

## PERCEIVED CONCERNS AND THREATS OF HEALTHCARE WORKERS FACING THE COVID-19 IN ARGENTINA

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**Abstract:** *Objectives:* The goal of this study was to provide a description regarding the perceived concerns and threats of the healthcare workers facing treatment of patients with COVID-19 during the early phase of the pandemic in Argentina, also analysing how these issues affected their psychological well-being. *Study design:* Cross-sectional design. *Methods:* During the third week (April 4-10) of mandatory quarantine, a questionnaire was administered to 809 healthcare workers from all over the country. The developed questionnaire covered: socio-demographic data, questions related to concerns of the health personnel about facing patients with coronavirus, and indicators of depression, anxiety, intolerance of uncertainty, and coping. *Results:* Results showed that the main worries of these healthcare workers were the possibility of infecting their loved ones (84%), followed by the possibility of infecting themselves (65%). Also, 76% considered that the work environment worsened, and 77% that it would help them to count with mental support staff in their workplace. In addition, the healthcare workers showed significantly increased levels in indicators of depression, anxiety, and intolerance of uncertainty and in developing coping strategies that were predominantly of emotional control. The results also indicated that fear of contagion and fear of infecting their loved ones, as well as fear of the possibility of having to choose who would receive attention and who would not, were perceived as stressors having the greatest influence on discomfort. *Conclusions:* Altogether, these results show the need for preventive contingency interventions targeted to healthcare workers in order to preserve the well-being of their mental health and the quality of the therapies they apply to patients with COVID-19.

**Keywords:** COVID-19, Argentine healthcare workers, subjective well-being, worries, stress

## INTRODUCTION

The pandemic of COVID-19 forces us to face a world health crisis as we have not seen in at least seven decades, which is killing people, spreading human suffering and changing the lives of people turning into a case of global disaster. From studying these situations of catastrophe, it is known that the population that is exposed runs the risk of suffering a variety of problems related to stress, such as depression, other anxiety disorders, somatoform disorders, drugs and alcohol abuse (O'Donnell et al., 2003).

Within the population that suffers this unprecedented crisis of COVID-19 pandemic, healthcare workers constitute a group of special risk, because they not only suffer from the anxiety of caring for people with diseases but also -in many cases- face a serious lack of personal protective equipment and the rapid rate at which hospital protocols change, which is directly related to intolerance of uncertainty. Their distress is completely different from the one faced by general population, generating several damages on their mental health, both in short and medium term (Marjanovic et al., 2007; Wu et al., 2009). Therefore, subjective well-being of healthcare workers becomes a serious danger and deserves special attention (Brooks et al., 2018). In this sense, these are considered as important indicators of mental exhaustion (Leung et al., 2005). Moreover, health professionals in this situation can experience considerable psychological anguish, due to the direct care of patients, indirect trauma, quarantine or self-isolation (Wu et al., 2020).

Taking into account the social, cultural and historical factors of each context when identifying particular stressors and its consequences in the perceived subjective wellbeing, there are few studies in Latin America, where the pandemic arrived around four months later, and which has historical,

cultural and social characteristics that are different from other parts of the world. Likewise, the different countries of Latin America adopted unique health decisions in order to face the pandemic, based on political reasons, the strength of the health system, and the idiosyncrasy of the population, among others (Barbagelata et al., 2020).

Argentina, in particular, has a weak health system, where working conditions are regularly difficult, lacking in equipment, with professionals who are well-trained but scarce (Barbagelata et al., 2020). The public policy of health in Argentina consisted of issuing a decree of preventive, strict, and mandatory social isolation, so as to gain enough time to strengthen the health infrastructure, although the healthcare workers knew there were not enough trained human resources, who could not be trained in such a short notice.

Based on the above background, including that there are cultural, political and social differences (e.g., the perception of political use of the pandemic, the economic problems related to the pandemic, the economic crisis prior to the pandemic in the country, etc.) that have an influence on the perception of stressors and the way of responding to them, the aim of this study in the Argentinean context was: (1) to describe in early stages the stressors perceived by the healthcare workers dedicated to the treatment of COVID-19; (2) to describe the indicators of depression, anxiety and intolerance to uncertainty, and the coping strategies of this population; (3) to analyse the difference in the indicators of psychological discomfort (depression, anxiety and intolerance of uncertainty) according to the perceived stressors.

