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Gomez, L., & Sullins, J. (2020). The Relationship Between Religiosity and Mental Health During the COVID-19 Quarantine. Retrieved from <https://scholarworks.harding.edu/mcnair-research/19>

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The Relationship Between Religiosity and Mental Health

During the COVID-19 Quarantine

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Abstract

Social isolation has become a public policy under the current circumstances. This isolation can lead to a life imbalance that is believed to affect physical, psychological, and spiritual well-being. Previous research shows that both, a defined sense of religiosity or affirmative secularity, can yield progressive emotional outcomes due to multiple factors such as community support, sense of structure, life guidance, mindfulness and a sense of unity with the world. However, a gap exists in the extant literature regarding the relationship between mental health and religiosity during global pandemics. In order to address this gap, this study sought to answer the following question: Does religiosity significantly affect mental health in those that have reported being impacted by COVID-19? The present study found no statistically significant differences in the levels of anxiety or depression as a function of religiosity. There also was no significant correlation between anxiety and the different dimensions of religiosity or depression and religiosity.

Keywords: mental health, psychological health, spiritual health, religiosity, isolation, COVID-19, global pandemic, quarantine

The Relationship Between Religiosity and Mental Health During the COVID-19

Quarantine

According to the Anxiety and Depression Association of America (ADAA), anxiety is the most common mental disorder in the U.S., affecting over 40 million adults. The World Health Organization (WHO) suggests that one in 13 people suffer from an anxiety disorder, and nearly one-half of those diagnosed with anxiety are also diagnosed with depression. The two go hand-in-hand, with depression being the leading cause of disability worldwide. With the onset of COVID-19, the concerns for mental health have increased. Mental Health America (MHA) used a database to screen the daily increase in anxiety in the U.S. and according to the monitored data, there was a 19 percent increase in clinical anxiety in February and a 12 percent increase in the first two weeks of March.

In January 2020, WHO declared the outbreak of COVID-19 a Public Health Emergency of International Concern. In March 2020, WHO classified COVID-19 as a pandemic. This translates to a new reality of canceled plans, virtual classes, economic crises, social isolation, and uncertainty. These are all stressors that are taking a toll on mental health. For this study, the researcher focused on the isolation aspect of COVID-19. Humans are not meant to be alone. Not having a social support system is a source of chronic stress resulting in higher levels of cortisol- a hormone related to poor cognition declined speed, attention, working and verbal memory (Montoliu et al., 2019).

Although the idea of religiosity being beneficial has been present for many centuries in Eastern ideologies (like Buddhism), the arguments about the interaction between mental health

and religiosity are continually evolving. Some argue that having negative religious views leads to poorer mental health (Pargament, 1997). Furthermore, over the past two decades, multiple studies have concluded that frequent attendance at religious services, as well as the acceptance of religious beliefs, tend to relate with greater psychological and physical well-being (Koenig, 2012; Tsaousis, Karademas & Kalatzi, 2013).

There is a gap in the literature about the interaction between religiosity and mental health during a global pandemic. To fill the gap mentioned above, this study aimed to determine if there was an association between religiosity and the self-reported mental/emotional well-being of those who reported being affected by the COVID-19 isolation period. For the current study, emotional well-being was measured by the levels of anxiety and depression reported by the participants. Religiosity was measured according to three different categories: participation in organizational religious activities (ORA), non-organizational religious activity (NORA), and intrinsic religiosity (IR). ORA refers to public activities or group-related activities (prayer groups, and Scripture study groups). NORA assesses religious activities presented in private (prayer, Scripture study, watching religious videos, or listening to religious podcasts). Lastly, IR estimates personal religious commitment and degree of motivation.

Literature Review

Religiosity and Mental Health

Religion may be a source of hope and meaning in the lives of believers and a source of social support for devotees. This support is manifested in the form of a religious fellowship and religious activities, as well as a feeling of closeness to God. Religiosity is also associated with positive traits such as self-efficacy, elevated mental health, and happiness (Abdel-Khalek &

Lester, 2017). Conversely, Baker and colleagues argue that atheists tend to have more positive mental health outcomes contrasted to religiously non-affiliated theists. Non-religiously connected theists have poorer mental health compared to both non-theists and religiously connected theists (Baker et al., 2018). This implies that both affirmative secularity and active involvement in a religious community can have beneficial effects on well-being.

