Measuring COVID-19 Fear in Australian, Indian, and Nepali University Students

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The present study describes the adaption and validation of a brief measure of contagion-related fear and threat in Australian, Indian, and Nepali university students in Australia at the height of the first wave of the COVID-19 pandemic. Adapted from Ho, Kwong-Lo, Mak, and Wong’s (2005) SARS-related fear scale, the Contagion Fear and Threat Scale (CFTS) was rapidly adapted to capture the experience of COVID-19 pandemic-related fear. The factor structure and validity of the 6-item scale were established among Australian (*n*=155), Indian (*n*=111), and Nepali (*n*=148) university students studying in Australia in May-June 2020. Factor analysis revealed two 3-item factors in the Australian student sample: Fear of Infection and Existential Threat. These factors were confirmed in the Indian and Nepali student samples and mirror those found by the Ho et al. (2005) in their original instrument. The convergent and discriminant validity of the full CFTS, Fear of Infection, and Existential Threat scales are indicated via correlations with established measures of depression, anxiety, stress, subjective wellbeing, and religiosity. Differences in the performance of the Fear of Infection and Existential Threat scales are considered in terms of the respective objective and subjective nature of the constructs.

# Introduction

It is well-established that Australian university students report poorer mental health than the general Australian population (Stallman et al., 2019). International university students in Australia report even poorer mental health than their domestic counterparts, especially in relation to financial stress, loneliness, depression, and anxiety (Forbes-Mewett, 2019). International education is Australia’s fourth largest export and, in 2019, the country welcomed 758,154 international students to its shores (Australian Government Department of Education, 2019). In accepting their cultural and economic contribution to the country, Australia is obliged to actively support international students’ psychological wellbeing.

On 12 March 2020, the World health Authority declared the COVID-19 outbreak a pandemic and by 23 March Australia had entered lockdown. Strict social-distancing measures were implemented, international borders were closed, and universities across the country shifted from on-campus delivery to online delivery (Ting & Palmer, 2020). While some restrictions loosened in some domains in early June 2020 (e.g., hospitality, primary and secondary education), the restrictions regarding social-distancing, international borders, and universities remain in place.

The impact of the lockdown on university students in Australia was immediate and significant. Campuses shut down with little warning and the main sources of part-time employment for university students – hospitality and retail – quickly dried up. The impact was compounded for international students in Australia who were geographically separated from their support networks and faced enormous financial and housing stress (Soong & Procter, 2020).

### Measuring contagion-related psychological responses

The Australian lockdown commenced shortly before the author was to commence a broad investigation into the psychological wellbeing of domestic and international students in Australia. A contagion-related psychological response measure was needed to measure, and determine the impact of, the pandemic on university students’ psychological wellbeing.

Interest in psychological responses to contagion has increased in the early 21st century in the wake of Severe Acute Respiratory Syndrome (SARS), Middle East Respiratory Syndrome, and Ebola outbreaks (World Health Organization, n.d.). Compared to other health threats, contagion engenders fear because of its imminence, invisibility, and transmissibility (Pappas et al., 2009), that is, it’s here, you can’t see it, and it’s on the move. This contagion-related fear is heightened by perceptions of the speed of transmission and exposure to contagion-related misinformation (Amin, 2020); (Pappas et al., 2009).

A search of the pre-2020 literature revealed a dearth of quantitative measures of contagion-related fear. Research emerging from the most recent comparable epidemic, the SARS epidemic of 2002-2004, mainly used semi-structured interviews and general measures of fear, trauma, and psychological wellbeing (Ho et al., 2005; Stuijfzand et al., 2020). SARS research also tended to focus on the experiences of healthcare professionals (Ho et al., 2005; Stuijfzand et al., 2020) rather than the general population.

With the rapid global spread of COVID-19, the first half of 2020 has seen a flurry of COVID-19-related psychological response scale development. Lee’s (2020) Coronavirus Anxiety Scale, is a brief, 5-item screener for clinical levels of anxiety related to COVID-19. Kachanoff et al. (2020) developed the COVID-19 Threat Scale, a 10-item measure of perceptions of realistic threat to financial and physical safety and symbolic threat to sociocultural identity. Ahorsu et al. (Ahorsu et al., 2020) developed the Persian language, 7-item Fear of COVID-19 scale measuring fear and anxiety clinical symptoms associated with COVID-19. Finally, Taylor et al (Taylor et al., 2020) developed the 36-item COVID Stress Scales, a comprehensive measure of psychological reactions to COVID-19: contamination fears, economic fears, xenophobia, compulsive behavior, and traumatic stress symptoms.

