind off things, 23.9%try to get advice or help from other people and seek advice from others , 20.9%make fun of situation, 18.3 % of the participant uses self-distraction, such as going to the movies, watching TV, reading, day dreaming, sleeping or shopping when Disturb with pandemic, going to movies, watching TV, reading, day dreaming, sleeping or shopping when Disturb with pandemic, 15.3% express negative feelings, 9.5 % avoid news about the pandemic, ”5.8% they use maladaptive coping methods like substance as a coping mechanism , and However, the least used coping method among the participants was 3.8% deny “covid is not real ” in order to alleviate the negative effect during the time of pandemic.

Problem-focused and Emotion focused coping among the staff of AMSH

As the above table shown that 398 participants of the study had their own coping mechanism during the time of covid-19 pandemic and they used both problems focused and emotion focused. From problem focused coping such as 66.8% of the participants used preventive measure, 21.1% of they seek emotional support from psychologist, where as the staff who used emotion focused coping such as47.1 % thinking hard about what steps to take during the pandemic, 47% of the participants were used religious activities,20.9 % of the participants they try to make fun of the situation,15.3of the participants were expressing the negative feeling , 18.3% of the participants they are going to movies, watching TV, reading ,day dreaming, sleeping or shopping. Some of the participants in this study used maladaptive emotion-focused coping mechanisms, such as 5.8% of the participants in this study using substance to reduce bad feelings during pandemics and 3.8 % of the participants using denial as a coping mechanism to reduce bad feelings during pandemics.

4.2. Finding of the study

Table 11: Socio-demographic characteristic of participants for interviews at AMSH

Respondent	Profession	Marital status	Age	Sex	Working experience
R1	Forensic department	Married	37	Male	9 year
R2	Psychiatrist	Married	44	Male	13 year
R3	Doctor	Married	34	Male	7 year
R4	Psychiatry(Masters)	Married	47	Male	12year
R5	Psychiatry nurse	Married	40	Female	13year
R6	Cleaner	Married	45	Female	5year
R7	Rehabilitation centre	Single	26	Female	4year
R8	Messenger	Single	40	Female	6year
R9	Register ion room	Single	32	Male	2year
R10	Psychiatry(Masters)	Married	35	Female	8year
R11	Nurse	Married	28	Female	7year
R12	Driver	Married	27	Male	9year
R13	Patient supporter	Divorce	47	Female	8year
R14	Psychiatry masters	Divorce	34	Male	12year

This section focuses on in-depth interview analysis. The data was collected through an in-depth interview that were recorded on a voice recorder, transcribed, and translated into English. The information obtained was organized into themes, manually summarized, and narrated data. 14 employees from various departments were participated, including forensic, emergency, neuropsychiatry, messengers, rehabilitation, driver, cleaning, patient supporter, outpatient, and impatient wards. Everyone was willing to work together.

1. Other Psychological problems during the time of covid-19 pandemic

The majority of participants stated that psychological issues associated to covid-19 had a psychological impact on people's lives, such as anxiety, loneliness, adjustment problems, wornness, depression, discomfort, and sadness, limited in social life, lack of freedom, developing scared surroundings, and discrimination.

Psychological problem

One of the participants replied that:-

> *Covid-19 affected our everyday living style, For example, we should wear a mask to every activity; this limits our freedom and restricts us from relaxing or socializing with a group of friends. In my workplace, we decrease the quantity of time we spent with our patients and decreased the number of patients we admitted, so Covid-19 has had psychological consequences, making it feel like we were infected with the virus. As a result, various psychological problems came with wornness of being infected any time such as anxiety and depression arise. We noticed those psychological issues in our staff.*

Another two participants were also replied that "covid-19 creates a scared environment."

One of the female participants replied ,ኮቪድ ሁሉም የህይወቴ እንቅስቃሴ ላይ የጥንቃቄ ኑሮ እንድኖር አርጎኛል" which affected my life because my job responsibilities always expose me to many transmissible diseases, and covid-19 has created psychological influence such as feeling being infected at any time.

Social problems

Two participants replied the following for the influence of covid-19:-

> Covid-19 has had a personal influence on one of the nurse participants, who stated that my living home has been transformed by force with the owner and that our lives have changed from social to aloneness. And one of the patient supporters suggested that we avoid doing basic things like kissing and hugging freely with my family, friends, and colleagues as we did before Covid-19.

One of the participants from one department stated, "Covid-19 disrupted our social life, but it was beneficial to me because it provided me time to focus on self-care and myself.

In addition of four of the participants reported "after Covid-19 entered our lives, our social lives were interrupted, and one of the above employees claimed that I couldn't freely go to the grave site because people in my environment knew where I work".

One of the participants also replied that:-

> *"I don't feel good when I think about covid-19 after I lost my brother and suffered from the illness for a month, plus I observed most people stay at home due to a positive covid-19 result." Covid-19 caused several changes in our lives, including a reduction in "**እድርናንርብትና**" was affected. I never discriminated against other persons who were exposed like me after I was sick with a virus and recover my health state. As I previously stated, discrimination is one of the influences, and in association with discrimination, additional psychological influences such as anxiety, loneliness, and adjustment problems will occur.*

Economic problems

Moreover Covid-19 has had an impact on our economy, according to one of the participant department employee and the registration room staff, who both said" the pandemic has had an impact on our economy". One of the female ward employee said that" during the first few months of the pandemic, we paid double when we took a taxi to work, and that cost had an impact on us".

3. Coping mechanism of covid-19 among the staff of AMSH

All of the participants uses their coping mechanism to reduce the bad feeling related with covid-19.from 14 respondents half of them said that they follow prevention methods recommended by WHO and by health professional .They list the activity after covid-19 came to them like using sanitizer, wearing mask, hand washing, keeping distance, exercise, enjoy them self's in medium, talking with their friends, reading books, watching TV, staying at home when we have no job.

Preventive and Religious coping methods

One of the participants said**"ከመደንገጥ መጠንቀቅ መርጫለሁ "** .*Moreover, another participants replied that the only thing I do is I went to church and praying to God , "***እሱ ያመጣውን እሱ ይመልሰዋል***'' and I pray to God* ***አባቱ ከነ ልጆቹ ጠብቀኝ*** *.*

According to Two participants from psychiatry department and emergency department, both preventive action and prying are their coping mechanisms.

Meditation and Avoidance coping methods

Some of the participant's staff members claimed that "he used meditation, avoided some negative news such as daily reports of cases in Ethiopia and around the world, followed a healthy diet, and exercised regularly".

Due to the virus, the majority of the participants in the interview were reported that even though we know the rule of covid-19 prevention methods, some conditions make us to risk our life due to the support need of patients some condition are unavoidable when patients come with our service, there is a need to give those service this consider the challenge of the staff members in relation to covid-19 preventive modes style especially keeping distance during supporting the patients and fulfilling those other WHO health professionals recommendation.

CHAPTER FIVE: DISCUSSION

This study was conducted to assess anxiety, depression, coping mechanisms and its significant relationship with socio-demographic characteristics and working department during the time of covid-19 among the staff of Amanuel hospital. In order to achieve the objective of the study 398 participants was selected by stratifying method. Standard instrument were used to assess anxiety, depression and coping mechanisms. In this part of the study the finding indicated the result section well be discussed with the available literatures and presented as follow.

5.1. Prevalence of Psychological problems on the hospital workers during covid-19 time

The current study result was shown that the prevalence of depression and anxiety among 398 AMSH employees. The majority of the participants in the study had depression and anxiety. According to the HADS analysis, the total prevalence of anxiety was 44.5% and depression 33.4% at the end of the second wave.

