



Research Paper

Fear of COVID-19, Psychological distress and Social support among the Working People of Assam during the 2nd Wave of COVID-19 Pandemic.

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Abstract

The global pandemic of COVID-19 has imposed psychological distress and fear across the globe; however, factors associated with those issues or the ways people cope may vary by country or context. This current study was conducted to investigate the relationship between psychological distress, fear, and social support for working professionals living in Assam during the COVID-19 pandemic. A correlational study was conducted from 28th May to 5th June of 2021 during the 2nd wave of COVID-19 using online platforms in Assam. Working professionals residing in Assam who were proficient in English and able to respond to online questionnaires. A total of 60 samples were comprised in the study (30= Healthcare Professionals, 30= Other Working Professionals). Kessler Psychological Distress Scale (K-10), Fear of COVID-19 Scale and The Multidimensional Scale of Perceived Social Support were used to gather data. The findings of the study revealed that there was a significant relationship between fear of COVID-19 and psychological distress, psychological distress and social support, but no significant difference existed between fear of COVID-19 and social support. Furthermore, it was seen that there was a significant gender difference between males and females on fear of COVID-19 and psychological distress female scored higher than the male, whereas no significant difference was seen in the level of social support. Regarding the implication of the study effective interventions should be provided to support the vulnerable groups and utmost importance should be provided to mental health services during the pandemic.

Keywords: Fear of COVID-19, Psychological distress, Social support, Healthcare professionals, other Working professionals.

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I. INTRODUCTION

The world is currently experiencing a dramatic disruption in daily life due to the rapid advance of the 2019 coronavirus disease (COVID-19) pandemic. Many countries, including India, are facing an unprecedented health emergency due to the spread of the novel coronavirus 2019 (COVID-19). The virus was first detected in a fish market in China in December 2019 (Yu et al., 2020). Due to the spread of the virus in almost all countries and territories in March 2020, the World Health Organization (WHO) declared it a pandemic. In 2020, 56,342 positive cases were reported in India. India, the second-largest population in the world with a population of more than 1.34 billion, has struggled to control the transmission of coronavirus, the severe acute respiratory syndrome, among its population. As of May 28, 2020, India became the country with the highest number of confirmed cases in the world (after the United States) with 26.7 million reported cases of COVID-19 infections and the third-highest number of deaths from COVID-19 (after the US and Brazil) with 307,231 deaths. But slowly on June 10, India's recovery surpassed active falls for the first time. Infection rates began to decline in September, along with the number of new and active cases. The number of cases peaked in mid-September, with more than 90,000 reported cases per day, and dropped to less than 15,000 in January 2021.

But again on 10th February 2021, the second wave re-appeared, India confirmed 11,000 cases of coronavirus, in the succeeding 50 days the average number of COVID-19 cases was around 22,000. But in the preceding 10 days, cases rose increasingly with the daily average reaching 89,800. Most of the cities in India were reporting a chronic shortage of hospital beds which was evident on social media platforms as a desperate

cry for help. Several state governments promised arrangements for new facilities but experts say it's going to be hard to keep up with the sustained pace of the rising number of infections. With a comparatively high transmission rate and fatal potential, the COVID-19 pandemic is responsible for widespread fear and psychological distress all over the world, including in India.

Fear is an adaptive emotion that helps to mobilize energy to cope with a potential threat. Fear has been reported as one of the most recurrent emotions linked with COVID-19 pandemic. Uncertainty, constant worry, anxiety, exposure to media, personal health and the risk to loved ones are the predictors of fear for this disease. Potential stressors associated with the virus might be the fear of infection with COVID-19 and the repercussions for oneself or loved ones. One study showed that fear is an adaptive response to the existence of danger and can develop chronic and burdensome when the threat is ambiguous and continuous, as in the case of the Coronavirus disease (COVID-19) pandemic (Mertens et al., 2020). Fear is a subjective conscious experience that is associated with various psychological and sociological factors (LeDoux 2014; Baldassarre et al., 2020; Taylor et al., 2020). Labrague and Santos (2020) found a positive relationship between fear of COVID-19 and psychological distress among frontline nurses. Since frontline nurses are actively involved as the caretakers of patients with coronavirus, their risk of contracting COVID-19 is higher than the general population which in turn increases the level of fear and psychological distress among them. The distress levels are primarily high amongst the young, females, people working in the private sector as well as health workers, especially those working in the frontline. Healthcare workers generally work under stressful conditions without proper protective equipment and make difficult decisions involving ethical implications. Health and social systems across the globe are struggling to cope. The situation is especially challenging in humanitarian, fragile and low-income country contexts, where health and social systems are already weak leading to psychological distress among the population globally.

