

Surviving social isolation during *COVID-19*: The importance of a Positive Attitude

COVID-19: A positive attitude to social isolation

Kathleen A. Moore¹, Petra Buchwald², Petra Begic² & Stephane L Bouchoucha^{3,4}

1. Federation University Australia, School of Health & Life Sciences, Northways Road, Churchill 3842 Australia
2. University of Wuppertal, School of Education, Gauß Str. 20, 42119 Wuppertal Germany
3. School of Nursing and Midwifery, Deakin University, Geelong, Vic., Australia
4. Centre for Quality and Patient Safety Research in the Institute for Health Transformation, Deakin University, Geelong, Vic., Australia

Corresponding author: Kate Moore, Federation University Australia, Northways Road, Churchill 3842 Australia. Email: k.moore@federation.edu.au

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Abstract

SARS-CoV-2, and its associated disease *COVID-19*, swept the globe in 2020 promoting governments to require their citizens to socially isolate in their homes to reduce its spread. Schools, universities, and workplaces were closed unless considered essential services such as hospitals and pharmacies. Many people work from home, while others were left unemployed; children were home schooled often by parents in dual roles: worker and teacher. While enforced restrictions have eased over months, many people remain cautious in their exposure outside the home. Our aim was to study people's psychological distress during social isolation and determine whether a positive attitude towards the need for social isolation, and worries during this time, as well as behaviours with which they engaged to cope with their social isolation would predict levels of psychological distress. Four hundred and fourteen people (320 females) (M age = 37.25 years, SD = 10.88) responded to an online survey. Four scales – Attitudes to Social Isolation, Psychological Distress, *COVID-19* Worries, and Positive Coping Behaviours, were designed specifically for this study. Results indicate that all scales had good construct validity and internal reliability. Multiple regression analysis revealed no relationship between age or sex on psychological distress. Psychological distress was negatively predicted by a positive attitude towards social isolation while financial/political worries was a negative predictor; health worries demonstrated a tendency to negatively predict psychological distress, while positive coping behaviours were not significant. Clearly government and health department strategies enlisting people's support for the need for social isolation and/or social distancing during this pandemic are important in ameliorating levels of psychological distress but it may be that more needs to be done to reduce financial/political worries.

Keywords: Coronavirus, *COVID-19*, attitude, psychological distress, worries, coping

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SARS-CoV-2 and its associated disease *COVID-19* is an infectious respiratory disease caused by a newly discovered coronavirus (Australian Government: Health.gov.au/news/health-alerts). At the end of 2021, there were over 300 million confirmed cases of *COVID-19* reported worldwide with a death rate over 5 million (<https://www.who.int>). There may well be a significant number of unreported cases as most people who are infected experience mild to moderate symptoms and will recover without the need for specialised treatment (Health.gov.au/news/health-alerts). Because of its highly contagious nature many governments, including Germany's, initially implemented strict social isolation procedures that effectively quarantine people in their homes unless they are engaged in essential services or need to seek medical care or buy food. These restrictions meant that people have little face-to-face interactions with any persons other than those within their household and for many their livelihood or study progress is threatened. Despite lessening of some restrictions, many people remain cautious and are maintaining self-imposed isolation and/or social distancing. All of these circumstances can lead to worry and psychological distress and a lack of attention to self-care. Furthermore, it is unclear what the public's attitude is towards social isolation. It was the aim in this study to investigate the psychological impact of social isolation imposed on citizens during the height of the *COVID-19* pandemic and determine whether people's attitudes towards social isolation, their worries about *COVID-19*, and their coping strategies were predictive of distressed mood.

Universally during this pandemic, people have been encouraged to wash their hands, avoid touching their faces and, where handwashing is not possible, to use hand sanitisers. Cafés, restaurants, hotels, and all non-essential services have closed, as have schools and universities. Where possible, people are required to work and study at home. Food stores and other essential services such as medical practices, have implemented various safety measures including QR codes to monitor people's movements, and mask wearing. Among these are

social distancing requirements that is, maintaining a minimum separation of 1.5 to 2 metres between people; the provision of hand sanitisers for both staff and public; increased cleaning routines and, where deemed necessary, the use of face masks and other personal protective equipment, previously adopted mainly by health workers. While designed to protect, these measures can also contribute to a higher level of fear, stress, or worry (Arslan et al., 2020) and can only be successful if everyone adheres to the recommendations. But what of people's attitude towards these measures and to social isolation more particularly? We know from studies using the Theory of Planned Behaviour (Ajzen, 1991) that a positive attitude predicts behaviour and we suggest that it might also reduce the psychological distress that previous studies have reported were experienced by people placed in quarantine.

