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Depression, Anxiety, and Suicidal Ideation in Health Care Professionals Attended at a Psychological Helpline for COVID-19 Pandemic Sufferers

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A B S T R A C T

The aim of this study was to examine the levels of depression, anxiety, and suicidal ideation among health care professionals who sought professional help for psychological problems during the COVID-19 pandemic. These psychopathological constructs were measured using the PHQ-2, the GAD-2, and the suicide item from the PHQ-9, respectively, in a sample of 238 health care professionals who contacted a nationwide psychological helpline. Findings show that 52.5% had clinical levels of depression, 71% had clinical levels of anxiety, and 7.1% reported suicidal ideation, with no differences across health care roles (nurses, physicians, other roles). These figures, for depression and anxiety, are two to three times higher than those found in the general population of health care professionals during the pandemic but are similar for suicidal ideation. The results also indicate a higher prevalence of clinical levels of depression and anxiety among professionals who were currently receiving or had received professional help for psychological problems (67.2% and 84.6%, respectively). These findings confirm global concerns about the psychological impact of the pandemic on health care professionals and underscore the importance of integrating mental health into future health crisis response planning.

Depresión, ansiedad e ideación suicida en profesionales de la salud atendidos en una línea de ayuda psicológica para afectados por la pandemia de COVID-19

R E S U M E N

El objetivo del presente estudio fue examinar los niveles de depresión, ansiedad e ideación suicida entre profesionales sanitarios que buscaron ayuda profesional por problemas psicológicos durante la pandemia de COVID-19. Estos constructos psicopatológicos se midieron utilizando el PHQ-2, el GAD-2 y el ítem de suicidio del PHQ-9, respectivamente, en una muestra de 238 profesionales sanitarios que contactaron con una línea de ayuda psicológica de alcance nacional. Los resultados muestran que el 52,5% presentaba niveles clínicos de depresión, el 71% niveles clínicos de ansiedad, y el 7,1% reportó ideación suicida, sin diferencias entre los distintos roles profesionales (enfermeros/as, médicos/as, otros). Estas cifras, en cuanto a depresión y ansiedad, son de dos a tres veces superiores a las encontradas en la población general de profesionales sanitarios durante la pandemia, aunque son similares en cuanto a la ideación suicida. Los resultados también indican una mayor prevalencia de niveles clínicos de depresión y ansiedad entre los profesionales que actualmente estaban recibiendo o habían recibido previamente ayuda profesional por problemas psicológicos (67,2% y 84,6% respectivamente). Estos hallazgos confirman las preocupaciones globales sobre el impacto psicológico de la pandemia en los profesionales sanitarios y resaltan la importancia de integrar la salud mental en la planificación de futuras respuestas a crisis sanitarias.

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Introduction

The COVID-19 pandemic has become the greatest catastrophe humanity has faced since World War II, with nearly 6 million dead and many millions more hospitalized (Johns Hopkins Coronavirus Resource Center [JHCRC], 2022). Given its characteristics, scope, and consequences, it was logical to assume that health care professionals would be among the groups most psychologically affected, and this for several reasons.

First, they were the group responsible for caring for the large number of people infected and hospitalized worldwide due to the pandemic. Treating patients with COVID-19 involved a high level of exposure to the virus and, consequently, a significant likelihood of contracting the disease or even dying from COVID-19, as at that time there were no effective preventive or therapeutic measures available. In fact, in most countries, there was a high incidence of infections and deaths from COVID-19 among health care professionals (World Health Organization, 2021). Second, attending to the large number of infected and hospitalized individuals due to the pandemic brought about significant and potentially very stressful changes in the usual professional activities of many health care workers (e. g., an increased workload exacerbated by the lack of adequate resources to treat patients and to protect themselves from infection; dealing with the emotional toll of caring for numerous patients who were dying from the virus). Third, health care professionals were also affected by the strict quarantine and lockdown measures adopted by many countries to control the pandemic. Fourth, the level of psychological distress experienced by a significant number of health care professionals before the pandemic was already high, likely as a consequence of the emotional toll of their work and the stressful conditions in which it is carried out, at least in many healthcare centers, clinics, hospitals, etc. For example, a recent meta-analysis on the prevalence of burnout syndrome in physicians working in Spain, which included 67 studies with 16,076 participants, found a 24% prevalence of burnout among physicians (Pujol-de Castro et al., 2024). This psychological distress could have served as a breeding ground for worsening the impact of the pandemic.