It is hard to define “religiosity,” but some researchers use scales that divide the term into subtests. A ‘subscale’ used to assess religious attendance (Organizational Religious Activity) in the Duke University Religiosity Scale (DUREL) is associated with more social support, less depression, improved physical health, lower use of health services, and a lower mortality rate (Koenig, 2008). Another subtest on the same scale was used to measure meditation, Scripture reading, and prayer (Non-organizational Religious Activity). This last variable was correlated to poorer physical health, greater social support, and has been associated with both less and more depression, depending on the subpopulation (Koenig et al., 1997). Intrinsic religiosity is the third subscale of the DUREL; it measures the degree of personal religious motivation and commitment. Cha and Wirth (2001) established that for every 10-point increase in a person’s intrinsic religiosity, there was a 70% increase in recovery from depressive behaviors after physical illness (Cha & Wirth, 2001).

Besides the emotional role that the different aspects of religiosity can play in a subject’s life, Pieper and van Uden (2005) point that religious communities can act as a safe place during tense and troubling times. Perhaps, they act as so because it provides support and sanctuary to the believer. Even beyond protection, religion has the capacity to influence behavior through

doctrines (i.e., The Ten Commandments) and spiritual role models (i.e., youth ministers) (Pieper & Uden 2005).

It is easy to assume that each person has different religiosity levels due to the nature of uniqueness that characterizes humans. The fluctuation between people's religiosity levels has a clear relationship with their perception of mental illness (Behere et al., 2013). Higher levels of religiosity are tied to more progressive mental health outcomes, and lower levels are related to poorer mental health outcomes. This correlation becomes more notable as the two notions (religiosity and mental health) are invoked in an internal, recognized way (Hackney & Sanders, 2003).

Mental Health During Isolation

The social isolation guidelines due to COVID-19 are taking a toll on people's emotional well-being. Woefully, the COVID-19 quarantine has shown a more significant psychological impact on women, younger people, people with previous diagnoses, and people who manifested symptoms of the virus, or had a close relative with it. Gonzales-Sanguino and colleagues claim that religious well-being and loneliness were the most notorious predictors for symptomatology of the emotional impact of COVID-19 (Gonzales-Sanguino et al., 2020). Moreover, Banerjee, 2020 found depression, panic, and anxiety to be the primary indicators of quarantine's negative impact. These effects were present on people with no previously known psychological conditions (Banerjee, 2020).

Female, Asian, Hispanic, foreign-born individuals, families with children, married people, and workers who are currently laid off reported higher levels of fear due to COVID-19 than their counterparts. Those who reported being more affected by COVID-19 reported more

symptoms of anxiety, depression, and other negative mental health symptoms (Fitzpatrick et al., 2020). Summers-Gabr (2020) found that certain subpopulations, such as rural residents, also have a greater risk for morbidity during COVID-19. A possible reason for the mental and physical health incongruities between these subpopulations could be the limited access to hospitals or specialty health workers (e.g., psychiatrists) available to them (Summers-Gabr, 2020).

It is no surprise that the social isolation mandated to contain the pandemic has made the traditional routine, and comfort of society a luxury not available. The mandate to socially isolate not only interferes with people's previous plans; it also comes with a sorrowful feeling—loneliness. This feeling can result in an increased risk of cognitive decline (Cacioppo, Capitanio, & Cacioppo, 2014). Despite the feeling of being alone and being sad about it, loneliness brings with it other well-defined clinical conditions and demoralization of a person (de Figueiredo, 2013).

The disruption and isolation caused by COVID-19 can be particularly challenging for those who previously struggled with mental health. Individuals with a history of mental illness are more likely to experience greater loneliness during social isolation than the general population (Borge et al., 1999). Borge and colleagues agreed that those who were previously diagnosed with a mental disorder are more susceptible to suffer more during isolation (Borge et al., 1999). On the bright side, it is possible that social media is a way by which some continue to stay connected, in touch with the world, and find comfort in the world society knew before COVID-19. People that have endured mental illness seem to engage in social media and virtual networking similarly to the general public (Wang et al., 2017).

Hypotheses

Based on the aforementioned research, the authors predict that a relationship exists between levels of religiosity and mental well-being. To examine this prediction, the current study sought to answer the following questions:

Q1: Is there a statistically significant difference in the levels of anxiety experienced by those who have been affected by the COVID-19 quarantine and have high religiosity as opposed to those with low religiosity levels?