Psychological distress is described as an emotional condition characterised by symptoms of depression and anxiety and is recognised as a widespread mental health problem in the population (Dohrenwend & Dohrenwend, 1982). Mental health and related difficulties are often overlooked by the general public, and these "silent" and insidious issues may go unreported in the face of a worldwide epidemic. Some of the factors noted, collective experiences that influenced overall well-being during lockdown included confinement in homes, lack of movement, worry when shopping, fear of COVID-19 contraction, loss of income, adjustment to the new normal, and growing ambiguity (Grover et al., 2020). The COVID-19 outbreak has added to the pressures already present, negatively impacting the population's mental health and making them vulnerable to mental disorders. COVID-19 has been linked to decreased mental health (Saladino et al., 2020), increased suicide thoughts (Sher, 2020), and anger for people who already have mental health problems (Asmundson et al., 2020). It has also had a significant impact on family and societal dynamics (Pietromonaco & Overall, 2021).

Research showed many physiological and psychological health advantages of social support, containing improved immune, cardiovascular, and neuroendocrine function; positive adjustment to chronic disease; reduced depression and anxiety; and effective buffering against the negative effects of stress (Umberson & Montez, 2015). Social support plays an important role in assisting people who experience fear and psychological distress, particularly in difficult times like the COVID-19 pandemic which has caused unprecedented disruption worldwide. Social support is defined as a set of supportive measures made available to an individual through social ties with family members, relatives, friends, and the larger community. One of the social resources for coping with difficult life situations is social support. The stress levels of patients with major health conditions were reduced when they received social support (Siegel et al., 2005; Widows et al., 2005). It is thought to be a protective factor against physical and mental health issues that occur as a result of traumatic life events (Grills, Taquechel et al., 2011; Kaniasty, 2012; Prati & Pietrantonio, 2010). It improves a person's ability to communicate toward mutual commitments, appreciation, and a sense of others so that social support can provide pleasant experiences and resources in stressful times (Panayiotou & Karekla, 2013).

In India, there are few studies on the impact of COVID-19 on mental health, and most of them were conducted among students. The COVID-19 pandemic has harmed people, particularly healthcare workers, not just physically but also mentally. (Al-Hanawi et al., 2020) reported that 40% of the Saudi population were distressed due to COVID-19, of which approximately 33% are mildly distressed, while 7% are severely distressed.

Therefore, the present study examines the interdependencies between fear of COVID-19, psychological distress and social support among the working people of Assam during the 2nd wave of COVID-19.

Objectives of the Study

O1: To explore the relationship between Fear of COVID-19, Psychological distress and Social support among working people of Assam during the 2nd wave of COVID-19 pandemic.

O2: To make a gender-wise comparison on Fear of COVID-19, Psychological distress and Social support among working people of Assam during the 2nd wave of COVID-19 pandemic.

Hypotheses of the Study

H1: There would exist a significant positive correlation relationship between Fear of COVID-19 and Psychological distress among working people of Assam during the 2nd wave of COVID-19 pandemic.

H2: There would exist a significant negative correlation between Psychological distress and Social support among working people of Assam during the 2nd wave of COVID-19 pandemic.

H3: There would exist a significant negative correlation between Fear of COVID-19 and Social support among working people of Assam during the 2nd wave of COVID-19 pandemic.

H4: There will be a significant gender difference in Fear of COVID-19 among working people of Assam during the 2nd wave of COVID-19 pandemic.

H5: There will be a significant gender difference in psychological distress among working people of Assam during the 2nd wave of COVID-19 pandemic.

H6: There will be a significant gender difference in social support among working people of Assam during the 2nd wave of COVID-19 pandemic.