Earlier research related to the effect of quarantine on people during *SARS-COV-1*, an outbreak of acute respiratory disease in 2003-2004 that infected approximately 8,000 persons, found they experienced significant psychological distress (Brooks et al., 2020). Others reported that confinement, accompanied by the loss of routine and the lack of face-to-face interactions that we typically experience at work, school and during our leisure activities, led to feelings of frustration and boredom (Blendon et al., 2004; Brooks et al., 2020; Robertson et al., 2004); psychological distress including depression (Hawryluck et al., 2004), low mood and irritability (Lee et al., 2005). While others, placed in quarantine because of contact with someone with *SARS-CoV-1*, reported experiencing feelings of fear, sadness and nervousness (Reynolds et al., 2008). Clearly, as well as disrupting people's daily routines, social isolation, restrictions on numbers able to gather in any one place, and social distancing can lead to feelings of psychological distress.

We suggest that these effects may be exacerbated during the present pandemic if people are worried about their own wellbeing and that of their family especially those members from whom they are separated and to whom they are unable to give any physical support. It might also be that people are worried about their work status and the uncertain impact of isolation, especially if prolonged, on their financial wellbeing and that of the economy more generally.

Each of these circumstances might exacerbate their negative mood and, as we know from past research, depressed mood is associated with a lack of volition and inactivity (Krämer et al., 2014; Marjanovic et al., 2015; Tomstad et al., 2017). In line with prior research, current research suggests that some aspects of everyday life (e.g., use of social media, informing oneself about *COVID-19*, being at work, and home-schooling children) may elevate negative affect (Lades et al., 2020).

Conversely, if people confined in social isolation engage in positive coping strategies which occupy their time and mind, this might reduce the distress of being socially isolated. For instance, spending time outdoors, pursuing a hobby, gardening, and engaging in social interactions with friends may enhance emotional well-being (Lades et al., 2020). Also self-care behaviours, such as eating well and exercising, while in social isolation are essential to maintain health and overall well-being and might further reduce people's level of distress.

The aim in this study was to explore people's attitudes to social isolation as a strategy to reduce the transmission of *COVID-19*; the types of worries people experienced during the height of this pandemic, as well as the strategies adopted to cope during social isolation, as predictors of psychological distress. Bandura (1986), although referring to self-efficacy, argued that it is important to utilise domain specific scales where possible. Accordingly, a further aim in this study was to develop scales domain-specific to *COVID-19* and social isolation in order to better understand people's distress at this time, their attitudes towards and their responses to living in social isolation.

Method

Design

A cross-sectional design was used to explore the psychosocial impact of *COVID-19* on people living in Germany. Data for this study were collected using an online questionnaire.

Participants

Four hundred and fourteen people (320 females) responded to an invitation to participate in an online study about the effects of social isolation during the *COVID-19* pandemic. The mean age of respondents was 37.25 years ($SD = 10.88$), the majority were married or cohabitating with a partner (70.3%), 25.6% were single, and .07% reported they were widowed. In terms of education, 8.4% reported they had completed Middle School, 19% had completed or were undertaking an apprenticeship, 65.4% had completed or were undertaking a University degree, and 7.2% reported they held a post graduate degree.

Procedure

The University's Human Ethics Committee provided approval for the conduct of this study. Participants were recruited via advertisements placed on the personal social media accounts of the authors (*Facebook, LinkedIn*) inviting interested people to access an online survey hosted on Qualtrics.com and Soscisurvey.de. Readers were encouraged to share the advertisement with their contacts. A Plain Language Statement on the opening page of the survey advised readers that participation was voluntary, their data anonymous, and submission of the completed questionnaire would be deemed to be their informed consent. No incentives were offered for participation.

Materials

Participants provided demographic data on their age, gender, marital and educational status, as well as answering questionnaires designed for use in several international studies. In accordance with Bandura's (1986) demand for domain-specific scales, items specific to *COVID-19* and social isolation were generated. Questions related specifically to people's attitude towards social isolation; their health and financial worries around *COVID-19*; feelings of psychological distress, and the use of positive behaviours to cope during social isolation. These items were sourced from past research addressing the psychological impact of quarantine and consultations with colleagues about their experiences at this time.

Attitudes towards Social Isolation Scale (ASIS) was assessed using eight items with the stem, 'I believe ... (e.g., Social isolation is essential for everyone; Only way to control

COVID-19)’ which were answered on a 5-pt Likert scale from 1 = *Not at all* to 5 = *Absolutely*. Four items were reversed coded, so that higher scores indicate a more positive attitude.