Q2: Is there a statistically significant difference in the levels of depression experienced by those who have been affected by the COVID-19 quarantine and have high religiosity as opposed to those with low religiosity levels?

Q3: Is there a relationship between the levels of anxiety and the level of religiosity of those who reported being affected by the COVID-19 quarantine?

Q4: Is there a relationship between the levels of depression and the level of religiosity of those who reported being affected by the COVID-19 quarantine?

Method

Participants

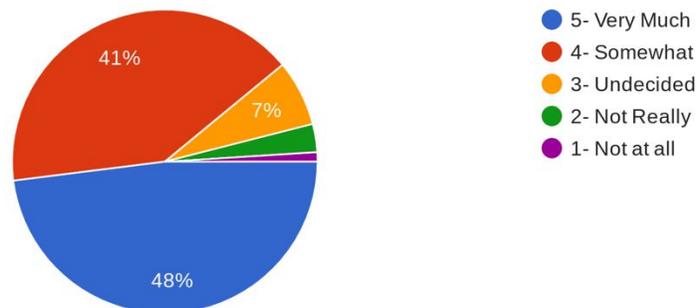
The participants of this study were a convenience sample of 100 voluntary participants. Their ages ranged from 18-65 years. 69% of the respondents were females, and 31% were males. The majority of the participants were White (72%). 16% of the sample was Hispanic/Latino, seven percent was Asian, and 5% was Black or African American. 81% of the sample reported being somewhat or very much affected by COVID-19 (See *Figure 1*).

Four participants were excluded because they reported not being affected by the COVID-19 isolation period. The majority of the participants were students at a private, liberal arts university in the southern United States. Of the students that volunteered, 19 of them received extra credit in their summer class for completing the survey. The remaining responses were from the researcher's personal Facebook account. All participants were voluntary and received informed consent, in line with APA's ethical standards.

Figure 1

The Effect of COVID-19

Would you say that the social isolation resulting from COVID-19 has affected you?
100 responses



Instrumentation

Both the PROMIS Emotional Distress- Anxiety- Short Form and the PROMIS Emotional Distress- Depression- Short Form are rated on a five-point scale (1=never; 2=rarely; 3=sometimes; 4=often; and 5=always). The anxiety scale has eight items, and the depression scale has seven. The score can range from seven to 35, with higher scores indicating greater severity of anxiety/depression (American Psychiatric Association, 2013). The score of each item

on the measure is reviewed by a clinician to determine the raw score. After obtaining the raw scores on each of the eight items, all raw scores are added to get a total raw score. A T-score table is used to find the associated T-score only if all questionnaire items were answered (American Psychiatric Association, 2013). If only over 75% of the questions were answered, the clinician designed the raw score (raw sum x number of items on the short form) and then looked up the conversion to T-Score. The interpretation of the T-score for both forms, the PROMIS Emotional Distress- Anxiety- Short Form and the PROMIS Emotional Distress- Depression- Short Form, is as follows: Less than 55 = None to slight, 55.0–59.9 = Mild, 60.0–69.9 = Moderate, 70 and over = Severe (American Psychiatric Association, 2013). Previous research has shown acceptable validity and reliability coefficients. Refer to Figure 2 to see an example question from the PROMIS-Anxiety. Figure 3 shows an example question from the PROMIS-Depression.

Figure 2

Example Question from the PROMIS-Anxiety

My worries overwhelmed me.	Never 1	Rarely 2	Sometimes 3	Often 4	Always 5
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Figure 3

Example Question from the PROMIS-Depression

I felt that I had nothing to look forward to.	Never 1	Rarely 2	Sometimes 3	Often 4	Always 5
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The instrument used to measure religiosity was the Duke University Religion Index (DUREL). The DUREL is a five-item assessment that measures the three major dimensions of religiosity: organizational religious activity, non-organizational religious activity, and intrinsic religiosity, or subjective religiosity. These dimensions were recognized during a meeting sponsored by the National Institute on Aging (Koenig & Büssing, 2010). This scale was designed to measure religiosity in Western religions (e.g., Christianity, Judaism, and Islam). The DUREL has high convergent validity with other measures of religiosity ($r = .71-.86$), high internal consistency (Cronbach's $\alpha = .78-.91$), and high test-retest reliability (intra-class correlation = .91) (Koenig & Büssing, 2010).