II. Method

The purpose of the study is to understand the relationship between Fear of COVID-19, Psychological distress and Social support among the working people of Assam during the 2nd wave of the COVID-19 pandemic. This research will address the correlation and gender differences between Fear of COVID-19, Psychological distress and Social support among the working people of Assam. Thus, the research design adopted in the current study is a correlational research design that will help the researcher to understand the relationship between the variables.

Participants

The geographical location used for the study is Assam, a northeast state of India. Out of 33 districts, Dibrugarh, Guwahati and Tezpur districts were taken into consideration for the collection of data. There is an alarming rate of increasing COVID-19 incidence in Dibrugarh, Guwahati and Tezpur districts particularly and all over Assam. Studies showed that the spread pattern was indeed exponential in Assam during the 2nd wave of COVID-19. However, no such studies have been carried out categorising the districts. The sample in this study comprised 60 working people of Assam, both male and female. (30= Healthcare workers, 30= Other Working Professionals) within the age group of 24-40.

Procedure-

An online survey for assessing fear of COVID-19, psychological distress, and social support among the working people of Assam during the 2nd wave of COVID-19 was conducted from 28th May to 5th June of 2021. The survey was done exclusively using a self-administered form in English. The response questionnaire was designed using simple Google Forms. A message requesting people to participate in the study, which included a consent form and the link to the study form, was shared with the contacts of authors through text messaging, Emails, and social media platforms such as What's app and Facebook. The sample was collected using a snowball sampling strategy. The participants were asked to forward the message or link further to their contacts. Anonymity was ensured and no personal identification, such as IP address, email IDs, or details of COVID-19 exposures, was collected. Participation in the study was on a purely voluntary basis. The survey also used previously validated questionnaires like the Fear of Covid-19 Scale, Kessler Psychological Distress Scale and Multi-dimensional Scale Perceived of Social Support and socio-demographic data. The time taken to complete the questionnaire was 10-20 minutes. Data were analysed using SPSS software. Descriptive statistics were used, including percentages (%), means, and standard deviations (SDs). Independent samples t-tests were used to check variations across demographic groups. Furthermore, Pearson's correlation coefficient was used to determine the relationships among the variables.

Measures

1. Socio-demographic Datasheet (Self, 2021)

The second section of the form collected information about socio-demographic profiles such as age, gender, place, and occupation.

2. Fear of COVID-19 Scale (Ahorsu et al., 2020)

The third section consists of the Fear of COVID-19 Scale which was developed by Ahorsu et al in 2020, is a novel self-rated scale with 7 items established after the coronavirus occurrence and has been validated for measuring fear in the general population and has robust psychometric properties (Cronbach's α : 0.82). In this scale, the participants score their level of agreement on a five-point Likert scale relating to fear about coronavirus disease 2019. Higher overall scores show a more severe fear of COVID-19.

3. Kessler's Psychological Distress Scale (Kessler & Mroczek, 1992)

The K-10 scale is a five-point Likert scale developed by Kessler & Mroczek in the year 1992 consisting of 10 questions that assess the emotional state of a person. The self-rated scale is used as a screening measure for psychological problems such as depression and anxiety among the general population, and higher scores on the scale indicate a warrant for further clinical assessment of an individual to confirm the diagnosis. The K-10 scale was chosen for the current study considering its brief nature, good reliability, and validity. Each item is scored from one 'none of the time' to five 'all of the time'. Scores of the 10 items are then summed, yielding a minimum score of 10 and a maximum score of 50. Low scores on the scale imply low levels of psychological distress and high scores show high levels of psychological distress.

4. Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet & Farley, 1988)

The Multidimensional Scale of Perceived Social Support (Zimet et al., 1988) is a 12-item measure of perceived adequacy of social support from three sources: family, friends, & significant other; developed by Zimet, Dahlem, Zimet and Farley (1988) using a 5-point Likert scale (0 = strongly disagree, 5 = strongly agree) each of these groups consists of four items. A seven-point rating scale spanning from very strongly disagree (1) to very strongly agree (7) was used to reduce the ceiling effect and boost response. The reliability of the scale was found to be .85, and the validity was found to be $r = .25, p.01$.