## METHODS

### STUDY DESIGN

A cross-sectional design was carried out in two parts: First, a descriptive study to

determine the distribution of the perceived stressors, the indicators of psychological discomfort, and the coping strategies of healthcare workers devoted to the treatment of COVID-19. Second, an ex post facto study to determine how the perceived stressors have an influence in psychological discomfort, defined through indicators of depression, anxiety and intolerance of uncertainty.

## **PARTICIPANTS**

During the third week (from April 4-10) of mandatory quarantine, established because of the spread of COVID-19 that started March 20 in Argentina, a questionnaire was administered to healthcare workers in 32 hospitals all over the country. During this period, 1,274 professionals had access to the questionnaire, and 809 completed it. Given the setting of the questionnaire, it was impossible to move forward with the questions if answers were left incomplete. Therefore, no missing data were observed.

Of these 809 participants, 647 (80%) were women and 162 were men, with an average age of 42.84 ( $SD = 10.68$ ) and that belonged to stratum II (middle class) according to the Graffar Scale (Méndez-Castellano & Mendez, 1994). Sixty-three percent works in state establishments and 37% in private establishments. In addition, 446 people (55.2%) work in emergency rooms, general hospitalization, ICU and intermediate hospitalization, outpatient offices (30.1%), laboratory (5.3%), administration (5.4%) and social service (4%). In regards to profession, 202 (25%) were doctors, 227 (28.05%) were nurses, 41 (5.07%) were physical therapists, 52 (6.43%) were biochemists, 107 (13.23%) were psychologists, 37 (4.57%) were social workers, 53 (6.55%) were administrators, 60 (7.40%) were technicians (laboratory workers, radiologists, etc.), and 30 (3.70%) were stretcher bearers, in contact with potentially

infected patients.

The data was collected through non-probabilistic volunteer sampling from a population of healthcare workers in Argentina, in the context of the COVID-19 pandemic. Firstly, the questionnaire was digitalized through the online survey tool Survey Hero for its subsequent distribution. We established contact with different health entities of the Argentine government, which allowed access to hospitals in the different provinces of the country. In addition, contact was made with directors of health centres and also spreading through social networks, such as health personnel Facebook groups, general Facebook, Twitter, Instagram and WhatsApp. In this way, there was a wider reach in the different provinces that integrate the Argentina. In the cover of the questionnaire, there was a mandatory field to be completed: the agreement with an informed consent that was included. To protect the privacy of the subjects, the survey was conducted anonymously.

## **INSTRUMENTS**

A questionnaire with three sections was developed (Richaud et al., 2021):

(1) Socio-demographic data. Professionals were consulted regarding their age, gender, type of institution they belonged to (public or private), profession, specialty and role in the health institution.

(2) Questions related to the stressors perceived by the health personnel, regarding the feelings and fears when facing the patients with coronavirus. Such stressors were taken from the responses reported by 30 healthcare workers in the preliminary interviews (Vargas Rubilar et al., 2020).

(3) Questions related to indicators of depression, anxiety, intolerance of uncertainty, and coping. Based on the view that during a catastrophe -in our case, a pandemic- stress is a

normal response to an extraordinary situation (Maunder et al., 2003), our interest was not to evaluate depression, anxiety, or intolerance of uncertainty as clinical entities, but to only analyse if some of their indicators emerged as signals of psychological discomfort.

All the items were presented in a Likert scale of 4 points, being (1) Almost never/ Never and (4) being Almost always/Always.

## STATISTICAL ANALYSIS

In order to address the first objective of our study, frequencies and percentages of answers Yes and No to categorical questions were calculated, as well as arithmetic means, standard deviations, skewness and kurtosis of each of the indicators of depression, anxiety, intolerance of uncertainty, and coping strategies of health professionals. Lastly, in order to analyse the influence of the different perceived stressors in the indicators of depression, anxiety, intolerance of uncertainty, and coping, MANOVAs were used. Each of the stressors perceived by the healthcare workers was used as independent variable, and each of the indicators of depression, anxiety, intolerance of uncertainty, and coping strategies of healthcare workers was used as dependent variable. For all the statistical calculations, the SPSS.24 statistical package was used.

## RESULTS

### **Descriptive analyses of the stressors perceived by the Argentine healthcare workers devoted to the COVID-19 pandemic**

Frequencies and percentages of the answers to ten categorical questions are presented in Table 1.

### **Descriptive analysis of the indicators of depression, anxiety, intolerance of uncertainty, and coping strategies**

Means, standard deviations, skewness and kurtosis of indicators of depression (dep),

anxiety (anx), intolerance of uncertainty (inc), and coping are shown in Table 2.

