Social, financial and psychological stress during an emerging pandemic: observations from a population survey in the acute phase of COVID-19


ABSTRACT

Introduction The negative impacts of COVID-19 have rippled through every facet of society. Understanding the multidimensional impacts of this pandemic is crucial to identify the most critical needs and to inform targeted interventions. This population survey study aimed to investigate the acute phase of the COVID-19 outbreak in terms of perceived threats and concerns, occupational and financial impacts, social impacts and stress between 3 April and 15 May 2020.

Methods 6040 participants are included in this report. A multivariate linear regression model was used to identify factors associated with stress changes (as measured by the Cohen’s Perceived Stress Scale (PSS)) relative to pre-outbreak retrospective estimates.

Results On average, PSS scores increased from low stress levels before the outbreak to moderate stress levels during the outbreak (p<0.001). The independent factors associated with stress worsening were: having a mental disorder, female sex, having underage children, heavier alcohol consumption, working with the general public, shorter sleep duration, younger age, less time elapsed since the start of the outbreak, lower stress before the outbreak, worse symptoms that could be linked to COVID-19, lower coping skills, worse obsessive–compulsive symptoms related to germs and contamination, personalities loading on extraversion, conscientiousness and neuroticism, left wing political views, worse family relationships and spending less time exercising and doing artistic activities.

Conclusion Cross-sectional analyses showed a significant increase from low to moderate stress during the COVID-19 outbreak. Identified modifiable factors associated with increased stress may be informative for intervention development.

Trial registration number NCT04369690; Results.

INTRODUCTION

An outbreak of COVID-19, a cluster of acute febrile respiratory illness, was first reported in Wuhan, China, in December 2019. The World Health Organization (WHO) declared a pandemic on 11 March 2020, after infections were reported in 110 countries and territories. As of 4 June 2020, COVID-19 had spread to 216 countries and territories, infected 6416828 individuals and caused 382867 deaths worldwide. This pandemic has created profound economic and social disruption, with the potential for widespread psychological impacts. Given the lack of specific treatments for the prevention and management of the COVID-19 infection and the rapid acceleration of the virus transmission, the negative impacts of COVID-19 are rippling through every aspect of society. Markedly, guidelines and new regulations have been put in place to promote self-isolation in order to limit the spread of the virus. As a result, most inpatient and outpatient health services cut down non-essential services. Several offices and businesses asked their employees to work from home; others reduced work hours or terminated jobs. Schools and universities were closed with...
some of them offering distance education. Overall, the pandemic situation has changed the core aspects of people’s lives in a unique and complex manner.

Early COVID-19 studies from China, India, Brazil, Paraguay and the USA indicated high levels of stress with associated sleep problems, poor life satisfaction and mental illness. Findings from a comparative study suggest that Western countries may have higher stress levels during the pandemic than Eastern countries, highlighting the needs for additional investigations in Western countries such as Canada. In the early phases of the COVID-19 pandemic, roughly 35% of 50,000 residents in China were experiencing psychological distress. In San Francisco (USA), there was an eightfold increase (from 7% to 66%) in feeling distressed compared to before the pandemic. In Australia, almost 80% of survey respondents reported moderate to extreme levels of uncertainty about the future, half reported feeling lonely and half reported moderate to extreme worry about their financial situation. Some financial stressors, such as employment loss, have also been associated with greater symptoms of depression and COVID-19-related concern. However, many of the previous studies did not estimate temporal changes before and during the outbreak, making it difficult to disentangle difficulties emerging in response to the outbreak from pre-existing ones. Also, many focused on isolated aspects of the consequences of the COVID-19 outbreak without presenting a comprehensive picture and thus have limited capacity to identify potential factors modulating the range of psychological responses to the outbreak.

The nature and extent of the outbreak consequences are bound to differ considerably from one individual to another and to be influenced by a range of demographic, occupational and physical/mental health factors. There is thus a need for comprehensive investigations to identify potential factors modulating psychological responses to this complex situation. Furthermore, most studies to date adopted a broad, representational sampling of adults, but increased efforts to reach individuals at elevated risk for negative outcomes and a lifespan perspective incorporating younger to older age ranges holds particular benefits in informing both prevention and intervention initiatives.

The current report presents the cohort characteristics and baseline observations from an ongoing longitudinal survey launched during the acute phase of the COVID-19 pandemic. Perceived threats and concerns, occupational, financial and social distancing behaviours, impacts on social life as well as psychological stress changes relative to retrospective pre-outbreak estimates are reported.

METHODS

Study design

A comprehensive longitudinal online survey was distributed via websites, social media and multiple organisations and hospitals across Canada. This recruitment strategy (see online supplemental section for details) was used to target three core groups: people with chronic mental or physical illnesses, healthcare providers and the general population. While subsequent reports will focus on specific subgroups, the current report introduces the full cohort.

The sole inclusion criterion was to be 12 years of age or older. The survey was available in English and French, nested in a secured access online platform (www.qualtrics.com), and designed on a decisional tree structure. It included a set of validated questionnaires and custom-built questions pertaining to the pandemic (see online supplemental section).

The survey was designed to address the following primary areas of interest: (1) symptoms related to COVID-19 and rates of positive tests; (2) physical and mental health conditions; (3) access to healthcare services; (4) social distancing practices; (5) consequences of the outbreak for family, work-related and financial outcomes; (6) factors and coping mechanisms that may be protective against adverse health, psychosocial and financial impacts; (7) organisational support, work resources and difficulties, degree of moral distress and moral resilience in healthcare staff. The survey also included general demographics and indices for geocoding and socioeconomic status. To enable future comparisons, questions were aligned wherever possible with previous surveys such as those used by Census Canada and recent COVID-19 surveys circulated in China. The survey included a briefer version for healthcare workers and an adapted version for adolescents. At the start of the survey, participants were informed that they had the choice to skip items. Median completion time was 53.1 min (IQR: 38.6 min).

Themes covered in the current report include factors linked to the pandemic (eg, testing, perceived threat and concerns); occupational and financial life; social life and psychological stress. Retrospective questions were used to estimate temporal changes from ‘before the outbreak’ (ie, in the last month before the outbreak) to ‘during the outbreak’ (ie, in the 7 days prior to filling out the survey). The survey was developed and conducted following guidelines from the Checklist for Reporting Results of Internet E-Surveys. Additional information about the survey and the psychometric properties of validated scales included are outlined in online supplemental material. Electronic informed consent was obtained from each participant.

Patient and public involvement

People from the general public, individuals with mental disorders, and healthcare professionals were consulted during the survey development and testing phase. They were asked to provide feedback on the survey content, both in terms of prioritising the most important questions (thereby influencing outcome measures) and the clarity of question formulation. They were also asked to comment on the survey format, notably in terms of the layout of the questions on the online platform, the
general survey length and the distinct survey sections specifically targeting certain subgroups (thereby influencing the study design). These individuals were not directly involved in active recruitment or the dissemination plan for the study.

**Primary outcome: psychological stress**

Respondents retrospectively assessed their stress levels on the Cohen’s Perceived Stress Scale (PSS) for the last month before the outbreak (ie, pre-outbreak) and for the past 7 days (ie, during the outbreak). PSS scores were analysed continuously (ie, scale of 0–40) and categorically based on established thresholds: 0–13 (low stress), 14–26 (moderate stress) and 27–40 (high stress) and previously estimated minimal clinically important change corresponding to a 28% relative change. Factors hypothesised a priori to be associated with stress changes were pre-outbreak stress level, time elapsed since the pandemic declaration by the WHO, age, sex, education level, total family income, employment status, working with the general public, political views, having underage children, having travelled abroad in the past 60 days, index reflective of the number and severity of potential COVID-19 symptoms (ie, COVID-19 symptoms index), the Dimensional Obsessive-Compulsive Scale (DOCS) contamination subscale, Big 5 Personality subscales, Brief Resilient Coping Scale (BRCS), having a mental disorder, alcohol and drugs use, having a physical condition at risk for COVID-19, sleep duration, quality of family relationships, amount of time spent outdoors, interacting with other people, following the news on COVID-19, and engaging in physical and artistic activities.

**Analyses**

Descriptive statistics were used to characterise survey respondents. To assess changes before and during the outbreak, \( \chi^2 \) analyses, paired t-tests/Wilcoxon tests and McNemar-Bowker tests were used as appropriate. A repeated measures ANOVA was used to assess the unadjusted cross-sectional temporal evolution of PSS change scores across the study period.

Multivariate linear regression was used to identify factors independently associated with PSS changes scores using the ‘enter’ pairwise approach with the predictors listed above. To improve sample homogeneity, this model was run solely on the subgroup of Canadian respondents. A series of multivariate linear models were also run to assess the relation between changes in stress and each independent variable separately while accounting for pre-outbreak PSS scores. Analyses were done using the Statistical Package for Social Sciences (IBM SPSS Statistics for Windows, V.23.0. Armonk, USA). Details on data cleaning procedures are provided in the online supplemental material.

**RESULTS**

**Survey and sample characteristics**

Between April 3rd and May 15th, 2020 (ie, 23–65 days after the pandemic declaration by the WHO, a period starting around the peak of the first wave in Canada where 900–2000 new reported cases were deemed to emerge each week), 6685 individuals consented to take part in this study and answered the first survey question. All 6040 respondents who filled out the minimally sufficient portion of the survey (90.4% of those who answered the first question; see details in online supplemental material) were included in the current report. From this sample, 81.7% respondents completed the entire survey.

Sample characteristics are presented in table 1. Respondents ranged between 12 and 83 years old. Most respondents were middle aged, women, Canadian (mostly from Ontario or Quebec), Caucasian, highly educated, lived in an urban residential area, had children, and were employed with a total yearly family income above $C40 000. More than 50% reported having a physical illness known to be at risks for adverse COVID-19 outcomes, and about 30% had a diagnosis of a mental disorder.

**COVID-19 testing, perceived threats/concerns and changes relative to before the outbreak**

79.3% of respondents endorsed at least two symptoms that could be linked to COVID-19 and 6.7% of respondents said they had been tested for COVID-19. Of those, 4.5% tested positive and 2.7% awaited results. Of those who had not been tested, 4.7% had contacted public health services to be tested. Within this group, 85.4% were declined testing. Rates of declined testing were similar between rural (85.0%) and urban areas (86.2%; \( \chi^2=0.02, p=0.886 \)).

Among all respondents, 43.0% estimated that a coronavirus infection would pose high to very high threat to their health and 32.8% estimated moderate threat. A high to very high threat was estimated by 28.1% for their financial situation, 41.5% for their jobs or businesses and 62.8% for their country. Figure 1 shows the degree of concern related to different secondary effects of the outbreak. Overall, the highest concerns pertained to one’s children or relatives not coping well with the pandemic situation, closely followed by being unable to access medications or medical services. When asked when they expected the global situation to go back to normal, 37.2% replied ‘I have no idea’, 27.8% estimated after March 2021, 17.4% by March 2021, 14.9% by September 2020 and 2.7% by June 2020. Of the total sample, 30.4% anticipated that their own personal situation would get back to normal before the global situation resolves and 10.1% anticipated that it would take longer for their personal situation than for the global situation to get back to normal.