In summary, the experiences endured by health care professionals during the pandemic exposed them to a heightened risk of psychological problems, particularly anxiety and depression, including suicidal ideation. Indeed, a substantial body of scientific literature, summarized in various meta-analyses, found that during the peak months of the pandemic, between 22.1% (Li et al., 2021) and 30% (Marvaldi et al., 2021) of health care professionals exhibited significant symptoms of anxiety. Similarly, between 21.7% (Li et al., 2021) and 31.1% (Marvaldi et al., 2021) experienced significant symptoms of depression, and 7.4% reported suicidal ideation (Du et al., 2023).

The vast majority of that scientific literature consists of studies conducted on samples selected from the general population of health care professionals. However, to better understand the effects of the pandemic on the mental health and well-being of these professionals—and thus aid in planning strategies to prevent them from experiencing harmful effects and ensure they can continue providing health care services—it is also important to examine the mental health status and characteristics of health care professionals who sought professional help for psychological problems during the pandemic.

This was precisely the aim of the present study. To this end, the presence of depressive symptoms, anxiety symptoms, and suicidal ideation was examined among health care professionals who sought assistance from a national psychological support helpline.

Between March 27 and May 26, 2020, the Ministry of Health and the General Council of Psychology of Spain launched a psychological first aid telephone service to help with the COVID-19 pandemic (in Spanish it is called Servicio de Primera Ayuda Psicológica, or SPAP). The SPAP consisted of three separate phone lines, which were publicized among the population and answered by psychologists: one for health care professionals and other responders or essential workers during the pandemic (e.g., members of law enforcement, nursing home staff, pharmacists, transport workers, social workers), another for patients and relatives of those who were ill or deceased due to COVID-19, and a third line for the general population (see [Berdullas Saunders et al., 2020](#), for a more detailed description of the SPAP). In the present study, the presence of emotional symptoms was examined among health care professionals who sought help through their specific phone line.

Method

Participants

During the two months that the SPAP was active, a total of 15,170 calls were recorded, of which 876 (6%) were made to the line designated for health care professionals and other responders or essential workers. Among the calls to this line, 13% were from physicians, 26.8% from nurses, 25.1% from clinical assistants or orderlies, and 1.5% from psychologists. In 76.3% of the calls from these health care professionals, some form of intervention was provided (e.g., brief psychological intervention, providing information, accompanied referrals to other resources, or case follow-up). In the remaining cases, no intervention was conducted due to various reasons, such as referrals to other professionals or interruptions in telephone communication for different reasons.

Additionally, among the health care professionals for whom some type of intervention was conducted, some chose not to respond to the instruments that evaluated depressive symptoms, anxiety symptoms, or suicidal ideation, or their responses were not recorded (36.9%). Consequently, the final sample of participants in this study consisted of 238 health care professionals, of whom 111 were nurses (46.6%), 37 physicians (15.5%), 3 psychologists (1.3%), and the remaining 87 (36.6%) were clinical assistants, orderlies, or other health care professionals.

Design

The present study responds to a cross-sectional correlational design of group comparison with three classification variables: type of health professional, having received previous professional help for psychological problems, and receiving current professional help for psychological problems.

Variables and Instruments

Depressive symptomatology. To evaluate depressive symptoms, the Patient Health Questionnaire-2 (PHQ-2; [Kroenke et al., 2003](#)) was used. The PHQ-2 consists of two items aimed to measure the two main symptoms of major depressive disorder according to the DSM-IV and DSM-5: anhedonia and depressed mood. The PHQ-2 instructions ask the respondent to rate how often they have been bothered by each of these two symptoms over the last two weeks, using a 4-point Likert scale ranging from “Not at all” (scored as 0) to “Nearly every day” (scored as 3). Consequently, PHQ-2 scores can range from 0 to 6. It has been recommended that a score of ≥ 3 would identify positive cases of

major depressive disorder (Kroenke et al., 2003), a cutoff score empirically supported (Manea et al., 2016). Martínez et al. (2023) reported Cronbach's alpha coefficients of 0.71 and 0.75 for the Spanish version of the PHQ-2. In this study, a Cronbach's alpha of 0.91 was found. Cronbach's alpha values of 0.70 or higher are generally acceptable, while those of 0.85 or higher are considered excellent (Hernández et al., 2016).

