Adolescents' Motivations to Engage in Social Distancing during the COVID-19 Pandemic:
Associations with Mental and Social Health

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Abstract

Purpose: Reducing the spread of infectious disease during the coronavirus disease 2019 (COVID-19) pandemic prompted recommendations for individuals to limit physical contact with others and engage in social distancing. Less is known about why youth are engaging in social distancing and how these motivations are connected with their engagement, mental health, and social health. Using a large sample of adolescents from across the United States, this study examined adolescents' motivations for social distancing, their engagement in social distancing, and their mental and social health.

Methods: Data were collected March 29th and 30th 2020, two-weeks after COVID-19 was declared a national emergency in the United States. The sample consisted of 683 adolescents recruited using social media. A series of multiple linear regressions examined unique associations among adolescents' motivations to engage in social distancing, social distancing behaviors, anxiety symptoms, depressive symptoms, burdensomeness, and belongingness.

Results: The most commonly reported motivations for social distancing concerned social responsibility and not wanting others to get sick. Motivations concerning state or city lockdowns, parental rules, and social responsibility were associated with greater social distancing, whereas motivations concerning no alternatives were associated with less social distancing. Engagement in social distancing was not significantly associated with adolescents' mental or social health. However, specific motivations for social distancing were differentially associated with adolescents' anxiety symptoms, depressive symptoms, burdensomeness, and belongingness.

Conclusions: Understanding adolescents' motivations to engage in social distancing may help inform strategies to increase social distancing engagement, reduce pathogen transmission, and improve mental and social health during pandemics.

Keywords: *COVID-19; social distancing; motivation; depression; anxiety; belongingness; burdensomeness*

Implications and Contributions

Using a large sample of US adolescents recruited during the COVID-19 pandemic, we found associations between social distancing motivations, social distancing behaviors, and mental and social health. Findings hold promise for the efficacy of local governments and parents to increase adolescents' social distancing while maintaining mental and social health.

Adolescents' Motivations to Engage in Social Distancing during the COVID-19
Pandemic: Associations with Mental and Social Health

On March 11, 2020, the World Health Organization (WHO) declared the novel coronavirus disease 2019 (COVID-19) outbreak a pandemic [1] and on March 13th, 2020 the US declared COVID-19 a national emergency [2]. The COVID-19 pandemic originated in Wuhan, Hubei Province, China and has since spread globally, with over 970,000 confirmed cases worldwide as of April 3 and over 210,000 confirmed cases in the United States [3]. To reduce the spread of the virus and lower the risk of overwhelming health systems around the world, one major recommendation from health organizations was to implement social distancing procedures, which involves minimizing social and physical contact between people [4]. Measures to promote social distancing include limiting the size of gatherings, maintaining at least 6 feet of distance between people, closure of non-essential businesses, teleworking, distance learning, and shelter-in-place orders. Past research suggests variability in the rate at which teenagers engaged in social distancing in the week following COVID-19 being declared a US national emergency [4]. Less is known about youths' motivations to engage in social distancing and how these motivations are connected with their social distancing behavior and their mental and social health.

The degree to which youth engage in social distancing—as well as the potential mental health consequences of social distancing—may differ based on youths' motivations or reasons to engage in the behavior. According to Self-Determination Theory [5], motivations vary in the degree to which they are controlled (e.g., rule-based) versus autonomous (e.g., volition-based; [5]). Autonomous motivations more strongly predict engagement in prosocial behavior than controlled motivations [6] and have been connected with greater mental health benefits [7].

Further, prosocial motivations, including concern for the welfare of others, have also been linked with greater prosocial action [8] and psychological well-being [9]. In the context of social distancing, youth may endorse motives connected with personal autonomy (e.g., not wanting to get personally sick), prosocial action (e.g., not wanting to get others sick), or control (e.g., parental rules, city/state lockdown). Youth motivated by autonomous or prosocial reasons may engage in more social distancing relative to those who are not motivated by these reasons. Further, autonomous and prosocial motivations may mitigate the potential mental health consequences of social distancing among youth.

