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# Stress, Coping, and Resilience Among Home-Quarantined Persons During the COVID-19 Pandemic: Findings From a Community Study

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## ABSTRACT

**Objective:** To assess stress, coping, and resilience among home-quarantined individuals via a community survey during the coronavirus disease 2019 (COVID-19) pandemic.

**Methods:** In this cross-sectional study, a combined list was generated of all contacts of positive COVID-19 cases, traced by a contact tracing team, and international travelers who had entered the country after March 8, 2020 (2 weeks before the air travel shutdown on March 22, 2020 in India). This community-based study was conducted among people who were quarantined in their homes and international travelers who arrived in the country after declaration of lockdown. Stress and coping were assessed via the 12-item General Health Questionnaire, 10-item Perceived Stress Scale, and Brief Resilient Coping Scale. The participants with higher perceived stress scores ( $\geq 14$ ) were asked to seek help from telemedicine services. Study data were collected from April 8, 2020, to May 20, 2020.

**Results:** The mean age of the 153 study participants was 40.10 years, and 41.8% were women. Poor coping was identified in 25.5% of the sample, and moderate/high stress was present in 49.7%. Significantly higher stress was noted in women ( $P = .007$ ). Higher age, joint family structure, and contacts of COVID cases were significant predictors of moderate/severe perceived stress in the logistic regression.

**Conclusions:** Adequate psychological supportive services should be provided to home-quarantined persons through provision of information, rapid communication, and timely supplies of general and medical items.

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Quarantine is an age-old strategy used for containment of infectious diseases that has been utilized to control the coronavirus disease 2019 (COVID-19) pandemic. Recently, many individuals with suspect cases of COVID-19 were advised to self-quarantine in their homes. Quarantine measures focus on restricting movements and separating people potentially exposed to a contagious disease to ensure that the risk from these individuals infecting others is reduced.<sup>1</sup>

Several qualitative studies<sup>2-5</sup> conducted focus group discussions, surveys, and semistructured and structured interviews to identify common problems that emerged from conversations with those who experienced quarantine. The respondents reported emotional difficulties such as feeling anxious, irritable, and depressed. Lack of proper communication, frustration, fear, boredom, sleep difficulties, somatic complaints, feeling helpless, and being worried were the other common problems that emerged.<sup>2-5</sup> The present study aimed to assess stress, coping, and resilience among home-quarantined individuals via a community survey.

## METHODS

This cross-sectional study was conducted in Chandigarh, which is an urban city in North India. The Departments of Psychiatry and Community Medicine of Government Medical College and Hospital, Chandigarh, India, collaborated for this study. The study data were collected from April 8, 2020, to May 20, 2020. The participants, who were aged  $\geq 18$  years, were contacts of cases of COVID-19 or international travelers who were home quarantined after entering the country on March 8, 2020. The questionnaire was made available in the English, Hindi, and Punjabi languages. Written informed consent was received from each participant before commencement of the study, and the assessment procedure with each participant took approximately 50 to 60 minutes. The study was approved by the institutional ethics committee.

## Sample Size

For sample allocation among contacts of positive cases and air travelers who were home quarantined, population proportionate to size method was adopted. Assuming

prevalence of psychological consequences among contacts of COVID-19 cases as 10% and precision of 5%, the minimum sample size was calculated as 139. For this study, we targeted 150 subjects.

### Data Collection

A combined list of all contacts of positive COVID-19 cases, traced by the contact tracing team, and international travelers who had entered the country after March 8, 2020 (which was 2 weeks before the air travel shutdown on March 22, 2020) was generated along with their address and phone details. The list of recent air travelers, who were residents of Chandigarh, was received from the Chandigarh Directorate Health Services through the appropriate channel. Random contacts who were selected by computer-generated random numbers among home-quarantined individuals and foreign travelers were approached by the research team comprised of trained research staff with master's degrees in social work. Patients with medical, surgical, or mental health conditions were excluded from the study. For subjects with limited literacy, the questionnaire was administered in the local vernacular language (Hindi and Punjabi), and responses were recorded.