On average, when comparing pre-outbreak estimates and current states: sleep duration shortened \( (Z=-4.9, p<0.001, r=0.07) \), family relationships deteriorated \( (Z=-13.4, p<0.001, r=0.18) \) and weekly alcohol and cannabis consumption increased \( (Z=-18.1, p<0.001, r=0.19) \).
Table 1  Characteristics of the survey responders at the time of the survey completion

<table>
<thead>
<tr>
<th>Time since outbreak start (days)</th>
<th>Total n</th>
<th>Missing values, % (frequency)</th>
<th>Mean±SD / % (frequency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General demographics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>6034</td>
<td>0.1 (6)</td>
<td>51.8±17.1</td>
</tr>
<tr>
<td>Biological sex (females)</td>
<td>6039</td>
<td>&lt;0.1 (1)</td>
<td>70.3 (4248)</td>
</tr>
<tr>
<td>Gender/sex change</td>
<td>5480</td>
<td>9.3 (560)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td>31.6 (1730)</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td>67.1 (3676)</td>
</tr>
<tr>
<td>Transexual</td>
<td></td>
<td></td>
<td>0.2 (10)</td>
</tr>
<tr>
<td>Gender queer or expansive</td>
<td></td>
<td></td>
<td>0.9 (50)</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td>0.3 (14)</td>
</tr>
<tr>
<td>Current location</td>
<td>6005</td>
<td>0.6 (35)</td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td></td>
<td></td>
<td>97.3 (5845)</td>
</tr>
<tr>
<td>USA</td>
<td></td>
<td></td>
<td>1.3 (79)</td>
</tr>
<tr>
<td>Others*</td>
<td></td>
<td></td>
<td>0.7 (40)</td>
</tr>
<tr>
<td>France</td>
<td></td>
<td></td>
<td>0.4 (26)</td>
</tr>
<tr>
<td>Australia</td>
<td></td>
<td></td>
<td>0.2 (15)</td>
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<tr>
<td>Ethnicity</td>
<td>5577</td>
<td>7.7 (463)</td>
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<tr>
<td>Caucasian</td>
<td></td>
<td></td>
<td>86.6 (4832)</td>
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<tr>
<td>Others</td>
<td></td>
<td></td>
<td>5.6 (311)</td>
</tr>
<tr>
<td>Asian</td>
<td></td>
<td></td>
<td>3.4 (191)</td>
</tr>
<tr>
<td>First Nation, Metis or Inuk</td>
<td></td>
<td></td>
<td>2.1 (115)</td>
</tr>
<tr>
<td>Arab</td>
<td></td>
<td></td>
<td>1.2 (68)</td>
</tr>
<tr>
<td>Black</td>
<td></td>
<td></td>
<td>1.1 (60)</td>
</tr>
<tr>
<td>Non-citizen (vs not)</td>
<td>5634</td>
<td>6.7 (406)</td>
<td>6.1 (343)</td>
</tr>
<tr>
<td>Political views (left-wing/right-wing)</td>
<td>5167</td>
<td>14.5 (873)</td>
<td>44.8 (2313)/14.6 (754)</td>
</tr>
<tr>
<td>Education</td>
<td>5495</td>
<td>0.8 (49)</td>
<td></td>
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<tr>
<td>University certificate, diploma or degree</td>
<td>5629</td>
<td>7.3 (439)</td>
<td>11.1 (624)/40.6 (2272)/48.3 (2705)</td>
</tr>
<tr>
<td>College</td>
<td></td>
<td></td>
<td>63.6 (3497)</td>
</tr>
<tr>
<td>High school</td>
<td></td>
<td></td>
<td>21.8 (1197)</td>
</tr>
<tr>
<td>Socioeconomic, occupational and living situation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total family income (&lt;$C40k/$C40k to $C100k/&gt;$C100k)</td>
<td>5601</td>
<td>7.3 (439)</td>
<td>61.1 (624)/40.6 (2272)/48.3 (2705)</td>
</tr>
<tr>
<td>Employment status</td>
<td>5958</td>
<td>1.4 (82)</td>
<td></td>
</tr>
<tr>
<td>Unemployed/retired/student</td>
<td></td>
<td></td>
<td>12.8 (764)/30.6 (1822)/3.6 (213)</td>
</tr>
<tr>
<td>Employed</td>
<td></td>
<td></td>
<td>53.0 (3159)</td>
</tr>
<tr>
<td>Having work involves contact with the general public (vs not)</td>
<td>5779</td>
<td>4.3 (261)</td>
<td>14.3 (826)</td>
</tr>
<tr>
<td>Dwelling (house/apartment or condo)</td>
<td>5417</td>
<td>10.3 (623)</td>
<td>77.4 (4191)/22.6 (1226)</td>
</tr>
<tr>
<td>Living situation (alone/with another person/with multiple people)</td>
<td>5606</td>
<td>7.2 (434)</td>
<td>20.0 (1123)/44.2 (2478)/35.8 (2005)</td>
</tr>
<tr>
<td>Living area (rural/urban)</td>
<td>5565</td>
<td>7.9 (475)</td>
<td>11.8 (665)/88.2 (4910)</td>
</tr>
<tr>
<td>Health and risks factors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C19 Symptoms index (0–30 scale)</td>
<td>6040</td>
<td>0.0 (0)</td>
<td>2.1±3.6</td>
</tr>
<tr>
<td>Presence of physical condition at risk for COVID-19 (vs not)</td>
<td>5629</td>
<td>6.8 (411)</td>
<td>52.1 (2934)</td>
</tr>
</tbody>
</table>
Table 1 Continued

<table>
<thead>
<tr>
<th>Total n</th>
<th>Missing values, % (frequency)</th>
<th>Mean±SD / % (frequency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleep duration (hours; before the outbreak/during outbreak)</td>
<td>4998</td>
<td>17.1 (1030)</td>
</tr>
<tr>
<td>Travelled abroad in last 60 days (vs not)</td>
<td>5548</td>
<td>8.1 (492)</td>
</tr>
</tbody>
</table>

**Psychological domain**

- PSS scores (0–40 scale; before the outbreak/during outbreak) | 5132 | 15.0 (98) | 12.9±6.8/14.9±8.3 |
- DOCS—contamination (0–20 scale) | 4920 | 18.5 (1120) | 6.1±3.7 |
- Big 5 subscales (2–10 scale) | 4881 | 19.2 (1161) |  |
  - Extraversion | 6.2±2.1 |
  - Agreeableness | 7.4±1.7 |
  - Conscientiousness | 7.8±1.8 |
  - Neuroticism | 5.6±2.3 |
  - Openness to experiences | 6.9±1.9 |
- Brief Resilient Coping Scale (4–20 scale) | 4856 | 19.6 (1184) | 14.7±2.9 |
- Mental disorder diagnosis (vs not) | 5607 | 7.2 (433) | 29.0 (1626) |

**Social domain**

- Family relationship (0–100 scale; before the outbreak/during outbreak) | 5328 | 9.5 (572) | 79.5±19.9/74.7±25.4 |
- Has underage children (vs not) | 5731 | 5.1 (309) | 17.2 (985) |

**Behavioural domain**

- Number of alcoholic drinks/week (before the outbreak/during outbreak) | 5557 | 7.9 (476) | 4.1±6.5/4.8±6.9 |
- Number of cannabis use/week (before the outbreak/during outbreak) | 5512 | 8.6 (518) | 0.9±5.1/1.0±5.1 |
- Spent 30 min or less: | 5612 | 7.1 (428) |
  - Outdoor | 39.3 (2203) |
  - Exercising | 47.7 (2668) |
  - Following C19 news | 44.0 (2457) |
  - Interacting with people in person | 50.6 (2767) |
  - Interacting with people virtually | 39.5 (2194) |
- Doing an artistic activity | 75.6 (4155) |

Means, SD, frequencies and percentages (calculated on each item’s total sample) for main sample characteristics; location others: Armenia (n=1), Azerbaijan (n=1), Burkina (n=3), Congo (n=1), Czech Republic (n=1), Denmark (n=1), Germany (n=3), Ireland (n=1), Italy (n=1), Ivory Coast (n=1), Jamaica (n=1), Lebanon (n=1), Malaysia (n=1), Netherlands (n=3), New Zealand (n=1), Pakistan (n=1), Poland (n=1), Romania (n=2), Singapore (n=3), Spain (n=1), Sweden (n=1), UK (n=8), Vietnam (n=1), Other (n=1); gender expansive: fluid/non-binary; alcohol consumption (number of drinks per week); cannabis consumption (number of times per week), living area based on postal code. *Physical condition at risk for COVID-19: for example, respiratory, cardiovascular or autoimmune conditions.

DOCS, Dimensional Obsessive-Compulsive Scale; PSS, Perceived Stress Scale.

$r=0.24$ and $Z=–18.1$, $p<0.001$, $r=0.10$). Specifically, 10.4% of the sample over 16 years of age increased their weekly alcohol consumption by five drinks or more.

**Occupational and financial impacts**

Within actively working respondents, 62.8% were working from home, 9.8% had increased work hours because of the outbreak, and 15.6% had decreased work hours. A total of 7.9% underwent a salary decrease due to the outbreak, with an overall median salary reduction of 35% (IQR=50). Of all respondents who were working in the month preceding the outbreak, 11.1% saw their employment terminated because of the outbreak.

Rates of employment termination due to the outbreak or salary loss exceeding 35% were higher in those with a family income below $C40k compared with those with higher family income (12.6%, $\chi^2=121.0$, $p<0.001$), in people without a university degree (23.6%) compared with those with a university degree (11.0%; $\chi^2=74.6$, $p<0.001$) and in people with a diagnosis of a mental disorder (16.8%) compared with those without (13.5%;
χ²=4.9, p=0.027). Rates of employment termination/salary decrease were similar in women versus men (χ²=2.3, p=0.132), Caucasians versus other ethnicities (χ²=0.9, p=0.335) and people with or without physical illnesses (χ²=0.1, p=0.719).

Across the entire sample, 64.5% reported that their expenses had decreased since the start of the outbreak and 15.5% reported an increase, with a mean estimated rise in health-related expenses of 10.4%±20.3%, compared with 29.2%±38.0% for food-related expenses.

Social life
Family and other relationships
Half of the parents with underage children (54.0%) said that they or their partner were homeschooling. Most respondents estimated that the outbreak was being somewhat disruptive for the management of their work/study and family life (mean rating on a scale from ‘0—very disruptive’ to ‘50—not different from usual’ and ‘100—easier than usual’: 21.6±45.6).

The proportion of respondents interacting with their family more frequently since the start of the outbreak was significantly higher than the proportion of those who were interacting less frequently (p<0.001). The reverse pattern was found for interactions with friends (p<0.001).

Among all respondents, 40.0% reported feeling more connected to their family during compared with before the outbreak, while 21.0% felt less connected. This pattern was reversed for connectedness to friends, with 36.2% reporting feeling less connected and 28.3% feeling more connected. On average, relationship ratings with both family and friends during the outbreak significantly deteriorated compared with pre-outbreak estimates (Z=−10.9, p<0.001 and Z=−28.1, p<0.001).

Social distancing
65.8% of respondents were following at least one social distancing guideline at the time of filling out the survey, with 51.6% maintaining a 2 metres distance from others, 46.3% avoiding gatherings in person, 42.5% not using public transport, 37.9% not attending public areas, 35.4% not going out of the home unless they had no choice (eg, to go to a medical appointment), 29.5% wearing a mask when leaving home and 17.9% having food/supplies delivered to their homes. A statistically significant proportion of individuals (between 57.7% and 89.0%) disengaged from some of the social distancing practices that they had initially followed since the start of the outbreak (all p<0.001).

Psychological stress
PSS scores globally increased from 12.9±6.8 before the outbreak to 14.9±8.3 during the outbreak (Z=−22.9, p<0.001, r=0.31), which reflects a transition from low to moderate stress. Rates of individuals with PSS score in the high stress range increased from 3.8% before the outbreak to 10.2% during the outbreak (figure 2). However, there was considerable heterogeneity in stress changes: a clinically meaningful increase in stress was noted in 30.3% of respondents, while 10.3% had a clinically meaningful reduction in stress.