Taking the absolute values as a guide, considering 1 to 1.99 as low scores, from 2 to 2.99 as medium scores, and from 3 to 4 as high scores, most indicators of depression, anxiety and intolerance of uncertainty presented medium-high and high values.

### **Perceived stressors and indicators of psychological discomfort (third objective)**

#### ***Relationship between fear of contagion and indicators of depression, anxiety, intolerance of uncertainty and strategies of coping with conflict***

*Depression:* there was a significantly higher difference in the indicators of depression in the group that fears contagion ( $F_{Hotelling(4,798)} = 21.50; p = .000$ ). When the specific items were analysed, they all resulted in significantly higher values in the group with fear of contagion (See Table 3).

*Anxiety:* In the case of anxiety, indicators were also significantly higher in the group that fears contagion ( $F_{Hotelling(6,795)} = 37.67; p = .000$ ). When the specific items were analysed, they were all significantly higher in the group that fears contagion, also increased in the group with no fear of contagion (See Table 3).

*Intolerance of uncertainty:* The group with fear of contagion showed values significantly higher than those of the group with no fear, regarding the indicators of intolerance of uncertainty ( $F_{Hotelling(3,801)} = 24.44; p = .000$ ) (See Table 3).

*Coping:* It is necessary to analyse this process by strategies more than as on overall, because each strategy has contextual value and functions according to the other strategies. If by doing a theoretical generalization, we consider that the strategies of logical analysis, cognitive restructuring, action over the problem, and search of support constitute strategies of functional coping; and that

avoidance, emotional control, acceptance with resignation, and lack of emotional control constitute strategies characteristic of dysfunctional coping, people with fear of contagion presented significantly higher dysfunctional coping ( $F_{Hotelling(2,789)} = 4.86; p < .001$ ). When analysed by item, this difference is due to only one indicator *I burst out over anything* (See Table 3). At the same time, they also presented significantly lower values in the item: *I try to bring something positive out of the situation* (See Table 3).

#### **Relationship between the fear of infecting their loved ones and the indicators of depression, anxiety, intolerance of uncertainty and strategies of coping with conflict**

**Depression:** The group that fears infecting their loved ones showed significantly higher values in the indicators of anxiety than those who claim not to be afraid ( $F_{Hotelling(4,798)} = 9.12; p < .000$ ) (See Table 4).

**Anxiety:** People who claim to fear infecting their loved ones showed higher values of the indicators of anxiety than those who claim not to fear it ( $F_{Hotelling(6,795)} = 37.67; p < .000$ ) (See Table 4).

**Intolerance of uncertainty:** Those who fear infecting their loved ones showed higher average values than those who claim not to fear ( $F_{Hotelling(3,801)} = 13.81; p < .000$ ) (See Table 4).

**Coping:** Those who fear infecting their loved ones presented significantly lower functional coping ( $F_{(1,792)} = 3.89; p < .05$ ) and significantly higher dysfunctional coping ( $F_{(1,792)} = 9.70; p < .002$ ) than those who do not fear the infection ( $F_{Hotelling(2,789)} = 7.27; p < .001$ ). Regarding the coping strategies indicators, there were found significantly higher value in *I burst out over anything* in those who fear the infection, indicating that emotional controls are not being successful (See Table 4).

#### **Relationship between having to decide**

#### **whether to attend or not and depression, anxiety, uncertainty and coping**

**Depression:** The group that fears having to decide who to attend presented significantly higher values in the indicators of depression than the other group ( $F_{Hotelling(4,798)} = 2.45; p < .000$ ) (See Table 5).

**Anxiety:** Those who fear having to decide showed a significantly higher mean value than those who do not ( $F_{Hotelling(6,795)} = 8.36; p < .000$ ) (See Table 5).

**Intolerance of uncertainty:** People who fear having to decide, showed a significantly higher mean value in intolerance of uncertainty ( $F_{Hotelling(3,801)} = 21.73; p < .000$ ) (See Table 5).

**Coping:** Those who fear having to decide who to attend showed significantly higher values in dysfunctional coping ( $F_{Hotelling(2,789)} = 8.59; p < .001$ ). The results corresponding to each indicator are presented in Table 5.

#### **Relationship between the participation in a group of psychological support and depression, anxiety, intolerance of uncertainty and coping**

**Depression:** non- significant differences were seen among the two groups ( $F_{Hotelling(6,379)} = 1.73; p < .113$ ) (See Table 6).