Missing from the research literature was a brief, non-diagnostic measure of contagion-related fear that could be applied to any contagious disease and across a wide range of adult populations. A potential basis for such a scale was Ho et al’s (2005) SARS-related fear scale.

The aim of this study was to adapt Ho et al’s (2005) SARS-related fear scale as a general contagion-related fear scale, suitable for use across a range of diseases and populations. The factor structure, validity and reliability of the adapted scale was examined in samples of Australian, Indian, and Nepali university students studying in Australia at the height of Australia’s first wave of COVID-19.

# Method

## Participants

Participants were domestic and international university students studying in Australia between 5 May 2020 and 7 June 2020, a period of nation-wide COVID-19-related social isolation and restriction in Australia. Data from three culturally distinct university student groups were analyzed: Sample 1, Australian domestic students; Sample 2, Indian university students studying in Australia; and Sample 3, Nepali university students studying in Australia. All participants were aged 18 or over and were fluent in written and spoken English as required for admission to Australian universities.

Sample 1 comprised 155 Australian domestic (i.e., citizens and permanent residents of Australia) university students. They ranged in age from 18-60 years with a mean age of 25.41 years (SD = 9.35). Sample 1 included 100 women (65%), 52 men (34%), and 3 participants who identified as non-binary (1%).

Sample 2 comprised 111 Indian nationals studying at Australian universities. They ranged in age from 18-33 years with a mean age of 24.16 years (SD = 3.22). Sample 2 included 63 women (57%), 47 men (42%), and 1 participant who did not indicate their gender (1%).

Sample 3 comprised 148 Nepali nationals studying at Australian universities. They ranged in age from 18-31 years with a mean age of 23.45 years (SD = 3.80). Sample 2 included 94 women (64%), 51 men (34%), and 1 participant who did not indicate their gender (1%).

## Materials and procedure

The study was approved by the Monash University Human Research Ethics Committee (Project ID: 22957) prior to the commencement of data collection. Participants were invited to participate in the online study via Facebook advertisements. Participation was voluntary, anonymous, and offered the opportunity to enter a draw (via a separate online form) for one of ten $100 Amazon vouchers.

Participants completed a range of measures as part of the broader investigation of university student psychological wellbeing. Only the measures and data pertaining to the present study are reported here. The measures were administered online at Qualtrics.com and included demographic items (age, gender, international-domestic student status, and home country), and measures of contagion-related fear, psychological distress (depression, anxiety and stress), subjective wellbeing, and religiosity.

### Contagion-related fear items

Ho et al.’s (2005) SARS-related fear scale was developed to measure the psychological impact of the 2002-2004 SARS outbreak on frontline health workers in Hong Kong hospitals. The 19-item scale comprises 18 items measuring fear of infection and one item measuring infection related self-efficacy. Factor analysis of the 18 fear items produced three significant 3-item factors: 1) fear of infection (i.e., *Fear I will be infected, Worry if my family will be infected, and I fear that I will infect others*), 2) feelings of insecurity (i.e., *Feel that I have lost control of life, Feel that life is threatening, and Feel very unsafe about myself* ), and sense of job-related instability (i.e., *Worry if my friends and family will keep a distance from me due to my job duties, Fear distressed because of the upsurge in workload, and Worry if I will be assigned to SARS wards*).

For the present study, the six items making up Ho et al.’s (2005) fear of infection and feelings of insecurity factors were retained, providing a focused, 6-item measure. In the present study, each item included the stem, *The current COVID-19 pandemic makes me….* The name of the disease or outbreak can be changed as necessary. Participants responded to each item on a 4-point Likert scale where *0 = Definitely false* and *3 = Definitely true.*

### Depression, Anxiety, and Stress Scales-21

A short form of the 42-item Depression, Anxiety and Stress Scales (DASS; Lovibond & Lovibond, 1996), the Depression, Anxiety and Stress Scales-21 (DASS-21) is a 21-item scale comprising three 7-item subscales measuring symptoms of depression (e.g., *I felt that I had nothing to look forward to*), anxiety (e.g., *I felt I was close to panic*), and stress (e.g., *I found it difficult to relax*). Participants respond to items on a 4-point Likert scale where *0 = Never* and *3 = Almost always*. Item responses are summed to create subscale scores and a total score. The DASS-21 authors recommend doubling the subscale and total scores so that they can be compared with scores from the original 42-item DASS-42, however, this was not considered necessary in the present study. As such, DASS-21 total scores are reported from a possible range of 0 - 63 and subscales scores are reported from a possible range of 0 - 21.