Figure 3 depicts the temporal dynamics of stress changes based on the time at which respondents filled out the survey. Over the course of the study period, there was an overall attenuation of stress worsening on PSS change scores (F(5, 5097)=20.07, p<0.001). There was a non-significant reduction in stress worsening
between April 3rd and 10th, followed by a plateau, which persisted until May 8th, after which there was a significant drop (p≤0.006), compared with all preceding time periods.

In the multivariate linear regression model, the following variables were found to be significant independent factors linked to stress worsening (table 2, right panel): shorter time elapsed since the start of the outbreak, younger age, female sex, having left wing political views, work involving in-person contact with the general public, having underage children, worse COVID-19 symptoms index, shorter sleep duration, lower PSS scores before the outbreak, higher scores on the DOCs—contamination subscale and on the extraversion, conscientiousness and neuroticism scales of the Big5, lower BRCS scores, having a mental disorder diagnosis, having had more than five alcoholic drinks in the past week, worse family relationships and spending less time exercising and doing artistic activities.

When assessed on their own, the following factors were found to be predictive of worse increases in stress levels (while controlling for stress levels before the outbreak) but became non-significant when controlling for confounders in the global model (table 2, left panel): lower family income (stronger relationship for the lowest income level), consuming cannabis or other drugs, spending less time outdoors and more time interacting with people virtually. Being retired, having travelled abroad in the past 60 days and having a physical condition at risk for COVID-19, were associated with lower stress worsening. Exploratory analyses stratified by biological sex are provided in supplemental materials.

**DISCUSSION**

Results from this survey in 6040 respondents suggest that the financial, social and psychological correlates of the COVID-19 outbreak may interact in a complex manner and that they vary considerably across individuals. While some of our findings echo previous observations, we propose a more comprehensive integrated model of independent factors associated with worse stress responses to this pandemic.

In line with previous polls reporting that many people perceived the COVID-19 pandemic as a greater threat to the economy than to their health,10 we observed higher sense of threat related to external/global as opposed to more personal matters. Our observation of concerns about access to medical services is aligned with high rates of potential COVID-19 symptoms with low access to testing for COVID-19, a combination which may increase stress. Nearly 40% of respondents endorsed being uncertain about when the global situation would get back to normal. This contrasts with the 80% of Australians who reported moderate to extreme uncertainty about the future in a previous survey done in March and April 2020.11 This difference could stem from temporal, cultural or public health variants.

Previous studies indicated that lower income is associated to higher incidences of COVID-19 infections,20 but such economic factors are also affecting many collateral effects of the pandemic. Consistent with Canadian rates of employment that plummeted by about 11% from February to April 2020,21 but lower than the 50% worldwide job losses anticipated by the UN labor agency,22 11% of our respondents lost their job because of the outbreak and an additional 8% underwent salary cuts, with a non-trivial median reduction in salary of 35%. Low income and the lack of a university degree were found to be major risk factors for adverse work and salary outcomes, a phenomenon that may further widen economic disparities. Similarly, reports in the USA showed that 40% of people earning US$40k or less lost their jobs due to the COVID-19 outbreak and that more than 50% of those who kept their job had a university degree. These figures are however much lower than those observed in developing countries, with about two-thirds of respondents to a survey circulated in Vietnam reporting decreased income.23 Importantly, the current study is, to our knowledge, the first one to identify having a mental disorder as a risk factor for employment termination during the outbreak. The psychological impacts of unemployment are likely to further worsen mental health in these individuals, and they may be at higher risks for subsequent unemployment.24 Therefore, this subgroup may face additional challenges not only to cope with the occupational and financial consequences of the pandemic but also to find work after deconfinement, which highlights potential needs for targeted governmental relief packages and supporting programmes to find work. Increased expenses since the start of the outbreak seemed to be most prominently related to food. Although concerns about lacking

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**Figure 3** Patterns of stress changes across time. Average changes in score on the Cohen’s Perceived Stress Scale (PSS) from pre-outbreak to during the outbreak (ie, current PSS minus pre-outbreak PSS; higher scores indicating stress worsening) measured cross-sectionally across each time period of survey completion (each comprising 7 days starting on the date of the survey launch). Higher change scores reflect higher stress worsening relative to pre-outbreak stress levels. Error bars indicate the SE of the mean. Sample sizes for each 7 day time period are as follows: April 3rd: n=516, April 10th: n=135, April 17th: n=453, April 24th: n=1035, May 1st: n=936, May 8th: n=2028. **p<0.001.

---

Table 2  Coefficients of the predictive model for changes in stress

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<thead>
<tr>
<th></th>
<th>Single predictor variables</th>
<th>Full model</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>B</td>
</tr>
<tr>
<td>Time since outbreak start (per 7-day increase)</td>
<td>5359</td>
<td>-0.55</td>
</tr>
<tr>
<td>General demographics</td>
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<tr>
<td>Age (per 10-year increase)</td>
<td>5357</td>
<td>-0.96</td>
</tr>
<tr>
<td>Male sex (vs female)</td>
<td>5358</td>
<td>-2.02</td>
</tr>
<tr>
<td>Political views (vs centre or others)</td>
<td></td>
<td></td>
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<tr>
<td>Left wing</td>
<td>4657</td>
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<tr>
<td>Right wing</td>
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<td>0.21</td>
</tr>
<tr>
<td>Education: no university (vs university)</td>
<td>5327</td>
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<tr>
<td>Socioeconomic, occupational and living situation</td>
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<td>Total family income (vs &gt;$C100k)</td>
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<tr>
<td>&lt;$C40k per year</td>
<td>5009</td>
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<tr>
<td>$C40 to $C100k per year</td>
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<td>0.39</td>
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<td>Employment status (vs employed)</td>
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<td>Retired</td>
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<tr>
<td>Work contact with general public (vs not)</td>
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</tr>
<tr>
<td>Living in apartment or condo (vs house)</td>
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<td>Health and risks factors</td>
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<td></td>
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<td>C19 Symptoms index (scale from 0 to 30)</td>
<td>5359</td>
<td>0.23</td>
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<tr>
<td>Physical condition at risk* (vs no condition at risk)</td>
<td>5342</td>
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<tr>
<td>Sleep duration (per hour increase)</td>
<td>4804</td>
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<tr>
<td>Travelled abroad in last 60 days (vs no travel)</td>
<td>4960</td>
<td>-0.45</td>
</tr>
<tr>
<td>Psychological domain</td>
<td></td>
<td></td>
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<tr>
<td>Preoutbreak PSS (0–40 scale)</td>
<td>4920</td>
<td>-</td>
</tr>
<tr>
<td>DOCS—contamination (0–20 scale)</td>
<td>4717</td>
<td>0.47</td>
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<tr>
<td>Big 5 Personality (2–10 scale)</td>
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<td>Extraversion</td>
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<tr>
<td>Agreeableness</td>
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<td>Conscientiousness</td>
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<td>Openness to Experiences</td>
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<td>Brief Resilient Coping Scale (4–20 scale)</td>
<td>1663</td>
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<tr>
<td>Mental disorder diagnosis (vs no diagnosis)</td>
<td>5326</td>
<td>2.34</td>
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</table>
food were rather mild in the current sample, some respondents may have been stocking up in the context of supply disruption and/or facing increases in pricing for food.26

In line with early COVID-19 reports from China describing major reductions in social contacts beyond the household,27 we observed increased interactions with family and decreased interactions with friends, which probably reflect social distancing. This change was accompanied by consistent changes in feelings of connectedness and, paradoxically, by a worsening in relationships quality. Together with previous observations of increased family violence during the pandemic,28 this stresses the need to better understand how close proximity in the context of confinement may create family tensions. Only 66% of respondents were following at least one social distancing guideline, a percentage similar to previously reported rates in a previous Canadian poll.29 Although the state of emergency still prevailed at the time of the survey, about 60%–90% of respondents had been phasing out their social distancing practices. This raises considerable concerns since even a 20% increase in adherence to social distancing can contribute to slow the spread of COVID-19.30

We found a significant increase in stress co-occurring with the outbreak, with 30% of individuals undergoing clinically meaningful stress worsening. This echoes findings from a recent systematic review31 and is consistent with rates of moderate to severe stress reaching 20%–27% in Asia, Europe and Australia.7 11 32–36 As anticipated, more acute stress reactions were observed in the earlier phases of the outbreak, with a sharp drop shortly after the mortality peak in Canada was announced. These preliminary observations suggest that although the degree of stress worsening during the outbreak may have been phasing out for many individuals, 2 months after the pandemic declaration, stress levels were not fully back to pre-outbreak levels. This supports the need for the development/promotion of self-help tools for stress management.

Having a current diagnosis of a mental disorder was found to be the strongest independent factor linked to stress worsening, a finding consistent with previous

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Continued</th>
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</thead>
<tbody>
<tr>
<td><strong>Social domain</strong></td>
<td><strong>Full model</strong></td>
</tr>
<tr>
<td>Family relationship (per 10 units; 0–100 scale)</td>
<td>5028</td>
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<tr>
<td>Has underage children (vs no underage children)</td>
<td>5092</td>
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<tr>
<td><strong>Behavioural domain</strong></td>
<td><strong>Full model</strong></td>
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<tr>
<td>Weekly alcohol consumption (vs no drinks)</td>
<td>5358</td>
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<tr>
<td>One to five drinks</td>
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<tr>
<td>More than five drinks</td>
<td>5312</td>
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<tr>
<td>Weekly cannabis or illicit drugs use (vs no use)</td>
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<td>Spent 30 min or less (vs more than 30 min):</td>
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<tr>
<td>Exercising</td>
<td>5296</td>
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<tr>
<td>Following COVID-19 news</td>
<td>5201</td>
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<tr>
<td>Social interactions in person</td>
<td>5277</td>
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<tr>
<td>Social interactions virtually</td>
<td>5210</td>
</tr>
</tbody>
</table>

Coefficient parameters for multiple linear regression models including only each single predictors and baseline stress (left panel) and for the full model (right panel). B: Unstandardised coefficients (calculated per one unit for continuous variables, except for the time elapsed since the start of the outbreak, which was calculated for each 7 days, as well as age and family relationships which were calculated per 10 units). Units (for continuous variables) and reference groups (for categorical variables) are presented in parenthesis in the first column. Family relationship rated on scale from ‘0—very difficult/confictual’, ‘50—neutral’ to ‘100—excellent’.*Physical condition at risk for COVID-19: for example, respiratory, cardiovascular or autoimmune conditions.

DOCS, Dimensional Obsessive Compulsive Scale; LL, lower limit; PSS, Perceived Stress Scale; SE, standard error of B; UL, upper limit.
observations about pre-existing psychiatric conditions. This stresses the importance of further investigations in this group who may require more intensive stress management resources. Poorer coping skills and personality traits loading heavily on neuroticism, extraversion and conscientiousness were also associated with worse increases in stress. High neuroticism has previously been linked to maladaptive stress coping strategies. While personalities loading on conscientiousness are usually well-organised, goal-directed and more effective in dealing with stress, the uncertainty associated with this unprecedented outbreak may prevent them from relying on their usual coping strategies, leading to heightened stress. Since extraversion is characterised by a tendency to be active and sociable, social distancing measures probably contributed to worse stress responses in extraverted individuals. Accordingly, a Brazilian COVID-19 survey showed that higher extraversion was associated with lower engagement in social distancing practices, likely reflecting how challenging it is for extraverted individuals to reduce their social proximity.

In line with our finding of an association between left-wing views and stress worsening, a recent Gallup poll in the USA found that liberals (as compared with conservatives) were more likely to worry about worst-case outcomes of the pandemic. Humans are known to outsource their understanding of the world to their political ingroup. The politicisation of the crisis and associated media bias (with risk-averse, pro-lockdown perspectives in the liberal media and the conservative media appearing to take the crisis less seriously) is one possible explanation for worse pandemic-related distress in liberals.