**Anxiety:** the group that participates in the support group showed significantly lower anxiety than the one that does not participate ( $F_{Hotelling(6,379)} = 1.73; p < .113$ ) (See Table 6).

**Intolerance of uncertainty:** people who participate in the containment or support group presented less intolerance of uncertainty ( $F_{Hotelling(3,801)} = 21.73; p < .000$ ) (See Table 6).

**Coping:** the group that participates in the support group showed significantly higher functional coping ( $F_{Hotelling(2,380)} = 3.43; p < .003$ ). The results corresponding to each indicator are presented in Table 6.

The stressors Feeling stigmatized, Not having the appropriate equipment, and the environment got worse did not have significant

effect over psychological discomfort.

## DISCUSSION

The way in which disasters such as pandemics affect people depend on their characteristics and those of the context in which they develop (Ozer et al., 2003; Porter & Haslam, 2005). Furthermore, beyond the more general social and cultural context, there are more specific sub-contexts, with their own specificities. It is very important to take these characteristics into account when planning mental health actions, which should be based on previous and current knowledge, appropriately contextualized, about the perceived stressors and the possible psychological reactions to them (Silove, 2005). Based on this theoretical conception, our first objective was to describe the stressors perceived by the healthcare workers devoted to the attention of patients with COVID-19 in the Argentine context, at early stages of the pandemic. At that moment, we observed that a high percentage of healthcare workers perceived some stressors, generated by the negative expectations regarding the development of the pandemic and the particularities of the Argentine health system: fear of contagion, fear of infecting others, not having the appropriate equipment, being in an increasingly negative working environment, and not having the support and psychological containment they feel necessary.

Regarding the second goal, we registered the psychological response of healthcare workers to the idea of having to care for patients with COVID-19, at that early moment in the development of the pandemic (time when COVID-19 disease was known to be caused by a virus of very fast transmission, with partly unknown effects, and for which there was neither effective method nor vaccine). The isolation of people who get sick from their families, in a filiative cultural context such as Argentina (Facio & Resett, 2011),

could determine a feeling of inefficacy and powerlessness in the healthcare workers that in turn could lead to behaviours such as sadness, irritability, and sleep problems, all indicators of depression. At the same time, not knowing when the peak of infections would be reached, if there would be enough resources to face it or if they would have enough preparation, generated anxiety and uncertainty. In fact, it was found that most indicators of depression, anxiety and intolerance of uncertainty were higher. In the case of coping, the strategies of logical analysis and emotional control were very high, which indicates strong emotional control, but also effective strategies, such as high cognitive redefinition, that allow for the stressor to be more manageable, and the search for support, which coincides with the expression of the desire to have a group of containment and psychological support. On the other hand, medium values of avoidance and acceptance with resignation were found, which can be functional to decompress tension created by strict control, provided they are not too prolonged in time.

Finally, the knowledge of how perceived stressors influence indicators of psychological discomfort and coping strategies, the following results were obtained. Both those who feared contagion and those who feared infecting their loved ones, as well as those who feared the possibility of having to choose who would receive attention and who would not, presented more indicators of depression, anxiety, intolerance of uncertainty, while developed a more dysfunctional coping than those who did not inform any of these fears. There were also stronger indicators of depression in those who were more fearful. These results would indicate that a psychosocial contingency plan should be focused, beyond ensuring the basic services and the fulfilment of the essential needs of healthcare workers and their safety (rotating schedule, adequate equipment,

enough food and water, etc.), on creating support, containment and accompaniment networks in order to guarantee the first psychological aid to all personnel who might require it. Also, given the sleep problems, it would be necessary to implement workshops of sleep hygiene, teaching strategies to face this disorder. In regards to anxiety, it was also significantly higher in those who were concerned than in those who claimed not to be concerned, in all cases, and it was manifested through items of cognitive anxiety, physiological anxiety, and behavioural anxiety. In the case of anxiety indicators, their values were increased, so it would be necessary to add a contingency plan for the development of emotional regulation strategies. In regards to intolerance of uncertainty, the values were increased, although the group of the more concerned ones showed values that were significantly greater than those who were not concerned. A psychosocial contingency plan should optimize the communication with the whole hospital community in order to leave minimum room for speculations and news that might confuse their receptors. In regards to coping, namely which strategies are used to try to solve concerns or conflict, it seems that in all cases, the group of people who were more concerned used more dysfunctional strategies than the less concerned. In the case of emotional control, it is a strategy that might be functional, when it means an adequate self-regulation; or dysfunctional, when it is extreme. The last would seem to be the case of this sample. What would be the difference between those who worry and those who apparently do not? For in the case of the former, the control was not being effective, while in the latter it was. Apparently, for the group of the less concerned, avoidance is working adequately in this context, since these people presented significantly lower values in lack of emotional control. Nonetheless, if these