Figure 4

Example question from the DUREL

My religious beliefs are what really lie behind my whole approach to life (Intrinsic Religiosity).	Definitely not true 1	Tends not to be true 2	Unsure 3	Tends to be true 4	Definitely true 5
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To determine the level of the effect that the COVID-19 quarantine period had on the participants and to obtain demographic information, the researcher created the Quarantine Questionnaire. The questionnaire is a 4-item survey. A copy of the Quarantine Questionnaire is included in Appendix D.

Procedure

This was a non-experimental comparative study. Once the researcher received IRB exemption, the link with the Google Form questionnaires was shared via email, and the researcher's personal social media accounts. The Google Form was shared on Facebook and sent out via email to students in a southern, private, liberal arts university of the United States. The Google Form included a statement explaining that completing the survey would be considered informed consent, and potential participants were informed of their right to withdraw from the research without penalization. Volunteering participants answered the PROMIS-Anxiety, PROMIS-Depression, DUREL, and Quarantine Questionnaire in that order and were debriefed at the end of the survey.

A Pearson's Correlation analysis, a Spearman's Correlation, and two independent sample t-test were performed to analyze the data. Each hypothesis was tested using a 2-tailed test and examined at an alpha level of 0.05.

Results

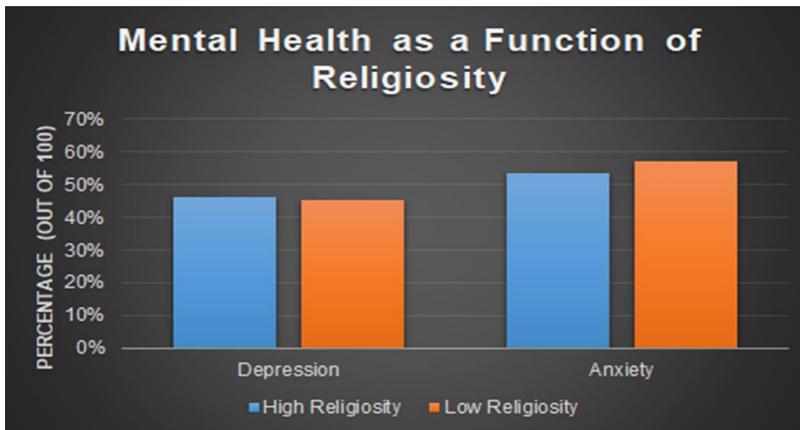
The authors of the DUREL recommend examining each subscale score (NORA, ORA, IR) independently when exploring the subscales' relationships to health outcomes (in this case: anxiety and depression). Performing separate correlations could prevent the subscale's scores from canceling out each other. However, the results obtained from combining the three subscales variables into a new variable named "religiosity" yielded similar results to those obtained by analyzing each subscale independently.

Results of the independent sample t-test with the "religiosity variable" (i.e., the summation of the three religiosity subscales) revealed no significant difference in levels of anxiety as a function of religiosity, $t(94) = -1.067, p > .05, d = .22$. Additionally, no significant

differences were found in levels of depression as a function of religiosity, $t(94) = .208, p > .05$, $d = .04$ (See *Figure 5*).

Figure 5

Mental Health as a Function of Religiosity



Additionally, results revealed no significant differences in levels of depression between those with high ORA levels ($M = 18.03$) versus participants with low ORA levels ($M = 19.08$), $t(94) = .606, p > .05$ (see *Figure 6*). There were no significant differences in levels of anxiety between those with high ORA levels ($M = 18.81$) and those with low ORA levels ($M = 20.58$), $t(94) = 1.291, p > .05$ (see *Figure 7*).