Our results confirm that several factors previously linked to stress, such as female sex, younger age, having children, and having symptoms that could be linked to COVID-19 independently contribute to stress worsening. While previous reports highlighted high risks in healthcare workers, our findings suggest that this extends to other types of workers physically interacting with the public (e.g., people working in public transport, grocery stores). Importantly, the current study also identified some modifiable factors that were associated with lower stress responses. For instance, protecting a sufficient period for sleep, minimising alcohol and drug consumption, promoting better family relationships, exercising and doing artistic activities may be helpful. Sleep disturbances often emerge in response to external stressors and can further worsen physiological and psychological stress responses. Since sleep is thought to contribute to emotional regulation and attenuating the adverse effects of the pandemic on sleep may enable better coping resources. In addition to the benefits of exercise on sleep, about 30 min of moderate-intensity aerobic exercise three times weekly may also boost mood and reduce psychological distress. Planning family activities that may help alleviate tensions and foster more positive relations, as well as creating some time and space for individuals to offset the challenges posed by sustained family proximity may also be relevant to manage stress. Appropriate homeschooling support as well as better work adaptation for parents may also be required. Increased access to testing is likely to have the collateral effect of attenuating stress levels. Further investigations may be required to better understand if limiting the time spent on virtual interactions with people may also play a protective role against stress. From the current study, it is not possible to differentiate virtual interactions that may be related to work from those related to family/friend contacts. Also, the association with increased stress worsening and virtual communications may be in part driven by individuals seeking more frequent virtual contacts to alleviate their stress, but the cross-sectional nature of the current analyses does not allow to determine whether this is an effective strategy or not. There was also considerable sex differences in factors associated with stress, which may call for the development of sex-specific interventions. Furthermore, although this was not investigated in the current report, other studies indicated that preventative measures and personal protective equipment may facilitate lower stress in relation to the pandemic.

The potential of several lines of psychological interventions to mitigate the mental health impacts of the pandemic is also rapidly being highlighted. The study has several important limitations. The observational and cross-sectional nature of this study precludes any causality inference and recall bias may have affected retrospective estimates of pre-outbreak metrics. Representativeness (e.g., age distribution skewed towards middle age, higher rates of women, highly educated individuals with high-income status, which are not representative of the global Canadian population) and generalisability are limited by the sample selection, dissemination strategy and volunteer bias; although our demographic characteristics are consistent with other published surveys. The length and online nature of the survey may have prevented some individuals from completing it. Although our multivariate model corrected for this, data collection spanned over a month, a period during which we did observe dynamic changes in stress responses. This study also has several strengths, such as a relatively large sample size, the comprehensive set of factors assessed and its launch in the acute phase of the outbreak.

**CONCLUSION**

Baseline data in 6040 respondents who shared their experiences in the acute phase of the COVID-19 pandemic highlighted adverse financial, social and psychological outcomes. Our preliminary findings start to draw a comprehensive model integrating multiple independent factors of the stress responses to this pandemic. Modifiable risk factors identified could inform the development of targeted interventions and support. Populations at risk that should be targeted include: people with pre-existing mental disorders, parents of underage children, people with low income, workers interacting with the general public (e.g., people working in public transport, grocery stores). Importantly, the current study also identified some modifiable factors that were associated with lower stress responses. For instance, protecting a sufficient period for sleep, minimising alcohol and drug consumption, promoting better family relationships, exercising and doing artistic activities may be helpful. Sleep disturbances often emerge in response to external stressors and can further worsen physiological and psychological stress responses. Since sleep is thought to contribute to emotional regulation and attenuating the adverse effects of the pandemic on sleep may enable better coping resources. In addition to the benefits of exercise on sleep, about 30 min of moderate-intensity aerobic exercise three times weekly may also boost mood and reduce psychological distress. Planning family activities that may help alleviate tensions and foster more positive relations, as well as creating some time and space for individuals to offset the challenges posed by sustained family proximity may also be relevant to manage stress. Appropriate homeschooling support as well as better work adaptation for parents may also be required. Increased access to testing is likely to have the collateral effect of attenuating stress levels. Further investigations may be required to better understand if limiting the time spent on virtual interactions with people may also play a protective role against stress. From the current study, it is not possible to differentiate virtual interactions that may be related to work from those related to family/friend contacts. Also, the association with increased stress worsening and virtual communications may be in part driven by individuals seeking more frequent virtual contacts to alleviate their stress, but the cross-sectional nature of the current analyses does not allow to determine whether this is an effective strategy or not. There was also considerable sex differences in factors associated with stress, which may call for the development of sex-specific interventions. Furthermore, although this was not investigated in the current report, other studies indicated that preventative measures and personal protective equipment may facilitate lower stress in relation to the pandemic.
public, people with potential COVID-19 symptoms, and those with sleep disruptions.

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Contributors RR, TK and JE were involved in project administration and participants’ recruitment as site primary investigators. RR, MS, AN and TK were additionally involved in the following: analyses of data and drafting of the manuscript. RR, MS, JE, Eso, M-HP, AD, SPLV, LQ, KO, AN, JP, RB, ESp, RG, BY, CR, WAG, MG, AB, RS, and TK were involved in the following: study conception and design, interpretation of data, revising the manuscript critically for the accuracy and important intellectual content, and final approval of the version to be published. RR, MS, JE, Eso, M-HP, AD, SPLV, LQ, KO, AN, JP, RB, ESp, RG, BY, CR, WAG, MG, AB, RS and TK are accountable for all aspect of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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Competing interests None declared.

Patient consent for publication Not required.

Ethics approval This study was approved by the Clinical Trials Ontario—Qualified Research Ethics Board via the Ottawa Health Science Network (Protocol number 2131).

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available upon reasonable request.

Proposals to access data from this study can be submitted to the corresponding author and may be made available upon data sharing agreement.

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REFERENCES
DATA SUPPLEMENT

**Title:** Social, Financial and Psychological Stress during an Emerging Pandemic: Observations from a Population Survey in the acute phase of COVID-19


1. Supplemental results
2. Additional information about the survey
3. Brief description of primary measures of Interest covered in this report
4. Detailed Survey description
5. References
1. Supplemental results

A) Loneliness

Scores on the UCLA Loneliness Scale were significantly higher in individuals who were avoiding going out of their home (Z=-2.2, p=0.027), living alone (Z=-4.7, p<0.001), younger than 65 years of age (Z=-6.8, p<0.001), diagnosed with a mental disorder (Z=-13.7, p<0.001), or unemployed (Chi-squared=70.0, p<0.001). There was no significant difference in loneliness based on other social distancing practice, sex or whether one worked from home (p>0.050).

B) Sex-stratified analyses

In exploratory analyses stratified by biological sex (Supplemental table 1), the following variables were found to be independent predictors of stress changes in females, but not in males: lesser time elapsed since the start of the outbreak, younger age, higher extraversion, conscientiousness and openness to experiences, having a current diagnosis of a mental disorder, having had more than 5 alcoholic drinks in the past week, and spending less time exercising and doing artistic activities. Conversely, the following variables were found to be independent predictors of stress changes in males, but not in females: work involving physical contact with the general public, having traveled in the past 60 days, and spending less time interacting with people virtually. The following variables remained significant independent predictors of higher stress worsening in both sexes: worse COVID-19 symptoms index, shorter sleep durations, lower PSS scores before the outbreak, higher scores on the DOCS - Contamination subscale, higher neuroticism scores on the Big5, lower scores on the BRCS, worse family relationships, and having underage children.
### Supplemental Table 1. Stress models stratified by sex

<table>
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<tr>
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<th>Males</th>
<th></th>
<th>Females</th>
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<td></td>
<td>95.0% CI</td>
<td></td>
<td>95.0% CI</td>
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<tr>
<td></td>
<td>n</td>
<td>B</td>
<td>LL</td>
<td>UL</td>
</tr>
<tr>
<td>Pre-outbreak PSS (Scale from 0 to 40)</td>
<td>1528</td>
<td>-2.22</td>
<td>-1.81</td>
<td>.006</td>
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<tr>
<td>Time elapsed since pandemic declaration (7days)</td>
<td>1643</td>
<td>-1.19</td>
<td>-.049</td>
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<tr>
<td>Age (10years)</td>
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<td>-1.40</td>
<td>.080</td>
<td>.203</td>
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<td>Education level</td>
<td>1625</td>
<td>.023</td>
<td>.505</td>
<td>.926</td>
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<td>Total family income below 40k (vs above 40k)</td>
<td>1539</td>
<td>-1.508</td>
<td>.338</td>
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<td>Employment status (vs employed):</td>
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<tr>
<td>Lost job due to pandemic, unemployed, on leave or student</td>
<td>1643</td>
<td>.530</td>
<td>.344</td>
<td>.202</td>
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<td>Retired</td>
<td>1643</td>
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<td>.347</td>
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<td>1.144</td>
<td>1.948</td>
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<td>Type of dwelling</td>
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<td>Has minor children (vs no minor children)</td>
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<td>1.557</td>
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<td>Travelled abroad since January 2020 (vs no travel)</td>
<td>1597</td>
<td>.429</td>
<td>-.951</td>
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<td>C19 Symptoms index (scale from 0 to 30)</td>
<td>1643</td>
<td>.111</td>
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<td>DOCS5 (scale from 0 to 20)</td>
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<td>.294</td>
<td>.360</td>
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<td>Diagnosis of a mental disorder (vs no diagnosis)</td>
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<td>Weekly alcohol consumption (vs no drinks)</td>
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<tr>
<td>1 to 5 drinks</td>
<td>1643</td>
<td>-.071</td>
<td>-.654</td>
<td>.810</td>
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<tr>
<td>More than 5 drinks</td>
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<td>.142</td>
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<td>.616</td>
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<td>Weekly cannabis or other drugs use (vs no use)</td>
<td>1632</td>
<td>.288</td>
<td>-.962</td>
<td>.403</td>
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<td>Physical condition at risk for COVID-19 (vs no condition at risk)</td>
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<td>.210</td>
<td>-.309</td>
<td>.428</td>
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<td>Sleep Duration (hours)</td>
<td>1539</td>
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<td>-.554</td>
<td>.231</td>
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<tr>
<td>Family Relationship (per 10 units; 0-100 scale)</td>
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<td>-.310</td>
<td>-.210</td>
<td>.000</td>
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<td>Spent 30min or less (vs more than 30min):</td>
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<tr>
<td>Outdoor</td>
<td>1633</td>
<td>.237</td>
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<td>Doing an artistic activity</td>
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<td>.517</td>
<td>1.101</td>
<td>.082</td>
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</tbody>
</table>

Coefficients parameters for multiple linear regression models in males (Left panel) and females (right panel). B: Unstandardized coefficients (calculated per one unit for continuous variables, except for the time elapsed since the start of the outbreak (calculated for each 7 days), and age and family relationships (per 10 units). CI: confidence interval, LL: lower limit, UL: upper limit, Dimensional Obsessive Compulsive Scale (DOCS), Cohen’s Perceived Stress Scale (PSS), † Physical condition at risk for COVID-19: e.g. respiratory, cardiovascular or autoimmune conditions.
2. Additional information about the survey

1.1 CHERRIES guidelines

In line with the CHERRIES guidelines, the survey data is stored in a secured access database (i.e. on a restricted access password protected server at the Royal Ottawa Mental Health Centre). The usability, decisional three, branching logic, and technical performance were tested with seven individuals prior to its launch. A “Save and Continue” feature was enabled, which placed a cookie on the participant’s browser to keep track of survey progress and allowed participants to continue the survey at a later time. Furthermore, to avoid duplicates, distinct entries submitted from the same Internet Protocol address (IP address) within a 12-hour period were automatically marked and excluded from the analyses, but IP addresses were not stored. 26/6,040 (0.4%) duplicate entries identified by matching emails were found. In these cases, the final entry to be kept in the database was selected based first on completeness and then on recency. The mean number of items per page ranged between 4.6 and 6.5 per page depending of the paths followed on the decisional three structure. A completeness check system enabled to document the percentage of the survey completed for each participant.

