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**COVID-19, Restrictions and Anxiety: A Cross-Sectional Study
of the Impact of COVID-19 and Restrictions on Generalised
Anxiety in Denmark and Sweden**

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Abstract

COVID-19 mitigation strategies have previously been argued to affect the mental health of people differently depending on sociodemographic factors. Denmark and Sweden have long used mandatory restrictions and guidelines, respectively, to curb the spread of COVID-19. This study compares generalised anxiety under Danish and Swedish mitigation strategies and the influence of suspected, vulnerable sociodemographic factors in relation to these. This contributes to an existing empirical gap of direct comparisons between Denmark and Sweden in this regard. An online cross-sectional survey covering a six-month reference period was adopted. Data was gathered using a snowball and convenience sampling of 503 respondents, 64.8% ($n = 326$) living in Denmark and 35.2% ($n = 177$) living in Sweden. Generalised anxiety scores were reported through an adjusted GAD-7 scale. Though effect sizes and mean differences tended to be small, results from Mann-Whitney U and Kruskal-Wallis tests showed that those who had lived under the Swedish mitigation strategy scored significantly higher levels of anxiety than those, who lived under the Danish strategy. Sociodemographic factors of age, gender, and occupational status had the biggest effect on anxiety across countries. While mitigation approaches certainly mattered in terms of generalised anxiety; younger age, female gender, and being a student mattered as well regardless of approach. It is argued that the Danish strategy, which combines its mandatory restrictions with a message of shared responsibility, may have been better at addressing general anxiety risks. Yet, younger, female, and student groups were vulnerable to general anxiety regardless of national context.

Keywords; COVID-19; Denmark; Sweden; Mitigation strategy; Restrictions; Generalised Anxiety; Sociodemographic factors; Terror Management Theory

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Introduction

Not long after the World Health Organisation, WHO, declared the rapid transmission of COVID-19 a global pandemic in early 2020, many countries responded by implementing various mitigation strategies to slow the spread of the disease. As the disease continues to proliferate, so does the need for mitigation. Yet, whilst severe restriction policies help slow the spread of the virus, they have long been known to also run the risk of giving rise to feelings of worry, anxiety, and panic (Chatterjee & Chauhan, 2020; Hawryluck et al., 2004). Worries of job loss, financial uncertainty, and loneliness, which might add to existing ones of health and safety already brought about by the pandemic (Blom et al., 2021; Clotworthy et al., 2021; Ding et al., 2021; González-Sanguino et al., 2020).

Though to what extent such mitigation measures affect us may depend on several sociodemographic factors or differences. Differences, such as whether you can work from home, if you live alone, if you are at risk for a more severe course if infected, can all create daily life tasking challenges in the age of COVID-19 (Ding et al., 2021; Rossi et al., 2020; Qiu et al., 2021). Particular constellations of mitigation measures might bring about vastly different changes to people's daily lives depending on these factors. In line with this, previous studies have stressed the importance of investigating the influence of public-health measures on mental health outcomes across various national and sociodemographic contexts (Clotworthy et al., 2021; Ding et al., 2021; Rossi et al., 2020). Ding et al. (2021) has shown mitigation strategies to be significant to mental health outcomes and some sociodemographic factors to be relevant across different restriction levels. Yet, studies such as this are few, and no study has yet been published which directly compares Denmark and Sweden in this regard.

Such a comparison is important because, despite their historical and cultural similarities, the two neighbours have diverged strongly in terms of COVID-19 responses. Denmark's particular approach has been described as a combination of swift lockdowns of non-essential private and public functions and restriction measures mandated by law. It has been guided by a principle of caution and has resulted in relatively low mortality and case rates, while at once also being criticised for infringing personal rights (Clotworthy et al., 2021; SST, 2020). Conversely, the Swedish approach started with what has been referred to as a more long-term sustainable strategy for the crisis (Claeson & Hanson, 2021). With only some restriction measures mandated by law and many being voluntary guidelines, this approach has allowed the Swedish population to move about

their daily lives more unhindered than their Danish counterparts for most of the pandemic. Sweden has received wide attention worldwide for this approach, but also its comparatively high number of cases and deaths (Claeson & Hanson, 2021; Olgagnier & Mogensen, 2020).