The DASS-21 demonstrates good to excellent internal consistency. Cronbach’s αs have been reported ranging from .82 - .90 for Depression, .74 - .83 for Anxiety, and 82 - .87 for Stress, across several countries (Lee, 2019; Rosenthal et al., 2008; Zanon et al., 2020). Cronbach’s αs for DASS-21 total scores range from .90 - .94 (Crawford et al., 2011; Scholten et al., 2017).

In non-clinical populations, DASS-21 total scores and subscale scores are typically at the very low end of the scoring range. DASS-21 total scores have been reported between 8.9 - 11.51 (Crawford et al., 2011; Sinclair et al., 2012). Mean subscale scores have been reported ranging from 1.57 - 5.03 for Depression, 1.44 - 4.51 for Anxiety, and 1.79 - 7.27 for Stress (Lee, 2019; Praharso et al., 2017; Sinclair et al., 2012; Zanon et al., 2020).

### Personal Wellbeing Index - Adult

The Personal Wellbeing Index-Adult (PWI-A; International Wellbeing Group, 2013) is a 7-item measure of satisfaction with various domains of life including Standard of Living, Personal Health, Achieving in Life, Personal relationships, Personal Safety, Community-Connectedness, and Future Security. Participants respond to statements on an 11-point Likert scale where *0 = No satisfaction at all* and *10 = Completely satisfied*. Scores for all seven items are multiplied by 10, summed, then averaged to create a Subjective Wellbeing score ranging from 10 - 100.

The PWI-A demonstrates good to excellent internal consistency with Cronbach’s αs reported between .70 - .91 in Australian samples (Hutton et al., 2013; International Wellbeing Group, 2013; Jovanović et al., 2019).

For individuals, the normative range for Subjective Wellbeing scores is 50 - 100 (International Wellbeing Group, 2013) with Australians typically reporting scores ranging from 72 - 75.43 (Khor et al., 2020; Misajon et al., 2016; Weinberg et al., 2018).

### Duke University Religion Index

The 5-item Duke University Religion Index (DUREL; Koenig & Bussing, 2010) measures frequency of engagement in Organisational Religious Activity (e.g., attending services; one item), frequency of engagement in Non-Organisational Religious Activity (e.g., private prayer; one item), and level of Intrinsic Religiosity (e.g., personal religious commitment). The Intrinsic Religiosity subscale comprises three items accompanied by 5-point Likert scales where *1 = Definitely not true* and *5 = Definitely true of me*. The DUREL demonstrates good to excellent internal consistency with Cronbach’s αs reported between .75 - .92 and mean scores between 3.15 and 10.4 (Lace & Handal, 2018; Palmer Kelly et al., 2019; Stanford et al., 2019)

# Results

## Exploratory Factor Analysis

Using SPSS 26.0, an exploratory factor analysis was carried out on the 6-item contagion-related fear items using the data from Sample 1: Australian domestic university students (*n* = 155). The 6 items were assessed as factorable based on a Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy value of .74, above the recommended value of .60 (Carpenter, 2018), and a Bartlett’s Test of Sphericity value of *x2*(15) = 274.67, *p* < .001.

Item-total correlations for all six items were ≥.3, however, Cronbach’s α (.76) could be marginally improved (to .77) by the removal of the item, *Feel that I have lost control of life*. All items correlated significantly with one another at ≥.3, again, with the exception of this item. Any gain in internal consistency achieved by the removal of this item would be offset by the reduction of one factor to, at best, an uninterpretable two items. For this reason, all items were retained, and the 6 items deemed suitable for factor analysis.