Some of the CHERRIES recommendations could not be implemented. For instance, participation rate could not be calculated since the survey was freely circulated notably via newsletters and social media, which prevented from the research team to keep track of the number of people who may have seen the survey invitations. Participants were not able to review their responses at the end of the survey. However, they were able to change some of their responses through a “Back Button”, except where responses were used as part of branching logic. Not all items had an “N/A” response option, notably to abide by the strict content of the validated questionnaires included. Responses were not forced; to follow guidelines from our research ethics committees, participants were free to skip any question (except age, which was necessary to determine eligibility to complete the survey). However, prompts appeared to warn participants that a response was skipped before moving to the next section.

1.2 Optional components

Consent was sought from all respondents to receive invitations to fill out follow-up surveys to monitor dynamic longitudinal changes prospectively across different phases of the outbreak (i.e., on a weekly, biweekly or monthly basis), and/or 3 and 6 months after the end of the outbreak. Respondents also had the option of linking the survey results to provincial health administrative data. Optional consent was also sought to link parent and adolescents survey data across parent-child dyads to enable finer analyses of family dynamics. Finally, respondents had the option of providing their Twitter and/or Facebook handles to help refine and apply new methods based on artificial intelligence to monitor the progression of the impacts of COVID-19 through social media data. Social media data will be collated retrospectively starting six months prior to study enrollment until six months after the end of the outbreak, therefore enabling to investigate changes in social media activity before, during, and after the outbreak. Of the 6040 respondents, 78.9% (4,765) agreed to be invited to do follow-up surveys, 63.0 % (3,803) consented for their data to be linked to provincial health administrative data, and 17.7% (1,068) consented for social media linkage. Findings from these optional parts of the survey will be reported in subsequent reports.

1.3 Recruitment Strategy

The survey deployment network currently includes: The Royal Ottawa Mental Health Centre, the University of Ottawa Heart Institute, the Ottawa Hospital, the Children's Hospital of Eastern Ontario, Sunnybrook Health Sciences Centre, Southlake Regional Health Centre, and the Centre for Addiction and Mental Health. The survey link was circulated via the participating sites' websites, email lists and newsletters. "Permission to contact" registries from some of the participating hospitals (the Royal Ottawa Mental Health Centre, the University of Ottawa Heart Institute, the Ottawa Hospital, and the Centre for Addiction and Mental Health) and existing pools of research participants were also used to invite patients who consented to be contacted for research. Partnership for the diffusion of the survey was also established with organizations including: Canadian Nurses Association, Canadian Physiotherapy Association, Canadian Association of Occupational Therapists, Ontario Public Health, Ontario Medical Association, Ontario Psychiatric Association, Ontario Society of Occupational Therapists, Canadian Counselling and Psychotherapy Association, Ordre des Psychologues du Québec, Mood Disorders Society of Canada, Canadian Arthritis Patient Alliance, Patients for Patient Safety Canada, the COVID-19 Resources Canada Platform, and Sleep On It! Canada.

1.4 Data cleaning and supplemental notes

Based on items content, it was deemed that a minimally informative proportion of the survey was completed after the 83rd item (i.e. “Have you been tested for COVID-19?” Corresponding to a 1/3 completion rate for the survey).
All available data from the participants having reached at least this item were included in the analyses. Survey completion times were calculated for those with at least 75% completion rates and all data points longer than 7 hours were systematically excluded from completion time estimates. For all continuous variables, negative values were excluded and treated as missing data. For time estimates, data points larger than the possible time limit (e.g. 40 hours per day) were systematically excluded and treated as missing data (e.g. habitual number of hours of sleep per night; 29/5037 data points (0.6%)). Extreme improbable values were excluded: number of drinks or cannabis use per week >125 (alcohol: 2 data points, cannabis: 1 data point). The time elapsed since the start of the outbreak was defined by the number of days between the declaration of the pandemic by the World Health Organization and the date at which the survey was completed). All categorical variables included in the multivariate model had at least 10% of cases per category.
3. Brief description of primary measures of interest covered in this report

3.1 Demographic information
Demographic variables included age, sex, gender, ethnicity, current location and country(ies) of citizenship, employment status, occupation, living arrangements, parental status, level of education, political beliefs, religious practice, and total yearly family income.

3.2 COVID-19 testing, perceived threat and concerns
We asked the participants to report on their experiences around COVID-19 testing and diagnoses. They were also asked if they have any symptoms suggesting COVID-19 or other risk factors. An index of the number and severity of symptoms that have been associated with COVID-19 (i.e. C19 Symptoms index) was calculated by summing the severity ratings on a scale from 1:mild, 2:moderate and 3:severe for all symptoms endorsed on a list of 11 symptoms (please see “Detailed survey description” section below). The level of perceived threat related to COVID-19 for one’s health, job or business, financial situation or country were rated on a five-point interval scale from very low to very high.

In addition, levels of concerns for several aspects of life, such as access to food or medical services were rated on a scale ranging from “0-Not concerned at all”, to 50-Neutral” and “100- Very concerned”. Respondents were also asked when they anticipated that the global situation and their personal situation would get back to normal.

3.3 Occupational and Financial Impacts
Consequences of the outbreak for school and work were documented, including school closure, working from home, being in contact with the general public, employment termination or salary reduction.

3.4 Impacts on Social Life
Rates of homeschooling and global assessment of work/study and family life management in the face of the outbreak were documented. The frequency of interactions, quality of relationships (with family, friends and work colleagues) and degree of connectedness were retrospectively estimated before the outbreak and at the time of the survey (i.e. during the outbreak). Respondents also indicated their adherence to various practices related to social distancing currently being followed at the time of filling out the survey and those who had been used earlier on after the start of the outbreak. To assess subjective feelings of loneliness and social isolation, the UCLA Loneliness Scale was administered (1).
4. Detailed Survey description (general adult version)

Text in grey represent items asked based on previous answers. The time scale of the following questionnaires was adjusted to align with the two study time points: i) “before the outbreak” (i.e. in the last month before the outbreak) and ii) “during the outbreak” (i.e. in the last seven days at the time of filling out the survey): Cohen’s Perceived Stress Scale (PSS-10), Generalized Anxiety Disorder Scale (GAD-7), Quick Inventory of Depressive Symptomatology - Self Report, short version (QIDS-SR16), Dimensional Obsessive Compulsive Scale – Germs and contamination subscale (DOCS), and the Pittsburgh Sleep Quality Index (PSQI).

Demographics
- Age _____ years
  - If < 12 y.o. - “Thank you for your interest. Unfortunately, you cannot participate in this study.”
  - If < 16 y.o. – Directed to the Adolescent version
- Are you currently a resident physician or working as a health care professional or health care administrator?
  - If No – Continue to general baseline survey described below
  - If Yes – Please select which version of the survey you can do
    - Regular survey for health care workers / administrators (about 20 to 65 minutes)
      - If selected – Directed towards regular survey (with targeted questions for healthcare staff)
    - Brief survey for health care workers / administrators (about 15-35 minutes)
      - If selected – Directed towards Healthcare worker brief version

- Where are you currently living? The house or apartment me or my family rent or own, Rehabilitation centre for youth in difficulty; retirement home, nursing home or long term care facilities, foster family, hospital, temporary accommodation: residence of other family, hotel, rooming/lodging house; camp, other: _____ [if temporary residence – Are you living in a temporary residence because of the outbreak? Y/N; If Rehabilitation centre for youth in difficulty; go to Adolescent version]

- Sex assigned at birth: Male, Female
  - If Female: Are you pregnant?
- Gender: Male, Female; Transsexual - female to male; Transsexual - male to female; Gender-queer; Gender-fluid; Gender non-binary; Other: ________
- Religious practice: Y/N [If yes: please specify: _______]
- Do you identify as (select all that applies):
  - First Nations (North American Indian)
  - Metis
  - Inuk (Inuit)
  - White
  - South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
  - Chinese
  - Black
  - Filipino
  - Latin American
  - Arab
  - Southeast Asian (e.g., Vietnamese, Cambodian, Lao, Thai, etc.)
  - West Asian (e.g., Iranian, Afghan, etc.)
  - Korean
  - Japanese
  - Other – specify

- Current country(ies) of citizenship: [list with other:____]
- Current location: [list with other:____]
  - If Canada selected: Current Province/Territory
  - If your current location is not one of your countries of citizenship, for how long have you been in your current location?: ___ years ___months ___days
  - Including yourself, how many persons currently live in your dwelling?
- Who is currently living in your dwelling: children, partner, husband/wife, mother, father, stepmother, stepfather, grandchild, brother/sister, other: ______
- Do you have any children?
  If Yes - (How many children? Ages (How old is your child (in years or months)? Are any of your children in shared custody??)
  If has a child between 12-18 years old:
    If you think that your child(ren) would be open to fill out the ‘adolescent’ version of this survey, would you agree for our research team to send you an email with the link to do this survey which you can transfer to your child(ren)? Y/N
    If yes (and if address not provided earlier) - Please provide your email address: ______
    If email entered - If your children agree to take part in this study, do you agree for the research team to link your answers to the answers of your children to enable a better analysis of family situations? If so, in addition to the survey link, we will also email you a unique anonymous “Family” code which your children will be able to enter in their survey in order to link it to yours. Your children will not be able to see your answers and you will not be able to see theirs. The research team will only be able to see that respondent ‘X’ is the child of respondent ‘Y’. Y/N
    N.B. If you have any questions about this, please contact us at C19Survey@theroyal.ca.
- Are you the primary carer of a person with a disability or chronic illness? Y/N – if yes: Is that person currently living with you? On their own? In a specialized care facility?
- Current residential postal code(s) or equivalent (3 first digits only): ______
- What type of dwelling do you live in?
  - 01: Single detached house
  - 02: Semi-detached house
  - 03: Row house or terrace
  - 04: Apartment in a flat or Duplex
  - 05: Apartment in a building that has five or more storeys
  - 06: Apartment in a building that has fewer than five storeys
  - 08: Mobile home or other movable dwelling
  - 09: Other - Specify
- How many rooms are there in your dwelling (the single unit in which you currently live)?
- Have you completed: high school diploma or equivalency certificate; college, CEGEP or other non-university certificate or diploma; university certificate, diploma or degree (if so - below bachelor level, bachelor’s degree, Master’s degree, professional degree, doctorate degree)
- Occupation In the last month before the outbreak:
  - Retired, Student (If so – Did your school close because of the outbreak? In how much time were you meant to obtain degree (e.g. graduating from high school or obtaining a diploma/certificate)? What impacts does the outbreak have on classes and exams? Did you receive any financial support from a scholarship, bursary or fellowship in the current school year? If so, what was the total amount you received?), Employed, on leave (for medical reasons, for familial reasons, other: ___), Other: _____
  - If employed is selected:
    - Are you a health care worker or health care administrative staff?
    - Self-employed? Job title? Usual number of work hours per week? Shiftwork (e.g. working in the evening or nighttime)? [if so- Is your shiftwork mostly: night shift, evening shift, rotating]; How often would you usually travel out of your country for work? ___/year
    - Current work status: working from usual workplace, working from home because of the pandemic, job has been terminated because of the pandemic, working hours were increased/decreased because of the pandemic, salary has been decreased because of the pandemic (if so- by how much was your salary decreased (estimate in percentage)?
    - Does your work currently involve: Contact (in person) with the general public? Contact (in person) with people at high risk for COVID-19 [i.e. elderly, chronic
illnesses)? Contact (in person) with people who tested positive for COVID-19? Providing essential services (e.g. hospital, public transport, grocery store)?