Understanding the connection between social distancing motivations and both mental and social health may be especially important for adolescents, who are potentially at risk for the negative psychological effects from COVID-19 social distancing. Adolescence is a period associated with increased risk for the development of many psychiatric disorders, such as anxiety and depression [10]. Additionally, a number of hormonal and neurobiological changes during adolescence correspond with heightened emotional reactivity and the ongoing development of coping strategies and stress regulation [11, 12]. Simultaneously, adolescence is marked by the increased importance of peer relationships and a greater reliance on peers for social support [13,14]. Peer interactions help contribute to adolescents' social health by enhancing their sense of belonging and reducing a sense of burdensomeness on others, both of which are considered interpersonal needs [15]. Examining connections between social distancing motivations and mental and social health among youth may provide important insight into potential avenues for reducing the psychological consequences of social distancing among this at-risk population.

The Current Study

The current study had three aims. The first aim was to identify youths' motivations for social distancing. We expected youth to endorse a wide variety of social distancing motivations, including those reflecting personal desires or autonomy (e.g., not wanting to personally get sick), prosocial action (e.g., not wanting others to get sick), and control (e.g., parental or state rules). The second aim was to determine the extent to which different motivations were related to the degree of social distancing. We expected that youth who endorsed autonomy and prosocial motives would engage in social distancing to a greater extent relative to those who did not endorse these motives. The third aim was to examine connections between social distancing engagement, social distancing motivations, and adolescents' mental health and social health. We expected that greater social distancing would be associated with worse mental health and social health. We also expected that youth who endorsed autonomous or prosocial motives would report better mental and social health.

Method

Participants and Procedure

Data came from Wave 2 of the Adolescent COVID-19 Study. The survey was completed by 683 adolescents residing in the United States and between the ages of 13-18 years ($M = 16.35$, $SD = 1.13$). The sample was primarily 10th (19.7%), 11th (30.6%), or 12th (31.5%) graders with fewer 9th (13.2%) graders and college students (4.0%). The sample was composed of primarily females (75.3%) with 22.7% males and 4.9% identifying as non-binary. The sample was primarily White/Caucasian (77.0%), followed by Hispanic/Latino (15.5%), African American/Black (5.6%), Asian American/Pacific Islander (11.1%), American Indian/Alaskan Native (3.2%), or other (2.9%). As a proxy for family financial strain [16], youth were asked whether their families had: enough money to buy almost anything they wanted (7.7%), no problem buying the things they need and can also sometimes buy special things (53.6%), just

enough money for the things they need (31.5%), or a hard time buying the things they need (7.2%). A total of 13 youth (1.9%) indicated that they were not currently social distancing and were thus omitted from the sample¹. Additionally, 13 youth (1.9%) were missing data on social distancing engagement and motivation and were removed from the sample. The final analytic sample consisted of $N = 657$ youth.

This study was advertised on various social media platforms (Facebook, Instagram, Twitter, Reddit) and participants self-selected into a study to complete a 10-minute survey once a week for eight weeks. Data from the current wave were collected from 8:00PM on March 29th through 9:00PM on March 30th, 2020. This study involved no more than minimal risk and thus, passive parental permission was used. Upon selecting into the study, participants were given a link to a letter explaining the study and asked to provide this letter to their parents. All youth who provided informed assent were invited to participate. Those who completed Wave 2 of the survey were entered into a drawing for a \$50 Amazon gift card. This study was approved by the Institutional Review Board at the first author's institution.

Social Distancing and Motivation. Engagement in social distancing was measured with a single item in which participants were asked "In the past 7 days, to what extent did you engage in social distancing?". Response options were given on a 5-point scale including 1 (*not at all*), 2 (*a little*), 3 (*somewhat*), 4 (*a lot*), and 5 (*a great deal*) with an option to indicate that they did not know what social distancing was. After reporting on their engagement in social distancing, participants were presented with a list of motivations for social distancing, which was created based on remote online discussions with a small focus group of teens ($n = 3$). A total of 10

¹ Note that these youth were excluded from our primary models because they were unable to indicate motivations to engage in social distancing, thus introducing a dependency in the data. Sensitivity analyses indicated that including these youth in models predicting mental and social health did not change the pattern of findings.

motivations were presented (see Table 1). Participants were able to select all motivations that applied to them, and an “other” option was provided along with an open-ended text box for teens to provide more information. A small percentage of teens selected “other” ($n = 29$, 4.4%), and a review of these qualitative responses indicated that each response qualified as one of the other already provided categories, suggesting that the majority of teens’ motivations were captured.