The *COVID-19* Worry Scale (CWS) has 11 items with the stem: ‘As a result of *COVID-19*, I worry that ... (e.g., I will be in debt if social isolation persists; My children will get *COVID-19*)’ answered on a 5-pt Likert scale from 1 = *Not at all* to 5 = *Pretty much all the time*.

Psychological Distress (PDS) was assessed by 15 questions: ‘Being in imposed social isolation because of *COVID-19* makes me feel ... (e.g., miserable, lonely, tense)’ rated on a 5-pt Likert scale from 1 = *Not at all* to 5 = *Pretty much always*.

Positive Coping Behaviours (PCB) were assessed with 10 items with the stem, ‘I am coping by ... (e.g., Gardening, Exercising)’ rated on a 5-pt Likert scale from 1 = *Not at all* to 5 = *Most of the time*.

Results

The data were downloaded from the web server into SPSS and AMOS (Version 26) for analyses. A series of Principal Components Analyses (PCA) and Reliability Analyses were conducted on the scale questions written for this study prior to testing the hypotheses. The Kaiser-Meyer-Olkin statistic and Bartlett’s Test of Sphericity indicated the suitability of each scale’s data for analyses.

The eight items written to assess Attitudes towards Social Isolation (ASI) revealed one factor (Table 1) which explained 52.79% of the variance. It demonstrated excellent internal reliability (Cronbach’s $\alpha = .86$).

The 11-item *COVID-19* Worry Scale (CWS) yielded two independent factors ($r = .24$) (Table 2) labelled Financial/Political Worries and Health Worries that together, explained 51.65% of the variance. Both factors demonstrated strong internal reliability (Cronbach’s $\alpha = .73$ and $.80$ respectively).

Table 1*Results of a Factor Analysis of the Attitudes towards Social Isolation Scale (ASIS)*

Items	Factor Loading
	1
Unnecessary R	.83
Essential for everyone	.82
Highly appropriate	.81
A waste of time R	.79
Only for those infected R	.69
Only way to control the virus.	.69
Only for the elderly R	.65
Isolation is Not Difficult	.47

R = items reversed coded

Table 2*Results of a Factor Analysis of the COVID-19 Worry Scale (CWS)*

Items	Factor Loadings	
	1	2
Factor 1: Financial/Political Worries		
I will be in debt if social isolation persists	.82	
My housing situation is at risk	.79	
Our political system will collapse	.69	
I'm going to lose my job/not get a job	.68	.11
Food supplies will run out or be restricted	.67	
The country will be plunged into economic depression	.39	.21
Factor 2: Health Worries		
My partner will get Covid-19	.11	.82
My parents/grandparents will get Covid-19	-.19	.78
My children will get Covid-19	.14	.78
People who don't isolate will infect me / my family		.69
The well-being of my circle of friends or colleagues		.54

Loadings <.10 are suppressed.

The 15 items written to assess Psychological Distress during social isolation revealed one factor (Table 3) which explained 55.33% of the variance. This scale demonstrated excellent internal reliability (Cronbach's $\alpha = .94$).

Table 3

Results of a Factor Analysis of the Mood Scale (MS)

Items	Factor Loadings
	1
Factor 1: Mood	
Miserable	.84
Sad	.84
Alone	.80
Bitter	.76
Tense	.76
Nervous	.75
Unhappy	.74
Scared	.74
Anxious	.74
Lonely	.73
Helpless	.718
Alone	.72
Secluded	.70
Angry	.67
Annoyed	.63

The ten items written to assess Positive Coping Behaviours (PCB) revealed two independent factors ($r = .27$) after the removal of one item (i.e., I engage in social distancing), which were labelled Household Tasks and Healthy Behaviours (Table 4). These factors explained 47.82% of the variance and demonstrated satisfactory internal reliability (Cronbach's $\alpha = .70$ and $.63$, respectively).

Items from each of the factors extracted were summated to yield scale scores used in the subsequent analyses. Higher scores were indicative of the construct measured.

Table 4*Results of a Factor Analysis of the Positive Coping Behaviours Scale (PCBS)*

Items	Factor Loadings	
	1	2
Factor 1: Household Tasks		
Getting things down around home	.74	.20
Crafts/Hobbies	.72	-.16
Completing my to do list	.66	
Gardening	.63	
Making most of time at home	.48	.32
Factor 2: Healthy Behaviours		
Eating well		.83
Cooking		.77
Exercising		.56
Listening to/Playing music		.50

Loadings <.10 are suppressed.

