Anxiety and distress among the first community quarantined in the U.S due to COVID-19:
Psychological implications for the unfolding crisis

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Abstract

Purpose: This study assesses distress/anxiety and predictors of distress/anxiety associated with quarantine due to COVID-19 exposure among the first quarantined community in the US, and to identify potential areas of intervention.

Design: An anonymous survey was distributed via community organization distribution lists to approximately 1250 constituents under a quarantine directive.

Setting: Members of the first community in the NYC area under quarantine orders due to the 2020 COVID-19 outbreak.

Intervention: We sought to uncover the most salient predictors of distress/anxiety in order to recommend specific areas for effective intervention to reduce distress

Measures: We measured distress by using the Subjective Units of Distress Scale and anxiety with the Beck Anxiety Inventory. A variety of psychosocial predictors relevant to the current crisis were explored.

Results: 303 individuals responded within 48 hours of survey distribution. Mean levels of distress in the sample were heightened and sustained, with 69% reporting moderate to severe distress. Modifiable behavioral factors, specifically with regard to media exposure and sleep quality, predicted the largest percentage of variance in the sample (41.9%, $F(3, 264) = 40.7$, $R = 0.65$, $p < .001$).

Conclusion: Distress levels were markedly elevated among those in quarantine. The highest percentage of distress/anxiety variance was accounted for by modifiable factors amenable to behavioral and psychological interventions, including promoting healthy sleep and curtailing media use. Access to professional mental health care as well as behavioral interventions should be prioritized.

Keywords: mental health, anxiety, quarantine,

Introduction

Quarantine, which refers to separation and restriction of movement of people who may have been exposed to a contagious disease, is commonly used to curb the spread of infection ¹. Since quarantine is relatively rare, there is limited research on the psychological impact on individuals while under quarantine, and most existing research studies have utilized exclusively retroactive assessments conducted post-quarantine ^{1,2}. In this study, we assessed anxiety among families under quarantine in the New York City (NYC) area, and examined predictors of anxiety while under conditions of quarantine. To our knowledge this is the first study to assess the psychological experience of individuals while under quarantine orders.

On March 2nd, 2020, the first community acquired case of COVID-19 was confirmed in New York State. This was quickly followed by the first large-scale quarantine directive in the United States in over a century, impacting lower Westchester County and the Northwest Bronx. In recent quarantines, such as the 2003 Toronto quarantine to stop the spread of SARS ³, the 2015 quarantine in Korea to contain the spread of MERS ⁴, the quarantine in West Africa to reduce the spread of Ebola ⁵, and the current COVID-19 lockdown in China ², retrospective reports found elevated levels of anxiety, distress, and depression among quarantined individuals ^{1,6,7}. Anticipating these psychosocial sequelae is critical to mitigating the negative impact of quarantine - especially now as we face unprecedented quarantine, isolation, and social distancing measures across the United States.

In this study we surveyed levels of distress and anxiety within the first community in the United States to be quarantined during the initial phases of COVID-19 containment. Data were collected during a forty-eight-hour time frame in order to rapidly understand individuals' experiences during this initial phase of containment. We also examined situational, behavioral, psychological, informational and medical predictors of anxiety, in order to identify potential areas of intervention if high levels of anxiety were observed.

Methods

Sample Recruitment

Study authors circulated email invitations to community institutions (e.g., schools, religious organizations), who were asked to circulate information about the study in daily emails to individuals under quarantine from Westchester County and the Northwest Bronx. Prospective participants were directed to an online study which contained a description of the study, an

informed consent form, and a link to an anonymous online questionnaire. Data were collected between March 15th and March 17th, 2020, while participants were in varying stages of quarantine, and before widespread shelter-in-place orders were issued for the rest of the state and country. The study was distributed to approximately 1250 individuals. The study received approval from the Institutional Review Board of Columbia University Medical Center.

Measures

Distress was measured using the Subjective Units of Distress Scale (SUDS)⁸ The SUDS asks respondents to rate their levels of distress and anxiety on a scale of 0 to 100, with response options ranging from ‘0’ = totally relaxed, to ‘100’ = Highest distress/fear/anxiety/discomfort that you have ever felt (see Table 5). Anxiety was measured using the Beck Anxiety Inventory (BAI)⁹. Because overall distress and anxiety are highly overlapping constructs, often representing similar psychological experiences, the term distress/anxiety will be used throughout this paper.