Anxiety Symptoms. Anxiety symptoms were assessed using the short fixed-form 8-item Patient-Reported Outcomes Measurement Information System (PROMIS) anxiety scale ($\alpha = .94$; [17]). Youth rated their agreement with 8-items (e.g., “In the past 7 days, I felt nervous.”) on a 5-point scale from 1 (*never*) to 5 (*almost always*). Mean scores were calculated with higher values indicating greater anxiety symptoms.

Depressive Symptoms. Depressive symptoms were assessed using the short fixed-form 8-item PROMIS depression scale ($\alpha = .95$; [17]). Youth rated their agreement with 8-items (e.g., “In the past 7 days, I felt sad.”) on a 5-point scale from 1 (*never*) to 5 (*almost always*). Mean scores were calculated with higher values indicating greater depressive symptoms.

Belongingness. Belongingness was measured with 3-items ($\alpha = .82$) adapted from the Interpersonal Needs Questionnaire [15]. Participants rated the extent to which they belong, that other people care about them, and they felt like they have many caring and supportive friends on a 7-point scale from 1 (*not at all*) to 7 (*extremely*). Mean scores were calculated with higher values indicating greater feelings of belongingness.

Burdensomeness. Burdensomeness was measured with 2-items ($r = .71$) adapted from the Interpersonal Needs Questionnaire [15]. Participants rated the extent to which they currently felt like a burden on society and make things worse for the people in their life on a 7-point scale

from 1 (*not at all*) to 7 (*extremely*). Mean scores were calculated with higher values indicating greater feelings of burdensomeness.

Demographic Characteristics. Participants reported their age, gender, race, financial strain, and parents' education. Highest level of mothers' and fathers' education were reported with separate items on a 3-point scale including 1 (*high school or less*), 2 (*some college*), and 3 (*college graduate or more*) with the option of indicating "I don't know" and were combined into one index representing 1 (*neither parent attended college*), 2 (*at least one parent completed some college*), and 3 (*at least one parent completed college*).

Results

Means, standard deviations, and bivariate correlations among study variables are presented in Table S1 (supplemental file). Most youth were engaging in social distancing a lot (26.9%) or a great deal (56.6%), with fewer youth engaging in social distancing a somewhat (13.0%) or a little (3.5%). Our first aim was to descriptively examine adolescents' motivations to engage in social distancing. Table 1 displays the frequencies of motivations to engage in social distancing. Youth most commonly referenced prosocial motivations to engage in social distancing including social responsibility (78.1%) and not wanting others to get sick (77.9%). Control-based motivations were also common and included being in a city or state on lockdown (60.9%) and parents making youth social distance (54.5%). Fewer youth reported personal motivations, such as not wanting to personally get sick (57.8%), having a preference to stay home (21.3%), or that there are no alternatives (i.e., there is nothing else going on; 17.8%). Additionally, some youth indicated that they engaged in social distancing because a friend told them they should (13.9%) or they did not want to be judged by others (7.0%).

Our second aim was to examine links between adolescents' motivations for social distancing and the degree to which they actually engaged in social distancing. Multiple regression analyses accounting for adolescent age, gender, race, ethnicity, financial strain, and parents' education were conducted. Table 2 displays the model estimates and Figure 1 displays boxplots for all significant effects. Youth who reported engaging in social distancing because their state or city was on lockdown, because their parents were making them, and because it is socially responsible reported engaging in more social distancing relative to youth who did not endorse these reasons. Additionally, youth who reported engaging social distancing because there are no alternatives reported less social distancing relative to youth who did not endorse this reason.

Our third aim of this study was to test associations between adolescents' social distancing engagement, their motivations for engaging in social distancing, and their mental and social health. Table 2 displays model estimates from four multiple regressions testing these associations accounting for age, gender, race, ethnicity, financial strain, and parents' education. Across all models, we did not find evidence of an association between social distancing and any indicator of mental or social health. Youth who were social distancing because they did not want to personally get sick or because they wanted to avoid judgment reported greater anxiety symptoms. Further, those who were social distancing because they would have otherwise preferred to stay home reported less anxiety symptoms. Youth who engaged in social distancing because a friend told them they should reported greater depressive symptoms. Those who were social distancing because they would have otherwise preferred to stay home reported lower depressive symptoms. Youth who were social distancing because they did not want get

personally sick reported lower feelings of burdensomeness and those who were social distancing because their parents made them reported greater belongingness.