If yes - [Hospital, Fire Services, Public transport, Police, Grocery Store, Pharmacy, Gas Station, Public Transport, Other:_______ ]

- If retired is selected:
  - Are you coming back to work (or volunteering) to assist with the outbreak?
    - If Yes - Does your work involve: Contact (in person) with the general public? Contact (in person) with people at high risk for COVID-19 [i.e. elderly, chronic illnesses]? Contact (in person) with people who tested positive for COVID-19? Providing essential services (e.g. hospital, public transport, grocery store)?

If employed/student is selected:
- How would you rate the degree of school/work-related stress you are currently experiencing? [0-Very low stress - - - - - - - - - - - 100 - very high stress]
- How would you rate the degree of school/work-related stress you have been experiencing in the last month before the outbreak? [0-Very low stress - - - - - - - - - - - 100 - very high stress]

- Usual mode of transport (to go to work, do groceries, etc) before the outbreak:
  [Public transport, driving a car, walking, cycling, other:_______]

- Total yearly family income: ________

- How would you rate your political beliefs
  [1-5 scale of very left- to very right-wing views, with one ‘other’, please explain]

Questions pertaining to COVID-19
- When would you say that the outbreak started in the region where you have been staying for the last month? Approximately... [DD/MM/YYYY]

- Have you travelled outside of your country of residence since January 30th 2020?
  - Has anyone currently living with you travelled outside of the country since January 30th 2020

Since the start of the Outbreak, dDid you have (please select all that applies or leave blank if you prefer not to answer this question) [Mild, Moderate, Severe]

Fever
Cough
Difficulty breathing or shortness of breath
Sore throat
Tiredness
Aches and pains
Nasal congestion
Runny nose
Sore throat
Diarrhea

Other symptoms you think could possibly be related to COVID-19 (Specify):

For any selected symptom: Still current?

Did anyone living with you have any symptoms that could be linked to COVID-19 (e.g. fever, cough, difficulty breathing, runny nose...) since the start of the outbreak? Y/N / I prefer not to answer this question

*If yes: Is this person currently awaiting testing? Yes
  No
  No, they have already been tested and are awaiting the
Did anyone else in your family have any symptoms that could be linked to COVID-19 (e.g. fever, cough, difficulty breathing, runny nose…) since the start of the outbreak? Y/N / I prefer not to answer this question

*If yes: Is this person awaiting testing? Yes No

No, they have already been tested and are awaiting the results

No, they have already been tested and were negative for COVID-19

No, they have already been tested and were positive for COVID-19

I don’t know

Is that person currently staying in hospital? Y/N

- Have you been tested for COVID-19? Y/N
  - If YES - Were the results: positive, negative, don’t know yet?
    - How long ago did you find out? ___months ___days
  - If NO - Have you reached out to health services to get assessed for COVID-19?
    - If Yes: Have you been told that you cannot be tested? Y/N
      - If yes: What reason was provided to decline your request to get tested?
        - If No: How long have you been waiting? ___months ___days

If indicated children above:
- For how long have your children been off from school? _____ months ___days N/A
- Are your children receiving instruction from the school at a distance? Are you or your partner homeschooling?

If indicated student or working above:
- How is the outbreak affecting how you deal with your work/study and family life?
  0 - Very disruptive  50 - Not different from usual  100 - Easier than usual

- Are you currently living with anyone who works at the front-line (e.g. health care staff, first responders, laboratory technician)? Y/N
- Do you have any other relatives working at the front-line? Y/N

Please select all statements that apply to you (currently / Since the start of the outbreak):
- Not going out of the home except if you really do not have a choice (e.g. to go to a medical appointment)
- Avoiding going out from a specific room in the home to avoid contamination from/to other people living in your home
- Not attending public areas
- Avoiding gathering in person with friend or family who do not live with you
- Not using public transportation (e.g. buses, subways, taxis)
- Having food/supplies delivered home or relying on food/supplies stocked in the home instead of running errands
- Wearing a mask (or covering mouth and nose with tissues) when having to leave the home
- Maintaining a 2 meter distance from others
- In mandatory quarantine (isolation imposed by medical staff)

If selected - For how long? ___ days
How serious do you think a coronavirus infection would be for your health?
{Very high threat, High threat, Moderate threat, Low threat, Very low threat, Don’t know}

What level of threat do you think COVID-19 poses to:
- your job or business?
- your country?
- your financial situation?

How concerned are you about:
{0-Not concerned at all Neutral 100- Very concerned}
- lacking food?
- public services shutting down?
- schools shutting down (or staying closed for an extended period)?
- your children or relatives not coping well with the situation?
- not being able to access medications or medical services?
Other:_____

When do you expect the global situation to go back to normal?
{by June 2020, by September 2020, by March 2021, after March 2021, “I have no idea”}

When do you think your life will get back to normal?
{by June 2020, by September 2020, by March 2021, after March 2021, “I have no idea”}

Did the outbreak overlap with a significant event in your life (e.g. wedding, funeral, break up, graduation…)? Y/N
if yes – Please specify the nature if the event and the consequences: ________________

How frequently were you interacting with your family
Past 7 days? [daily, weekly, monthly, less often than monthly, N/A]
In the last month before the outbreak? [daily, weekly, monthly, less often than monthly, N/A]

How would you rate your relationship with your family
Past 7 days? [0-Very difficult/confictual 50- Neutral 100- Excellent, N/A]
In the last month before the outbreak? [0-Very difficult/confictual 50- Neutral 100- Excellent, N/A]

How frequently were you interacting with your friends
Past 7 days? [daily, weekly, monthly, less often than monthly, N/A]
In the last month before the outbreak? [daily, weekly, monthly, less often than monthly, N/A]

How would you rate your relationship with your friends
Past 7 days? [0-Very difficult/confictual 50- Neutral 100- Excellent N/A]
In the last month before the outbreak? [0-Very difficult/confictual 50- Neutral 100- Excellent N/A]

How would you rate your relationship with work colleagues?
Past 7 days? [0-Very difficult/confictual 50- Neutral 100- Excellent N/A]
In the last month before the outbreak? [0-Very difficult/confictual 50- Neutral 100- Excellent N/A]

How much do you agree with the following statements: Please select the circle that best describes your opinion on the continuum from ‘strongly disagree’ to ‘strongly agree’.
(NA) - (strongly disagree) (neutral) (strongly agree)

Since the beginning of the outbreak, I have experienced significant levels of support from:
- my family
- friends and acquaintances
- my employer, colleagues
- medical staff and other professionals
- my religious/spiritual community
- strangers
- internet-based communities
Since the beginning of the outbreak, I have reached out to offer help and support to:
- my family
- friends and acquaintances
- my colleagues
- my religious/spiritual community
- strangers
- internet-based communities

Compared to how you felt before the outbreak, to what degree do you currently feel connected to:

[(NA) - 0 (More disconnected)  50 (No Change)     100 (More connected)]

- Family
- Friends
- Work colleagues
- Religious/spiritual community
- Community at large (neighbors, strangers)

In the past 7 days, how much time per day have you been spending:

- 0 minutes / day
- 1-30 min / day
- 31-60 min / day
- 1-2 hours /day
- 2-4 hours /day
- More than 4 hours /day

- Outdoors?
- Doing physical activity?
- Following COVID-19 updates in the media?
  If > than 0 min: Where do you get your information about COVID-19? [Newspaper, websites, YouTube, reddit, radio, television, social media (e.g. facebook, twitter), talking with other people]
- Watching television, series or movies (excluding the news)
- Playing video games
- Doing an artistic activity (music, drawing, etc) ?
- Doing contemplative/spiritual practice (meditation, prayer, etc.)?
- Interacting with other people:
  - In person:
  - Virtually (e.g. phone, texting, Skype, Facetime etc):

- To what degree have your daily activities been affected by the outbreak in the past 7 days?
  [0- Negatively Affected  50- Not Really Affected  100 – Positively Affected]
- How many cigarettes per day were you smoking:
  In the last month before the outbreak?
  If > 0 - Are you regularly smoking (please tick all that applies): standard cigarettes, electronic cigarettes (vaping)
- How many alcoholic drinks did you have (Consider a "drink" to be a can or bottle of beer, a glass of wine, one cocktail or a shot of hard liquor (like scotch, gin, or vodka)):
  Total number of drinks in the past 7 days? Number of drinks per week in the last month before the outbreak?
- How frequently were you taking cannabis products:
  Total number of times in the past 7 days? Number of times per week in the last month before the outbreak?
- How frequently were you taking illicit drugs (e.g. cocaine, amphetamines, mushrooms, ecstasy):
  Total number of times in the past 7 days? Number of times per week in the last month before the outbreak?
- Did your overall stress level change since the start of the outbreak?
  [0- greatly reduced  50- No change  100- Greatly increased]
- What coping strategy(ies) (i.e. actions or thought process used to try to tone down the impacts of a stressful situation) do you find most helpful to help you go through the current pandemic situation?

- Has your household spending changed since the start of the outbreak?
  [Decreased / No change / Increased]
  - If Increased By how much (in percentage (%))for health? for food? for other expenses? (please specify)

In the last 7 days, how much have you been feeling like time seems to
{0 - Not at all to 100- Very Much}
- ● speed up (e.g. hours feel like minutes)
- ● slow down (e.g. days seem like weeks)
- ● stop (e.g. things seem frozen)

Physical health
- Have you ever had any of the following health problems (Please select all that applies): {Type 1-2 diabetes, respiratory disease {Asthma, chronic obstructive pulmonary disease (COPD) or hypoventilation}, Autoimmune disease (e.g. rheumatoid arthritis, lupus, inflammatory bowel disease (IBD), multiple sclerosis (MS), psoriasis), High blood pressure (hypertension), Heart disease or coronary artery disease (e.g., Heart failure, heart attack, myocardial infarction, atrial fibrillation, angina), Cerebrovascular disease (e.g., stroke, cerebral hemorrhage), High cholesterol (hypercholesterolaemia) or triglycerides, Thyroid disease, Severe infection (e.g., pneumonia, mononucleosis (glandular fever), mumps, tuberculosis, hepatitis),cancer, HIV/AIDS Other); For all selected options: Please indicate which of your health problems are still current

- Has there been any worsening in your physical health since the start of the outbreak? Y/N
  If Yes – Please explain: _______

- Has there been any changes in your medications (including changes in dosage) since the start of the outbreak?
  Yes No N/A
  If Yes - a) Please select all that applies:
  Adding a new medication
  No longer taking a medication
  Because I no longer need it; because it is uneasy/no possible to go to the pharmacy; because of financial constraints; Other: __________
  Dosage increase
  Dosage decrease
  Because I no longer need it; because it is uneasy/no possible to go to the pharmacy; because of financial constraints; Other: __________

  b) Did you discuss these changes with your doctor? Y/N

- Are you currently taking (select all that applies):
Antihypertensive medications (for ex.: calcium channel blockers, ACE inhibitors, angiotensin II receptor antagonists (ARBs), beta blockers)
Antidepressant medications (for ex.: Zoloft (sertraline), Celexa (citalopram), Prozac (fluoxetine), Desyrel (trazodone), Lexapro (escitalopram), Cymbalta (duloxetine), Effexor XR (venlafaxine), Wellbutrin (bupropion))
Antianxiety medications, Anxiolytics, Benzodiazepines (for ex: Rivotril (clonazepam), Xanax (alprazolam), Ativan (lorazepam))