Anxiety symptomatology. To evaluate anxiety symptoms, the Generalized Anxiety Disorder Scale-2 (GAD-2; Kroenke et al., 2007) was used. The GAD-2 consists of two items aimed to measure the two main symptoms of generalized anxiety disorder according to the DSM-IV and DSM-5: excessive anxiety and excessive worry combined with difficulty controlling it. The GAD-2 instructions ask the respondent to rate how often they have been bothered by each of these two symptoms in the past 14 days, using a 4-point Likert scale ranging from "Not at all" (scored as 0) to "Nearly every day" (scored as 3). Thus, GAD-2 scores can range from 0 to 6. It has been recommended that a score of ≥ 3 identifies positive cases of generalized anxiety disorder (Kroenke et al., 2003), a cutoff score empirically supported (Plummer et al., 2016). García-Campayo et al. (2012) reported a Cronbach's alpha coefficient of 0.93 for the Spanish version of the GAD-2. In this study, a Cronbach's alpha of 0.87 was found.

Suicidal ideation. To evaluate suicidal ideation, item 9 from the Patient Health Questionnaire-9 (PHQ-9) was used. The PHQ-9 is a tool developed to assess depressive symptoms based on the symptom diagnostic criteria for major depressive disorder in the DSM-IV (Kroenke et al., 2001). The item 9 aims to measure suicidal ideation by asking respondents to rate how often they have been bothered by "Thoughts that you would be better off dead or of hurting yourself in some way" in the last two weeks, using a 4-point Likert scale ranging from "Not at all" (scored as 0) to "Nearly every day" (scored as 3). Thus, scores on this item can range from 0 to 3. A cutoff score of ≥ 1 ("Several days") has been empirically supported for identifying cases with an elevated risk of suicide (Rossom et al., 2017).

Previous professional help for psychological problems. This variable was assessed through the following telephone question, answered with a "yes" or "no": "Have you ever received professional help for emotional or psychological problems?"

Current professional help for psychological problems. This variable was assessed through the following telephone question, answered with a "yes" or "no": "And currently, are you receiving professional help for emotional or psychological problems?"

Procedure

The SPAP operated with three simultaneous telephone lines to assist health care professionals and other responders during the pandemic. The service was available Monday through Sunday, continuously from 9:00 to 20:00, and was organized into two six-hour shifts. A specific protocol was established for conducting interventions: 1) initial telephone assistance, needs assessment, and psychological support; 2) brief psychological intervention and follow-up with the individual if necessary; 3) crisis intervention for situations involving suicide risk or violence; and 4) accompanied referrals and collaboration with other resources.

During the needs assessment phase, callers were asked if they would agree to answer a few questions about issues that people might face in crisis situations like the COVID-19 pandemic. If they consented, the PHQ-2, the GAD-2, and item 9 of the PHQ-9 were administered in that order over the phone.

This psychological evaluation, and the overall psychological care provided by SPAP, was conducted by a professional team of 42 psychologists specialized in crisis, emergency, and grief intervention and treatment. These psychologists were specifically selected and hired to work for this service and received specialized training on SPAP's psychological care protocols, including the evaluation protocol using the PHQ-2, the GAD-2, and item 9 of the PHQ-9. All calls were recorded, as stated in the welcome message heard by users when calling, which also assured them of confidentiality.

The use of SPAP's care database for this study received ethical approval from the Research Ethics Committee of the Universidad Complutense de Madrid (ref. CE_23012025_18_SAL).

Statistical Analysis

Three groups of health care professionals (nurses, physicians, and other health care professionals) were created, and they were compared in terms of their sociodemographic and clinical characteristics using chi-square tests or a one-way ANOVA.

Subsequently, the three groups of health care professionals were compared in terms of their depressive symptoms (PHQ-2), anxiety symptoms (GAD-2), and suicidal ideation (PHQ-9 item 9) using a one-way ANCOVA, where sociodemographic or clinical variables with statistically significant differences among the groups were included as covariates. The effect size for the between-subjects factor (type of health care professional) was estimated using partial eta squared, and values equal to 0.01, 0.06, and 0.14 were considered to indicate small, medium, and large effect sizes, respectively (Cohen, 1988).