Discussion

The COVID-19 pandemic is a global event that has had unprecedented effects on adolescents' daily lives. Reducing the spread of the virus requires individuals to limit physical contact with others by engaging in social distancing. The purpose of this study was to examine adolescents' motivations for social distancing and how these motivations were connected with engagement in social distancing, mental health, and social health. Youth endorsed a variety of motivations for social distancing, including social responsibility, not wanting to personally get sick or get others sick, complying with state or parental rules and peer recommendations, and because alternative activities were unavailable. These motivations were differentially associated with varying degree of social distancing, as well as depressive symptoms, anxiety symptoms, burdensomeness, and belongingness.

Adolescents most commonly reported engaging in social distancing for prosocial reasons—including recognition that social distancing is a social responsibility and to help ensure that others do not get sick. Further, social responsibility motivations were associated with engaging in more social distancing. These findings extend previous research which indicates that adolescents' social responsibility values were associated with greater disinfecting behavior and less hoarding behavior in the week following COVID-19 being declared a US national emergency [4]. Overall, these findings highlight that social distancing is viewed primarily as a social responsibility among youth. In contrast, youth who indicated that they were engaging in social distancing because they lacked alternatives reported less social distancing. Youth motivated by a lack of alternatives may be social distancing only if it is convenient and does not conflict with more appealing experiences. Importantly, youth who reported that they were social

distancing due to governmental sanctions or parental rules were also more engaged in social distancing compared to those who did not endorse these motives. These findings hold promise for the efficacy of local governments and parents to help increase adolescents' compliance with social distancing recommendations.

Adolescents' reason for social distancing may be more important for mental and social health relative to the degree of social distancing. We did not find evidence that degree of social distancing was connected with adolescents' anxiety symptoms, depressive symptoms, or feelings of belongingness or burdensomeness. However, several motivations to engage in social distancing were associated with adolescents' mental and social health during COVID-19. For instance, youth who were social distancing to avoid personal illness reported greater anxiety, but also less burdensomeness. Disease-related threat may be highly salient to some youth, thus prompting feelings of anxiety [18]. Alternatively, youth who are more anxious may be more focused on their personal health and thus engage in social distancing as means of self-protection. Further, youth who are social distancing to avoid becoming personally sick may be more concerned or vigilant, prompting less worry from family members and providing them with a lower sense of burdensomeness. Youth who engaged in social distancing to avoid social judgment reported more anxiety symptoms and those who were social distancing because of friends' recommendations reported greater depressive symptoms, which may reflect differences in symptomatic youth and sensitivity to social judgment or peer rejection [19]. Our findings highlight how these processes may be associated among youth during a time of heightened social distancing.

Notably, we did not find evidence that control motivations for social distancing (i.e., government or parental rules) were negatively associated with mental or social health. Rather,

youth who reported social distancing because of parental rules also reported feeling a *greater* sense of belongingness. Potentially, youth may interpret parental rules about social distancing as a reflection of warmth, caring, and concern for their well-being. It is also possible that youth with a greater sense of belonging are more likely to follow parental rules.

It is important to highlight that a subset of youth (25%) reported that they were social distancing because they would prefer to stay home regardless of whether social distancing policies and recommendations were in place. Youth who reported that they would prefer to stay home also reported lower anxiety and depressive symptoms, relative to those who did not report this motivation. These findings may indicate that youth who prefer stay home may be struggling less with this reduced social contact. Conversely, youth who did not indicate that they would prefer to stay home (suggesting that they would rather be engaged in social activity outside of their home) may be at greatest risk for experiencing anxiety or depressive symptoms. Future research is needed to examine the long-term impact of social distancing on the mental and social health of these youth.

Limitations and Future Directions

Findings should be interpreted in the context of certain limitations. Data were cross-sectional and casual or temporal interpretations cannot be made. Future research is needed to examine within-person, longitudinal associations between social distancing, motivation, and mental and social health. Social distancing may be connected with within-person change in mental health across time as youth experience a longer duration of social distancing. Although our sample was recruited from across the US, youth were primarily White and female, and future studies would benefit from examining social distancing motivation in a more diverse sample of youth. Additionally, the burdensomeness and belongingness measures used in this study were

adapted for repeated assessment and were composed of only a few items, and social health may be better assessed using a larger battery of questions [20].