Predictors of anxiety were assessed using a series of individual items exploring psychological (concern about becoming infected, financial impact and preparedness), situational (needing but not yet receiving COVID-19 testing, having a chronic medical condition, having children at home), informational (satisfaction with clarity of government notices, confidence about having enough information to stay safe), and behavioral factors (sleep quality, time spent reading news about COVID-19, time spent communicating with others about COVID-19). The objective of this approach was to identify characteristics that might exacerbate or alleviate distress/anxiety among individuals placed in quarantine, with the hope of informing public health policy and psychological intervention. Each predictor, including the full question, response options, response percentages for each response option, and the dependent variable mean for each response option are presented in Tables 2 - 5.

Analytic Approach

The data were analyzed in three stages. First, each predictor was entered into a separate Ordinary Least Squares (OLS) regression equation, with the SUDS score as the dependent variable, and then separately with the BAI as the dependent variable. This was done to assess whether each predictor alone was significantly associated with anxiety. Results of these analyses are presented in Tables 1 through 5. As a second step, significant predictors from each domain were entered into a single multivariate regression equation to measure the amount of variance

accounted for by each domain. In the final step, all significant predictors were entered in a single multivariate regression model in order to examine the total variance in anxiety accounted for by all predictors in this study. Categorical and binary predictors were factor-analyzed using OLS regression.

Results

Sample characteristics

A total of 303 individuals completed the survey. Mean age was 43 years ($SD = 14.8$), and ranged from 18 - 95. More than half (68.2%) of respondents were female, and 89.2% of respondents had a 4-year college degree or higher. Half of the sample lived in a private home, 47% lived in an apartment building and 3% lived in a multi-family home or “other” type of dwelling. 63% of the sample reported being under full quarantine at the time they filled out the questionnaire, 16% reported having just completed quarantine, and 22% had been placed under limited quarantine (e.g., social isolation directives). Time under quarantine ranged from one to fourteen days, with 71% of the sample being in quarantine between 12 - 14 days. The mean family size was four, with 16% of households having more than four members. 45% of households had children under 10 years old, and 17.4% of households had adults over 60 years old.

1.1% of the sample reported having someone in the household with a confirmed COVID-19 diagnosis, and 13.1% reported that someone in their household was experiencing COVID-19-like symptoms. More than three quarters (76%) of those sampled reported that someone in their household had been in close contact with an individual who had a confirmed case of COVID-19. One fifth (20%) of respondents had a serious chronic medical condition such as diabetes or heart disease.

Relationship between the BAI and the SUDS

The BAI consists of two factors: the cognitive and the somatic components of anxiety. Somatization of anxiety is measured by questions about physiological symptoms such as feeling hot, difficulty in breathing, and hot/cold sweats. Cognitive and psychological aspects of anxiety are measured by questions about being scared, nervous, terrified and fear of losing control. A factor analysis using Varimax rotation confirmed the presence of the somatic and psychological factors in the present sample. Correlations between the SUDs and the total BAI, as well as the somatic and cognitive factors revealed high levels of convergence, particularly between the

SUDS and the BAI cognitive factor. Specifically, the correlation between the SUDS and the total BAI was $r = .57$, ($p < .001$), the cognitive component of the BAI was $r = .65$, ($p < .001$), and the somatic component of the BAI was $r = .32$, ($p < .001$). Thus, constructs of anxiety as measured by the BAI and distress as measured by the SUDs are highly correlated and overlapping constructs in this sample, with the cognitive component of anxiety as measured by the BAI being particularly correlated with the SUDS. It should be noted that many if not most somatic expressions of anxiety overlap with COVID-19 symptoms (e.g. difficulty breathing and hot sweats) and may have complicated accurate measurement of somatic anxiety in the BAI.

For all regression models below, the BAI outcomes mirrored the outcomes of the SUDs scale. Specifically, the outcomes of all models were highly significant with both the BAI and the SUDS, and the percent of variance explained in each model differed by only a few percentage points between the two outcome measures. To simplify the presentation of results, all models below present the results using the SUDs as the outcome measure.

Survey outcomes

The mean SUDS anxiety/distress score was 50.0 ($SD = 19.9$) on a scale from 0 - 100, with 69% of the sample reporting moderate to severe levels of anxiety/distress of 50 and above. 24.8% of the sample indicated a level of anxiety/distress of 70 or above, high enough to significantly impair functioning (See Table 1).