Correlations and Multiple Regression Analysis (MRA)

A Pearson's Correlation matrix is presented in Table 5 together with descriptive statistics for the study variables. Both financial/political and health worries correlated positively with psychological distress while attitude towards social isolation and engagement in household tasks were negative predictors. There was no relationship between healthy behaviours or sex with psychological distress. Being female was positively related to attitude towards social isolation, but negatively related to household tasks and health worries. Age was negatively related to health behaviours but positively related to health worries.

A hierarchical MRA was conducted with psychological distress as the dependent variable. We controlled for age and gender by entering them on Step 1, with attitudes towards social isolation, *COVID-19* Worry factors (financial/political and health worries), and positive coping behaviours (household tasks and healthy behaviours) on Step 2.

On Step 1, neither age nor gender significantly predicted psychological distress ($R^2 = .026$, Adjusted $R^2 = .008$, $F_{2, 395} = 1.47$, $p = .233$). On Step 2, attitudes towards social isolation, the two worry factors, and the two coping behaviours were added and together explained a further 32.5% of the variance ($\Delta R = .325$, $\Delta F_{5, 390} = 10.60$, $p < .001$). By Cohen's (1988) convention, a combined effect of this magnitude ($R^2 = .351$) can be considered large ($f^2 = .54$).

In combination the variables explained 35.1% of the variance in psychological distress. A positive attitude towards social isolation negatively predicted psychological distress; financial/political worries were a positive predictor of distress while health worries were borderline ($p < .10$). Unstandardised (B) and standardised (β) regression coefficients for each predictor by steps in the hierarchical regression are reported in Table 6.

Table 5

Descriptive Statistics and Correlations of Study Variables

Variable	1	2	3	4	5	6	7	8
1 Psychological Distress								
2 Attitude	-.24***	1						
3 Household Tasks	-.11*	.11*	1					
4 Healthy Behaviours	-.06	.04	.33***	1				
5 Financial/Political Worries	.42***	-.20**	.05	.04	1			
6 Health Worries	.26**	.37***	.09	.02	.29**	1		
7 Sex	-.07	-.17**	-.13*	-.01	-.03	-.19*	1	
8 Age	-.11	-.01	.06	-.14**	-.05	.13*	-.06	1
Means	31.22	31.87	16.65	13.22	10.65	13.07	-	37.25
SD	12.50	6.46	3.84	3.14	3.60	4.28		10.88
Range	15-75	8-40	5-25	4-20	6-30	5-25		18-77

Sex 1 = Female, 2 = Male

* $p < .05$, ** $p < .01$, *** $p < .001$

Table 6*Hierarchical Regression Results for Psychological Distress*

Variable	B	95% CL for B		SE B	β	R ²	ΔR^2
		LL	UL				
Step 1						.03	.03
Constant	43.96	31.04	56.88	6.52			
Sex	-2.35	-7.93	-7.93	2.81	-.08		
Age	-.21	-.47	.06	.13	-.14		
Step 2						.35	.32
Constant	44.88	23.40	66.36	10.83			
Sex	-3.51	-8.49	1.45	2.51	-.12		
Age	-.13	-.35	.09	.11	-.09		
Attitude toward S.I	-.39	-.77	-.01	.19	-.19*		
Financial Political	1.37	.79	1.95	.29	.41***		
Health Worries	.53	-.01	1.06	.27	.17		
Household Tasks	-.30	-.91	.30	.31	-.09		
Healthy Behaviours	-.49	-1.20	.22	.36	-.12		

Note. CI – Confidence interval; *LL* = lower limit; *UL* = upper limit.

* $p < .05$, *** $p < .001$

Discussion

The aim in this study was to explore the impact of respondents' attitudes to this imposed social isolation, their worries, and positive coping strategies, on their level of psychological distress during the COVID-19 pandemic. In order to address these concerns specifically related to the *COVID-19* pandemic, we followed Bandura's (1986) recommendation and developed four domain-specific questionnaires for use in this study which yielded satisfactory construct validity and internal reliability.

The Psychological Distress and the Attitudes towards Social Isolation Scales each yielded one factor. The *COVID-19* Worries Scale and the Positive Coping Behaviours Scales yielded two factors each: Financial/Political and Health Worries, and Household Tasks and Healthy Behaviours, respectively. All scales demonstrated adequate internal reliability for new measures (Nunnally & Bernstein, 1988).

The finding of psychological distress (e.g., I feel ...miserable, sad, alone) among people socially isolated accords with Reynolds et al.'s (2008) finding from their study of people quarantined during the 2003-2004 *SARS-CoV-I* pandemic, although levels here were only moderate. People generally had a highly favourable attitude towards the need for government imposed social isolation during this pandemic as evidenced by the high mean score for this scale. They were not unduly worried about their finances or the political situation as a result of *COVID-19* and neither did they express high levels of health worries. However, as would be expected, both worry factors correlated positively with psychological distress while a positive attitude towards social isolation was negatively related.