The prevalence of the current study is higher than several earlier study reports from Iran the prevalence of anxiety 24.9% and depression 24.83% among the health care worker, in health professional in Ethiopia was 26.8% of anxiety, France 38.6% including anxiety and depression, and India 25.3% including anxiety and depression, The study conducted in an Addis Ababa community, the extent of the psychological disturbance ranged from mild to severe was 66.4% and In China, medical health workers had a higher prevalence of anxiety (13.0% vs. 8.5%), depression (12.2% vs.9.5%) as compared with non-medical health workers with medical health worker ,respectively(Zhang et al, 2020; Bonati, 2021; Wang, 2020;Dagen, 2021; Fari ,2021; Kassaw,2020).And lower than the study reports from health worker in Ethiopia anxiety was 78%and 60.3% was depression, the prevalence of depression done in china 46.5%, in Italia the magnitude of depression was 47.1%(Lai et al., 2021; sahebi et al., 2021; Lai et al., 2020).

Many things could be said about the possible explanation for differences between the current study and the results from other studies. However, the researcher generally expected that the difference occurred due to the socio-cultural factors, the time of the research done, the instrument they used, the number case of COVID-19, the staff coping strategy(Kassaw, 2020).

Anxiety and depression are two of the most common mental health concerns in our society. People who suffer from anxiety or depression might experience a wide range of feelings. They are typically defined as a mix of emotional and functional difficulties. Some people only have moderate anxiety and depression symptoms, while others experience life-threatening anxiety attacks or severe depression. Symptoms may also shift over time, from difficult periods to periods of relief (ADAA, 2020).

Globally, due to, higher level of exposure hospital staffs are more prone to experience a wide range of psychological problems such like Anxiety, Depression following an emergency or disaster. These Previous research, including the 2003 severe acute respiratory syndrome (SARS) epidemic, have found considerable emotional stress among hospital staff during or after infectious illness outbreaks (Tam, Pang & Lam , 2003). In addition to this, due to the severity of the COVID-19 outbreak and the stress on hospital staffs, particularly those on the front lines, are currently experiencing high levels of mortality, unknown quarantine duration, insufficient medical supplies, fear of infection, stigma, discrimination and other factors have a psychological problems such like anxiety and depression during an outbreak (Cabarkapa, 2020).

The corona virus pandemic is causing widespread anxiety, fear, and concern among the general public, as well as specific groups such, caregivers, and increased rates of stress or concern have been the most significant psychological impact on public mental health to far (WHO, 2021).In the finding and the result part of the present study have anxious, fear were common psychological problems due to the pandemic.

The psychological well-being of individuals has a substantial influence on their performance. COVID-19 has been found in a number of countries to have a negative impact on mental health in a variety of groups, including health professionals. The mental health impact of a pandemic is typically disregarded during pandemic management, despite the fact that the consequences of a disease outbreak are costly (Pedrosa, 2020).

According to a new WHO survey, the COVID-19 pandemic has delayed or suspended vital mental health services in 93% of nations globally, despite rising demand for mental health care. The survey of 130 nations provides the first global evidence of COVID-19's devastating impact on mental health care access, highlighting the urgent need for more funding (Who, 2021).

The study was released ahead of whose Big *Event for Mental Health on 10 October*, which will bring together world leaders, celebrities, and advocates to demand for higher mental health spending in the aftermath of COVID-19.Prior to the pandemic, countries were spending less than 2% of their national health budgets on mental health, and were struggling to satisfy their people' requirement (WHO, 2021).

And the pandemic is increasing demand for mental health services. Bereavement, isolation, loss of income, and fear can all trigger or exacerbate mental health problems. Many people may be experiencing an increase in alcohol and drug use, as well as insomnia and worry. COVID-19, on the other hand, can cause neurological and mental problems like delirium, agitation, and stroke People with pre-existing mental, neurological or substance use disorders are also more vulnerable to SARS-CoV-2 infection they may stand a higher risk of severe outcomes and even death. (WHO, 2021).

"Good mental health is extremely important to overall health and well-being," said World Health Organization Director-General Dr. Tedros Adhanom Ghebreyesus. "At a critical time, COVID-19 has affected mental health - related services around the world. During the epidemic and beyond, world leaders must act quickly and decisively to increase investment in life-saving mental health programs."(World Health Organization, 2021).

5.2. Relationship between Socio demographic characteristics and Prevalence of anxiety and depression during the time of covid-19 pandemics

Is there a significant relationship between socio demographic characteristics and anxiety, depression during the time of covid-19 .The assessment of socio-demographic characteristics of the participants of Amanuel hospital where age, educational level, work experience, marital status, living status and profession and working department where as Admistrative staff, supportive staff and clinical staff.

The chi-square analysis was conducted to determine the associated factors of anxiety and depression. The findings show that there were significant association for anxiety with gender, working department, and educational status. However, there were no significant association for anxiety with marital status, age, living status, and working year. Again for depression, it has shown that there were significant association with gender and age. However there were no significant association with working department, educational status, working years, marital status, living status, and job responsibility.

According to logistic regression gender have statistically associated with anxiety during the time of pandemic .However, other demographic characteristics such as working department, educational status, work experience, marital status, living status and their profession have no significant relationship with anxiety. In depression also gender have significant association and other demographic characteristics age, working department, educational level, work experience, marital status, living status and profession have no statistically significant.

According to the current AMSH employee survey, the participants average age between 25 and 41 years old. Employees who were not married made up nearly half of the participants. In terms of education level, 110 (27.6%) of them were first-degree holders. Anxiety was higher in females (122, 52.5 %) than in males (55, 33.1%). Anxiety was also higher among participants with certificates (48, 57.8%) and diplomas (48, 57.8%) as compared to those with masters (14, 36.3 %) and degrees (14, 36.3 %). The majority of the participants, 305 (76.6%), were living with their families.

The research done in India, health care workers with an unmarried status and a young age group of 20 to 30 had higher anxiety symptoms (Gupta. S et al, 2020). Likewise the empirical data has done in turkey shown that, anxiety level is high among the age group of 20-29 and also the female Gender (Damla, AylinAkça, Enes et.al.,2021) . The present study also indicated that employees who were single had a higher level of anxiety than those who were married. The report also noted that those aged 20-30 had a higher anxiety level of than those in other age groups (79, 40.9%). Regression analysis of the present study revealed that there were an association between anxieties with gender and living status indicating that gender and living status have statistically associated with anxiety. In contrast with Alabama result was seen younger age and being unmarried statistical difference in the presence of anxiety (Ali et al., 2020).

The result shown that the staffs that have anxiety were higher among participants with certificates (48, 57.8%) and diplomas (48, 57.8%) as compared to those with masters (14, 36.3 %) and degrees (14, 36.3 %). Unpublished Study done in AMSH in 2020 reported that staffs that have educational level in primary school have significant association with anxiety. The present study's logistic regression analysis also revealed that anxiety and educational status have no a significant association.

The present study was reported the prevalence anxiety was higher in administrative and supportive staffs than clinical staff.Research done in Singapore was shown non medical staffs health care workers had higher prevalence of anxiety even after adjustment for the possible confounders (Benjamin et al., 2020).Also unpublished research done in AMSH previous year shown same result with the Singapore research and also higher psychological distress on non-medical staffs. However, there was a contrast with the finding with the research done in china on medical/non-medical staffs. Staff members who are helpful, such as cleaners, patient advocates, security guards, and messengers, account for half of the respondents, with an anxiety score of 56(50%). According to logistic regression analysis of the present study results was indicated that there were no significant association between anxieties with working department.