Notably, there were no differences in anxiety between people who were under full versus partial quarantine orders ($p > .05$), indicating that social isolation without legally imposed quarantine is a significant context for distress/anxiety. We also did not observe any significant changes in levels of anxiety across days in quarantine ($p > .05$), indicating that the high levels of anxiety were sustained across days (see Table 3). Type of dwelling and family composition were not significantly associated with anxiety levels (p 's $> .05$).

All psychological variables significantly predicted anxiety. Greater levels of concern about becoming infected, concern about financial impact, and feeling underprepared were associated with higher levels of anxiety. Psychological factors accounted for 21% of anxiety variance, $F(4, 230) = 15.1$, $R = 0.46$, $p < .001$ (see Table 2).

Situational factors, including requesting or desiring a COVID test but not receiving one, having pre-existing psychological or medical conditions impacted by quarantine, observing signs of distress in children, and having children under age ten were each significantly associated with

greater distress/anxiety and together accounted for 12.3% of the variance in anxiety, $F(2, 269) = 6.8$, $R = 0.22$, $p = .001$ (see Table 3).

All informational factors were also significant predictors of anxiety. Lower levels of trust in the information received from government agencies, and not having access to information to keep the family safe were associated with higher levels of anxiety, and accounted for 13.7% of anxiety variance, $F(2, 264) = 20.9$, $R = 0.37$, $p < .001$ (see Table 4).

Behavioral factors accounted for the largest amount of variance in anxiety. Specifically, spending more time reading COVID-related news, communicating with others about COVID-19, and poor sleep quality were all associated with increased anxiety and accounted for 41.9% of the variance, $F(3, 264) = 40.7$, $R = 0.65$, $p < .001$ (see Table 5). Entering all of the predictors into an omnibus regression model accounted for 47% of the variance in anxiety, $F(12, 259) = 14.3$, $p < .001$. $R^2 = 0.49$.

Discussion

We studied more than 300 individuals who were quarantined in the United States due to COVID-19 in order to assess the psychological impact of quarantine, and predictors of distress/anxiety. Even as stay-at-home directives have become widespread in the United States, most research studies that have examined the psychological impact of COVID-19 have not studied individuals who are under a quarantine directive. Those who are not under active quarantine, even when self-isolating at home, are generally able to go outside, shop, and interact with others at a distance. The ability to be mobile outside the home and to have social interactions with others even in a limited capacity, provides significant psychological relief compared to complete home-bound quarantine that was experienced by participants in our sample. Thus, the overall objective of the current study was to understand levels of distress/anxiety during active quarantine (versus using retrospective recall) and identify areas for potential public health policy as quarantine, stay-at-home, and social distancing orders continue to expand throughout the United States.

Our findings show individuals under quarantine experience distress/anxiety at elevated levels. Notably, we observed no differences in distress/anxiety over time or number of days in quarantine, suggesting that emotional distress is heightened as well and sustained over an extended period of time. The average reported SUDS score corresponded to “moderate anxiety/distress - uncomfortable but can continue to perform.” Within the SUDS scale, this

represents a markedly heightened state of anxiety and distress. Moreover, a SUDS score of 50 is typically defined as the maximum level of anxiety and distress an individual will experience without loss of real-world functionality. Individuals may experience such anxiety intermittently when stressed, however it is clinically notable for a person to sustain this level of anxiety for a prolonged period of time ⁸.

Additionally, a considerable number of participants (24.8%) reported very high levels of anxiety/distress characterized by difficulty functioning.

All of these results highlight that distress/anxiety is a significant concern at the present time, as more people will experience active quarantine as a results of them or household members being COVID-19 positive. These findings are not entirely surprising given the prolonged nature of the fight against COVID-19, rising death tolls, and the expanding number of people who will likely experience financial and other direct stressors related to the pandemic. However, heightened and sustained levels of anxiety and distress are known to have a negative impact on both psychological and physical health outcomes in both the short and long term ¹⁰, including weakened immune responses ^{11, 12}, and less protective immunity ¹³, inferior cardiovascular health ¹⁴, difficulty managing chronic medical conditions ¹⁵, increases in health-compromising coping mechanisms ¹⁶⁻¹⁸, and worse overall health outcomes ^{16, 19}. Furthermore, residual trauma and post-traumatic stress-related behaviors are to be expected given what now appears to be the prolonged nature of the COVID-19 crisis. Previous research related to the SARS epidemic has demonstrated elevated distress and signs of PTSD for several years after the epidemic ²⁰. Comparatively, the SARS epidemic was shorter lived and on a smaller scale than the current COVID-19 pandemic and as such we can likely expect large segments of the population to experience residual and lasting distress and trauma, especially those from COVID-19 ‘hot-spots’.