An exploratory factor analysis, with unrotated Principal Axis Factoring extraction, was conducted as recommended by Carpenter (2018). Communalities were all ≥.3, except for the item, *Feel that I have lost control of life* (*r* = .22). Two factors emerged with Eigenvalues greater than 1, explaining 67.10% of the variance. Ho et al’s three ‘feelings of insecurity’ items loaded at ≥.4 on the first factor which explained 46.84% of variance and their three ‘fear of infection’ items loaded ≥.4 on the second factor which accounted for an additional 20.26% of the variance.

A further factor analysis, with Maximum Likelihood extraction and Promax rotation, was conducted on the six items confirming the two-factor solution explaining 67.10% (see Table 1). The two 3-item factors were labelled Fear of Infection (Fear) and Existential Threat (Threat). This model demonstrated good fit, *x2*(4) = 3.18, *p* = .53, and was retained for further investigation.

## Confirmatory factor analysis

Confirmatory factor analysis of the 2-factor solution for the 6 items was conducted for the Indian (KMO = .77; Bartlett’s *x2*(15) = 234.71, *p* < .001) and Nepali (KMO = .76; Bartlett’s *x2*(15) = 172.91, *p* <.001) samples. The Maximum Likelihood method of extraction was used with Direct Oblimin rotation. The Indian sample reproduced the 2-factor solution with good model fit (*x2*(4) = 3.15, *p* =.53) and explaining 69.98% of the variance. The same 2-factor solution emerged from the Nepali sample explaining 59.90% of variance and demonstrating good fit (*x2*(4) = 4.83, *p* = .31; see Table 1).

<insert Table 1 here>

## Descriptives

Table 2 shows the descriptive statistics for the 6 items (herein, the Contagion-related Fear and Threat Scale [CFTS]) total, Fear, and Threat scores in the Australian, Indian, and Nepali university student samples. CFTS total scores had a possible range of 0 – 18; Fear and Threat scores had a possible range of 0 to 9.

<Insert Table 2 here>

ANOVA revealed significant differences between Australian, Indian and Nepali students on CFTS total (*F*(2, 411) = 9.96, *p* < .01; *ƞ*2=.03), Fear (*F*(2, 412) = 8.28, *p* < .01; *ƞ2* = .04) and Threat (*F*(2, 411) = 15.68, *p* < .001; *ƞ2*=.07) scores.

Post Hoc tests (Dunnett’s C) showed that Nepali students scored significantly higher than Australian and Indian students on CFTS total and Threat scores while Nepali and Australian students scored significantly higher on Fear than Indian students.

Fear and Threat subscale scores correlated at .52, .54, and .55 in the Australian, Indian, and Nepali student samples, respectively.

## Construct validity

Correlations for CFTS total, Fear, and Threat scores and scores for psychological distress, wellbeing, and religiosity are shown in Table 3.

<Insert Table 3 here>

Across all three samples, mild to moderate correlations were found between the CFTS total, Fear, and Threat scores and DASS total, Depression, Anxiety, and Stress scores with the exception of Fear and Anxiety and Fear and Stress in the Nepali sample. Across all samples, Subjective Wellbeing was mildly to moderately negatively associated with CFTS total and Threat scores. Subjective Wellbeing was also negatively associated with Fear in the Australian sample.

Across all samples, CFTS total, Fear and Threat scores were unrelated to Intrinsic Religiosity.

# Discussion

The aim of the present study was to adapt Ho et al’s (2005) SARS-related fear scale as a brief, reliable, and valid measure of contagion-related fear for use across a range of diseases and populations. The adapted scale, the CFTS, was validated among Australian, Indian, and Nepali university students studying in Australia at the height of the first wave of the COVID-19 pandemic.

## Factor structure and internal consistency

Factor analysis of the 6-item CFTS revealed the same two factors originally identified by Ho et al. (2005) across all three samples: one factor reflecting fear of infection, and the second factor reflecting existential threat related to the pandemic. The two factors were moderately correlated (*r* = .52 - .55) and, along with the CFTS full scale, demonstrated acceptable to good internal consistency across the three samples with Cronbach’s α ranging from .62 to .80.

## Construct validity

Convergent validity of the CFTS was indicated by the significant mild to moderate correlations between CFTS total and Threat scores and DASS total, Depression, Anxiety, and Stress scores across all three samples (*r* = .27-.59). Fear scores were correlated with all DASS scale and subscale scores in the Australian sample (*r*=.20-.35), DASS total, Anxiety, and Stress scores in the Indian sample (*r* = .27-.29), and DASS total and Depression scores in the Nepali sample (*r* = .21 and .23, respectively). Where correlations with Fear scores were not significant, they approached significance.