The magnitude of staff depression was (43, 22.8%) higher in unmarried staff in Amanuel hospital as compared with married, separated and widowed. The level of depression among educational status certificate level staffs reported was higher (42, 50.5%) as compared other educational status. And also the of depression was higher in female (92, 39.6%) than male (41, 24.7%). logistic regression analysis of the present study was indicated that there is no significant association of depression with marital status and educational status.

While younger age and the working place of the primary care hospital is a risk factor for depressive symptoms (Gupta et al, 2020). Similar finding were reported in Alabamian, younger, less experienced nurse reported more psychological problem as compared to older, senior professionals and the present study was reported that employee with less than five years experience were more exposed to psychological problem during the time of covid-19. However, logistic regression analysis of the current study was shown that depressions have no significant association with the work experience (Ali et al., 2020).

Admistrative staffs such as human power, fiancé, office worker, and secretary were higher anxiety level (40, 60.6%) as compare with other profession. The logistic regression analysis was indicated there were no association between depression and profession

According to a study conducted in Pakistan, health-care workers are concerned about their safety and the risk of infecting themselves and their families (Noreen, 2020) and the qualitative study done in china caregivers was reported they expressed the worry of about impact of the pandemic on the health of the family(Sun et al .,2020).

However the cross tabulation current statistics, anxiety is more common among employees who live with their families however, chi-square and the logistic regression analysis have shown living status have no significant association with anxiety but it contrast with the previous research because of the present study shown that living alone have no risk to develop anxiety during the time of covid-19. However, according to previous research, hospital workers were quite concerned during the initial period since they had become the cause of their family's mortality but the current results demonstrate the reverse. The researcher implication on this issue is anxiety more for the staff that reason may be due to the staff have emotional support from family, relative and friends .The second reason also it may be the duration of the research done.

Another finding was that staff with 16 or more years of work experience reported lower levels of anxiety and depression than staff with less than 5 years of work experience. The following factors may explain why employees with more years of work experience reported fewer depression symptoms: 1) practical expertise negotiating challenging situations; 2) prior epidemic management experience; 3) the development of adaptive coping skills over time; 4) strong social supports; and 5) job security. These results are in similar to the study by Zhu and colleagues who found that increasing years of work experience was less severe depressive symptoms and anxiety among healthcare center workers during the COVID-19 pandemic(Zhu Z, Xu S, Wang H et al.,2020).

Therefore logistic regression was conducted to determine the significant associated factors of anxiety and depression levels. The findings show that there were significant association for anxiety with gender However, there were no significant association for anxiety with marital status, age, working department, educational status, living status and work experience. Again for depression, it has shown that there were statistically significant association with gender.

However there were no significant association with age, working department, educational status, work experience, marital status, living status and job responsibility. Because the significant values were less than or equal to 0.05, there was significant association between anxiety and depression with demographic characteristics, but there was no significant association between anxiety and depression with demographic characteristics when the opposite was true.

Those suffering from emotional, behavioral, and psychiatric diseases are, in fact, more prevalent than those suffering from COVID-19 during this ongoing health crisis. As a matter of fact, the fear of contracting COVID-19 seems not to be as high as concerns about the psychological and social impact of the pandemic, as reported in a United Kingdom survey (Mental health Covid-19, 2020).

5.3. In-depth interview of the hospital worker during the pandemic

And in the present study the finding of the study has shown majority of participants psychological issues associated during the time of covid-19in addition of anxiety and depression such as adjustment problems, loneliness, wornness, depression, discomfort, and sadness, limited in social life, lack of freedom, developing scared surroundings, and discrimination and also most of the respondents report when they think of the pandemic, they feel of discomfort, አስፈሪ ፤ አስጨናቂ ፤ መረበሽ ፤ መደንገጥ ፤ ዝግንን ማለት፡ , during the first wave of the pandemic, the above feelings were intense, but as the case number decreased, the staff felt relieved, and now that the third wave is underway, the above feelings are gradually returning.

Globally, the year 2020 will be an extraordinary year of transition, and many people's careers, social lives, and well-being will be negatively impacted (Stone, 2020) and according to World Bank updated report, like the rest of the world; Ethiopia has been experiencing the unprecedented social and economic impact of the COVID-19 pandemic. The present study was also shown that rather than psychological influence some participants were report covid-19 have economic and social influence on their life after the pandemics came their life.

5.4. Coping Mechanism of participants

According to the findings, preventive methods were the most frequently used coping mechanism for participants, providing for 266 (66.8%), and religious or spiritual activities were the second most frequently used coping mechanism 189(47%).The staffs tried to find

comfort in their own religion or spiritual believes attend a religions site, pray to God, and read religious book. The Ethiopian people's religious natures, as well as their deeply ingrained social and cultural effects over the respondents, For the Ethiopian community, culture and religion are vital parts of the social and moral fabric of the people, and our staff is also a part of that community. As a result, the majority of individuals prefer to participate in religious activities. In addition to taking precautions to avoid crowds and public gatherings, the majority of Addis Ababa people continued to attend religious activities depending on their beliefs, they may attend religious events. They participate in social conditions with preventive approaches as hospital employees, and they have been thinking hard about what steps to do during covid-19.

The finding part of the this study was also same as coping mechanism as previously listed in result part, mean majority of the participants were reported the they took preventive action like wearing mask, washing hands every touching their patients and materials, they try to keep distance as much as possible and the second action they took is they participate in religious activities like attending in prying time, reading the religious books, spending some time in Amanuel church. Some participant in this study were reported the presence of the Amanuel church beside the hospital it gives relief for most staffs their religion is orthodox. Another finding report shown in china caregivers of covid-19 patients , Caregivers used existing knowledge and new knowledge of psychological decompression communicated by colleagues or the internet to adjust themselves and actively or passively used psychological techniques, such as writing diaries and letters, breathing relaxation, mindfulness, music meditation, and emotional expression and venting as coping mechanisms (Sun.N.et.al,2020). According to the research done in china humor is the most coping mechanism rather than avoidance (Canestrari et al., 2020), also the research done in turkey they used short-term coping strategies and needed psychosocial support and resource management, which support this idea, as we discovered that seeking social support was the most common coping method used by health workers (Kackin O et al., 2020)

A cross-sectional study of mental health status and self-psychological adjustment among Chinese nurses who work with Covid-19 the findings reveal that frontline nurses working in isolation wards have mental health issues during the COVID-19 outbreak they use professional psychological service the guidance of national policy (Chen and Sun et al., 2020).

The current findings show that different coping methods are used by AMSH staff. Out of 398 participant, 41.7% thinking hard about what steps to take during the pandemic ,25.6 % believe the pandemic will happen a good thing in the future , 24.1 % were used transference, turning to work or other activities to take their mind off things, 23.9% try to get advice or help from other people and seek advice from others , 20.9% make fun of situation, 18.3 % of the participant uses self-distraction, such as going to the movies, watching TV, reading, day dreaming, sleeping or shopping when Disturb with pandemic, ,15.3% express negative feelings, 9.5 % avoid news about the pandemic, ”5.8% they use maladaptive coping methods like substance as a coping mechanism , and however, the least used coping method among the participants were3.8% deny “covid is not real to reduce the bad feeling due to the pandemic.

During the time of covid-19 pandemic the staff were used both problems focused coping and emotion focused coping. From problem focused were such as 66.8% of the participants used preventive measure, 21.1% of they seek emotional support from psychologist, whereas the staff who used emotion focused coping were such as 47.1 % thinking hard about what steps to take during the pandemic, 47% of the participants were used religious activities, 20.9 % of the participants they try to make fun of the situation,18.3% of the participants they are going to movies, watching TV, reading ,day dreaming, sleeping or shopping. Some of the participants in this study used maladaptive emotion focused coping mechanisms, such as 5.8% of the participants in this study used substance to reduce bad feelings during pandemics, and 3.8 % used denial as a coping method to reduce the negative ongoing outcome of the pandemic, so the staffs used both problem focused and emotion focused coping methods to reduce their negative feeling during the pandemic.