Of all the predictors of distress/anxiety evaluated in our study, behavioral factors accounted for the largest percentage of variance. Specifically, sleep quality predicted the greatest amount of variance in anxiety, followed by the amount of time spent reading the news about COVID-19, and the amount of time discussing COVID-19 with friends. This is an optimistic result, given that behavioral factors are more modifiable compared to the other factors observed. Situational factors such as family composition, number of days in quarantine, access to COVID-19 testing, and informational factors such as having access to valid and helpful government information, are largely unchangeable and outside of individuals’ control. Similarly,

psychological factors such as concern about becoming infected, or finances, are much more complex and may require professional clinical intervention to address. Improving sleep quality and reducing time spent reading about or discussing COVID-19 are relatively easy to address and promote

Public health campaigns could easily highlight the importance of attending to sleep quality at this time, by promoting adequate sleep hygiene including preparing one's bedroom for sleep, only utilizing one's bed for sleep and sexual activity, and most of all keeping to a relatively regular sleep schedule. The Center for Disease Control has ample information including clear guidelines on its website regarding healthy sleep habits (CDC, 2020). This is critical given that clear evidence suggests a bidirectional relationship between sleep disturbance and anxiety ²¹. The link between sleep disturbance and anxiety is perhaps even more pronounced among children and adolescents ²², highlighting the importance of addressing sleep disturbance across the population.

Notably, one key sleep hygiene approach involves non-use of electronic devices immediately prior to bed (30-60 minutes). Encouraging compliance with this recommendation would simultaneously reduce reviewing of news on COVID-19 while potentially improving sleep quality. The goal of reducing engagement with COVID-19 related media is critical for those experiencing high levels of anxiety given the very strong association between media consumption and anxiety in our results, as well prior research which consistently demonstrates a cumulative and causal relationship between increased media consumption and distress during or following negative events ²³.

Given that these simple factors accounted for more than 2/5 of variance in anxiety, they seem to be priority areas for public health and psychological interventions at the current time. With that said, our results suggest that situational factors also play a key role in anxiety during quarantine. Some of these may mitigate the long-term psychological impacts of quarantine and/or self-isolation. For example, individuals can make efforts to improve psychosocial support via virtual technology if necessary, ²⁴, exercise ²⁵, mindfulness ²⁶, and also access professional mental health treatment ²⁷. All of these factors have previously been shown to reduce anxiety and associated negative outcomes, and psychologists as well as public health policy should continue to emphasize these recommendations as well within the context of current guidelines that limit social interaction.

Our results also show that there is significant value in working to increase the perceived trustworthiness of information sources, especially concerning governmental organizations and local public health resources, as individuals are less anxious when they receive information they see as trustworthy. Governmental programs to address looming financial concerns as well as increasing the availability of COVID-19 testing should have a positive impact as both of these are predictive of anxiety. Finally, programs targeted at reducing the stressful impact of COVID-related isolation on children may be effective interventions for families under quarantine as reduced child distress is also associated with levels of anxiety reported by parents.

Limitations

The current sample represents a specific demographic of individuals, connected via various educational and community organizations. They were all residents of New York City or lower Westchester and were directly or peripherally related to “patient 1,” or the first confirmed community acquired case of COVID-19. As such, the sample is not representative of the much larger population of individuals that have now experienced quarantine and related restrictions. At the time, these individuals were among the only ones quarantined in the state of New York and the United States. As the scope of the COVID-19 crisis became more apparent, our goal was to quickly survey members of this community to help predict what others around the country were likely to experience. Out of roughly 1250 individuals, 303 individuals completed the survey within a 48-hour time frame. This two-day time period was deliberately imposed in order to ensure that data collection occurred while the majority of participants were still quarantined, as previous studies had relied on retrospective recall of quarantine experiences.

Furthermore, the cross-sectional nature of the study prohibits assumptions about causality. However, distress/anxiety levels were markedly elevated and at clinically relevant levels. In addition, the behavioral factors that predicted the most variance (ie, sleep quality and media consumption), are associated with ample experimental evidence to suggest that these factors can directly influence levels of distress. Therefore, these factors are the most salient and appropriate to target for modification and health promotion.