III. Results and Discussion

Socio-demographic data

The following tables highlight the proportion among the certain socio-demographic categories of male and females working people of Assam during the 2nd wave of COVID-19.

Figure 1.1 represents the total no. of participants

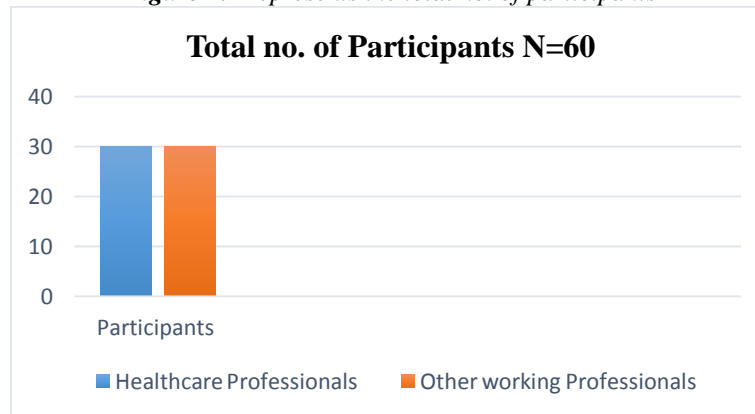


Figure 1.2 represents the gender of participants

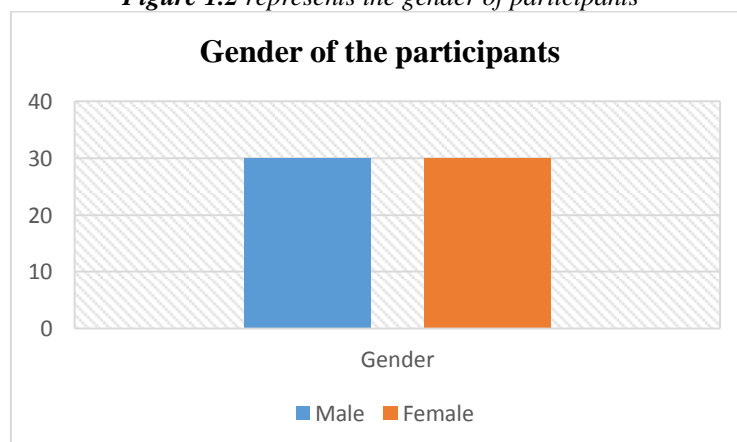
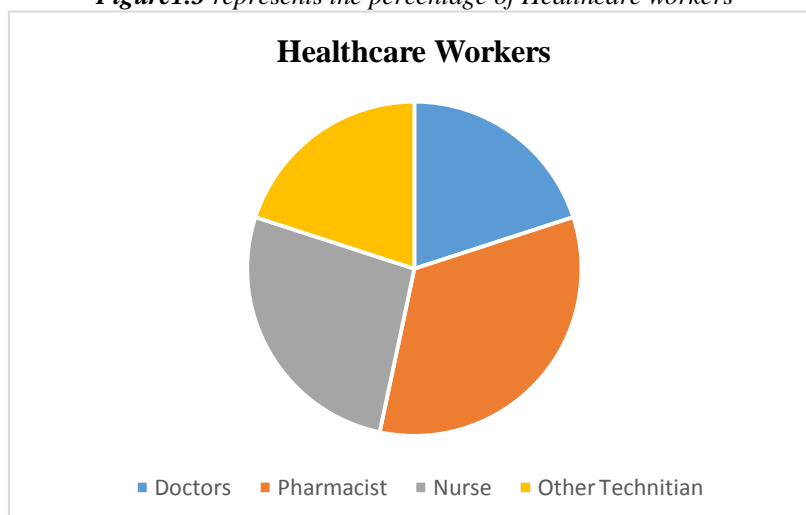
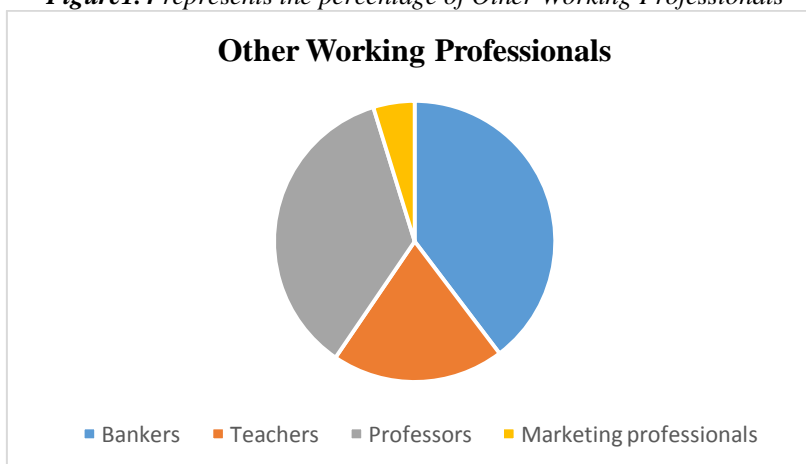