In the present study majority of the participants in the interview were follow preventive methods like wearing mask, keeping distance, washing hands and they also took another action they relief bad feeling of the pandemic by participating religious activity. However, other researches done in different countries coping methods are different for example, research done in Alabama show that health workers in Alabama, half of the participants believe that relying on an avoidance strategy, two-third of the participants they use protective methods, 41.2% participants uses prying, edition and reading and also 73% of the participants use talking with their friends about bad feeling of the pandemic(Ali H.et.al, 2020) so the present research have some similarity the ways of coping mechanism but differs in the

magnitude(Stone, 2020). Continental and local coping mechanisms are the same, but they differ in terms of a country's economic capacity.

Therefore the researcher generally assumed that the differences occurred due to the variation in the study area, working area of the staffs, duration of the research done, their selection of coping mechanism and the instruments that were used in the researcher are different. Especially the researcher assumed the staffs were used both problem focused and emotion focused strategies would promote better mental health outcomes and well-being.

CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1. Summary

The research questions, as well as the study's results and findings, are taken into consideration when assessing the primary points of the summary, conclusions, and recommendations.

The main purpose of the study was to assess anxiety, depression and coping mechanism and explore other psychological problems experienced among the staff of Amanuel Specialized Hospital. In order to achieve the purpose of the study in the staff of Amanuel hospital were selected as a population of the study. From the total population 398 samples of the staff were selected by using stratifying and systematic sampling methods. The data was collected from the samples by using structured questionnaire and standardized scale. The structured questionnaire was used to gather socio-demographic information and in-depth interviews. Regarding the standardized scale HADS and Brief coping were used to assess anxiety, depression and coping mechanisms. The goal of this study was to find out the answers to the following questions.

- What are the prevalence of anxiety and depression during Covid-19 pandemic among staff members of AMSH
- Is there statistically significant association between socio demographic characteristics and working department with anxiety and depression among staff members AMSH during the time of covid-19
- What types of coping mechanisms used to reduce psychological problems during Covid-19 among the staff of AMSH?
- What are other psychological problems during the Covid-19 time among staff of AMSH?

The collected data from the samples was organized and analyzed by using SPSS version 21. The researcher used descriptive statistical approaches used to such as frequency count was done for socio demographic characteristics for 398 participants, means and standard deviation to analyze age and work experiences of 398 participants. A particular response for an individual questions and percentage was done. Logistic regression was conducted to

investigate socio-demographic characteristics and working department which show a significant relationship to report of anxiety and depression during covid-19.

The qualitative data was gathered through audio-recorder and using some hand note. The original expressions of the participants were well organized without any change. The transcripts were sorted with codes and all the interview guide questions collected in Amharic language, were directly translated into English by the researcher. After reading the materials, the researcher wrote some sort of summaries from each transcript to identify the issue mentioned frequently by the participants. Then the transcribed data really helped the researcher to see an overall sense of labeling of key topics, phrase, feelings and activities as well. Finally the researchers created the general themes were identified through notifying similar and frequent statements across the code available. The interpretations of these themes were integrated into the interpretation of other psychological problems in addition of anxiety and depression

Key findings of this study are:

- During the end of second wave covid-19 anxiety levels among AMSH employees, and with the total of anxiety level was 44.5% and depression 33.4%
- A chi-square analysis revealed that anxiety is associated with gender, working department, and educational status, while depression is associated with gender and age. However, the logistic regression analysis, on the other hand, was used to identify the independent predictor of anxiety and depression. The analyses were shown that there was significant statistical association for anxiety with gender. However, there were no significant association with marital status, age, working department, and educational status, living status and working year. Again for depression, it has shown that there were significant associations with gender and living status. However there were no significant association with age, working department, educational status, working years, marital status, and their profession.
- The most common coping mechanism utilized by participants was preventive techniques, which accounted for 266 (66.8%), followed by religious or spiritual activities, which accounted for 189 (47%). Denial coping mechanism was the staffs' least effective coping method (3.8 %).
- In addition to anxiety and depression, other psychological issues were listed, including adjustment issues, the worry of getting infected at any time, loneliness, discomfort, unhappiness, social limitations, a loss of freedom, developing a fearful environment, and discrimination.

6.2. Conclusion

The present study indicated that the hospital staffs are affected high level of anxiety and depression during the COVID- 19 pandemic. The COVID-19 pandemic has disrupted mental health of both administrative and supportive staffs and also the clinical staff have exposed the pandemic ,but even more anxiety and depression were seen in the administrative and supportive staff than the clinical staffs and also other psychological problems was listed in addition anxiety and depression like ,adjustment problems, wornness of being infected anytime, loneliness, depression , discomfort, sadness, limited in social life, lack of freedom, scared surroundings, and discrimination. Regarding the coping methods, most staffs were preferred preventive methods and religious activities to cope with anxiety and depression due to covid-19. Depending upon the results it can be conclude, the pandemic effect on the

hospital staffs due to covid-19 related with anxiety and depressions, highly affected however the staffs uses both problem focused and emotion focused coping. The staffs were most commonly uses preventive coping and religious preventive mechanisms. In addition the power of religion, the presence of the Amanuel church next to the hospital may have an influence in some way, and as the demographics table shows, the majority of the staff is orthodox; consequently, they spend some time at the Amanuel church during lunch and break time. The staffs were taken the action of both problem-focused and emotion focused coping mechanism. Because everyone is at risk of being exposed to covid-19, both directly and indirectly, these strategies might be extended to target the entire hospital staff, resulting in psychological problems for everyone.

6.3. Recommendations

The investigator was proposed the following based on the study's findings:

- It is critical to keep their staffs up to update with training about the psychological problems related with the pandemic especially they should focus anxiety and depression, particularly among administrative and supportive staffs, as well as difficulties associated to Covid-19 so the hospital administrator should focus on result of the study, and they should seek psychological support
- During the time of Covid-19, AMSH hospital management worked more closely with the psychology department to help the staff by giving counseling, individual and group therapy to hospital employees.
- Increasing the number of psychologists on staff at the hospital is important. As the pandemic continues, continuous psychological assistance for hospital workers will be particularly essential. Administrative and support staff, such as cleaners, runners, patient supporters, security, and messengers, should be given special attention. Furthermore, identifying the employees who are more important and providing those with extra attention may assist to lessen their risk of developing psychological problems as a result during the time of covid-19. Assisting hospital community workers in coping with their anxiety, fear, and sadness. Maintaining positive interpersonal relationships, and having access to appropriate practical assistance are all essential.
- AMSH hospital management body prepares enjoyment and recreation time for the whole hospital staffs on a regular basis.

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APPENDIX-1

ADDIS ABABA UNIVERSITY

COLLEGE OF EDUCATIONAL AND BEHAVIARAL STUDIES

SCHOOL OF PSYCHOLOGY

Dear Participants, My name is: Hayat Mekarim; I am a student at Addis Ababa University, undertaking a Master's degree in counseling psychology. One of the requirements for the master degree is to conduct a research project. This letter serves to ask consent from you to take part in this research. The objective of this questionnaire is to gather information about anxiety, depression and coping mechanisms during the time of covid-19 pandemic among Amanuel Mental Specialized hospital staffs. Your participation in this research is voluntary. If you decide not to participate there will be no negative consequences for you. If you decide to participate there will be no benefits for you. However your participation on this study is very important for to know about anxiety, depression and coping mechanisms during the time covid-19 pandemic and the finding will help to develop appropriate intervention. There is no any risk will occur to you because of your participation in this study. "The reliability of the study highly depends on your accurate response for question given here for you. You are kindly requested to give the reliable information. All of your responses and the results obtained will be kept confidential using a coding method that ensures no one else has access to them.