avoidance strategies are maintained over time, they lead to pathologies (Richaud de Minzi & Sacchi, 2001). However, the avoidance strategies might be effective in a specific moment, which is why we say that coping is contextual and dynamic, but if sustained in time, it could derive in pathologies, such as post-traumatic stress.

Concerning the involvement of a psychological support team, it has lowered the intolerance of uncertainty and it has fundamentally increased the strategies of coping, since it has lowered the lack of control and increased the strategies focused in the problem, in the search for help and in cognitive restructuring.

It should be noted that, contrary to what was reported in other contexts, the Argentine healthcare workers did not feel stigmatized, and although a high percentage answered that equipment was insufficient and that the working environment had worsened, these stressors did not generate significant differences in the psychological discomfort, probably because, given the characteristics of the Argentine health system, professionals are used to working in difficult conditions. They did, however, manifest the need of containment and psychological support.

## CONCLUSIONS

In general terms, the present study indicates that the Argentine health personnel dedicated to the treatment of patients with COVID-19, during the third week (April 4-10) after the mandatory quarantine started in that context, showed high percentages of perceived stressors and increased levels of *depression*, *anxiety* and *intolerance of uncertainty*, and it developed *coping strategies that were predominantly of emotional control*, which should be dealt with quickly by mental health specialists (psychiatrists and psychologists) trained in handling crisis situations.



## STRENGTHS AND LIMITATIONS

In first place, we understand this is the first study on stressors perceived by healthcare workers devoted to the treatment of COVID-19 and their effect on the subjective well-being, carried out in Argentina and possibly in Latin America. This knowledge is fundamental when implementing psychosocial protocols to face the pandemic, taking the sociocultural factors of the context into account.

On the other hand, the fact that this study was carried out in the third week from the onset of the COVID-19 pandemic in Argentina constitutes a strength, since there are no known studies which have assessed these indicators from such an early stage. Its importance lies in that it sets base values for comparison with subsequent studies that may show what the process of affecting the subjective well-being of the healthcare workers throughout the pandemic is like.

Finally, having such a detailed study about the perceived stressors and their effect on the subjective well-being of healthcare workers has allowed the outlining of a cross-sectional psychosocial contingency plan for all the areas intervening in the response to the pandemic, with two objectives: (1) to prevent additional factors produced by the pandemic, (2) to alleviate the impact on the subjective wellbeing of healthcare workers.

This study would have some limitations. First, data obtained from self-reported questionnaires could facilitate social desirability. Furthermore, no complete tests of anxiety, depression and other variables, such as loneliness, have been included, for practical reasons, such as not to exceed the number of questions made to professionals who were already very demanded because of the circumstances they had to endure. Another limitation refers to the anonymity of the answers, since in future longitudinal studies

it will not be possible to conduct designs of repeated measures. We have not taken into account the differences of gender, neither the differences among the different types of health institutions (clinics, hospitals, etc.), nor the different sectors (intensive care, emergency, etc.), etc., and it would be important to study these differences in future studies.

These follow-up studies on the psychological state of healthcare workers, during the pandemic and after a span of time from its finalization, are essential, as has been recommended in previous studies (Leung et al., 2005). Future studies should contemplate the evolution of these indicators in time in order to adjust the interventions to the changing reality.

The results presented focused on the Argentine cultural context. In other studies, it would be interesting to carry out transcultural evaluations that allow to have the perspective from other countries in Latin America.

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	Yes		No	
	<i>N</i>	%	<i>n</i>	%
Possibility of contagion	525	65	284	35
Possibility of infecting your loved ones	679	84	130	16
Feeling stigmatized	113	14	696	86
Having the appropriate equipment	284	35	525	65
Possibility of infecting your loved ones	116	14	693	86
Having to decide	295	36	514	64
Got worse	553	76	256	24
Group of psychological containment	239	28	570	72
Participate in a group of psychological containment	112	26	127	74
Helping to have mental health personnel	574	77	235	22

Table 1. Frequencies and percentages of the responses to the 10 categorical questions.