Figure 1.3 represents the percentage of Healthcare workers



Health care workers comprised 20% doctors, 33% pharmacists, 27% nurses, and 20% other technicians.

Figure 1.4 represents the percentage of Other Working Professionals



Other Working Professionals comprised 40% bankers, 20% teachers, 36% professors and 5% marketing professionals.

H1: There would exist a significant positive correlation relationship between Fear of COVID-19 and Psychological distress among working people of Assam during the 2nd wave of COVID-19 pandemic.

Table 1: Showing Pearson's correlation coefficient between Fear of COVID-19 and Psychological distress among the working people of Assam during the 2nd wave of COVID-19 pandemic. (N=60)

Variables	Mean	SD	Fear of COVID-19	Psychological distress
Fear of COVID-19	27.08	5.93	1	.538** .000
Psychological distress	21.23	4.09		1

**p<0.01

From the above table 1, it is evident that there is a significant relationship between fear of COVID-19 and psychological distress (.588*, p<0.01). The findings of the present study are consistent with the previous findings which were conducted by Sathe et al., (2020) during the COVID-19 lockdown among the Indian population and reported a relationship between fear of COVID-19 and Psychological distress. Similarly, Masuyama et al., (2021) found that fear of COVID-19 was positively correlated with psychological distress among the Japanese people. Labrague and Santos, (2020) found a positive relationship between fear of COVID-19 and psychological distress among frontline nurses. Since frontline nurses are directly involved in patient care, their risk of contracting COVID-19 is higher than the general population which in turn increases

level of fear and psychological distress among them. In Ethiopia 25.5% of participants had high psychological distress during the COVID-19 pandemic (Ambelu et al., 2020). Reizer et al., (2020) found a positive relationship between Fear of COVID-19 and psychological distress among Israeli women. Apart from the people working in the health care departments, Maity et al., (2020) reveal that a significant segment of employees are severely challenged by the life-threatening virus especially the employees absorbed in private commercial establishments or factories where the sector of employment, nature of the industry, or job profile denies the concept of “work from home”. Constant disclosure of the news about worldwide fatalities or infection rate of the pandemic has led individuals to experience fear and distress among the people. The worries about the risk of getting infected increase fear among the general public (Lin, 2020).

Thus, hypothesis 1 “There would exist a significant positive correlation relationship between Fear of COVID-19 and Psychological distress among working people of Assam during the 2nd wave of COVID-19 pandemic” is accepted.

Table 2: Showing Pearson’s correlation coefficient between Psychological distress and Social support among the working people of Assam during the 2nd wave of COVID-19 pandemic (N=60).

Variables	Mean	SD	Psychological distress	Social support
Psychological distress	21.23	4.09	1	.327* .011
Social support	65.62	9.74		1

*P<0.05

H2: There would exist a significant negative correlation between Psychological distress and Social support among working people of Assam during the 2nd wave of COVID-19 pandemic.