- Do you currently have any difficulty: seeing (even when wearing glasses or contact lenses)? hearing (even when using a hearing aid)? walking, using stairs, using your hands or fingers or doing other physical activities? learning, remembering or concentrating?
(Answer choice: No, Sometimes, Often, Always)

<table>
<thead>
<tr>
<th>If selected current respiratory disease: Have you been using any of the following</th>
<th>In the last month before the outbreak</th>
<th>Past 7 days</th>
</tr>
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<tbody>
<tr>
<td>Nebulizers</td>
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<tr>
<td>Positive airway pressure treatment</td>
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<tr>
<td>Inhaled corticosteroids</td>
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<td>Oral corticosteroids</td>
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<td></td>
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<tr>
<td>Asthma puffer</td>
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</table>

Mental health
- Have you ever had a formal diagnosis of (Please select all that applies): [General Anxiety Disorder, Social anxiety disorder, Specific phobia, Panic Disorder, Agoraphobia, Depression, Dysthymia, Seasonal affective disorder, Premenstrual dysphoric disorder, Bipolar Disorder (manic depressive disorder), Obsessive-compulsive or related disorders (e.g., OCD, hoarding, excoriation, trichotillomania), Post-Traumatic Stress Disorder (PTSD), Anorexia, Bulimia, Schizophrenia or other Psychotic Disorder, Personality disorder, Substance Use Disorder, Alcoholism, Substance use disorder (drug addiction), Gambling disorder, Somatiform disorder; Attention-deficit/hyperactivity disorder (ADHD), Other neurocognitive disorders (e.g., Alzheimer’s disease, Parkinson’s disease, vascular dementia, amnestic disorder). Please specify: For all selected options: Please indicate which of your diagnoses are still current:]
- Have you previously been exposed to a major difficult or stressful event (for example: natural disaster, fire/explosion, transport accident, physical or sexual assault, combat/exposure to a war zone, life-threatening illness or injury...)? Y/N

Cohen’s Perceived Stress Scale (PSS-10)
The 10 item PSS is used to quantify the perception of stress (2). Participants answer from a five-point Likert scale, with total scores ranging from 0 – 40, where higher scores indicate greater perceived stress (2). The Cronbach α and test-retest of the PSS-10 were both reported as greater than 0.70 (3).

The Quick Inventory of Depressive Symptomatology-Self Report, short version (QIDS-SR16)
The QIDS-SR16 is a questionnaire assessing the nine symptom domains of depression used in the DSM-IV. It contains 16 items for which respondents are asked to rate the severity of symptoms such as sleep disturbances (either reductions or increases in sleep), sadness, appetite and weight changes (either reductions or increases), and restlessness. Scores range from 1-27, with higher scores indicating more severe depression symptoms (4). The minimum clinically important difference for this questionnaire was found to be ≥ 28.5% (± 28.7%; 5). Based on a meta-analysis, the QIDS-SR16 was found to be unidimensional and to have an internal consistency (Cronbach’s α) ranging from 0.69 to 0.89 (6). This questionnaire was included due to the low mood that may be associated with the imposed isolation.

Generalized Anxiety Disorder Scale (GAD-7)
The GAD-7 is a 7 items questionnaire, which is used to screen and assess severity of generalized anxiety disorder. Scores can range from 0 – 21, with a higher score indicating a greater severity. Internal consistency was found to be excellent (Cronbach α = 0.92) and test-retest reliability as good (intraclass correlation = 0.83). The GAD-7 was also found to have good sensitivity (89%) and specificity (82%; 7). The minimal clinically important difference on the GAD-7 was estimated at changes of 4 or greater (8). This questionnaire was included since several factors related to the pandemic can cause an increase in anxiety (e.g. isolation, the unknown, change).

Dimensional Obsessive-Compulsive Scale (Germs and contamination subscale)
The DOCS is a 20-item measure that measures the four dimensions of obsessive-compulsive symptoms (contamination, responsibility, unacceptable thoughts, symmetry) that have been identified in research (9). Test scores range from 0-80 (0-20 on each subscale). For the purpose of this study, only the contamination subscale, which relates to obsessions and cleaning compulsions, was used. Cronbach’s α for the four subscales were in the good to excellent range (0.83-0.89) and test-retest correlations were considered to be of adequate stability for the total score (r = 0.66) and subscales (r = 0.55-0.66). Factorial validity was supported in both clinical (OCD and other anxiety disorders) and
nonclinical (undergraduate students) samples. The DOCS can distinguish individuals with OCD very well from nonclinical individuals, and quite well from individuals with other anxiety disorders. The DOCS can be used during the pandemic to identify new or pre-existing obsessive-compulsive symptoms exasperated by pandemic-related stress.

**Big Five Personality Inventory, short version**

The Big Five Inventory (short version), or BFI-10, is a 10-item questionnaire used to measure the Big Five Dimensions that was adapted from the BFI-44 item scales (10). Each scale (Extraversion, Neuroticism, Openness, Agreeableness, Conscientiousness) is comprised of two items. The four samples tested (US public and private university students, US dog owners, and German students) demonstrated that the BFI-10 scales differ from the BFI-44 scales in their part-whole correlations, with lower correlations for Openness (0.79) and Agreeableness (0.74), and higher ones for Extraversion (0.89), Neuroticism (0.86), and Conscientiousness (0.82). The test-retest stability showed respectable levels of 0.75 overall (0.72 for one US sample and 0.78 for German sample) and there was an average Cronbach’s α of 0.75. The BFI-10 can be useful during the pandemic to measure peoples’ personality traits and to observe whether certain traits are related to mental health challenges.

**Brief Resilient Coping Scale (BRCS)**

The BRCS is a 4-item measure, with scores ranging from 4-20, that aims to identify adaptive tendencies that individuals use to cope with stress (11). Cronbach’s α for the combined samples (men and women diagnosed with rheumatoid arthritis) was 0.69 (ranging from 0.64-0.71). The test-retest reliability was \( r = 0.71 \) (\( p < 0.001 \)). The BRCS is sensitive to changes in cognitive and behavioural resilient coping patterns as demonstrated by changes in BRCS scores after the intervention (\( p < 0.05 \)). Under the current circumstances of living through a pandemic, this measure can capture the healthy strategies individuals are using to cope with stress that may be caused by new financial concerns, childcare arrangements, adapting to working from home, or caring for elderly family members or those who have compromised immune systems.

**Sleep**

- Have you ever had, a formal diagnosis [being told by a physician] of:  *Insomnia, Sleep-related breathing disorder (e.g. Sleep apnea), Restless legs syndrome, Narcolepsy, Nightmare Disorder, Non 24 Sleep Wake Disorder, Delayed Sleep Phase Syndrome, Advanced Sleep Phase Syndrome, Excessive daytime sleepiness or hypersomnia; For all selected options: Which of your diagnoses are still current?*
- How would you assess your sleepiness during a typical day? (By "sleepiness", we mean the strong tendency to doze off): {0- "no sleepiness" to 10 -"extremely sleepy")

**Pittsburgh Sleep Quality Index (PSQI)**

The PSQI is a 24-item questionnaire initially developed to assess sleep disturbances related to mood disorders and various clinical populations. It has seven components score with a range of 0-21 points. The questionnaire has been reported to have a high degree of internal consistency (Cronbach’s α = 0.83), as well as high sensitivity (89.6%) and specificity (86.5%) in distinguishing good and poor sleepers. Test-retest reliability was also found as high (\( r = 0.85, \) \( p < 0.001; \) 12). This questionnaire has been included because sleep can be influenced by several factors related to the pandemic (e.g. stress), as well as factors related to confinement (e.g. working from home with more flexible hours, family duties, etc.).

<table>
<thead>
<tr>
<th></th>
<th>Past 7 days</th>
<th>In the last year</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many times per week did you have bad dreams (negative dreams that do not wake you up)</td>
<td>[_____]/week</td>
<td></td>
</tr>
<tr>
<td>How intense were these bad dreams?</td>
<td>1 (not intense) 50 (moderately intense) 100 (extremely intense)</td>
<td></td>
</tr>
<tr>
<td>how many times per week did you have nightmares (negative dreams that wake up)</td>
<td>[_____]/week</td>
<td></td>
</tr>
</tbody>
</table>
If ≥1 nightmare:

How intense were these nightmares?

0 (not intense) 50 (moderately intense) 10 (extremely intense)

What level of distress are your nightmares causing?

0 (none) 50 (moderate) 100 (extreme)

Reduced Morningness-Eveningness Questionnaire (rMEQ)

The rMEQ assesses one’s preferred timing for sleeping and waking up, as well as for doing various activities (e.g. intellectual, physical activities). Made with five items, the score can range from 4 – 25 and are sub-divided into 5 categories ranging from “definitely evening type” to “definitely morning type”. The rMEQ correlated strongly with the MEQ ($r = 0.898$, $p < 0.00001$), and its five items ($r = 0.73$, $p < 0.001$), suggesting high reliability (13). A correlation was also found between rMEQ and the acrophase of motor activity ($r = -0.34; p < 0.001$), which suggest good external validity (14). The rMEQ was utilized due to the link between chronotype and mood as well as other behavioural variations, which have most likely been impacted by the pandemic.

If indicated a diagnosis of sleep disordered breathing:

<table>
<thead>
<tr>
<th>Past month before the outbreak</th>
<th>Past 7 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Airway Pressure machine (e.g. CPAP; “breathing machine”)</td>
<td></td>
</tr>
<tr>
<td>Mandibular advancement device</td>
<td></td>
</tr>
<tr>
<td>Positional therapy</td>
<td></td>
</tr>
<tr>
<td>Stimulant medication (e.g. modafinil)</td>
<td></td>
</tr>
</tbody>
</table>

Subsections for specific subgroups

Health care providers and administrative staff

(Based on Demographic section)

Position: Resident Physician, Specialist physician, GP, allied health professional [Audiologist, Chiroprist/Podiatrist, Chiropractor, Dentist, Dietitian, Massage Therapist, Medical Laboratory Technologist, Medical Radiation Technologist, Midwife, Nurse, Occupational Therapist, Optician, Optometrist, Pharmacist, Pharmacy Technician, Physiotherapist, Psychologist, Respiratory Therapist, Speech-Language Pathologist, Other - Please specify: ____], administrative staff [Medical Administrative Assistant, Medical Receptionist, Family Health Organization Administrator, Health Records Clerk, System Coordinator, Other - Please specify: ____]

If Resident: “Program year”: [PGY1 (postgraduate year 1) to PGY6 (postgraduate year 6)]

Principal contact with patients:

inpatient {non-essential; essential; not sure}; outpatient {non-essential; essential; not sure}; both

Discipline: Anatomical Pathology, Anesthesiology, Cardiology, Cardiovascular/Thoracic Surgery, Clinical Immunology/Allergy, Critical Care Medicine, Dermatology, Diagnostic Radiology, Emergency Medicine, Endocrinology/Metabolism, Family Medicine, Gastroenterology, General Internal Medicine, General/Clinical Pathology, Geriatrics, Hematology, Medical Biochemistry, Medical Genetics, Medical Microbiology and Infectious Diseases, Oncology, Nephrology, Neurosurgery, Nuclear Medicine, Obstetrics/Gynecology, Ophthalmology, Orthopedic Surgery, Otolaryngology, Pediatrics, Physical Medicine and Rehabilitation, Plastic Surgery, Psychiatry, Public Health and Preventive Medicine, Radiation Oncology, Respiratory Medicine/Respirology, Rheumatology, Urology, Other: ________

Since the outbreak:

Have you been reallocated to work in a different unit or discipline? Y/N

If Yes - Please specify:

Have you been using virtual tools to connect with your patients or colleagues (e.g. phone, video): Y/N
If Yes - Please specify: ____________
How satisfied are you with these tools?   {0 Not at all  50 somewhat  100 Extremely}
If No – Why (please select all that applies)? {Not relevant for my current work, No/Insufficient resources available for this, This is not approved in my unit/hospital, I am not at ease with these methods, Other: ____________}

To what degree do you agree with the following statements in relation to your work since the start of the outbreak?:
{Strongly agree, Somewhat agree, Neutral, Somewhat disagree, Strongly Disagree, N/A} - asking for before and after outbreak
Guidelines and instructions from my superiors are clear.
Instructions from my superiors change rapidly and it is difficult to keep track.
There are inconsistencies in instructions from my superiors making it hard to know what I should be doing.
I am receiving too many updates via email.
I have access to adequate personal protective equipment (PPE).
I have sufficient remote access to the information I need (e.g. patient files).
I am concerned I may develop COVID-19.
I am concerned I may pass COVID-19 to my patients/work colleagues.
I am concerned I may pass COVID-19 to my immediate family or others who live with me.