Convergent validity was further suggested by mild to moderate negative correlations between CFTS total and Threat scores and Subjective Wellbeing scores across all three samples (*r* = -.22- -.48). The Fear scale correlated with Subjective Wellbeing in the Australian sample but not in the Indian and Nepali samples.

Discriminant validity was indicated by the lack of association between CFTS total, Fear, and Threat scores and Intrinsic Religiosity across all three samples.

## Fear of Infection versus Existential Threat

It is notable that, across all samples, Fear scores were higher than Threat scores and Threat scores were more strongly related to DASS-21 total and subscale scores and Subjective Wellbeing scores than were Fear scores. This may be explained by the nature of the two CFTS subscales. The object of Fear of Infection is specific and external to the self (i.e., COVID-19 infection). Existential Threat, however, has no specific object, rather it is an unanchored and subjective experience of threat to one’s own existence, albeit triggered, in this case, by the COVID-19 pandemic. The moderate relationship between Threat and DASS total, Depression, Anxiety and Stress scores can be understood as capturing the subjective and non-specific character of these constructs (Lovibond & Lovibond, 1996). Similarly, Subjective Wellbeing represents satisfaction with a range of life domains rather than a specific domain such as Standard of Living or Personal Health.

## Limitations and future research

As all participants were studying in Australia at the time of data collection, features specific to the Australian experience of this first wave of COVID-19 are likely to have moderated CFTS full, Fear, and Threat scores. At the time, restrictions were swiftly implemented, actively enforced, and broadly adhered to in Australia (Australian Government, 2020). Furthermore, Australian infection rates were low by global standards, all participants had access to socialised, high-quality healthcare, and the capacity of health system was not at risk of being overwhelmed (Australian Government, 2020).

Futhermore, data were collected around six weeks after Australia’s first wave peak of daily cases, when new infections were typically in the single digits. At that time, COVID-19 hadn’t taken a hold in India and Nepal which were still weeks away from their first wave peak of daily infections (Roser et al., 2020). So, while COVID-19 was recognized (Ho et al., 2005) as a significant threat in Europe and the Americas during May and June 2020, the threat was objectively less for Australian, Indian and Nepali students in Australia and their families in India and Nepal.

Finally, the age of participants may also have affected CFTS full, Fear, and Threat scores. In Australia, although people in their 20s (90% of the current sample) are more likely to contract the disease, people over the age of 70 are far more likely to die from the disease. Compared to older age groups, the present sample may not have perceived COVID-19 to be life-threatening (covid19data.com.au, 2020; Ting et al., 2020).

The CFTS should be administered to people from a range of age groups and countries at different stages in the pandemic to determine its psychometric performance across the lifespan and across pandemic waves. Translation of the measure is encouraged to broaden its utility and use.

## Conclusion

Future pandemics are inevitable and the impact on psychological wellbeing variable depending on geographic location, age, local policy, and other sociocultural variables. The CFTS represents a brief, reliable, and valid measure of contagion-related fear and threat suitable across a range of diseases and populations. Knowledge of, and preparation for, the psychological impact of pandemics will go a long way toward helping the world’s citizens adapt to the ‘new normal’.

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# Conflict of Interest

The author declares that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

# Author Contributions

The author confirms being the sole contributor of this work and has approved it for publication.

# Data Availability Statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

# Contribution to the Field Statement

In a highly globalized world, pandemics are inevitable. The presence of a highly contagious disease in the community, combined with its invisibility and fast transmission, can be a significant source of fear. This fear can impact the experience of everyday life and make existing mental and physical health problems worse. The advent of the COVID-19 pandemic has increased contagion-related fear around the world. We need a way of measuring this fear so we can understand how it affects mental and physical health and how we can best treat it. This paper describes the adaption of a contagion-related fear scale used during the most recent, comparable pandemic, the SARS outbreak of 2002-2004. The adapted scale, the Contagion Fear and Threat Scale (CFTS) measures fear of infection and contagion-related existential threat. Unlike other, recently developed measures of the psychological impact of COVID-19, the CFTS it draws directly on the important scale-development work already done during the SARS outbreak, and it can be used in any pandemic, regardless of the disease or the population being investigated, and has been validated cross-culturally in Australia, Indian, and Nepali populations. A better understanding of psychological responses to pandemics will help adjust to the ‘new normal’.