	<i>M</i>	<i>SD</i>	Skewness		Kurtosis	
			Statistical	Standard Error	Statistical	Standard error
I am more irritated than before	2.23	.834	.161	.086	-.492	.172
I feel sad	2.36	.813	-.050	.086	-.596	.172
I do not sleep as well as before	2.34	.951	.096	.086	-.945	.172
I feel guilty when I am resting	1.74	.892	.885	.086	-.226	.172
I feel insecure	2.20	.872	.199	.086	-.737	.172
I feel scared	2.36	.840	.022	.086	-.634	.172
I feel discomfort in my stomach	1.90	.901	.594	.086	-.679	.172
My body is tense	2.51	.895	-.095	.086	-.750	.172
I cry or am moved easily	2.39	.957	.010	.086	-.974	.172
I move and do things without an end in themselves	1.88	.844	.542	.086	-.640	.172
I cannot be at peace if I do not know what will happen tomorrow	2.17	.924	.242	.086	-.895	.172
Unexpected circumstances bother me a lot	2.44	.886	.002	.086	-.736	.172
I feel that even with the best planning, a small unexpected inconvenience might ruin it all	2.32	.936	.051	.086	-.871	.172
I exclusively focus in what I have to do, step by step	3.32	.767	-1.060	.087	.878	.173
I propose a different solution when the protocol fails	2.74	.927	-.597	.086	.044	.172
I speak to someone who can help me when the situation overwhelms me	3.01	.826	-.510	.086	-.308	.173
I try to bring something positive out of the situation	3.15	.776	-.660	.087	.019	.173
I try not to think about what is happening	2.21	.904	.060	.086	-.470	.172
I accept it since there is nothing I can do about it	2.63	.888	-.183	.087	-.683	.173
I burst out over anything	1.92	.833	.587	.087	-.308	.173
I try to control my emotions	3.04	.758	-.615	.087	.317	.173

Table 2. Means, standard deviations, skewness and kurtosis of indicators of depression, anxiety, intolerance to uncertainty, and coping

<b>Depression</b>	Contagion		Non contagion		<i>F</i> (1,801)	<i>p</i>
	<i>M</i>	<i>DE</i>	<i>M</i>	<i>DE</i>		
<i>F</i> Hotelling(4,798) = 21.50; <i>p</i> = .000 ; Cohen's d .34, 95% CI .19-.48						
I am more irritated than before	2.38	.04	1.99	.05	42.09	.000
I feel sad	2.54	.03	2.06	.04	71.87	.000
I do not sleep as well as before	2.48	.04	2.10	.05	29.76	.000
I feel guilty when I am resting	1.84	.03	1.58	.05	15.96	.000
<b>Anxiety</b>						
<i>F</i> Hotelling(6,795) = 37.67; <i>p</i> = .000; Cohen's d .45, 95% CI .30-.59					<i>F</i> (1,801)	
I feel insecure	2.43	.04	1.81	.05	107.26	.000
I feel scared	2.66	.03	1.86	.04	213.50	.000
I feel discomfort in my stomach	2.05	.04	1.64	.05	39.23	.000
My body is tense	2.66	.04	2.24	.05	43.93	.000
I cry or am moved easily	2.54	.04	2.15	.05	32.29	.000
I move and do things without an end in themselves	1.96	.04	1.75	.05	11.58	.000
<b>Intolerance of uncertainty</b>						
<i>F</i> Hotelling(3,801) = 24.44; <i>p</i> = .000; Cohen's d .36, 95% CI .22-.51					<i>F</i> (3,801)	
I cannot be at peace if I do not know what will happen tomorrow	2.38	.04	1.83	.05	70.47	.000
Unexpected circumstances bother me a lot	2.56	.04	2.24	.05	26.00	.000
I feel that even with the best planning, a small unexpected inconvenience might ruin it all	2.47	.04	2.09	.05	32.07	.000
<b>Coping</b>						
<i>F</i> Hotelling(8,783) = 4.90; <i>p</i> = .000; Cohen's d .16, 95% CI .02-.30					<i>F</i> (1,790)	
I exclusively focus in what I have to do, step by step	3.31	.03	3.31	.04	.06	.804
I propose a different solution when the protocol fails	2.76	.04	2.80	.05	.31	.576
I speak to someone who can help me when the situation overwhelms me	2.99	.04	3.06	.05	1.35	.247
I try to bring something positive out of the situation	3.08	.03	3.28	.04	13.16	.000
I try not to think about what is happening	2.26	.04	2.22	.05	.38	.537
I accept it since there is nothing I can do about it	2.62	.04	2.65	.05	.51	.581
I burst out over anything	2.04	.04	1.72	.05	27.62	.000
I try to control my emotions	3.05	.03	3.03	.04	.14	.713