### Measures

Sociodemographic details were obtained, which included age, type of family, marital status, education, occupation, income, and religion. All eligible participants were administered the 12-item General Health Questionnaire (GHQ-12),<sup>6,7</sup> the 10-item Perceived Stress Scale (PSS-10),<sup>8,9</sup> and the Brief Resilient Coping Scale (BRCS).<sup>10</sup> The participants with higher perceived stress scores ( $\geq 14$ ) were asked to seek help from telemedicine services provided by the Department of Psychiatry through a toll-free number.

### Statistical Analysis

The data were entered and checked for accuracy. Data analysis was conducted using SYSTAT software for Windows version 13.2. Qualitative data were presented as frequency and proportions, whereas quantitative data were depicted as mean and standard deviation. Independent *t* test (Mann Whitney if normality violated) was used for comparison of 2 groups with continuous data. Statistical significance was considered as  $P < .05$ .

### RESULTS

The mean (SD) age of the respondents was 40.10 (17.54) years, with a range of 18–85 years. The sample comprised more men (58.2%) than women (41.8%). Of 153 participants, 35 (22.9%) chose not to reveal their income. The participants included 38 (24.8%) foreign travelers. Sociodemographic details of the contacts of positive COVID-19 cases and foreign travelers, which were statistically similar in both groups, are provided in Table 1.

Table 2 shows the difference in coping and stress scores among local contacts and foreign travelers. Coping scores

**Table 1. Sociodemographic Details of the Study Participants<sup>a</sup>**

Variable	Contacts	Travelers	P Value
Age, y			
≤20	20 (17.4)	3 (7.9)	.378
21–35	41 (35.7)	16 (42.1)	
36–50	21 (18.3)	5 (13.2)	
>50	33 (28.7)	14 (36.8)	
Type of family			
Nuclear	72 (62.6)	24 (63.2)	.199
Extended	4 (3.5)	4 (10.5)	
Joint	39 (33.9)	10 (26.3)	
Marital status			
Single	45 (39.1)	14 (36.8)	.921
Married	68 (59.1)	23 (60.5)	
Widowed/divorced	2 (1.8)	1 (2.6)	
Occupation			
Professional	30 (26.1)	13 (34.2)	.330
Semiprofessional	12 (10.4)	3 (7.9)	
Clerk/shop owner/farmer	7 (6.1)	2 (5.3)	
Skilled/semiskilled/unskilled	14 (12.2)	1 (2.6)	
Housewife	18 (15.7)	3 (7.9)	
Retired	9 (7.8)	6 (15.8)	
Unemployed/student	25 (21.7)	10 (26.3)	
Education			
Illiterate	3 (2.6)	1 (2.6)	.565
Primary	2 (1.7)	0	
Middle	3 (2.6)	0	
Matric	10 (8.7)	3 (7.9)	
Inter/diploma	18 (15.7)	5 (13.2)	
Graduate	54 (47)	17 (44.7)	
Postgraduate	22 (19.1)	8 (21.1)	
Professional/honors	3 (2.6)	4 (10.5)	
Income, ₹ (US \$)			
<2,554 (33.39)	13 (14.9)	5 (16.1)	.990
2,555–7,587 (33.40–99.19)	3 (3.4)	1 (3.2)	
7,588–12,646 (99.20–165.32)	6 (6.9)	1 (3.2)	
12,647–18,969 (165.34–247.98)	5 (5.7)	2 (6.4)	
18,970–24,293 (248.00–317.59)	6 (6.9)	3 (9.6)	
24,294–49,586 (317.60–648.48)	18 (9.2)	7 (22.5)	
>49,586 (648.48)	36 (41.3)	12 (38.7)	
Religion			
Hindu	86 (74.6)	25 (65.8)	.554
Islam	4 (3.5)	2 (5.3)	
Sikhism	25 (21.7)	11 (28.9)	

<sup>a</sup>Data are presented as n (%).

were significantly higher among illiterate local contacts compared to foreign travelers ( $P = .032$ ). Significantly higher stress scores were found among local contacts with a semiprofessional occupation ( $P = .041$ ), with a professional education ( $P = .022$ ), and who were Sikh by religion ( $P = .013$ ).

Coping and perceived stress scores were similar, with no statistically significant differences between local contacts and foreign travelers. There were significantly higher mean (SD) perceived stress scores among women (15.15 [5.26]) compared to men (12.32 [6.12]) ( $P = .007$ ). However, scores were similar between both sexes regarding coping ( $P = .298$ ) and the GHQ-12.