It can also be observed from table 2 that there is a positive relationship between Psychological distress and Social support (.327**, p<0.05), which means that as the scores of psychological distress increase, the scores of social support also increase. Previous studies which are consistent with the finding of this study as such Shechter et al., (2020) conducted a study among health workers during the COVID-19 pandemic in New York and found a relationship between psychological distress and social support. Health-care workers are a vital part of the population particularly affected by stress (Garcia-Castrillo et al., 2020; Lai et al., 2020). Health-care workers are at threat to develop symptoms common in catastrophic situations, such as post-traumatic stress disorder, burnout syndrome, physical and emotional fatigue, depersonalization, and dissociation (Grassi & Magnani, 2000; Mache et al., 2012; Øyane et al., 2013). So, it is important to look after the mental health of the working people, especially in this time of crisis, social support becomes an essential part of everybody’s lives. Previous studies on COVID-19 pandemics have shown that the psychological effects of infectious disease outbreaks can persist long after the event, negatively impact mental well-being (Magnavita et al., 2020) and cause post-traumatic stress disorder, depression and stress in health workers (Mauder, 2020; Bissonet al., 2010). In the context of the pandemic crisis, healthcare workers are expected to be exposed to traumatic experiences from patients and the unexpected loss of friends, family and colleagues, which results in healthcare workers suffering from psychological distress such as depression, anxiety and are affected by stress (Li, 2021).

Thus hypothesis 2 “There would exist a significant negative correlation between Psychological distress and Social support among working people of Assam during the 2nd wave of COVID-19 pandemic” is accepted.

Table 3: Showing Pearson’s correlation coefficient between Fear of COVID-19 and Social support among the working people of Assam during the 2nd wave of COVID-19 pandemic (N=60).

Variables	Mean	SD	Fear of COVID-19	Social support
Fear of COVID-19	27.08	5.93	1	-.106 .421
Social support	65.62	9.74		1

H3: There would exist a significant negative correlation between Fear of COVID-19 and Social support among working people of Assam during the 2nd wave of COVID-19.

It can be seen from table 3, that there is no significant relationship between the Fear of COVID-19 and social support among the working people of Assam during the 2nd wave of COVID-19 pandemic. Alnazly et al.,(2021) found a weak relationship between fear and social support among Jordanian healthcare workers during the COVID-19 pandemic. The study conducted by Sasaki et al.,(2020)suggested amount of prevention measures was negatively relatedto the psychological distress of the employees and positively associated with their performance, signifying how scrupulous prevention measures decrease psychological distress, safeguarding work outcomes, which might reduce the level of fear among them. One possible reason could be that throughout the time people are trying to adaptto the new situation of COVID-19 and awareness of proper health measure were described by the health authority. By the time of the 2nd wave, people came to know about the precautions techniques such as wearing a mask, using hand sanitizers, and maintaining social distancing due to COVID-19. Additionally, as people are confined to their homes, so family members provide helping hands to each other’s therefore, increasing the level of bonding. Furthermore, not many studies have been conducted to explore the relationship between Fear of COVID-19 and social support.

Thus the hypothesis 3 “There would exist a significant negative correlation between Fear of COVID-19 and Social support among working people of Assam during the 2nd wave of COVID-19 pandemic” is not accepted.

H4: There would exist a significant gender difference in Fear of COVID-19 among working people of Assam during the 2nd wave of COVID-19 pandemic.

Table 4: Showing the gender difference in Fear of COVID-19 among the working people of Assam during the 2nd wave of COVID-19 pandemic (N=60).

Variable	Gender	N	Mean	df	t-value	Sig/not sig
Fear of COVID-19	Female	30	23.83	58	-6.36	.000
	Male	30	18.63			

It is evident from Table 4that the t-value of Fear of COVID-19 of male and female working people of Assam is (-6.36) which is significant. It indicates that the level of Fear of COVID-19 is different among both genders. Further, the mean score revealed that females (M=23.83) are found to be higher compared to their male counterparts (M=18.63).

The result of the current study is consistent with the previous findingswhere Srivastava et al., (2020), andBroche-Pérez et al.,(2020) found in their study that the level of fear of COVID-19 among females was comparatively high than the male counterparts.Lim, (2018); Wang et al.,(2020) found that females are moreprone to stress, depression and anxiety. Likewise, females have 1.29 times significantly higher odds to fear COVID-19 compared with their male counterparts.Isolation, social distancing and quarantine during a pandemic affected people emotionally and psychologically, which lead to higher rates of loneliness, fear etc.(Brooks et.al 2020).Fear is related to the stigmatization of citizens who are perceived as the source of the disease, with the risk of civil conflicts. The data analysed byQui et al., (2020), and Sakib et al.,(2020) showed that women show increased fear compared to men which correspondswith the findings of recent studies as women display a higher vulnerability to stress. Yildirim et al., (2021) reported that females had a greater vulnerability, perceived risk, fear, and preventive behaviours than males.Rahman et al., (2021) found in their study that females, with married status, lower educational status and being health care workers displayed significantly higher odds of a high level of fear compared to their respective counterparts in the study population.Hu et al., (2020) examined mental health (burnout, anxiety, depression and fear) and their associated factors among frontline nurses who were caring for COVID-19 patients in Wuhan, China and found on an average, the participants had a moderate level of burnout and a high level of fear.