Table 3. Influence of fear of contagion over the items of depression, anxiety, intolerance of uncertainty and coping

<b>Depression</b>	Contagion		Non contagion		<i>F</i> (1,801)	<i>p</i>
	<i>M</i>	<i>DE</i>	<i>M</i>	<i>DE</i>		
<i>F</i> Hotelling(4,798) = 9.12; <i>p</i> <.000 [Cohen's <i>d</i> = .29; 95% CI (.09 - .47)]						
I am more irritated than before	2.28	.03	1.99	.07	13.80	.000
I feel sad	2.43	.03	2.05	.07	29.89	.000
I do not sleep as well as before	2.40	.04	2.04	.08	16.27	.000
I feel guilty when I am resting	1.79	.03	1.51	.08	10.86	.000
<b>Anxiety</b> <i>F</i> Hotelling(6,795) = 37.67; <i>p</i> <.000 [Cohen's <i>d</i> = .58; 95% CI (.39 - .77)]						
					<i>F</i> (1,801)	
I feel insecure	2.28	.03	1.81	.07	33.16	.000
I feel scared	2.47	.03	1.82	.07	69.51	.000
I feel discomfort in my stomach	1.96	.03	1.56	.08	22.39	.000
My body is tense	2.57	.03	2.15	.08	24.55	.000
I cry or am moved easily	2.47	.04	2.02	.08	24.23	.000
I move and do things without an end in themselves	1.93	.03	1.60	.07	17.15	.000
<b>Intolerance of uncertainty</b> <i>F</i> Hotelling(3,801) = 13.81; <i>p</i> <.000 [Cohen's <i>d</i> = .35; 95% CI (.16 - .54)]						
					<i>F</i> (3,801)	
I cannot be at peace if I do not know what will happen tomorrow	2.26	.04	1.76	.08	33.46	.000
Unexpected circumstances bother me a lot	2.49	.03	2.19	.08	12.89	.000
I feel that even with the best planning, a small unexpected inconvenience might ruin it all	2.40	.04	1.95	.08	27.54	.000
<b>Coping</b> <i>F</i> Hotelling(8,783) = 3.14; <i>p</i> <.000 [Cohen's <i>d</i> = .16; 95% CI (.02 - .35)]						
					<i>F</i> (1,790)	
I exclusively focus in what I have to do, step by step	3.31	.03	3.36	.06	.082	.775
I propose a different solution when the protocol fails	2.77	.03	2.82	.07	.357	.550
I speak to someone who can help me when the situation overwhelms me	2.99	.03	3.09	.07	1.43	.231
I try to bring something positive out of the situation	3.12	.03	3.32	.06	7.67	.006
I try not to think about what is happening	2.26	.03	2.15	.08	1.59	.207
I accept it since there is nothing I can do about it	2.63	.03	2.58	.08	.377	.539
I burst out over anything	1.97	.03	1.64	.07	17.87	.000
I try to control my emotions	3.02	.03	3.13	.07	2.30	.130

Table 4. Influence of the fear of infecting their loved ones over the items of depression, anxiety, intolerance of uncertainty and coping