The percentages of individuals in each group of health care professionals showing clinically significant levels of depression, anxiety, and suicidal ideation were calculated based on established cutoff scores for the PHQ-2 (≥ 3), GAD-2 (≥ 3), and PHQ-9 item 9 (≥ 1), respectively. Differences in percentages were examined using chi-square tests, and the effect size of these differences was estimated using Cramer's V, with values equal to 0.10, 0.30, and 0.50 indicating small, medium, and large effect sizes, respectively (Cohen, 1988). To control for the effect of sociodemographic or clinical variables on these differences, binary logistic regression analyses were conducted on the presence of clinically significant levels of depression, anxiety, and suicidal ideation. These analyses included as predictor variables the sociodemographic or clinical variables, as well as two dummy variables related to the type of health care professional (physicians vs. other health care professionals and nurses vs. other health care professionals).

Finally, four groups of health care professionals were created based on their responses to questions about previous or current professional help received for psychological problems: those who had never received help, those who had received help in the past, those who were currently receiving help, and those who had received help in the past and were also currently receiving help. The percentages of individuals in each group showing clinically significant levels of depression, anxiety, and suicidal ideation were calculated based on established cutoff scores for the PHQ-2 (≥ 3), GAD-2 (≥ 3), and PHQ-9 item 9 (≥ 1), respectively. Differences in percentages were examined using chi-square tests, and the effect size of these differences was estimated using Cramer's V. If chi-square tests revealed statistically significant differences among the four groups, post hoc tests comparing percentages between pairs of groups were subsequently conducted using the Bonferroni correction to counteract the likelihood of Type I errors from multiple comparisons.

Table 1.
Differences between Groups of Health Care Professionals in Sociodemographic and Clinical Characteristics

Characteristics	Nurses (n = 111)	Physicians (n = 37)	Others (n = 90)	χ^2 / F	p
Sex (% of women)	84.7%	91.9%	93.3%	4.18	.124
Mean age in years (SD)	42.81 (11.38)	53.75 (7.41)	42.82 (11.50)	15.23	.001
Previous help for psychological problems (%)	38.9%	45.7%	45.1%	0.949	.622
Current professional help for psychological problems (%)	37.7%	34.3%	25.6%	3.13	.209

Results

Differences between Groups of Health Care Professionals in Sociodemographic and Clinical Characteristics

Participants' ages ranged from 20 to 71 years, with a mean age of 44.5 years ($SD = 11.6$), and 89.1% were women. A total of 39.9% of participants had previously received professional help for psychological problems, and 30.7% were receiving it at the time of the study.

Table 1 presents the differences among the three groups of health care professionals (nurses, physicians, and other health care professionals) in terms of their mean age, the percentage of women, and the percentage of individuals who had previously received professional help for psychological problems or were currently receiving such help. The results of the chi-square tests and ANOVA revealed that there were no statistically significant differences among the three groups in any of these sociodemographic and clinical characteristics, except for mean age. Physicians had a higher mean age compared to the other two groups, between which there were no differences (53.75 vs. 42.81 and 42.82; $F(2, 229) = 15.23$, $p < .001$) (Table 1).

Differences between Groups of Health Care Professionals in Depression, Anxiety, and Suicidal Ideation

Table 2 presents the differences among the three groups of health care professionals regarding their depressive and anxious symptoms, and suicidal ideation. The results of the ANCOVA, controlling for the effect of the covariate age, revealed no statistically significant differences among these groups in depressive symptomatology, anxious symptomatology, or suicidal ideation, $F(2, 228) = 2.32$, 0.43, and 0.26, respectively, all with $p > .05$. In all three

cases, the effect size of the type of health care professional was small or even negligible (Table 2).

Percentages of Health Care Professionals with Clinical Levels of Depression, Anxiety, and Suicidal Ideation

Table 3 presents the percentages of nurses, physicians, and other health care professionals who exhibited clinical levels of depression, anxiety, and suicidal ideation according to the recommended cutoff points for the instruments used to measure these symptoms. For depressive symptoms, these percentages ranged from 45.6% in the group of other health care professionals to 64.9% in the group of physicians, with chi-square tests revealing no statistically significant differences among the three groups of health care professionals (Table 3). For anxiety symptoms, the percentages ranged from 64.9% in the group of physicians to 72.2% in the group of other health care professionals, and again, chi-square tests revealed no statistically significant differences among the three groups of health care professionals (Table 3). Finally, for suicidal ideation, the percentages ranged from 5.6% in the group of other health care professionals to 10.8% in the group of physicians, with chi-square tests once more revealing no statistically significant differences among the three groups of health care professionals (Table 3). In all three cases, the effect size of the type of health care professional was small or even negligible (Table 3).