Conclusion

This study offers a “first-glance” of the psychological impact of quarantine from within the community in which community spread of COVID-19 was first identified. In many ways the individuals surveyed comprise a historical sample whose experiences highlight a defining

moment in New York's and the United States' fight against COVID-19. The current findings suggest that distress/anxiety is a considerable problem under quarantine, and that several factors predict higher levels of distress/anxiety at the present time. Given the rapidly evolving nature of the crisis, the extent to which these findings can be generalized will depend on continued research in COVID-19 "hotspots," as well as other areas across the country. We feel that the current study sets the stage for a wide scale research agenda related to the psychological impact of the crisis. It is likely that predictors of distress will change as the healthcare infrastructure and economic sectors are further strained. In addition, anxiety may represent an initial response but as normalcy begins to feel more remote, depression, loneliness and hopelessness may become more pronounced especially for the most vulnerable members of US society. Given the rapidly growing scale of COVID-19 in the United States, there is a commensurately growing public health challenge of managing anxiety symptoms in the population. Interventions to promote sleep hygiene and reduce media use, alongside other ongoing efforts aimed at increasing access to mental health services should be recommended. In addition, prioritizing individuals' psychological health with a focus on reducing anxiety may help to prevent the long-term trauma related consequences that are likely to emerge without such interventions.

SO WHAT?

What is already known on this topic? An understanding of the psychosocial impact of quarantine is limited. Previous studies focusing on other epidemics have all used retrospective recall post-quarantine. Current studies have examined individuals who are self-isolating but not under quarantine orders. The unrepresented nature of the current crisis necessitates an understanding of how quarantine manifests on a psychological level.

What does this article add? To our knowledge this is the first study of its kind to assess distress while individuals were actively quarantined. Findings reveal clinically relevant levels of anxiety/distress among those first quarantined due to COVID-19 and identifies potential areas for intervention.

What are the implications for health promotion practice or research? Behavioral factors were the most salient predictors of distress/anxiety. This suggests that modifiable health related behaviors such as sleep hygiene and limiting consumption of COVID-19 related media are actionable interventions on an individual and community level.

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Table 1. Distribution of SUDs scores in the sample

	% of sample	SUDS anxiety Mean (SD) = 50.0 (20.2)
Imagine you have a 'distress thermometer' to measure your feelings according to the following scale. Please select the option below that best describes your current experience.		
0 = totally relaxed	0.3%	
10 = Alert and awake, concentrating well	4.8%	
20 = Minimal anxiety/distress	5.2%	
30 = Mild anxiety/distress, no interference with performance	16.2%	
40	4.5%	
50 = Moderate anxiety/distress, uncomfortable but can continue to perform	37.2%	
60	6.9%	
70 = Quite anxious/distressed, interfering with performance	13.4%	
80 = Very anxious/distressed, can't concentrate	6.6%	
90 = Extremely anxious/distressed	3.8%	
100 = Highest distress/fear/anxiety/discomfort that you have ever felt	1.0%	

Table 2. Psychological factors

	% of sample	SUDS anxiety Mean (SD)
How concerned are you about becoming infected with Covid-19?		
[F = 46.0, R = 0.42, p. < .001]		
Very concerned	29.7%	60.8 (15.6)
Mildly concerned	40.8%	50.3 (17.4)
Slightly concerned	22.1%	41.5 (19.9)
Not concerned at all	7.5%	35.4 (23.4)
How concerned are you about the continued financial impact of the Covid-19 crisis on your household?		
[F = 19.5, R = 0.3, p. < .001]		
I fear this will have devastating financial consequences	6.4%	67.3(15.5)
Extremely concerned	8.4%	60.7 (18.5)
Very concerned	11.5%	53.0 (20.2)
Somewhat concerned	25.9%	46.2 (18.8)
Not at all concerned	5.8%	44.3 (19.7)
Do you feel you are properly prepared for the current outbreak?		
[F = 9.3, R = 0.21, p. = .003]		
Yes, completely	3.1%	34.4 (25.5)
Mostly	46.4%	47.8 (19.8)
Not prepared enough	42.3%	53.6 (17.7)
Not prepared at all	6.1%	55.5 (26.6)