Figure 6

Levels of depression as a function of ORA

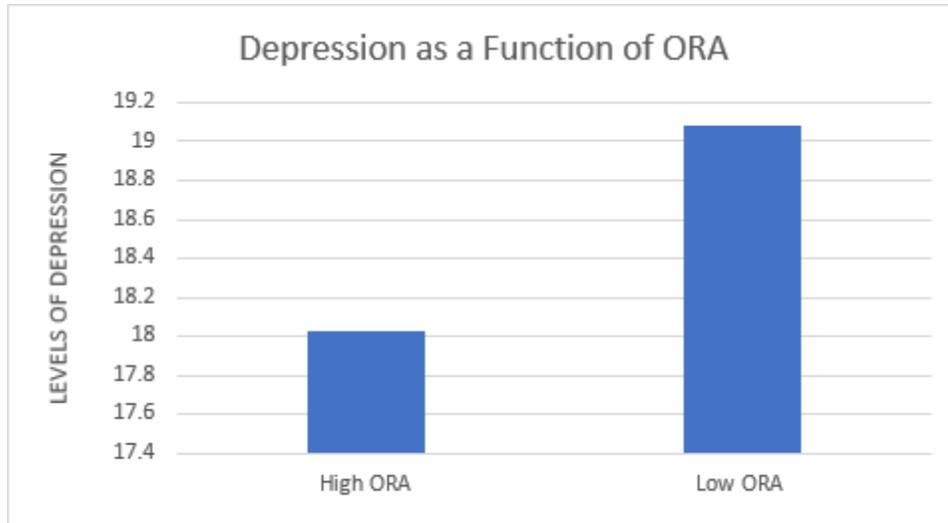
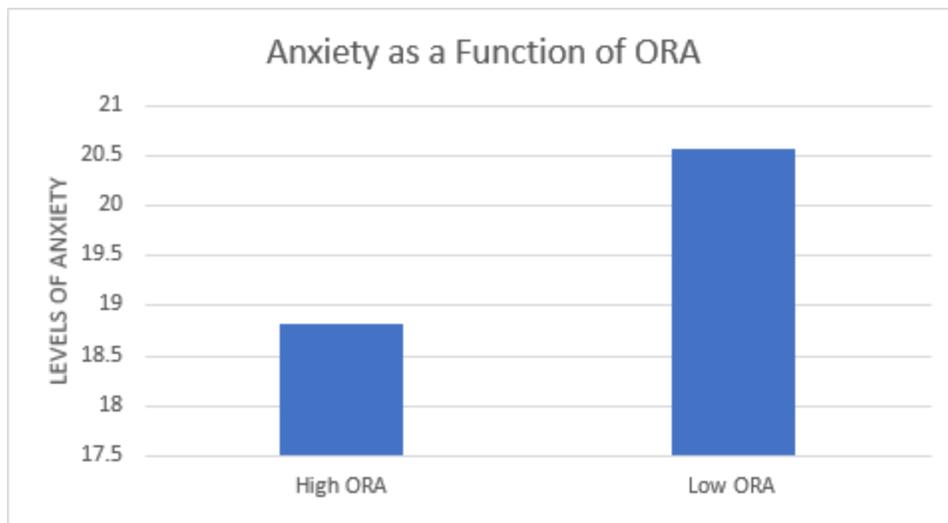