Name of investigator: Hayat mekarim
Name of advisor: Dr: Tigist (PhD)

Are you voluntary to participate …….? Yes ☐ No ☐

Questionnaires

Part one; Socio-demographic data

Item No	Items	
1	Gender	1 Male 2 Female
2	Working department	1 Clinical staffs 2 Administrative or supportive staffs
3	Age	_____ year
4	Religion	1 Orthodox 2 Catholic 3 Protestant 4 Muslim 5 Other_____
5	Educational level	1. Specialist 2. Masters degree 3. Degree 4. Diploma 5. certificate 6. below certificate_____
6	Work experience	_____Years
7	Marital status	1. Married 2. Single 3. Divorce 4. Separated 5. Widowed 6. Others (Specify)_____
8	Living status	1) live alone 2) live with family 3) live with friend 4)Other ……
9	Profession	1 nurse deplma/ BSC nurse 2 Psychiatry specialist (masters) 3 Psychiatry officers l(degree) 4 Psychiatry specialist and GP 5 pharmacy and laboratory proff 6 Administrative staffs(HR, finance, office, secretary…….etc 7supportive staff(runner, cleaner, security, Messengers, patient supporter…etc)

Part two: HADS (Hospital anxiety and depression scale to measure the psychological impact).

Instructions: Read the following questions and circle the answer. There is no correct or incorrect response. Simply give the answer based on what you feel in the previous 2 weeks. Answer each of the following questions by drawing a circle under each one. Please try to answer to each item separately from the others in your head. There are no "correct" or "wrong" answers, so choose the most accurate answer for you not what you believe "most people" would say or do.

0 Not all time

1 Sometime

2 Lot of time

3 Most of the time

Item no	Items	Not all time	Some time	Lot of time	Most of the time
1	**Due to covid-19 I feel tenses or 'wound up' (A)**	**0**	**1**	**2**	**3**
2	**I still enjoy the things I used to enjoy after the pandemic (D)**	**0**	**1**	**2**	**3**
3	**I get a sort of frightened feeling like 'butterflies' in the stomach when I bad feeling about covid-19(A)**	**0**	**1**	**2**	**3**
4	**I feel as if I am slowed down after (D)**	**0**	**1**	**2**	**3**
5	**I get a sort of frightened feeling as if covid-19 awful is about to happen:(A)**	**0**	**1**	**2**	**3**
6	**I have lost interest in my appearance in covid-19 time (dressing, eating) (D)**	**0**	**1**	**2**	**3**
7	**I can laugh and see the funny side of things after the pandemic: (D)**	**0**	**1**	**2**	**3**
8	**feel restless as I have to be on the move when I have bad feeling of covid-19: (A)**	**0**	**1**	**2**	**3**
9	**Worrying thoughts go through my mind when I thought covid-19: (A)**	**0**	**1**	**2**	**3**
10	**During covid-19 time I look forward with enjoyment to things : (D)**	**0**	**1**	**2**	**3**
11	**I feel cheerful After the pandemic (D)**	**0**	**1**	**2**	**3**
12	**I get sudden feelings of panic when I have bad feeling of covid-19: (A)**	**0**	**1**	**2**	**3**
13	**I can sit at ease and feel relaxed after covid-19:** (A)	**0**	**1**	**2**	**3**
14	**I can enjoy a good book, walk or radio or TV program when I feel bad about the pandemic (D)**	**0**	**1**	**2**	**3**

Part three: Brief coping scale

Scale of Brief Cope

These items are about how you've dealt with stress in your life. There are numerous approaches to dealing with issues. These questions inquire about what you've been doing to deal with these issues. Each item provides information on a specific coping strategy.

Make use of these response options. Try to rate each item individually from the others in your mind.

Make your answers as true for you as you can.

1= I haven't been doing this at all

2= I have been doing this a little bit

3= I have been doing this a medium amount

4= I have been doing this

Please give your answers by putting (x) in the box in front of your choice

Coping Item	1	2	3	4
1 I've been turning to work or other activities to take my mind off things when I want to escape the bad of feeling covid-19				
2 "Covid-19 isn't real," I've been telling myself.				
3 When I've been having unpleasant feelings due to covid-19, I've been utilizing alcohol or other medications to make myself feel better.				
4 I've been getting emotional support from others when I became disturbed with the pandemic I try to connect myself with psychologist				
5 I have been taking steps to improve the situation following the epidemic (such as staying a safe distance, washing my hands, and wearing a mask).				
6 I've been refusing whether or not Covid-19 has occurred. for example, avoiding news about the pandemic				
7 I've been looking for something good in the pandemic is happening				
8 I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping when I disturbed with the pandemic				
9 Due to covid-19, I've started expressing my negative feelings.				
10 When I'm suffering bad feeling from covid-19, I've tried to find comfort in my religion or spiritual beliefs. Attend a religious site, pray to God, and read a religious book				
11 I've been trying to get advice or help from other people about what to do during the pandemic.				
12 I've been thinking hard about what steps to take during covid-19.				
13 I've been making fun of the situation when I feel not good due to pandemic				

14 List others methods of coping mechanisms you have used

_____

_____

_____

APPENDIX-2

አዲስ አበባ ዩኒቨርሲቲ

የሥነ-ትምህርት እና ሥነባህሪኮሌጅ

የሳይኮሎጂ ት/ት ክፍል

ይህ የመመረቂያ ጽሁፍ ወይም ምርምር አላማው ኮቪድ19 ምክንያት በሰራተኛው ላይ ምን አይነት ስነለቦናዊ ተጽኖ እንዳደርስባቸው ለማወቅና ምን አንነት የመፍትሄ ዘዴን እደተጠቀሙ ለማወቅ ያስችላል፡፡

በቅድሚያእናመሰግናለን፡፡

<u>ክፍል አንድ</u>:-ግላዊ የሆኑ መረጃዎች ፡ መልሱን በማክበብ ይጀምሩ

ተራቁጥር	ጥያቆዎች	የመልስ አማራጮች
1	ጸታ	1 ወንድ 2 ሴት
2	አሁን የሚሰሩበት ክፍል	1 ክሊኒካል ስታፍ 2 የአስተዳደር ሰራተኛ ወይም ድጋፊ ሰጪ ሰራተኛ
3	እድሜ	_____አመት

ክፍል ሁለት

4	ሀይማኖት	1. ኦርቶዶክስ 2. ካቶሊክ 3. ፕሮቲስታነት 4. ሙስሊም 5. ሌላ ካለ ይግለፁ ___
5	የትምህርት ደረጃ	1. ስፔሻልስት ሀኪም 2. ማስተርስ ዲግሪ 3. ዲግሪ 4. ዲፕሎማ 5. ሰርተፊከተ 6. ከ ሰርተፊከተበታች__

6	የስራ ልምድ (ምን ያህል ግዜ በዚ ሆስፒታል ሰርተዋል)	ኣመት
7	የጋብቻ ሁኔታ	1 ያላገባ/ያላገባች 2 ያገባ/ያገባች 3 የፈታ/የፈታች 4 አብሮው የማይኖሩ (የተለያዩ) 5 ባል/ሚስት በህይወት የለም
8	የአኗኗር ሁኔታ	1 ለብቻ 2 ከቤተሰብ 3 ከጓደኛ 4 ሌላ___
9	ሙያ	1. ክሊኒካል ነርስ/ ዲግሪነርስ 2. ሳይኪአትሪ ፕሮፌሽን(ማሰትርስ) 3. ሳይኪአትሪ ፕሮፌሽን(ዲግሪ) 4. ሳይኪአትሪ ስፔሻሊስት 5. ፋርማሲ ወይም ላበራቶሪ ባለሙያ 6.አስተዳደር ሰራተኛ (የሰው ሃብት፣ ፋይናንስ ፣አፊስ፣ ፀሀፊ …….. 7. ድጋፍ ሰጪሰራተኛ (ራነር፣ፅዳት፣ ጥበቃ፣አስታማሚ፣ተላላኪ፣…….