Table 3. Situational factors

	% of sample	SUDS anxiety Mean (SD)
Have your children expressed any signs of distress due to being quarantined or because of worries related to the virus?		
[F = 46.0, R = 0.42, p. < .001]		
Yes, I see signs of significant distress in my children	5.5%	54.6 (15.6)
Yes, but the signs of child distress seem manageable	40.1%	52.6 (17.5)
I am not sure	6.3%	53.3 (13.9)
No, I see no signs of significant distress in my children	30.9%	46.3 (21.9)
Not Applicable	17.3	47.7 (18.8)
Are there some members of your household for whom you desire COVID-19 testing but who have not as of yet been tested?		
[F = 9.7, R = 0.19, p. = .002]		
Yes	15.1%	59.3 (19.4)
No	84.9%	48.8 (19.9)
Do you have chronic medical or psychological conditions that have been impacted due to quarantine?		
[F = 15.8, R = 0.23, p. < .001]		
Yes	14.2%	60.9 (17.6)
No	85.8%	47.9 (20.1)
Do you have children under 10 years old?		
[F = 7.3, R = 0.18, p. = .007]		
No	56.2%	46.5 (19.2)
1	14.0%	53.1 (17.8)
2	17.7%	54.4 (20.1)
3	10.2%	53.0 (21.8)
4	1.9%	66.7 (20.8)
How many days have you or a member of your household been under quarantine?		
7	7.0%	57.1 (17.0)
8	10.5%	58.0 (23.5)
9	2.9%	54.0 (8.9)
10	2.9%	62.0 (16.4)
11	1.7%	46.7 (20.8)
12	8.7%	44.7 (23.9)
13	40.1%	49.1(20.4)
14	22.1%	51.0 (18.2)

Table 4. Informational factors

	% of sample	SUDS anxiety Mean (SD)
How would you rate the clarity of information you have received from government agencies (i.e. the NYS DOH) regarding parameters for self-quarantine? Would you say the information is:		
[F = 20.6, R = 0.30, p. < .001]		
Completely inadequate	5.5%	54.6 (15.6)
Somewhat adequate but with significant gaps	40.1%	52.6 (17.5)
More or less adequate but I could have used more	6.3%	53.3 (13.9)
Adequate	30.9%	46.3 (21.9)
Very clear and informative	17.3%	47.7 (18.8)
Overall, do you feel like you have the information you need to keep your family safe?		
[F = 15.9, R = 0.26, p. < .001]		
I feel informed enough to be confident that I know how to keep my family safe	20.3%	38.9 (19.2)
I am mostly confident that I know enough to keep my family safe	62.0%	52.2 (20.0)
I am not very confident that I know enough to keep my family safe	15.5%	55.0 (14.8)
I feel uninformed, and am not at all confident that I know enough to keep my family safe	1.8%	58.0 (23.9)

Table 5. Behavioral factors

	% of sample	SUDS anxiety Mean (SD)
On a scale of 1-10 with 1 being terrible and 10 being excellent, how would you rate your overall sleep quality, since hearing about or being in quarantine.		
[F = 46.0, R = 0.42, p. < .001]		
2	6.9%	70.0 (17.9)
3	9.4%	60.7 (19.8)
4	8.4%	58.8 (12.0)
5	14.8%	56.5 (17.7)
6	13.8%	55.0 (13.6)
7	15.3%	46.3 (19.4)
8	16.3%	41.4 (15.3)
9	10.3%	27.8 (16.3)
10	4.4%	27.8 (21.1)
About how much time on average every day would you say that you spend reading news about the coronavirus?		
[F = 33.2, R = 0.35, p. < .001]		
Less than 15 minutes	2.6%	36.3 (16.9)
15-30 minutes	11.7%	39.0 (15.8)
30-60 minutes	21.4%	46.9 (20.0)
1-2 hours per day	25.6%	50.0 (18.5)
2-3 hours a day	17.9%	54.2 (19.5)
3-4 hours a day	7.8%	56.5 (22.1)
More than 4 hours a day	12.7%	65.0 (19.3)
About how much time on average every day do you spend communicating with others about the coronavirus either through social media, email, phone, or text or in person?		
[F = 39.3, R = 0.38, p. < .001]		
None	1.3%	62.5 (30.0)
Less than 15 minutes	5.2%	42.0 (19.7)
15-30 minutes	12.3%	34.3 (18.1)
30-60 minutes	19.0%	47.3 (19.8)
1-2 hours per day	22.9%	48.2 (18.0)
2-3 hours a day	17.7%	57.0 (19.1)
3-4 hours a day	10.6%	60.5 (17.3)
More than 4 hours a day	11.0%	63.1 (17.6)