Figure 7

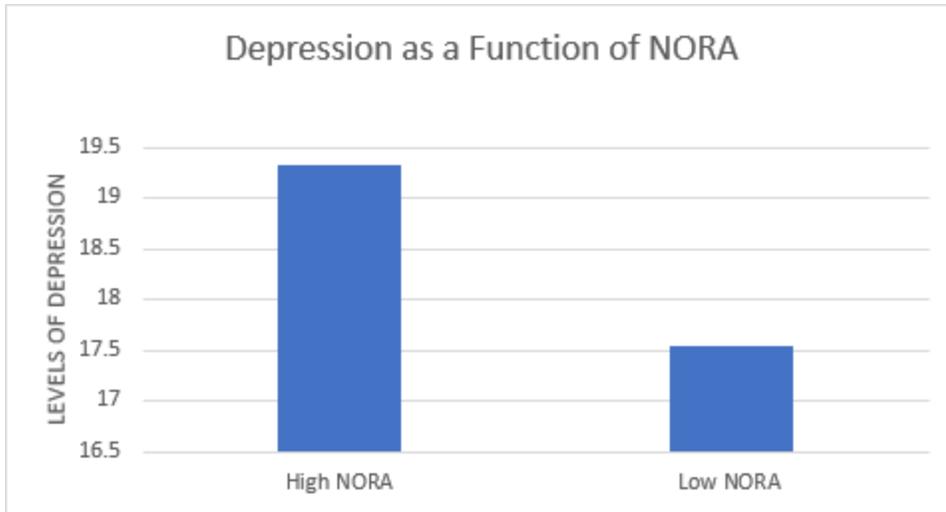
Levels of anxiety as a function of ORA



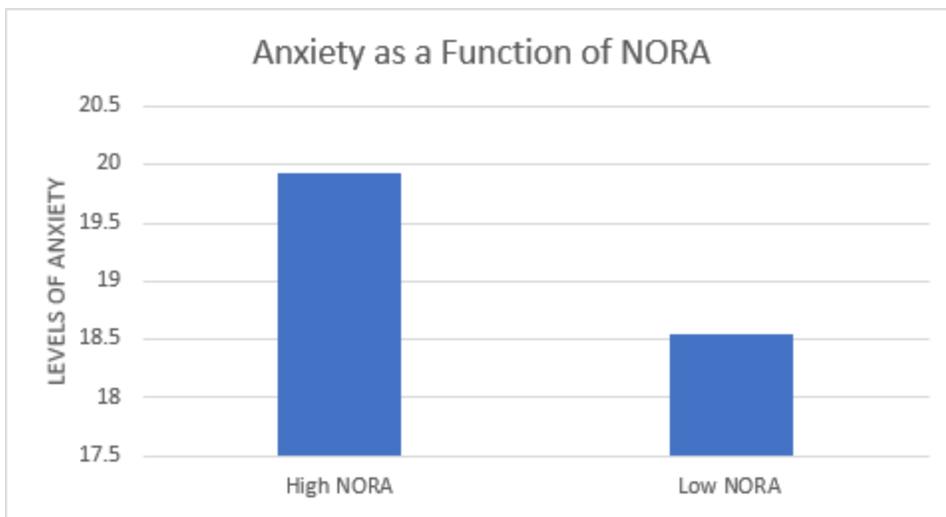
No statistically significant difference was found in the levels of depression between those with high NORA levels ($M= 19.33$) and those with low NORA levels ($M=17.55$), $t(94)=$, $p>.05$ (see *Figure 8*). There were also no significant differences in the levels of anxiety between those with high NORA ($M=19.92$) and those with low NORA levels ($M=18.74$), $t(94)$, $p > .05$ (see *Figure 9*).

Figure 8

Levels of anxiety as a function of NORA

**Figure 9**

Levels of anxiety as a function of NORA



There was no significant difference between the levels of depression of volunteers with high IR ($M=17.76$) and those with low IR levels ($M= 19.65$), $t(94)$, $p>.05$ (see *Figure 10*). There

was no statistically significant difference between the levels of anxiety between those with high IR ($M= 18.67$) and low IR ($M=20.62$), $t(94)$, $p>.05$ (see *Figure 11*).

Figure 10

Levels of depression as a function of IR

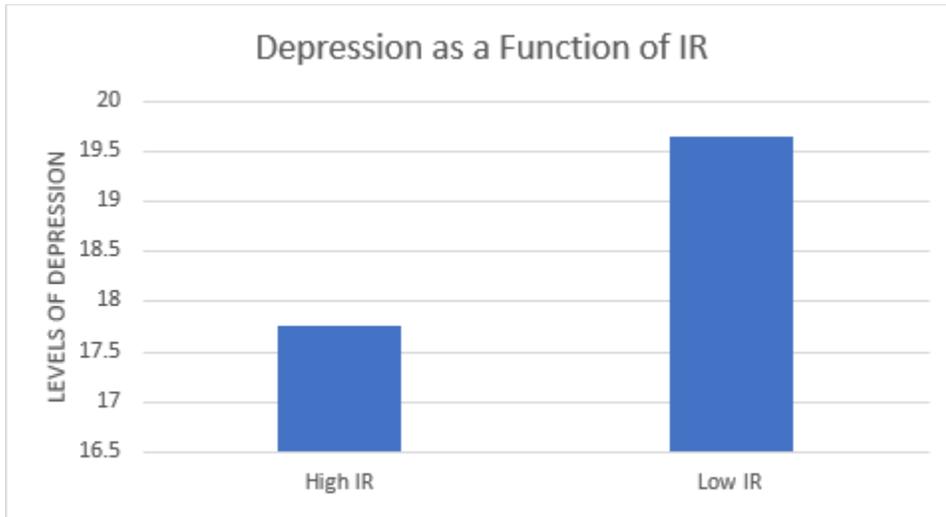
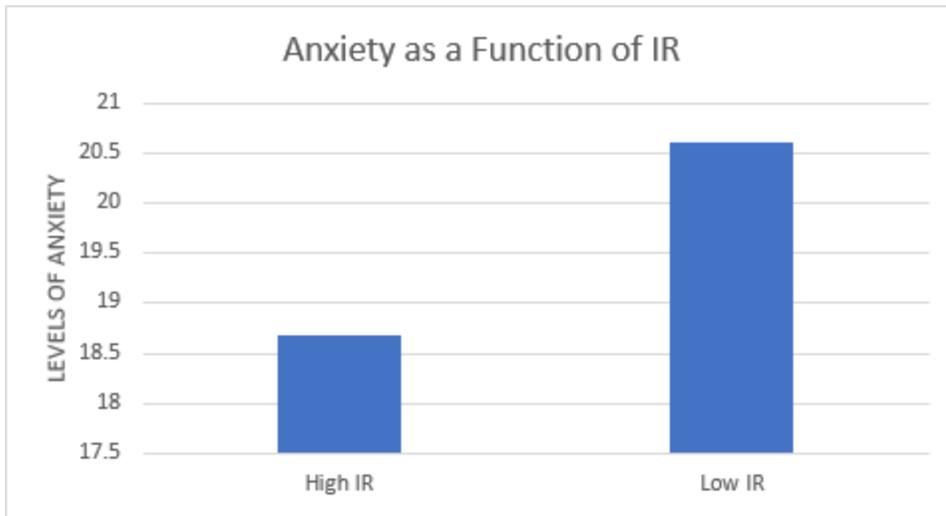