የጭንቀት እና የቁዘማ (ሀዘን) መገምገሚያ መጠይቅ, አንድ ዓረፍተ ነገር ብቻ በማክበብ ምረጡ::

ተራቁ.	ጥያቄዎች	መልስ
1	በኮቪድ -19 መከሰት ምክንያት የመጨነቅ ወይም የመወጠር ስሜት ምን ያህል ተሰምቶታል?	0)ምንም አልተሰማኝም 1)አልፎ አልፎ 2)ብዙጊዜ 3)በጣም ብዙ ጊዜ
2	ከኮቪድ-19 በፊት ወይም ቀደም ሲል ያስደስቶት የነበረ ነገር አሁን ላይ ምን ያህል ያስደስቶታል?	0)እንደ ድሮ ያስደስቱኛል 1)ከድሮ ትንሽ ቀንሷል 2), በጥቂቱ ያስደስቱኛል 3), ጭራሽ አያስደስቱኝም
3	በኮቪድ-19 ምክንያት ሆዴ አካባቢ የሚሰማኝ የመደንገጥ ወይም የመረበሽ ስሜት ይሰማዎታል?	0)ምንም አልተሰማኝም 1)በጥቂቱ ተሰምቶኛ 2), በጣም ተሰምቶኛል 3), እጅግ በጣም ተሰምቶኛል
		0) ምንም አልቀነሰም

4	በኮቪድ -19 ተዕኖ ምክንያት ስራዎን በሚያከናውኑበት ወቅት የስራዎ ፍጥነት ምን ያህል የቀነሰ ይመስሎታል	1) አልፎ አልፎ 2) በጣም ብዙ ጊዜ 3) እጅግ በጣም ብዙ ጊዜ
5	በኮቪድ -19 ምክንያት አንድ መጥፎ ነገር ያጋጥመኝ የተቃረበ ይመስሌ የፍርሀት ስሜት ይሰማዎታሌ	0) ምንምአይሰማኝም 1) በጥቂቱ ይሰማኛሌ 2))በጣም ይሰማኛሌ 3) እጅግ በጣም ይሰማኛሌ
6	በኮቪድ19 ምክንያት ለራስ ትኩረት መስጠት አቁመዋል? ለምሳሌ አለባበስ አመጋገብ ላይ	0)ሁሌም የምሰጠው ያህል ትኩረት እሰጣለሁ 1) ድሮ ከምሰጠው በጥቂቱ ያነሰ ትኩረት እሰጣለሁ 2) የምፈልገውን ያህል ትኩረት አይደለም 3), አዎን ምንም ትኩረት እየሰጠሁ አደለም
7	በኮቪድ-19 ምክንያት መሳቅና የነገሮችን አስቂኝ ጎን ማየት ይችላሉ	0) አብዛኛዉን ጊዜ እችላለው 1) እንደ ድሮው ባይሆንም እችላለው 2) በጥቂቱ እችላለው 3) ምንምአሌችልም
8	በኮቪድ-19 ምክንያት አንድ ቦታ መሄድ ኖሮበት ከሄዱ በሓላ ተረጋግተቶ ያለመቀመጥ ችግር አጋጥሞታል ?	0)ምንም አልቸገረኝም 1)ብዙም አይቸግረኝም 2)ብዙ ጊዜ ይቸግረኛል 3), በጣም ብዙ ጊዜ ይቸግረኛል
9	በኮቪድ - 19 ምክንያት ጭንቀት የሚጭሩ ሀሳቦች አእምሮ ውስጥ ምን ያህል ጊዜ ተመላልሶቦታል?	0)አንዳንዴ ብቻ 1)አብዛኛውን ጊዜ ባይሆንም አልፎአልፎ 2)ብዙ ጊዜ 3)በጣም ብዙ ጊዜ
10	በኮቪድ19 በሓላ በህይወትዎ ላይ ወደ ፊት ሚመጡ ነገሮችን በደስታ ይጠብቋቸዋል?	0),አዎ እንደሁሉ ጊዜ በደስታ እጠብቃቸዋለሁ 1)ከበፊት በቀነሰ ደስታ እጠብቃቸዋለሁ 2)ከበፊት በጣም ባነሰ ደስታ እጠብቃቸዋለሁ 3)ምንም በደስታ አልጠብቅም
11	ከኮቪድ -19 በሓላ ደስተኛኖት ?	0), አብዛኛውን ጊዜ ደስተኛ ነኝ 1)ብዙ ባይሆንም ደስተኛ ነኝ 2)ብዙ ጊዜ ደስተኛ አደለሁም 3)ምንም ደስተኛ አደለሁም
12	በኮቪድ-19 ምክንያት በድንገት የመደንገጥ ወይም የመረበሽ ስሜት ይሰማዎታል ?	0)ምንም አይሰማኝም 1)አልፎ አልፎ ይሰማኛል 2)ብዙ ጊዜ ይሰማኛል 3)በጣም ብዙ ጊዜ ይሰማኛል
13	ከኮቪድ -19 በሓላ ተረጋግተው መቀመጥ እና መዝናናትይችላሉ ?	0)ሁሌም እችላሁ 1)አብዛኛውን ጊዜ እችላለሁ

		2)ብዙ ጊዜ አልችልም 3)ምንም አልችልም
14	ከኮቪድ -19 በሓኺላመጥፎስሜትሲሰማኝየእግርመንገድማድረግ፣የቲቪፕሮግራሞችንመከታተል፣ ሬዲዮማዳመጥ፣ መጻፍማንበብየመሳሰሉነገሮችያስደስታቹአል?	0). አዎን ብዙ ጊዜ 1).ብዙም ባይሆን አዎ 2). አሌፎ አሌፎ 3.) በጣም አሌፎ አሌፎ

ከዚህ በታች መጠይቅ የጭንቀት/ዉጥረት ችግር በሚገጥሞ ጊዜ የሚጠቀሙትን የመፍትሄ ዘዴን ለመለየት የሚያገለግል ሲሆን በሚሞሉበት ጊዜም ካለፉት/ወቅት/ወራት ጀምሮ ያሉትን ታሳቢነት በማድረግ የመፍትሄ ፍለጋ ስልቶችን በማስቀመጥ ይተግብሩ።።