Thus, hypothesis H4“There would exist a significant gender difference on Fear of COVID-19 among the working people of Assam during the 2nd wave of COVID-19 pandemic” is accepted.

H5: There would exist a significant gender difference in psychological distress among the working people of Assam during the 2nd wave of COVID-19 pandemic.

Table 5: Showing the gender difference inpsychological distress among the working people of Assam during the 2nd wave of COVID-19 pandemic (N=60).

Variable	Gender	N	Mean	df	t-value	Sig/not sig
Psychological distress	Female	30	30.73	58	-6.02	.000
	Male	30	23.43			

It is evident from Table 5that the t-value of psychological distress among males and females of the working people of Assam is (-6.02) which is significant. It indicates that there is a significant difference in the level of psychological distress among both genders. Further, the mean score reveals that females (M=30.73) are found to be higher as compared the males (M=23.43).

The findings of the present study are consistent with the previous studies as such Salgado et al., (2020) analysed psychological distress during the COVID-19 pandemic and found a high level of psychological distress (72.0%), with a higher ratio in women and people belonging to lower-middle age. The predictive variables with the highest weight were sex, presence of symptoms, and have had close contact with an individual with confirmed COVID-19. Rahman et al., (2020) showed that females had higher distress and fear of COVID-19, which was consistent with studies done in China, Italy and the USA by (Qiu et al., 2020; Gausman & Langer, 2020; French et al., 2020), indicating that women were a consistent predictor for psychological distress. A host of possible reasons can be suggested for this, as females disproportionately dedicate a large proportion of caregiving roles, in both formal and informal sectors. They also serve as the primary caregivers more frequently, within a household, which may further accentuate their anxiety and stress in a pandemic situation (Langer et al., 2015). Another reason may be such distress could be correlated with increased use of social media, as participants may watch and listen to much more negative news, which would then exaggerate their feelings of anxiety and depression in times of despair. Worries about the health-related dangers of the COVID-19 have been strongly linked to distress (Taylor et al., 2020). Al-Hanawi et al., (2020) reported that 40% of the Saudi population were distressed due to COVID-19, of whom approximately 33% are mildly distressed, while 7% are severely distressed. The distress levels are predominantly high amongst the young, females, people working in the private sector and health workers, especially those working on the frontline. Ruiz-Frutos (2020) conducted a study among non-health workers during a pandemic and found that 65.1% revealed psychological distress, 71.6% were women and 52.4% were men showed.

Being female, perceived distress due to change of employment status, self-identification as a health care professional, people working in private sectors being affected by the change of financial situation, comorbidity with mental health conditions, unsure and indirect contact with COVID-19 patients, use of healthcare service to overcome COVID-19 related stress, and higher levels of fear of COVID-19 were found to be associated with moderate to very high levels of psychological distress.

Thus, hypothesis H5 “There would exist a significant gender difference on psychological distress among the working people of Assam during the 2nd wave of COVID-19 pandemic” is accepted.

H6: There would exist a significant gender difference in social support among the working people of Assam during the 2nd wave of COVID-19 pandemic.

Table 6: Showing the gender difference in social support among the working people of Assam during the 2nd wave of COVID-19 pandemic (N=60).

Variable	Gender	N	Mean	df	t-value	Sig/Not sig
Social support	Female	30	66.50	58	-6.99	Not sig
	Male	30	64.73			

It is evident from table 6 that the t-value of social support among the female and male working peoples of Assam is (-6.99) which is not significant. It indicates that there is no significant difference in the level of social support among both genders. Further, the mean score reveals that females (M=66.50) are found to be higher as compared to the males (M=64.73).