Overall, our findings highlight that adolescents have varied motivations for complying with social distancing recommendations during the COVID-19 pandemic, and that these motivations may be indicative of individual differences in how social distancing may impact teens. Future research should explore moderators of these associations between mental health and experiences with social distancing or isolation from peers (e.g., introversion/extraversion). Our results highlight the importance of considering youths' motivations for engaging in social distancing during the COVID-19 pandemic. It will be important to continue to monitor teens' motivations for social distancing and their connections with compliance and mental health as these associations may change as the pandemic evolves and social distancing may occur for an extended duration.

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Table 1

Adolescents' Motivations to Engage in Social Distancing

Label	Motivation	<i>N</i>	%
Social Responsibility	It is socially responsible	513	78.1
Avoid Others Sick	I don't want others to get sick	512	77.9
Lockdown	My state/city is on lockdown	400	60.9
Avoid Personal Sick	I don't want to personally get sick	380	57.8
Parents' Rules	My parents are making me	358	54.5
Prefer Stay Home	I prefer to stay at home anyway	140	21.3
No Alternatives	There is nothing else going on	117	17.8
Friends Said I Should	My friends told me I should	91	13.9
Avoid Judgment	I don't want to be socially judged	46	7.0
Other	Other	29	4.4

Notes: Total *N* = 657. Adolescents could select multiple motivations.

Table 2

Associations among Adolescents' Social Distancing, Motivations, Mental Health, and Social Health

	Social Distancing			Anxiety			Depression			Burdensomeness			Belongingness		
	<i>Estimates</i>	<i>SE</i>	<i>95% CI</i>	<i>Estimates</i>	<i>SE</i>	<i>95% CI</i>	<i>Estimates</i>	<i>SE</i>	<i>95% CI</i>	<i>Estimates</i>	<i>SE</i>	<i>95% CI</i>	<i>Estimates</i>	<i>SE</i>	<i>95% CI</i>
Age	.02	.03	-.04,.07	.02	.04	-.06,.09	.00	.04	-.07,.08	-.05	.06	-.16,.07	.03	.05	-.07,.13
Gender: Female	.09	.08	-.07,.25	.48	.11	.27,.70	.38	.11	.17,.60	.27	.17	-.06,.60	-.23	.15	-.53,.06
Race: White	-.21	.08	-.36,-.05	.11	.11	-.10,.32	.11	.10	-.10,.31	.01	.16	-.31,.34	-.05	.15	-.34,.24
Hispanic	-.21	.09	-.39,-.02	.12	.12	-.13,.36	.22	.12	-.02,.46	.12	.19	-.26,.50	.03	.17	-.31,.37
Financial Strain	.07	.05	-.02,.16	-.15	.06	-.27,-.03	-.17	.06	-.29,-.06	-.25	.09	-.44,-.07	.16	.08	-.00,.33
Parents' Education	.12	.05	.02,.21	-.02	.07	-.15,.11	-.03	.06	-.16,.09	.01	.10	-.19,.21	.24	.09	.06,.42
Social Distancing	-	-	-	-.03	.09	-.20,.15	-.12	.09	-.28,.05	.00	.14	-.27,.27	.23	.12	-.01,.47
Motivation															
Lockdown	.20	.06	.07,.33	.02	.09	-.15,.19	.13	.09	-.04,.29	-.01	.13	-.28,.25	-.07	.12	-.31,.17
Parents' Rules	.22	.07	.09,.35	.06	.09	-.12,.23	-.01	.09	-.19,.16	-.02	.14	-.29,.25	.28	.12	.03,.52
Friends Said I Should	-.06	.10	-.25,.13	.11	.13	-.14,.36	.26	.13	.02,.51	.34	.20	-.05,.73	-.06	.18	-.41,.29
Social Responsibility	.21	.09	.03,.39	.03	.12	-.21,.27	-.05	.12	-.29,.19	-.35	.19	-.73,.03	.10	.17	-.23,.44
Avoid Personal Sick	.07	.07	-.07,.21	.19	.10	.01,.38	-.12	.09	-.31,.06	-.32	.15	-.61,-.03	.07	.13	-.19,.33
Avoid Others Sick	.15	.10	-.04,.34	.24	.13	-.01,.50	.14	.13	-.11,.40	.17	.20	-.22,.57	.25	.18	-.10,.60
No Alternatives	-.20	.08	-.36,-.04	-.20	.11	-.41,.02	-.02	.11	-.23,.19	-.17	.17	-.50,.16	.10	.15	-.20,.40
Prefer Stay Home	.09	.08	-.06,.25	-.30	.11	-.51,-.09	-.35	.10	-.55,-.14	.03	.16	-.29,.35	-.18	.15	-.46,.11
Avoid Judgment	-.24	.12	-.48,.01	.35	.17	.03,.68	.27	.16	-.05,.59	.31	.26	-.20,.81	-.12	.23	-.57,.33
R ² / R ² adjusted	.139 / .118			.105 / .083			.080 / .057			.044 / .020			.055 / .031		