የሚወክሉት ቁጥሮ

1.በፍፁም

2.አልፎ አልፎ

3. በመጠነኛ መልኩ

4. ብዙጊዜ

መልሶቹ ላይ (✓) ምልክት ያድርጉ

ጥያቄዎች	1	2	3	4
1 በኮቪድ19 ምክንያት የሚፈጠሩ መጥፎ ስሜቶችን ላለማሰብ ስራ ላይ ወይም ሌላ ትግባራት ላይ እራሴን እጠምዳለሁ።				
2, ኮቪድ -19 እውነት እንዳልሆነ ለራሴ እነግረዋለሁ				
3,በኮቪድ19 ምክንያት የሚመጡ ጥሩ ያልሆኑ ስሜቶችን ለማምለጥ በመጠጥ ወይም የተለያዩ ሱሶችን በመጠቀም ጥሩ ስሜት እንዲሰማኝ አደርጋለሁ				
4,በኮቪድ19 ምክንያት ለሚያጋጥሙኝ የመረበሽ ስሜቶችን ባለሙያ በማማከር መፍትሄ ለማግኘት እሞክራለሁ				
5, ኮቪድ -19 ከመጣ ጊዜ ጀምሮ የመከላከያ መንገዶች (እጅመታጠብ , ማስክ በማድረግ ,እርቀትን በመጠበቅ) እራሴን የመከላከል ተግባር ውስጥ እገባለሁ				
6,በኮቪድ19 ምክንያት የሚመጡ የስሜት መረበሽ እንዳያጋጥመኝ እራሴን ከኮቪድ19 ጋር ከተያያዙ ዜናዎች ወይም ማህበራዊ ገጽ ላይ ከሚለቀቁ መረጃዎች እራሴን አገላለሁ				
7, በኮቪድ -19 ምክንያት ከመጡ ነገሮች በጎ ጎኑን ለማየት እሞክራለሁ				
8,ስለ ኮቪድ19 የማስባቸው መጥፎ ነገሮችን ለመቀነስ ቲቪ በማየት መጻፍ በማንበብ ገበያ በመሄድ በመተኛት እራሴን እወጥራለሁ				
9, በኮቪድ -19 ምክንያት የሚሰሙኝ አሉታዊ ስሜቶችን እገልጻለሁ				
10,በኮቪድ19 ምክንያት የሚፈጠሩ መጥፎ ስሜቶች እንዲቀንስልኝ ሀይማኖታዊ ተግባሮችን አከናውናለሁ (ቤተክርስቲያን ወይም መስጂድ እየሄድኩ ጸሎት በማድረግ መንፈሳዊ መጽሀፎችን በማንበብ) ከመጥፎ ስሜት ለመውጣት እሞክራለሁ				
11,በኮቪድ19 ምክንያት የሚመጡ ችግሮችን ለመከላከል ምን ማድረግ እንዳለብኝ ሌሎች ሰዎችን እጠይቃለሁ				
12, በወረርሽኙ ጊዜ ምን አይነት እርምጃ መውሰድ እንዳለብኝ በጣም ሳስብ ነበር				
13,በወረርሽኙ ምክንያት ከመጨነቅ ይልቅ እራሴን አዝናናበታለሁ				

14 ሌላ ካለ ጥቀሱ

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ስለ ትብብሮ አመሰግናለው

YunivarstiiFinfinnee

KolleejiiSirnaBarnootaa Fi SirnaAmalaa

KutaaBarnootaxin-sammuu

Waraqaaneebbaakunyknqorannoon kun kaayyonisaasababadhibee koovid-19tinhojjettootarradhiibbaanakkamiiakkaisaanirragahe fi tooftaafurmaataaakkamiiakkafayyadamanbeekuufnamadandeechisa. Duursineeisingalatoomfanna.

KutaaTokko:-Ragaaleedhuunfaa: Deebittigeengessudhanjalqabaa

Lak. T	Gaafilee	Filannoowwandeebii
1	Koorniyaa	1. Dhiira 2. Dhalaa
2	KutaaammaittiHojjetan	1. KilinikaalIstaafii 2. HojjetaabulchiinsayknDeeggarsaa
3	Umrii	_____Waggaa
Kutaa lama		
4	Amantaa	1. Ortodoksii 2. Kaatoolikii 3. Pirooteestaantii 4. Musilima 5. KanBiroohoojiraateibsaa _____
5	Sadarkaabaruumsaa	1. HakiimaIspeeshaalistii 2. Digiriimaastersii 3. Digirii 4. Dippiloomaa 5. Sartafikeeta 6. Kanbiroo_____
6	Muuxannoohojii (yeroohammamiitifhospitaala kana keessahojjetaniirtu	_____Waggaa
7	Haalagaa'ilaa	1. Kanhinfuudhin/hinheerumin 2. Kanfuudhe/kanheerumte 3. Kan hike/hiikte 4. Kanwajjiinhinjiraanne(kangargarbahan) 5. Dhirsi/niitinkanlubuudhaanhinjirre
8	Haalajireenyaa	1. Kophaa 2. Maatiiwajjiin 3. Hiriyaawajjiin 4. Kanbiro_____
9	GaheeHojii	1. KilinikaalNarsii/ narsiiDigrii

		2. Ogummaaxin-sammuu(maastersii 3. Ogummaaxin-sammuu(Digrii) 4. Ogummaaxin-sammuuispeeshaalistii 5. Hojjetaa/ttuubulchiinsaa(humnana maawaajjira……faayinaansii,barreessituu 6. Hojjetaa/ttuudeeggarsaa(qulqulleessituu/waardiyyaa… 7. Kanbiraahoojiraateibsaa_____
Gaafiigamaaggmadhiphuu fi gaddaa (gom'uu) himatokkoqofafilaa		
Lak. T	**Gaafilee**	**Filannoowwandeebii**
1	Sababadhufaatii kovid-19tin miirridhiphummaaykngarmaleeyaadda'uuisinittidhagahamehangami?	0Hoomtuunattihindhagahamne 1. 2Dabredabree 2. Yerooheddu 3. Yeroodaranbaay'ee
2	Koovid-19 durawantiisingammachiisuamarrattihangamisingammachiisa?	0Akkumaduraanittinagammachiisu 1. kanduraanirraaxiqqoohir'ateera 2. xiqqoonagammachiisu 3. Gonkumaanahingammachiisan
3	Sababadhibee koovid-19tin tooragaraakeessaniimirrirrifannaayknbibir'annaaisinittinidhagahamaa?	0Hoomtuunattihindhagahamne 1. Hangaxiqqoonattidhagahameera 2. Heddunattidhagahameera 3. Daranbaay'eenattidhagahameera
4	Sababadhiibbaa kovid-19tin yeroohojjikeessanhojjettansaffisinhojiikeessaniihammamkanhir'ateisinittifakkaata?	0Homaahinhir'anne 1. Dabreedabree 2. Yeroobaay'ee 3. DaranYeroobaay'ee
5	Sababadhibee koovid-19tin mirriwantibadaantokkowaanisinmuudachuufdeemuisinittinidhagahamaa?	0Hoomtuunattihindhagahamne 1. Hangaxiqqoonattidhagahameera 2. Heddunattidhagahameera 3. Daranbaay'eenattidhagahameera
6	Sababadhibee koovid-19tin mataakeessaniifxiyyeeffannaakennuudhiistaniirtuu?fakkeenyafufannaa fi nyaatairratti?	0Hammumaxiyyeennaayeroohundakennuufitankennaaf 1. Xiyyeeffannaanduraanduraankennuufi gad xinnookangadibu'enkennaaf 2. Xiyyerffannahammanbarbaaduumiti 3. Eyyenxiyyeeffannaahomaatuukennaahinjiru
7	Sababadhibee kovid19tin kolfuu fi wantootanamakofalchisanilaaluunidandeechuu?	0Yeroobaay'eenandanda'a 1. Akkaduraanittista'uubaatullee nan danda'a 2. Hammaxinnoo nan danda'a 3. Homaahindanda'u
8	Sababadhibee koovid-19tin iddootokkodeemunisinirrajiraateeergadeemtaniiboodarakkoontasgabbooftaniitaa'uuisinmuudateejiraa?	0Hoomtuunahinrakkisnu 1. Baay'eenahinrakkisu 2. Yeroobaay'enarakkisa 3. Yeroobaay'eedarannarakkisa