Figure 11

Levels of anxiety as a function of IR



A Pearson correlation coefficient was also computed to assess the relationship between anxiety and the three dimensions of religiosity and depression and the three dimensions of religiosity. No statistically significant correlations were discovered between religiosity and depression/anxiety. See Figure 12 for the correlation matrix.

Figure 12

Pearson's correlation between anxiety, depression, ORA, NORA, and IR

Correlations				
		ORA	NORA	IR
Anxiety	Pearson Correlation	0.019	-0.04	-0.008
	Sig. (2-tailed)	0.855	0.697	0.936
	N	96	96	96
Depression	Pearson Correlation	0.054	-0.01	0.012
	Sig. (2-tailed)	0.601	0.926	0.908
	N	96	96	96

Because all variables except for anxiety are normally distributed, the researcher decided to perform a Spearman's analysis in addition to the Pearson's to explore any possible differences due to the distribution of the variables (*Figure 13*).

Figure 13

Spearman's correlation between anxiety, depression, ORA, NORA, and IR

Correlations					
			ORA	NORA	IR
Spearman's rho	Anxiety	Correlation Coefficient	-0.049	-0.013	-0.129
		Sig. (2-tailed)	0.635	0.9	0.21
		N	96	96	96
	Depression	Correlation Coefficient	0.038	0.024	-0.042
		Sig. (2-tailed)	0.717	0.819	0.686
		N	96	96	96

Pearson and Spearman's correlational analyses revealed no significant relationships between depression, anxiety, and religiosity.

Discussion

Existing research shows a relationship between psychological well-being and a person's level of religiosity. Some writings support the argument that religiosity is negatively correlated with mental health issues. In contrast, others affirm that affirmative secularity has the same effect on a person as religiosity does. However, there is little research about the relationship between these two variables during a global pandemic. That is why the researcher chose to study the

interaction between religiosity and mental health and focus on the social isolation aspect of the current pandemic, COVID-19.

Many religious beliefs, like the Christian faith, encourage believers to not be anxious during times of hardship. The Bible (King James) states in Isaiah 41:10, “but even if you should suffer for what is right, you are blessed. “Do not fear their threats; do not be frightened.” The present study revealed no statistically significant relationship neither between religiosity and anxiety or religiosity and depression in those who reported being affected by the COVID-19 quarantine. It seems as if the quarantine (i.e., the global pandemic) potentially negates the progressive effects that religion has been found to have on mental health. One possible explanation for this is that due to the social distancing guidelines, many group-related activities have been postponed. This has possibly taken away part of the community support that believers find through religiosity. In addition to this, the frequency of participation in non-organizational religious activity, organizational religious activity, or the scores of intrinsic religiosity did not predict the levels of either anxiety or depression in those affected by COVID-19 quarantine.