The result of the present study is consistent with previous findings conducted by Alnazly et al., (2021) where no significant difference existed among both the gender on the level of social support during the COVID-19 pandemic among Jordanian healthcare workers. Heath et al., (2020) suggested that healthcare professionals who have strong, healthy meaningful personal and professional relationships are happy and shown to have a lower risk of burnout. Even though some studies showed that females have a high level of social support than males as such (Kahn & Antonucci, 1980) reported that women, compared to men, tend to have broader and more supportive networks with a greater number of close partners. Acitelli and Antonucci, (1994) also found that women were more likely to be in contact with people in their support network than men. But in the present study, no significant gender difference was seen in social support, one possible reason might be that, during the pandemic period, where people are trying to adjust to the new normal, in this social world, every individual needs social support irrespective to their gender. Since people’s mental health was at stake, family members and close ones tried to support the working people, so that they could have better job performance during a pandemic such as health workers saving other people’s lives. So, Social support is essential as a coping mechanism to decrease healthcare workers’ as well as other working professionals’ psychological distress and enhance positive feelings.

Social support is an important coping mechanism that can help decrease psychological distress among healthcare workers and foster positive feelings. Spinale et al., (2008) suggested that social support is associated

with spirituality. Spirituality is related to transcendental values that are normally inclined by personal experiences of an individual and rooted in religious backgrounds. Spirituality can promote positive feelings and foster physical and psychological health (Spinale et al., 2008). Studies suggested that people with superior spirituality have also been reported to experience higher levels of well-being. Thus, enhancing spirituality among healthcare workers during the COVID-19 pandemics may assist them to relieve their physiological and mental distress, and also support co-workers, patients and their family members. This is specifically imperative during traumatic calamities, as these are tough times when spiritual experts or religious leaders are incompetent to diligently contact patients and healthcare workers.

Thus, hypothesis H6 “There would exist a significant gender difference on social support among the working people of Assam during the 2nd wave of COVID-19 pandemic” is not accepted.

IV. Conclusion

The current COVID-19 pandemic caused psychological distress, and fear among large proportions of the general population as well as people working in the health care sector. Potential stressors associated with the coronavirus might be the fear of infection with COVID-19 and the consequences for oneself or loved ones. This study indicated a relationship between fear of COVID-19 and psychological distress, psychological distress and social support except no relationship was found between fear of COVID-19 and social support. The present findings suggest the symptoms of psychological distress and fear of COVID-19 are common among females. As such symptoms may adversely disturb the job performance of healthcare workers (Kolehmainen et al., 2015) and their health if continuously (Bisson, 2019). An evaluation of mental health check-ups is necessary if they are facing any kind of mental stress. Moreover, future research is required to explore the long-term effects of the COVID-19 pandemic on healthcare workers and other working professionals.

Implication

People with pre-existing mental health problems are more prone to experience higher psychological distress, which could worsen their well-being. An automated alert from primary healthcare professionals to those susceptible individuals for a follow-up visit would help manage their distress. In addition, this study indicated that females were more vulnerable to psychological distress, and as such socio-cultural contexts should be recognised and supported accordingly. Specific interventions to support the mental health of people with high risk as identified in this study should be considered within primary healthcare settings. Innovative technologies such as interactive mobile apps to support mental health can be developed and tested for effectiveness in future. In addition, to deal with the adverse effects of the pandemic, resilience training programs should be conducted particularly for healthcare professionals, law enforcement and the general public: (a) equilibrium between family life and work-life; (b) transparency of information on the disease and its significances on psychological well-being; (c) knowledge and training of people for pandemics and epidemics in the future; and (d) frontline healthcare worker’s validation and evaluation for their noteworthy contribution.

Limitations

As the study is conducted through an online survey, rather than face-to-face random sampling, and requirements of participants to use the internet. Therefore, it is unclear whether the results can be generalized to the whole population. Its reach is also limited by its small sample size and snowball sampling approach; larger research with randomised sampling are required for more accurate forecasts. Furthermore, the tool used for assessing fear of COVID-19 is relatively new. As the study followed a correlational approach, it could not capture the changing trends during multiple lockdowns observed in India.

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