Table 3 depicts subjects regarding coping and perceived stress, with poor coping among 25.5% and high perceived stress among 2.6% of the total sample. The distribution of subjects was similar for both coping and perceived stress among contacts and foreign travelers. Regarding the GHQ-12, 106 (69.3%) had no psychological morbidity, whereas 47 (30.7%) did have psychological morbidity. The reliability

**Table 2. Difference in Coping and Stress Scores Among Contacts of Positive COVID-19 Cases and Foreign Travelers According to Sociodemographic Variables**

Variable	BRCS		PSS	
	Contacts	Travelers	Contacts	Travelers
Age, y				
≤ 20	15.55 (2.37)	15.33 (0.57)	12.80 (7.48)	10.66 (2.51)
21–35	14.87 (2.22)	15.18 (1.97)	13.53 (6.65)	15.12 (7.20)
36–50	14.71 (2.30)	14.00 (2.00)	15.23 (4.49)	15.60 (3.43)
> 50	14.66 (2.25)	14.92 (1.26)	13.27 (4.43)	10.42 (5.13)
Type of family				
Nuclear	15.13 (2.28)	15.16 (1.40)	12.68 (5.95)	12.75 (5.61)
Extended	13.75 (2.50)	15.50 (1.29)	16.00 (2.16)	16.25 (8.77)
Joint	14.58 (2.19)	14.20 (2.20)	15.17 (5.68)	12.70 (6.65)
Marital				
Single	15.35 (2.11)	15.07 (1.54)	13.55 (6.97)	15.71 (6.05)
Married	14.55 (2.32)	14.86 (1.79)	13.89 (5.03)	11.86 (5.73)
Widowed/divorced	16.50 (2.12)	15.00 (0.0)	7.00 (2.82)	5.00 (0.0)
Occupation				
Professional	14.73 (2.18)	15.30 (1.60)	12.66 (6.40)	11.23 (7.02)
Semiprofessional	14.41 (1.88)	13.33 (1.52)	16.83 (4.23)*	11.66 (2.30)*
Clerk/shop owner/farmer	14.57 (3.90)	13.00 (1.41)	11.71 (4.95)	15.50 (7.77)
Skilled/semiskilled/unskilled	14.71 (2.19)	13.00 (0.0)	15.21 (5.80)	17.00 (0.0)
Housewife	15.16 (2.06)	15.66 (1.52)	15.27 (3.89)	12.66 (0.57)
Retired	14.33 (2.06)	14.83 (0.75)	10.22 (4.02)	12.83 (5.84)
Unemployed/student	15.56 (2.31)	15.40 (1.89)	13.00 (7.08)	15.40 (6.91)
Education				
Illiterate	15.66 (0.57)*	12.00 (0.0)*	12.66 (3.51)	21.00 (0.0)
Primary	13.5 (0.71)	...	22.00 (0.0)	...
Middle	13.66 (2.88)	...	16.33 (0.57))	...
Matric	15.20 (2.34)	14.33 (0.57)	13.30 (4.27)	11.00 (1.00)
Inter/diploma	15.05 (1.89)	15.80 (0.83)	13.61 (6.33)	11.40 (2.07)
Graduate	15.05 (2.60)	14.64 (1.49)	13.38 (6.64)	15.47 (6.56)
Postgraduate	14.54 (1.84)	15.25 (1.83)	13.09 (4.72)	11.75 (6.64)
Professional/honors	14.33 (2.30)	15.75 (2.62)	16.33 (2.08)*	7.50 (4.20)*
Income, ₹ (US \$)				
< 2,554 (33.39)	15.07 (2.21)	16.60 (1.14)	17.53 (6.10)	12.80 (5.11)
2,555–7,587 (33.40–99.19)	14.33 (1.52)	14.00 (0.0)	9.33 (8.08)	14.00 (0.0)
7,588–12,646 (99.20–165.32)	15.33 (3.20)	12.00 (0.0)	12.16 (5.87)	21.00 (0.0)
12,647–18,969 (165.34–247.98)	15.00 (3.16)	14.50 (0.70)	14.40 (4.72)	11.50 (2.12)
18,970–24,293 (248.00–317.59)	14.33 (2.73)	14.66 (2.88)	16.50 (4.96)	13.00 (4.00)
24,294–49,586 (317.60–648.48)	14.38 (1.61)	15.28 (1.11)	13.05 (6.06)	13.14 (5.36)
> 49,586 (648.48)	15.25 (2.37)	15.08 (1.78)	12.88 (5.57)	9.66 (6.12)
Did not reveal income	14.78 (2.26)	14.00 (1.00)	13.39 (5.83)	18.42 (6.60)
Religion				
Hindu	14.76 (2.40)	14.76 (1.47)	13.70 (6.14)	14.80 (5.81)
Islam	15.00 (1.82)	15.50 (2.12)	16.50 (0.57)	18.50 (7.77)
Sikhism	15.36 (1.80)	15.27 (2.05)	12.96 (5.35)*	8.27 (3.71)*