The results of the binary logistic regression analyses revealed, consistent with the chi-square test results, that the two predictor variables —physicians vs. other health care professionals and nurses vs. other health care professionals— showed no significant relationship, after controlling for the effect of age, with the presence of clinically significant levels of depressive symptomatology ($\text{Exp}(B) = 2.08$ and 1.44, respectively, both with $p > .05$), anxious symptomatology ($\text{Exp}(B) = 0.69$ and 0.87, respectively, both with

Table 2.
Differences between Groups of Health Care Professionals in Depression, Anxiety, and Suicidal Ideation

Symptomatology	Nurses (n = 111)	Physicians (n = 37)	Others (n = 90)	F	p	η_p^2
Depression: PHQ-2 (SD)	3.13 (1.97)	3.67 (2.01)	2.77 (1.70)	2.32	.101	.020
Anxiety: GAD-2 (SD)	3.66 (1.79)	3.66 (1.71)	3.59 (1.69)	0.43	.958	.001
Suicidal ideation: item 9 of the PHQ-9 (SD)	0.11 (0.46)	0.14 (0.42)	0.07 (0.30)	0.26	.771	.002

Note. F = value of the F test for the effect of the health care professional group as determined by ANCOVA, with age as a covariate. PHQ-2: Patient Health Questionnaire-2. GAD-2: Generalized Anxiety Disorder Scale-2. PHQ-9: Patient Health Questionnaire-9.

Table 3.
Percentages of Health Care Professionals with Clinical Levels of Depression, Anxiety, and Suicidal Ideation and Differences between Groups of Health Care Professionals in These Percentages

Symptomatology	Nurses (n = 111)	Physicians (n = 37)	Others (n = 90)	χ^2	p	Cramer's V	Total (n = 238)
Depression: PHQ-2	54.1%	64.9%	45.6%	4.11	.128	.132	52.5%
Anxiety: GAD-2	72.1%	64.9%	72.2%	0.80	.669	.059	71.0%
Suicidal ideation: item 9 of the PHQ-9	7.2%	10.8%	5.6%	1.09	.579	.055	7.1%

Note. PHQ-2: Patient Health Questionnaire-2. GAD-2: Generalized Anxiety Disorder Scale-2. PHQ-9: Patient Health Questionnaire-9.

Table 4.

Percentages of Health Care Professionals with Clinical Levels of Depression, Anxiety, and Suicidal Ideation Based on whether They Had Previously Received or Were Currently Receiving Professional Help for Psychological Problems

Symptomatology	None (n = 105)	Before (n = 45)	Current (n = 24)	Before and current (n = 48)	χ^2	p	Cramer's V
Depression: PHQ-2	35.2%	61.4%	70.8%	70.8%	23.59	.001	.327
Anxiety: GAD-2	58.1%	80.0%	95.8%	83.3%	21.35	.001	.310
Suicidal ideation: item 9 of PHQ-9	5.7%	4.4%	16.7%	10.4%	4.48	.213	.142

Note. PHQ-2: Patient Health Questionnaire-2. GAD-2: Generalized Anxiety Disorder Scale-2. PHQ-9: Patient Health Questionnaire-9.

$p > .05$), or suicidal ideation ($\text{Exp}(B) = 1.31$ and 1.10 , respectively, both with $p > .05$). On the other hand, in none of the binary logistic regression analyses did the control variable age show significant relationships with the presence of clinically significant levels of depression, anxiety or suicidal ideation.