One of the limitations of the current study is that the questionnaire used to assess the effect of quarantine on the participants was extremely vague. It only explores whether someone has been affected by the isolation period or not; future research should be more specific and explore directly how the person is being affected. In addition to this, future research could provide insight into whether there is a significant difference in the relationship between religiosity and mental health in those who report being affected by the COVID-19 quarantine as opposed to those who were not.

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Appendix A

LEVEL 2—Anxiety—Adult*

*PROMIS Emotional Distress—Anxiety—Short Form

Name: _____ Age: _____ Sex: Male Female Date: _____

If the measure is being completed by an informant, what is your relationship with the individual? _____

In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions to patient: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you (individual receiving care) have been bothered by “feeling nervous, anxious, frightened, worried, or on edge”, “feeling panic or being frightened”, and/or “avoiding situations that make you anxious” at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often you (individual receiving care) have been bothered by a list of symptoms **during the past 7 days**. Please respond to each item by marking (✓ or x) one box per row.

							Clinician Use
In the past SEVEN (7) DAYS....							Item Score
		Never	Rarely	Sometimes	Often	Always	
1.	I felt fearful.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
2.	I felt anxious.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
3.	I felt worried.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
4.	I found it hard to focus on anything other than my anxiety.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
5.	I felt nervous.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
6.	I felt uneasy.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
7.	I felt tense.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
Total/Partial Raw Score:							
Prorated Total Raw Score:							
T-Score:							

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Appendix B

LEVEL 2—Depression—Adult*

*PROMIS Emotional Distress—Depression—Short Form

Name: _____ Age: _____ Sex: Male Female Date: _____

If the measure is being completed by an informant, what is your relationship with the individual receiving care? _____

In a typical week, approximately how much time do you spend with the individual receiving care? _____ hours/week

Instructions: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you (the individual receiving care) have been bothered by “no interest or pleasure in doing things” and/or “feeling down, depressed, or hopeless” at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often you (the individual receiving care) have been bothered by a list of symptoms **during the past 7 days**. Please respond to each item by marking (✓ or x) one box per row.

						Clinician Use
In the past SEVEN (7) DAYS....						Item Score
		Never	Rarely	Sometimes	Often	Always
1.	I felt worthless.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2.	I felt that I had nothing to look forward to.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
3.	I felt helpless.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
4.	I felt sad.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
5.	I felt like a failure.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
6.	I felt depressed.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
7.	I felt unhappy.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
8.	I felt hopeless.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Total/Partial Raw Score:						
Prorated Total Raw Score:						
T-Score:						

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Appendix C

Duke University Religion Index (DUREL).

(1) How often do you attend church or other religious meetings? (ORA)

1 - Never; 2 - Once a year or less; 3 - A few times a year; 4 - A few times a month; 5 - Once a week; 6 - More than once/week

(2) How often do you spend time in private religious activities, such as prayer, meditation, or Bible study? (NORA)

1 - Rarely or never; 2 - A few times a month; 3 - Once a week; 4 - Two or more times/week; 5 - Daily; 6 - More than once a day

The following section contains three statements about religious belief or experience. Please mark the extent to which each statement is true or not true for you.

(3) In my life, I experience the presence of the Divine (i.e., God) - (IR)

1 - Definitely not true; 2 - Tends not to be true; 3 - Unsure; 4 - Tends to be true; 5 - Definitely true of me

(4) My religious beliefs are what really lie behind my whole approach to life - (IR)

1 - Definitely not true; 2 - Tends not to be true; 3 - Unsure; 4 - Tends to be true; 5 - Definitely true of me

(5) I try hard to carry my religion over into all other dealings in life - (IR)

1 - Definitely not true; 2 - Tends not to be true; 3 - Unsure; 4 - Tends to be true; 5 - Definitely true of me

Appendix D

Quarantine Questionnaire

Please select the response that you identify with the most.

1. Would you say that the COVID-19 has affected you?

*

- 5- Very Much
- 4- Somewhat
- 3- Undecided
- 2- Not Really
- 1- Not at all

2. Gender

*

- 1- Female
- 2- Male
- 3- Prefer not to say
- Other...

3. Age

*

- 18-28
- 28-38
- 38-48
- 48-58
- 58 or older

4. Ethnic origin

*

- 1- White.
- 2- Hispanic or Latino.
- 3- Black or African American.
- 4- Native American or American Indian.
- 5- Asian / Pacific Islander.
- Other...