<b>Depression</b>	Fears		Does not fear		<i>F</i> (1,801)	<i>p</i>
	<i>M</i>	<i>DE</i>	<i>M</i>	<i>DE</i>		
<i>F Hotelling</i> (4,798) = 2.45; <i>p</i> < .000 [Cohen's <i>d</i> = .115; 95% CI (-.03 - .26)]						
I am more irritated than before	2.40	.05	2.14	.04	19.10	.000
I feel sad	2.56	.05	2.25	.04	27.34	.000
I do not sleep as well as before	2.56	.05	2.14	.04	25.56	.000
I feel guilty when I am resting	1.96	.05	1.63	.04	26.41	.000
<b>Anxiety</b> <i>F Hotelling</i> (6,795) = 8.36; <i>p</i> < .000 [Cohen's <i>d</i> = .212; 95% CI (.07 - .36)]						
					<i>F</i> (1,801)	
I feel insecure	2.39	.05	2.09	.04	21.82	.000
I feel scared	2.59	.05	2.23	.04	36.25	.000
I feel discomfort in my stomach	2.10	.05	1.79	.04	22.52	.000
My body is tense	2.72	.05	2.38	.04	25.84	.000
I cry or am moved easily	2.39	.05	2.09	.04	21.82	.000
I move and do things without an end in themselves	2.59	.05	2.23	.04	36.25	.000
<b>Intolerance of uncertainty</b> <i>F Hotelling</i> (3,801) = 21.73; <i>p</i> < .000 [Cohen's <i>d</i> = .342; 95% CI (.20 - .49)]						
					<i>F</i> (3,801)	
I cannot be at peace if I do not know what will happen tomorrow	2.47	.05	2.00	.04	49.33	.000
Unexpected circumstances bother me a lot	2.62	.05	2.34	.04	18.67	.000
I feel that even with the best planning, a small unexpected inconvenience might ruin it all	2.62	.05	2.17	.04	45.44	.000
<b>Coping</b> <i>F Hotelling</i> (8,783) = 4.43; <i>p</i> < .000 [Cohen's <i>d</i> = .154; 95% CI (.01 - .30)]						
					<i>F</i> (1,790)	
I exclusively focus in what I have to do, step by step	3.32	.04	3.31	.03	.07	.793
I propose a different solution when the protocol fails	2.82	.05	2.75	.04	1.27	.259
I speak to someone who can help me when the situation overwhelms me	2.97	.05	3.04	.04	1.16	.282
I try to bring something positive out of the situation	3.12	.05	3.18	.04	1.11	.293
I try not to think about what is happening	2.31	.05	2.21	.04	2.33	.127
I accept it since there is nothing I can do about it	2.67	.05	2.61	.04	1.04	.307
I burst out over anything	2.13	.05	1.80	.04	30.16	.000
I try to control my emotions	3.02	.04	3.05	.03	.21	.644

Table 5. Fear of having to decide who to attend related to the items of depression, anxiety, intolerance of uncertainty and coping

<b>Anxiety</b>	Containment		Non containment		<i>F</i> (1,384)	<i>p</i>
	<i>M</i>	<i>DE</i>	<i>M</i>	<i>DE</i>		
<i>F</i> Hotelling(6, 379) = 1.73, <i>p</i> < .113 [Cohen's <i>d</i> = .13; 95% CI (.06 - .31)]						
I feel insecure	1.99	.08	2.12	.05	1.85	.18
I feel scared	2.13	.09	2.38	.05	6.09	.01
I feel discomfort in my stomach	1.69	.09	1.96	.05	6.45	.01
My body is tense	2.39	.09	2.48	.05	.75	.39
I cry or am moved easily	2.28	.10	2.36	.06	.56	.46
I move and do things without an end in themselves	1.76	.09	1.85	.05	.81	.37
<b>Intolerance of uncertainty</b> <i>F</i> Hotelling(3,801)=21.73; <i>p</i> < .000 [Cohen's <i>d</i> = .44; 95% CI (.25 - .63)]						
<i>F</i> (1,383)						
I cannot be at peace if I do not know what will happen tomorrow	2.00	.09	2.17	.05	2.40	.112
Unexpected circumstances bother me a lot	1.15	.08	2.49	.05	11.97	.001
I feel that even with the best planning, a small unexpected inconvenience might ruin it all	2.08	.09	2.34	.05	6.46	.011
<b>Coping</b> <i>F</i> Hotelling(8,374) = 2.65; <i>p</i> < .008 [Cohen's <i>d</i> = .16; 95% CI (.03 - .34)]						
<i>F</i> (1,790)						
I exclusively focus in what I have to do, step by step	3.39	.08	3.29	.05	1.04	.307
I propose a different solution when the protocol fails	2.95	.09	2.73	.05	4.74	.030
I speak to someone who can help me when the situation overwhelms me	3.20	.08	2.96	.05	6.52	.011
I try to bring something positive out of the situation	3.34	.08	3.14	.05	4.69	.031
I try not to think about what is happening	2.29	.08	2.29	.05	.005	.944
I accept it since there is nothing I can do about it	2.63	.09	2.55	.05	.609	.436
I burst out over anything	1.71	.08	1.98	.05	7.51	.006
I try to control my emotions	2.98	.07	3.05	.04	.641	.424

Table 6. Influence of the participation in containment groups over the items of anxiety, intolerance of uncertainty and coping