Percentages of Health Care Professionals with Clinical Levels of Depression, Anxiety, and Suicidal Ideation Based on Receiving Previous or Current Professional Help for Psychological Problems

Table 4 shows the percentages of health care professionals presenting clinical levels of depression, anxiety, and suicidal ideation based on whether they had received previous or current professional help for psychological problems. Chi-square tests revealed statistically significant differences among the four groups of health care professionals for depressive and anxiety symptoms ($\chi^2(3, 222) = 23.59$ and 21.35 , both $p < .001$). In both cases, the effect size of those differences was medium (Cramer's $V = .327$ and $.310$, respectively). Subsequent post hoc pairwise group comparisons showed that the group of professionals who had neither previously received nor were currently receiving professional help for psychological problems had a lower percentage of individuals with clinical levels of depressive or anxiety symptoms (35.2% and 58.1%, respectively) compared to the other three groups. In contrast, there were no statistically significant differences among the latter three groups, where the percentages of professionals with clinical levels of depressive or anxiety symptoms ranged between 61.4% and 95.8% (Table 4).

For suicidal ideation, the chi-square test revealed no statistically significant differences in the percentage of health care professionals with clinical levels of suicidal ideation among the four groups of professionals based on whether they had received previous or current professional help for psychological problems, and the effect size of those differences was small (Table 4).

Discussion

The main objective of this study was to examine the presence of symptoms of depression and anxiety, and suicidal ideation among health care professionals who sought psychological help during the peak months of the COVID-19 pandemic. The findings suggest that, among these health care professionals, half (52.5%) exhibited clinical or significant levels of depressive symptoms, and nearly three out of four (71%) exhibited clinical or significant levels of anxiety symptoms.

As expected, these prevalence rates of significant depressive and anxiety symptoms are higher than those found in the general population of health care professionals during the same critical months of the pandemic. Specifically, the prevalence of significant depressive symptoms among health care professionals who sought psychological help (52.5%) is double that found in the

general population of health care professionals, which has been estimated in various meta-analyses at approximately 22-31% (Li et al., 2021; Marvaldi et al., 2021). The prevalence of significant anxiety symptoms among health care professionals who sought psychological help (71%) is double or nearly triple that found in the general population of health care professionals during the peak months of the pandemic, estimated in various meta-analyses to be around 22-30% (Li et al., 2021; Marvaldi et al., 2021).

The fact that the prevalence of significant depressive and anxiety symptoms was significantly higher among health care professionals who sought psychological help compared to the general population of health care professionals is consistent with findings from various studies. These studies show that the severity of psychological symptoms, including depressive and anxiety symptoms, is positively and significantly associated with seeking professional help for mental health problems. This suggests that individuals experiencing more severe levels of depressive or anxiety symptoms—or psychological symptoms in general—tend to have more favorable attitudes toward or are more likely to seek professional help (Dean et al., 2018; Fox et al., 2018; Komiya et al., 2000; McLaren et al., 2023).

Kang et al. (2020) conducted a study with health care professionals during the COVID-19 pandemic and did not find a significant relationship between the severity of psychological symptoms and the use of psychological counseling or psychotherapy services (including individual or group therapy). However, the study by Kang et al. (2020) was cross-sectional, whereas some of the data supporting the positive relationship between the severity of psychological symptoms and the use of psychological help services come from longitudinal studies. These longitudinal studies provide stronger evidence that individuals with higher levels of psychological symptoms are subsequently more likely to utilize or receive these services (Fox et al., 2018). In this sense, the findings of the present study are consistent with the results of these latter longitudinal studies.

However, the results of the present study also indicate that not all types of psychological symptoms were higher during the COVID-19 pandemic among health care professionals who sought psychological help compared to the general population of health care professionals. Specifically, this study found that among health care professionals who sought psychological help, 7.1% exhibited clinical or significant levels of suicidal ideation. This prevalence was similar to that found in the general population of health care professionals during the most critical periods of the pandemic, which has been estimated to be approximately 7.4% (Du et al., 2023).

This finding is somewhat surprising, as the present study identified a significant, positive, moderate correlation between depressive symptoms and suicidal ideation ($r = .32$, $p < .001$), a relationship that is consistently reported in the scientific literature (Ribeiro et al., 2018). Therefore, given this correlation and the higher levels of depressive symptoms found in this study, it would also be expected to find a higher prevalence of suicidal ideation among health care professionals who sought psychological help. However,

this was not the case, which may have several alternative, and not necessarily mutually exclusive, explanations.