When entered into the multiple regression, a positive attitude towards social isolation (e.g., I believe that social isolation is: *necessary, essential for all, and appropriate*) was predictive of lower levels of psychological distress. While attitude has previously been associated with changing or enhancing a range of behaviours, the finding that it is predictive of reduced psychological distress in the current circumstances confirms the importance of government and health agencies engaging with the public on the need for social isolation to reduce disease transmission.

Of the two *COVID-19* Worry scale factors: one that people were concerned about financial/political matters, that is, their own level of debt and that of the country post *COVID-19* and two, health concerns that their partner or family might contract *COVID-19*, only financial/political worries was positively predictive of psychological distress. In fact, it was a stronger predictor than attitudes. In terms of financial/political worries, individuals were concerned that they would 'be in debt if social isolation persists', and also their 'housing' and 'job could also be at risk'. On a more macro level, there was some concern that 'our political system will collapse' and 'the country will be plunged into economic recession'. All of these are realistic worries due to the rapid economic downturn at this time (Fernandes, 2020). The German government is among those cognisant of these worries and has been proactive in implementing economic strategies to assist individuals and organisations during this period.

For instance, short-time work programs supported by government, were adopted by many organisations affected significantly by the economic downturn. One such program designed to maintain employment stability saw employers reduce their employee's working hours instead of laying people off. Employees with or without children receive 67% or 60% of their previous salary, respectively, from the Federal Employment Agency (Schulten & Mueller, 2020).

The second worry factor: health worries (e.g., My partner/parents/children will get *Covid-19*; People who don't isolate will infect me / my family) demonstrated only a tendency to predict psychological distress ($p < .10$). It may be that as German people's adherence to social isolation is typically high (Bennhold & Eddy, 2020), they have fewer concerns about contracting the disease and therefore the lower impact on psychological distress is understandable.

The hypothesis that people's engagement in proactive coping behaviours, assessed here as engagement with household tasks such as gardening and cooking, and healthy behaviours, for instance, eating well and exercising, would negatively predict psychological distress was not supported. Despite people reporting they kept occupied by participating in activities around the house and engaging in healthy behaviours, both of which are important for ongoing health and possibly resilience to disease, neither exerted a significant impact on psychological distress. It seems that people engaged in such behaviours, to keep occupied and look after themselves, independently of any feelings of distress.

While our results provide some novel insight into people's attitudes towards social isolation, their level of psychological distress, worries, and the positive coping behaviours people adopted during this time of social isolation designed to reduce the transmission of *COVID-19*, there are some limitations. Firstly, we followed Bandura's (1986) recommendation and designed situation-specific scales to assess the constructs of interest. Clearly these scales need further validation in future studies. Secondly, the sample was highly

educated and demonstrated an imbalance in gender with the sample highly skewed towards female respondents.

It will be important for future studies to take into account the psychological impact on people working from home in what for many would be a *makeshift* office while also balancing engagement in more household activities (e.g., cooking, gardening). A further possible unknown is the burden of home-schooling children on participants' mood and coping behaviours and whether the role of teacher/facilitator was shared between partners.

The years of this pandemic are not over, and we shall all remember them and they will be part of history. It is a time when a highly contagious disease swept across the globe affecting citizens in most countries either directly or indirectly. Social isolation and social distancing were mandated more universally perhaps than at any other time in recorded history and our results show that people generally had a positive attitude towards social isolation in the context of *COVID-19*. This positive attitude negatively predicted psychological distress suggesting that such an attitude is perhaps, a form of resilience. At the same time, people's worries about financial matters positively predicted their levels of psychological distress. Participants also expressed some level of concern about their own health and that of their partner/family, and for these participants this is not to be discounted although it was not a predictor of distress.

While governments have reduced some of the stringent requirements around social isolation as fewer cases of *COVID-19* are reported on a daily basis, the emergence of new strains such as Delta and Omicron, have heightened our sensibilities and need for vigilance. The need for vigilance against this disease in a world where not everyone is vaccinated, and where booster shots are essential is imperative; so too the need to evaluate and monitor the psychosocial as well as economic aftermath of social isolation as these costs are likely to be high. There may be some for whom distressed mood, especially if combined with financial realities, transitions into clinical depression, anxiety or even trauma. It is not just health care professionals who need to be cognisant of these possible outcomes, but employers, teachers

and financial institutions, and all areas of society and government need to make appropriate accommodations.

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