\*Indicates statistical significance.

Abbreviations: BRCS = Brief Resilient Coping Scale, PSS = Perceived Stress Scale.

coefficients of the scales used were GHQ-12: 0.806, PSS-10: 0.719, and BRCS: 0.603. Thirty (39.5%) of the participants who were referred for higher perceived stress scores connected to telemedicine services.

Table 4 highlights the sociodemographic predictors of moderate/severe perceived stress among participants. Older contact subjects from joint/extended families had higher odds of perceived stress.

## DISCUSSION

Our findings show low perceived stress levels in 50.3% of the study population, closely followed by moderate stress levels in 47.1%, with only 2.6% reporting severe stress levels. Also, women had significantly higher perceived stress scores than men. In contrast, a study<sup>11</sup> from India reported that

about 80.8% of participants had severe stress levels. With the increasing number of days in quarantine, stress levels of the participants also increased.<sup>11</sup> Regarding higher stress scores, women are more likely to report stress levels as well as their physical and emotional symptoms compared to men.

The subjects had similar sociodemographic characteristics across both groups, most likely due to the common cultural factors and residence of the subjects. The international travelers were local residents who had traveled abroad for business, education, or leisure activity. Coping and perceived stress scores were similar in both groups, with significantly higher stress scores among semiprofessional subjects, which includes those pursuing social work, journalism, librarianship, teaching, and nursing. Stress levels may have increased among semiprofessionals due to mandatory quarantine and limited scope of work from home.

**Table 3. Distribution of Contacts According to BRCS and PSS Scores<sup>a</sup>**

Variable	Contacts	Travelers	P Value
BRCS			
Low	32 (27.8)	7 (18.4)	.292
Medium/moderate	59 (51.3)	25 (65.8)	
High	24 (20.9)	6 (15.8)	
PSS			
Low	52 (45.2)	25 (65.8)	.08
Medium/moderate	60 (52.2)	12 (31.6)	
High	3 (2.6)	1 (2.6)	

<sup>a</sup>Data are presented as n (%).

Abbreviations: BRCS = Brief Resilient Coping Scale, PSS = Perceived Stress Scale.

A previous study<sup>12</sup> reported that 2 of the most frequently cited issues associated with quarantine were emotional difficulties related to confinement and not getting paid due to having to missing work. During quarantine, various other stressors can be fear of infection, longer duration, inadequate supplies, frustration, and inadequate information. Also, it may be that stress present among subjects might not be due to fear of disease but to the restrictions stemming from quarantine itself. Financial loss and stigma can also cause significant stress post quarantine.<sup>13</sup> A study<sup>14</sup> from China using the Impact to Event Scale-Revised reported that 53.8% of respondents rated the psychological impact of outbreak and subsequent lockdown as a cause of moderate or severe stress.

Higher age, being a contact subject, and subjects belonging to joint/extended families were identified with increased odds of perceived stress. In an online study<sup>15</sup> with 10.8% of subjects reporting stress due to lockdown restriction, female sex, lower education level, and unmarried status were significantly associated with depression, anxiety, and stress. Stress in higher age group subjects in the present study might be explained by risk of mortality, as they often have concomitant comorbid conditions. Also, compared to nuclear families, joint family members might have difficulty quarantining due to limited space and risk of spreading infection within the whole family. Another online study<sup>16</sup> reported stress levels in 11.6% of subjects, with increased odds of stress among subjects with less family income, lower educational levels, and presence of binge drinking. The probable cause of higher stress among COVID contacts compared to international travelers is stigma regarding COVID-19 infection.