Table 1. Factor loading for the 6-item CFTS in Australian, Indian, and Nepali university student samples.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Australian (*n* = 155) | Indian (*n* = 111) | Nepali (*n* = 148) |
|  | Threat | Fear | Threat | Fear | Threat | Fear |
| Fear that I will be infected | .08 | **.63** | .13 | **.70** | -.01 | **.77** |
| Fear that I will infect others | -.11 | **.75** | -.14 | **.94** | .03 | **.65** |
| Worry that my family will be infected | .04 | **.71** | .06 | **.45** | .01 | **.40** |
| Feel very unsafe about my self | **.80** | .07 | **.67** | .17 | **.44** | .27 |
| Feel that life is threatening | **.88** | -.04 | **.86** | .04 | **.91** | -.13 |
| Feel that I have lost control of life | **.48** | -.03 | **.74** | -.13 | **.41** | .20 |

Table 2. Descriptive statistics for scores on CFTS total and subscales, DASS-21 total and subscales, Subjective Wellbeing, and Intrinsic religiosity in the Australian, Indian, and Nepali university student samples.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Australian (*n* = 155) |  | Indian (*n* = 111) |  | Nepali (*n* = 148) |
|  | *Mean* | *SD* | *α* |  | *Mean* | *SD* | *α* |  | *Mean* | *SD* | *α* |
| CFTS total | 8.14 | 3.79 | .76 |  | 7.59 | 4.22 | .80 |  | 9.22 | 3.76 | .73 |
| Fear | 5.65 | 2.33 | .73 |  | 4.52 | 2.34 | .73 |  | 5.20 | 2.04 | .62 |
| Threat | 2.48 | 2.22 | .74 |  | 3.07 | 2.61 | .80 |  | 4.01 | 2.36 | .68 |
| DASS-21 total | 20.20 | 13.15 | .94 |  | 18.97 | 13.06 | .94 |  | 15.25 | 13.18 | .95 |
| Depression | 7.73 | 5.92 | .92 |  | 6.87 | 5.10 | .88 |  | 5.36 | 4.89 | .86 |
| Anxiety | 4.41 | 3.93 | .82 |  | 5.10 | 4.17 | .82 |  | 4.28 | 4.30 | .85 |
| Stress | 8.15 | 5.09 | .88 |  | 7.10 | 4.90 | .87 |  | 6.16 | 5.02 | .87 |
| Subjective Wellbeing | 48.45 | 14.90 | .89 |  | 52.01 | 15.32 | .89 |  | 50.99 | 14.50 | .87 |
| Intrinsic Religiosity | 7.31 | 4.21 | .93 |  | 9.62 | 3.21 | .75 |  | 10.17 | 2.82 | .79 |

Table 3. Correlations for CFTS total, Fear, and Threat scores and scores on psychological distress, wellbeing, and religiosity.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Australian (*n* = 155) |  | Indian (*n* = 111) |  | Nepali (*n* = 148) |
|  | CFTS | Fear | Threat |  | CFTS | Fear | Threat |  | CFTS | Fear | Threat |
| DASS-21 total | .53\*\* | .30\*\* | .59\*\* |  | .50\*\* | .27\*\* | .57\*\* |  | .33\*\* | .21\* | .36\*\* |
| Depression | .43\*\* | .20\* | .52\*\* |  | .42\*\* | .20a | .50\*\* |  | .33\*\* | .23\*\* | .35\*\* |
| Anxiety | .48\*\* | .26\*\* | .54\*\* |  | .51\*\* | .29\*\* | .56\*\* |  | .27\*\* | .15b | .30\*\* |
| Stress | .51\*\* | .35\*\* | .51\*\* |  | .47\*\* | .27\*\* | .52\*\* |  | .28\*\* | .16c | .31\*\* |
| Subjective Wellbeing | -.30\*\* | -.22\* | -.27\*\* |  | -.36\*\* | -.10 | -.48\*\* |  | -.22\* | .11 | -.24\* |
| Intrinsic Religiosity | .01 | -.03 | .04 |  | -.09 | .01 | -.15 |  | .03 | -.02 | .07 |

\**p*=.05, \*\**p*=.01, a*p*=.053, b*p*=.10, c*p*=.07.