Notes: Bolded values are significant at $p < .05$. Motivations were coded as endorsed/not endorsed.

Figure 1. Boxplots displaying differences between degree of social distancing by motivation. *Figure 1a.* Associations between social responsibility motivation and social distancing. *Figure 1b.* Associations between state lockdown motivation and social distancing. *Figure 1c.* Associations between parents' rules motivation and social distancing. *Figure 1d.* Associations between no alternatives motivation and social distancing.

Notes: Only significant effects are displayed.

Supplemental File

Table S1: Means, Standard Deviations, and Bivariate Correlations.

Table S1

Means, standard deviations, and correlations

Variable	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
1. Age	16.35	1.13																			
2. Gender	-	-	-.04																		
3. White	-	-	-.00	-.02																	
4. Hispanic	-	-	.08*	-.07	-.33*																
5. Fin Strain.	2.61	0.73	.05	-.02	.14*	-.18*															
6. Parent Edu	2.59	0.69	.07	.01	.20*	-.22*	.31*														
7. SD Engagement	4.37	0.84	-.01	.08*	-.06	-.11*	.09*	.11*													
8. Lockdown	0.61	0.49	-.07	.04	-.01	-.04	-.01	.06	.16*												
9. Parent Rule	0.54	0.50	-.14*	.13*	-.01	-.09*	.06	.03	.20*	.13*											
10. Friend Sh.	0.14	0.35	-.05	.08*	.09*	-.05	.04	.10*	.05	.09*	.27*										
11. Social Resp	0.78	0.41	.00	.11*	.05	-.09*	.07	.11*	.22*	.13*	.17*	.15*									
12. Av. P. Sick	0.58	0.49	-.08	.07	-.00	-.06	.02	-.04	.16*	.14*	.19*	.15*	.34*								
13. Av. O. Sick	0.78	0.42	-.04	.13*	.08*	-.07	-.01	.04	.18*	.11*	.23*	.17*	.57*	.43*							
14. No Alt.	0.18	0.38	-.05	-.05	.06	-.00	-.02	-.01	-.09*	-.00	-.05	.03	-.02	-.01	.02						
15. Pref. Home	0.21	0.41	-.12*	.04	-.07	.00	-.13*	-.13*	.01	-.01	-.06	-.00	.02	.08	.04	.16*					
16. Avoid Judg.	0.07	0.26	-.01	.06	.02	.01	.02	.06	-.06	-.04	.05	.18*	.03	.02	.06	.04	.08				
17. Anxiety	2.93	1.08	.01	.19*	.04	.00	-.08	-.02	.08*	.05	.10*	.09*	.11*	.16*	.19*	-.05	-.09*	.10*			
18. Depression	2.98	1.07	.01	.14*	.02	.02	-.14*	-.05	.02	.04	.03	.10*	.02	-.01	.07	.01	-.09*	.09*	.69*		
19. Burden.	2.81	1.64	-.04	.04	-.00	.03	-.12*	-.03	-.03	-.01	-.03	.06	-.08*	-.09*	-.02	-.01	.01	.06	.50*	.60*	
20. Belong.	4.21	1.49	.04	.00	.03	-.03	.12*	.12*	.04	-.00	.12*	.04	.09*	.05	.10*	.01	-.08*	-.01	-.21*	-.45*	-.42*

Note. *M* and *SD* are used to represent mean and standard deviation, respectively. * indicates $p < .05$. Fin. Strain = Financial Strain. Edu = Education. SD = Social Distancing. Sh = Should. Resp = Responsibility. Av. P. Sick = Avoid Personal Sickness. Av. O. Sick = Avoid Others Sickness. No Alt = No Alternative. Pref. Home = Prefer Home. Avoid Judg. = Avoid Judgement. Burden = Burdensomeness. Belong. = Belongingness.