9	Sababadhibee koovid-19tin yaadonnidhiphummaakakaas angarasammuukeessanittiyer oohangamdeddeebi'aniru?	0Altokkoqofa 1. Yeroobaay'eeta'uubaatusdabredabree 2. Yeroobaay'ee 3. Daranyerooheddu
10	Dhufaatii koovid-19tin boodawantootagarafuulduraaj ireenyakeessnirrattidhufanga machudhannisimattuu?	0Eyyenakkumayeroohundaagammachu dhananeega 1. Gammachuukanaanduraatiigadinane ega 2. Gammachuukanaanduraatiigadinane ega 3. Homaagammachudhanhineegu
11	Erga koovid-19tin dhufeegammadoodhaa?	0Yeroobaay'eegammdaadha 1. Baay'eeta'uubaatusgammadaadha 2. Yeroobaay'eegammadaamiti 3. Homaagamadaamiti
12	Sababa koovid-19tin miirritasarifachuuyknjeeqamu uisinittinidhagahamaa?	0Hoomtuunattihindhagahamu. 1. Dabreedabreenattinidhagahama 2. Yerooheddunattinidhagahama 3. Daranyerooheddunattinidhagahama
13	Erga koovid-19 as tasgabbooftaniitaa'u fi bashannanuunidandeessuu?	0Yeroohundaa nan danda'a 1. Yeroobaay'ee nan danda'a 2. Yeroobaay'eehindanda'u 3. Homaahindanda'u
14	Erga koovid-19 boodayeroomiirribadaansittid hagahamumiilaandeemun,sag antaaleeteleviziyoonaailaaluu, raadiwoodhaggeeffachuu,kifaa badubbisuu fi K.K.F. isingammachiisun	0Eyyenyeroobaay'ee 1. Baay'eeta'uubaatuseeyyn 2. Dabreedabree 3. Baay'eedabree

Gaafinkanaagadiiyeroorakkoondhiphachuuykndaranyaadda'uunamamuuda tutooftaaleeittifayyadamanaddaanbaasufkannamafayyadu hoota'uyerooguuttanwantootayeroo/ ji'oottandabraniieegalejiranyaadakeessagalchudhantooftaaleefurmaatabarba achaakaa'udhaanraawwadhaa

1.Gonkumaa 3. Bifgiddugaleessata'een

2. Dabreedabree 4. Yeroobaay'ee

deebiiirrattimallatto ‘’√’’ godhaa.

	Gaafilee	1	2	3	4
1	Miirotabadaasababakoovid 19tin dhufanyaaduudhabudhafhojiiyookiigochootabirootinofantursa.				
2	Koovid-19 akkdhugaahinta’inmataakootti nan hima				
3	Miirotasababakoovid 19tin dhufanjalaabahudhafdhugaatiiyknaraadotabiroottifayyadamud hanmiirrigaarinakkanattidhagahamu nan gadha.				
4	Mirootajeequmsaasababakovid 19tin nattidhagahamanogeessanmarsisudhanfalaargachuuf nan yaala				
5	Ergakoovid 19 dhufeeboodatooftaaleeittisaa(harkadhiqachuu,maaskiigodhachudhan,fageenyaeegudhaan) hojiiittisaakeessaofangalcha.				
6	Sababakoovidinmiirrijeeqamuuakkanahinmuudanneeoduukoovid 19tin walqabateyknoduukanaanwalqabatanyknfuulamarsaaleaddun yaarrattigadhiifamanirraaofanlaga.				
7	Wantootasababakoovid 19tin dhufankeessaacarraagaariiillaluf nan yaala				
8	Yaadotabadaawaa’eekoovid 19 yaaduhir’isudhafTvilaaludhaan,kitaabadubbisudhangabaadeemudhaan,rafudhanofanjaataneessa				
9	MiirootaSababakoovid 19tin guyyaaguyyaattinattidhagahaman nan ibsa				
10	Miironnisababakoovid 19tin nattidhufanakkanarraahir’atangochaaleeamantaa nan raawwadha,(betaskaanayknmasgidadeemeekadhannaagochudhan,kitaabotahafuraqulqulluudubbisudhan) yaadabadaakeessaabahuuf nan yaala.				
11	Rakkooleesababakoovid 19tin dhufanirraaof ittisudhafmaalgochuunakkanarrajirunamootabiroo nan gaafadha				
12	Yerooweerarichaatarkaanfiiakkamiifudhachuuakkanarrajirudaranyaadaanture				
13	Sababaweerarichaatindhiphachuumannaa nan bashannansiisa.				

14 Kan biro hoojiraatieibsaa

_____

_____

_____

Deeggarsakeessaniifisiningalatoomfadha.

Addis Ababa University

College of Education and Behavioral Studies

In-depth Interview Guide

Part I: Personal Information

1. Code_____
2. working department_____
3. profession_____
4. Age in years _____
5. Sex _____
6. Educational level_____
7. Working year _____
8. Religion_____
9. Marital status_____
10. Leaving status_____

Interview Guide Questions

1 What covid-19 mean for you?

2 What did you feel about this pandemic?

3 What has been changed in your life?

4 What do you think the influence of covid-19..?

5 How the covid-19 did affect you and how did you respond?

6 Do you believe that covid-19 has brought psychological consequences? If it yes explain What type of psychological consequence for you

7 What type of coping mechanism is using to escape from bad feeling of the pandemics…..?

8 List other staffs coping mechanism is using to reduce bad feeling of covid-19?

9 Do you follow the rules of advised by world health organization or health professional to protect yourself from the pandemic?

10 Are there any other ideas you would like to express?

አዲስአበባዩኒቨርሲቲ

የሥነ-ትምህርትእናሥነባህሪኮሌጅ

የሳይኮሎጂት/ትክፍል

<u>ክፍልአንድ፡-</u>ግላዊየሆኑመረጃዎች

1. **ኮ ድ**_____
2. **አሁንየሚሰሩበትክፍል**_____
3. **ሙ ያ**_____
4. **እድሜ**_____
5. **ጾታ** _____
6. **የትምህርትደረጃ**_____
7. **የስራልምድ**_____
8. ***ሀይማኖት***_____
9. **የጋብቻሁኔታ**_____
10. **የአኗኗርሁኔታ**_____

Interview Guide Questions (Amharic version)

1,ኮቪድ-19ን እንዴት ትገልጸዋለህ/ትገጪዋለሽ?

2, ስለ ኮቪድ -19 ወረርሽኝ ምን አይነት ስሜትአለህ/ አለሽ?

3, በ ኮቪድ-19 ምንክንያት በህይወትህ/ህይወትሽ ምን ተቀይሮአል?

4, የኮቪድ-19 ተፅኖ ምንድ ነው ብለህ ታስባለህ/ታስቢአለሽ?

5,ኮቪድ-19 የስነልቦናዊ ችግር አምጥቷል ብለህ ታስባለህ/ታስቢአለሽ? አዎ ከሆነ ያስረዱ

6, ኮቪድ19 በምን አይነት መልክ ተፅኖአሳደረብህ/ሽ? በምን አይነት መንገድ ምላሽ ሰጠኽው/ሰጠሽው?

7በኮቪድ19 ምክንያት ከሚመጣ መጥፎ ስሜት ለመውጣት ምን አይነት የመፍትሄ ዘዴዎችን ትጠቀማለህ/ሽ?

8,ሌሎች ሰራተኞች በኮቪድ19 ምክንያት ከሚመጣ የስነልቦናዊ ችግር ጭንቀት እና ቁዘማ ለመውጣት ምን አይነት የመፍትሄ ዘዴ ሲጠቀሙ አስተውለህል(ሻል)?

9,የአለም ጤና ድርጅት ያወጣቸውን የመከላከያ ዘዴዎች ወይም የጤና ባለሙያዎች የሚመክሩትን የመከላከያ ዘዴዎች ትጠቀማለህ/ትጠቀሚአለሽ?

10, በ ስተመጨረሻ ተጨማሪ ሀሳብ ካለህ/ካለሽ?