Measure of Moral Distress – Healthcare Professionals (MMD-HP)
A 27-item self-report questionnaire developed to assess moral distress (15). Participants rate each item on a 5-point Likert scale indicating the frequency of each situation ranging from 0 (never) to 4 (very frequently). For each item, participants also rate how distressing the situation is when or if it occurs (0 = never and 4 = very distressing). The frequency score \((f)\) is multiplied by the distress score \((d)\) to obtain a composite score. An overall MMD-HP score is obtained by summing the composite item scores. Overall scores range from 0 to 432, with higher scores indicating higher levels of moral distress (15). The MMD-HP demonstrates high validity and strong internal consistency (Cronbach’s \(\alpha = 0.93\); 15). This questionnaire was included to assess the extent to which healthcare professionals have experienced moral distress since the COVID-19 outbreak.

Rushton Moral Resilience Scale (RMRS, Rushton et al, in preparation)
A 17-item self-report questionnaire developed to assess moral resilience. Participants are required to consider their response to challenging ethical situations in the past 3-months in their professional role. The RMRS consists of 4 subscales including: response to moral adversity, personal Integrity, relational integrity, and moral efficacy. Items are rated on a 4-point Likert scale, ranging from 1 (disagree) to 4 (agree). The total RMRS score can be derived by computing the mean of all 17-items, with higher total scores indicating more resiliency. This questionnaire was included to assess moral resilience as it is an indicator of an individual’s capacity to restore their integrity in response to moral complexities, setbacks, or distressing situations (e.g., COVID-19 outbreak). The instrument is currently in the process of validation.
Individuals with a current diagnosis of a mental/medical illness
(based on Physical/Mental health sections)

A) If hospitalized (based on demographic section):

How many other people are sleeping in your hospital room?

This week, if you wanted, could you have:

- received visitors? {Yes, Yes, but only for a short time, No}
- Contacted your family or friends using virtual communications (e.g. via telephone, video camera (e.g. Skype, Zoom, Facetime)? {Yes, Yes, but only for a short time, No}
- Gone outside to take some fresh air: {Yes, Yes, but only for a short time, No}

- How frequently were you interacting with hospital staff
  Before the outbreak? [N/A daily, weekly, monthly, less often than monthly]
  In the last week? [daily, weekly, monthly, less often than monthly]

- How would you rate your relationship with hospital staff
  Before the outbreak? [N/A 0-Very difficult/confictual 50-Neutral 100-Excellent]
  In the last week? [0-Very difficult/confictual 50-Neutral 100-Excellent]

- How frequently were you interacting with other patients
  Before the outbreak? [N/A daily, weekly, monthly, less often than monthly]
  In the last week? [daily, weekly, monthly, less often than monthly]

- How would you rate your relationship with other patients
  Before the outbreak? [N/A 0-Very difficult/confictual 50-Neutral 100-Excellent]
  In the last week? [0-Very difficult/confictual 50-Neutral 100-Excellent]

B) If not hospitalized:

- have you ever stayed in hospital overnight?
  If yes - What was the approximate date of: last admission {DD/MM/YYYY} discharge {{DD/MM/YYYY}

- How many appointments have you been attending for your physical health in the last 6 months before the outbreak?
  {daily, weekly, every 2 weeks, monthly, 2-5 times, once, none}

- How many appointments have you been attending for your physical health since the start of the outbreak?
  {daily, weekly, every 2 weeks, monthly, 2-5 times, once, none}

- How many appointments have you been attending for your mental health in the last 6 months before the outbreaks?
  {daily, weekly, every 2 weeks, monthly, 2-5 times, once, none}

- How many appointments have you been attending for your mental health since the start of the outbreak?
  {daily, weekly, every 2 weeks, monthly, 2-5 times, once, none}

- Are you doing anything on your own (not proposed by your doctor, therapist or health care provider) to improve your physical or mental health? Yes/No
  If yes – Please describe
Optional additional questionnaires

**Revised Adult Attachment Scale (RAAS)**

The RAAS is an 18-item, self-report measure used to assess individual differences in adult attachment style (16). It comprises 3 subscales: Close, which measures the extent to which a person is comfortable with closeness and intimacy; Depend, which measures the extent to which a person is comfortable depending on and trusting in others; and Anxiety, which measures the extent to which a person is concerned about being abandoned or unloved. Each subscale is scored on a scale of 1 (not at all characteristic of me) to 5 (very characteristic of me). The RAAS subscales have demonstrated acceptable to good internal consistency (Cronbach's alphas = 0.77-0.85) and good convergent validity. This scale was included as attachment to close others may change as a result of social distancing, virtual communication, and heightened anxiety during the pandemic.

**UCLA Loneliness Scale (UCLA L-Scale – Version 3)**

The UCLA L-Scale (version 3) was created to evaluate subjective feelings of social isolation and loneliness (1). This questionnaire has 20 items with a possible score range of 20 – 80, where higher scores indicate a greater degree of loneliness. The UCLA L-Scale has been found to have a good internal consistency (Cronbach α ranging from 0.89 - 0.94) and test-retest correlation (0.73; 1). Due to the imposed social distancing regulations that accompanied this pandemic, loneliness is likely to occur, which is why this questionnaire was included.

**The Typical Dreams Questionnaire (TDQ)**

The TDQ is used to better understand the dimensional structure of dreams. This instrument has previously been validated in a sample of undergraduate students across three Canadian universities (N=1181; 17) and in an online study (N=28,888; 17,18). In addition to the 56 items from the original questionnaire, we added 4 new themes to reflect potential themes and concerns directly associated with the pandemic. The original TDQ measures dream themes over the lifetime, but we have modified it to reflect dream themes in the past 7 days to accommodate the temporal structure of our study. The original results of the first TDQ study (17), and follow ups of the translated version in Germany (19) and in China (20) indicate a relative stability of predominant dream themes across ages and cultures. The instrument presents different dream themes and prompts participant to indicate how often they have experienced each of the dream themes on the following scale: 0=never; 1=once; 2=2-3 times; 3=4-10 times; 4=11+ times. Since dreams are influenced by daily life concerns and, in particular so by affectively charged personally significantly events, this questionnaire was included to capture the changes in dream content, specific to the pandemic.

**Exeter Identity Transition Scales (EXITS)**

An adapted version of the EXITS (21) was used to assess multiple group memberships. Four items measured multiple group memberships before the pandemic, four items measured the maintenance of group memberships since the pandemic, and four items measured the development new group memberships since the pandemic. Items were rated on a seven-point scale with item responses ranging from 1 (do not agree at all) to 7 (agree completely). The original EXITS demonstrated good to excellent internal consistency (Cronbach’s α = 0.85-0.94) in a sample of adults recovering from stroke. The EXITS has also shown good convergent validity with another group membership measure. This instrument was included as the maintenance and development of group memberships during the pandemic may be affected by the transition to virtual communication.

**Interpersonal Reactivity Index (IRI)**

The IRI is a 28-item, self-report instrument designed to assess empathy (22). The IRI consists of four subscales: Perspective Taking, Fantasy, Empathic Concern, and Personal Distress. Each subscale includes seven items rated on a Likert-type scale ranging from 1 (does not describe me well) to 5 (describes me very well). The IRI has demonstrated acceptable internal consistency (Cronbach’s alphas = 0.70-0.78) and good test-retest reliability (r_{males} = 0.61-0.79, r_{females} = 0.62-0.81). Good convergent validity has also been shown by correlations with other validated measures of empathy. The IRI was included because empathy levels may be influenced by factors related to the pandemic (e.g., shared experience of struggle, rise in solidarity).
Liebowitz Social Anxiety Scale (LSAS)

A 24-item questionnaire developed to assess social anxiety by measuring both fear and avoidance across various situations (23). The LSAS is divided into 2 subscales addressing social interactional (11-items) and performance (13-items) situations (24). Each item depicts a situation and participant’s level of fear and avoidance is rated on a 4-point Likert scale. The fear scale ratings range from 0 (no fear) to 3 (severe fear). The avoidance scale ratings are based on the percent of time a situation is avoided and range from 0 (never) to 3 (usually – 67 to 100%). The total fear and total avoidance scores are summed to obtain an overall total LSAS score. Higher scores indicate greater presence of social anxiety. The LSAS is a valid measure and demonstrates strong internal consistency (Cronbach’s α = 0.96; 24). This questionnaire was included to assess the presence of social anxiety in participants prior to the COVID-19 outbreak.

Peters et al. Delusions Inventory (PDI-21)

A 21-item self-report questionnaire developed to assess delusional symptoms (25). Each item is responded to using a “yes/no” format. The sum of the positive responses on each item provides a total score for a maximum score of 21. Higher scores indicate great delusional symptoms or proneness to paranoid thinking (26). For each item, there are also 3 subscales that measure degree of conviction, preoccupation, and distress. Each subscale is rated on a 5-point Likert scale ranging from 1 (not at all distressing) to 5 (very distressing). The PDI-21 demonstrates adequate internal consistency (Cronbach’s α = 0.82; 25). The test retest reliability is also high (r = 0.78, p < 0.001; 25). This questionnaire was included to assess delusional symptoms during the current pandemic situation. Delusional ideations are thought to have a strong social component (27) and may be exacerbated by sudden changes in social life, such as social distancing practices during the COVID-19 outbreak.

Smartphone Addiction Scale (SAS; items 3, 5, 8, 9)

The SAS is a 33-item, self-report measure designed to assess smartphone addiction (28). Items are rated on a six-point Likert scale ranging from 1 (strongly disagree) to 6 (strongly agree). Subscale scores are summed to create a total score (range = 33-198), with higher scores indicating a more serious smartphone addiction. The SAS has previously demonstrated excellent internal consistency (Cronbach’s α = 0.97), as well as good concurrent validity. This measure was included because smartphone use may increase as a result of limited activities and in-person interactions during the pandemic.

Cognitive emotion regulation questionnaire (CERQ)

The CERQ is a 36-item questionnaire, with scores ranging from 4-20, developed to measure cognitive emotion regulation strategies that individuals use in response to a stressful life event (29). It includes nine distinct subscales (self-blame, other-blame, rumination or focus on thought, catastrophizing, putting into perspective, positive refocusing, positive reappraisal, acceptance and refocus on planning). Good factorial validity and high Cronbach’s α reliability coefficients were demonstrated, ranging from 0.75-0.87. Strong relationships were demonstrated between certain cognitive strategies (self-blame, rumination, catastrophizing, positive reappraisal) and symptoms of both depression and anxiety. Test-retest reliabilities of the subscales were considered adequate with values ranging from r = 0.48 to r = 0.65 (p < 0.01). The CERQ can be used during the pandemic to assess emotional problems people are experiencing, how they are coping, and to subsequently develop interventions.
5. References