It is important for individuals to have effective coping strategies to utilize in stressful situations, as they may prevent experiences from leading to stress-related psychiatric disorders. Most of our study population had medium/moderate levels of coping skills with no significant difference among males and females. Coping measures among both sexes might include doing household chores, revisiting an old hobby, exercising, and yoga, which tend to provide a temporal escape from the perceived stressor.

In our study population, the majority had no psychological problems as assessed using the GHQ-12.

**Table 4. Binary Logistic Regression for Depiction of Predictors of Increased Stress Levels**

Variable	P Value	Odds Ratio (95% CI)
Age, y		
≤ 20 (reference)		
21–35	.031	5.24 (1.16–23.60)
36–50	.012	13.57 (1.77–103.82)
> 50	.209	3.52 (0.49–25.05)
Sex		
Male (reference)		
Female	.084	2.60 (0.88–7.68)
Occupation		
Professional (reference)	.297	
Semiprofessional	.201	2.69 (0.42–17.41)
Clerk/shop owner/farmer	.600	0.280 (0.04–1.97)
Skilled/semiskilled/unskilled	.061	1.55 (0.29–8.13)
Housewife	.832	0.13 (0.01–1.09)
Retired	.447	0.81 (0.12–5.66)
Unemployed/student	.063	0.53 (0.10–2.76)
Income, ₹ (US \$)		
< 2,554 (33.39) (reference)		
2,555–7,587 (33.40–99.19)	.299	0.21 (0.01–3.97)
7,588–12,646 (99.20–165.32)	.104	0.11 (0.009–1.56)
12,647–18,969 (165.34–247.98)	.019	0.019 (0.001–0.52)
18,970–24,293 (248.00–317.59)	.028	0.077 (0.008–0.753)
24,294–49,586 (317.60–648.48)	.007	0.055 (0.007–0.46)
> 49,586 (648.48)	.003	0.040 (0.005–0.336)
Did not reveal income	.387	0.496 (0.102–2.42)
Religion		
Hindu (reference)		
Islam	.448	2.75 (0.20–37.71)
Sikhism	.004	0.21 (0.07–0.60)
Group		
International traveler (reference)		
Local contacts of COVID cases	.011	4.02 (1.37–11.75)
Marital status		
Single/widowed/divorced (reference)		
Married	.260	2.03 (0.592–6.98)
Education		
Below graduate (reference)		
Graduate and above	.749	0.840 (0.289–2.44)
Family structure		
Nuclear (reference)		
Joint/extended	.006	3.53 (1.44–8.68)

This finding contrasts with an Indian study<sup>17</sup> that reported greater psychological distress in quarantined children and adolescents than nonquarantined children and adolescents. Among those who had psychological morbidity, the main causes for stress were being worried, feeling helpless, and fear of catching infection.<sup>17</sup>

In our view, to improve stress levels in the quarantined population, it is imperative to disseminate adequate information regarding the disease and available emergency facilities. Social media (such as Facebook, Twitter, YouTube) is a powerful tool to do so while tackling the spread of false information. Other tools include text messages providing general information regarding COVID-19 (ie, hand hygiene, wearing of masks, vaccination) and COVID-appropriate behavior designed to increase family member participation to curb stress, implementation of telemedicine services with institutions, telecasting of self-care practices via video and audio messages, and publication of educational material in newspapers.

The limitations of this study include small sample size and difficulty in conducting face-to-face surveys during



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home quarantine. Furthermore, comparison between nonquarantined/quarantined populations and mandatory/voluntary quarantine populations could have been done.

## CONCLUSION

This study revealed low to moderate stress levels perceived by the quarantined population with moderate

resilience coping skills. Women reported higher stress levels. However, most of the study population had no psychiatric disorders. There is a need to identify groups at high risk for increased levels of stress so that the issue can be addressed through public health services and individuals can be provided adequate psychological support, including reliable information, rapid communication, and general (medical) supplies.

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