First, it is possible that item 9 of the PHQ-9 is not sufficiently sensitive to detect differences in suicidal ideation between the general population of health care professionals during the pandemic and those health care professionals within this population who sought psychological help. Second, it is possible that many health care professionals experiencing severe suicidal ideation do not seek help due to the stigma associated with suicide-related problems or due to the unique characteristics of these issues, such as the level of hopelessness associated with suicide (Ribeiro et al., 2018). Hopelessness is also a significant barrier to seeking psychological help, particularly among those experiencing suicidal ideation (Wilson & Deane, 2010). If future research supports this latter explanation, it could be inferred that the figures reported in this study on the prevalence of suicidal ideation among health care professionals who sought psychological help during the peak months of the pandemic might underestimate the true magnitude of suicide-related problems.

The scientific literature on the prevalence of clinically significant symptoms of depression, anxiety, or suicidal ideation in the general population of health care professionals during the pandemic has found that this prevalence varies depending on factors such as the type of health care professional (Marvaldi et al., 2021). However, in this study, no statistically significant differences were found among three types of health care professionals (nursing, medical, and other types of health care workers) in the prevalence of clinically significant symptoms of depression, anxiety, or suicidal ideation, nor in the overall presence of depressive symptoms, anxious symptoms, or suicidal ideation. Moreover, the effect size of those differences was small or even negligible. Therefore, unlike what was observed in the general population of health care professionals during the COVID-19 pandemic, among those who sought psychological help, differences based on the type of health care professional do not appear to exist. This finding is particularly novel, as very few studies have focused on health care professionals who actually sought psychological help during the peak months of the pandemic.

Finally, the results of the present study suggest that among health care professionals who sought psychological help during the pandemic, those who were receiving or had previously received professional help for psychological problems, compared to those who were not receiving and had never received such help, exhibited a higher prevalence of clinically significant symptoms of depression (67.2% vs. 35.2%), or anxiety (84.6% vs. 58.1%), and these differences were both medium. These findings are coherent with those found in the general population during the pandemic. For example, Lewis et al. (2022) found that individuals with a history of anxiety or depression were more likely to experience worsened mental health during the pandemic compared to those without such histories. Therefore, the results of the present study suggest that the extreme circumstances of the pandemic for health care professionals (e.g., work overload, exposure to patient suffering or death, fear of infection) exacerbated preexisting psychological problems or disorders or triggered relapses in those problems or disorders. Such cases appear to be more frequent among health care professionals seeking help than cases where the extreme circumstances of the pandemic caused new psychological problems or disorders.

Consequently, for planning responses to future pandemics or public health disasters, it would be important to consider that health care professionals with a history of psychopathology are a particularly vulnerable population in need of specific screening and, if necessary, easily accessible psychological support.

The results and conclusions of this study should be assessed considering the limitations of the study itself. Some limitations relate

to the sample size and the percentage of the sample for which no information on emotional symptoms was available, either because participants chose not to respond to the instruments used to assess these symptoms or because their responses were not recorded. Indeed, although the initial sample of health care professionals was relatively large ($N=876$), after excluding those who had not received any type of psychological help and those for whom no information on emotional symptoms was available, the sample was reduced to 238 health care professionals. While this is an acceptable sample size, it may raise some doubts about the generalizability of the findings due to both the percentage of missing data and the sample size itself. Another limitation of the study relates to the impossibility of examining the effect on depression, anxiety or suicidal ideation of some relevant variables such as the type of health service in which the health care professionals worked (e.g., emergency department, ICU), some basic sociodemographic characteristics other than sex and age (e.g., social class, marital status), or the type of professional help that some health care professionals were receiving or had previously received for their psychological problems (e.g., pharmacological, psychological). Unfortunately, the SPAP's care database did not include data for those variables. A final limitation relates to the fact that all study variables were measured using a self-report technique, specifically a telephone interview, and that self-report measures can be affected by social desirability biases. However, the effects of social desirability biases are less pronounced when individuals seek professional help and do so under conditions of confidentiality (as indicated in the welcome message health care professionals heard before being attended by a psychologist) and a degree of anonymity (no personal data of the health care professional, such as their last name, ID number, postal address, workplace, etc., were requested or recorded).

Nonetheless, despite these limitations, the results of the present study confirm and amplify global concerns about the psychological impact of the pandemic on health care professionals. They underscore the importance of integrating mental health into the planning of future responses to health crises and emphasize the need to design psychological support strategies aimed at the most affected subgroups, such as those actively seeking help or those with a history of psychopathology.

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