Knowing the differences and similarities in generalised, or general, anxiety between these differing approaches and sociodemographic factors may help shed further light on how to better balance the potentially adverse effects of various mitigation strategies with other public health needs, such as mental health. Using a cross-sectional design, the aim of this study is to compare the general anxiety from living under the Danish and Swedish mitigation strategies, and the relative influence of suspected vulnerable sociodemographic factors in relation to these different COVID-19 responses.

The research question for this study is threefold. First, a comparison of country-level differences in generalised anxiety between Denmark and Sweden is made. This is done to measure the general anxiety of the two different mitigation strategies, as represented by each country. Secondly, to explore relations between sociodemographic factors and generalised anxiety, we also examine which sociodemographic factors have the greatest effect size across countries. Thirdly, to understand the relative influence between different mitigation strategies and sociodemographic factors on general anxiety during the pandemic, we compare the effect sizes of the different sociodemographic factors with the effect sizes from the country comparison. Answering these questions arguably allows for a better understanding of not only if mitigation approaches influence mental health outcomes, but also which demographic groups may be particularly vulnerable to negative mental health outcomes regardless of mitigation approach. We thus pose the following three-part research question;

1. Have the different COVID-19 mitigation strategies in Sweden and Denmark resulted in significant differences in levels of general anxiety?
2. Which sociodemographic factors have had the greatest effect in terms of general anxiety, regardless of country?
3. Do individual sociodemographic factors across Denmark and Sweden affect general anxiety more than country level differences in mitigation strategy?

COVID-19 and the mitigation strategies of Denmark and Sweden

Historically and culturally, Denmark and Sweden have long had close ties and have often compared themselves. Like other Nordic countries, they are both stable democratic welfare states

with well-equipped and adaptable public sectors. Yet, as noted above, they differed altogether in COVID-19 mitigation strategies.

On average, Denmark has had a lower infection and death rate throughout the pandemic than Sweden. In the six months reference period this study covers, both countries have seen similar trajectories in terms of daily new cases per million people. Denmark has experienced an increase in daily new cases per million people of +60.45, while Sweden has experienced an increase of +511.4. Looking at the change in death rates within the same period, Denmark experienced an increase of +0.15%, a relative change of 55%, and Sweden experienced an increase of +2.12%, with a relative change of 1001% (Appendix A). This difference has been argued to be in no small part due to their differences in strategies (Claeson & Hanson, 2021).

The Swedish public health agency Folkhälsomyndigheten, FHM, approached the crisis with what was argued to be a more long-term strategy, with only a few measures mandated by law (Blom et al., 2021; Cleason & Hanson, 2021). However, in January 2021, the Swedish government passed new pandemic laws, permitting it to enforce stricter COVID-19 restriction measures previously not possible, in a similar manner to Denmark. This law came into effect in January, but the tightening of mandatory restrictions has been a gradual process over several months; introducing face masks in public spaces, greater limitations on social gatherings, and giving bars, restaurants, and shops earlier closing times (FHM, 2021). Though recent months' increases in restrictions have brought Sweden closer to the Danish level of mandatory restrictions, these restrictions have in this study's six-month reference period not been enforced to the same extent as those in Denmark. It can, therefore, be argued that despite nearing the Danish mitigation strategy in terms of stringency, Sweden may still to an extent be considered an outlier in its handling of the pandemic, though not to the same extent it was at the start of the pandemic (Blom et al., 2021; Cleason & Hanson, 2021).

In Denmark, the implementation of restriction measures and guidelines has been more fluid. The Danish public health authority Sundhedsstyrelsen, SST, and the Danish government implemented full lockdown measures at the beginning of the pandemic and have gradually loosened and tightened restrictions throughout the pandemic based on the threat of infection (SST, 2020). An approach very similar to what has been seen in other parts of the world (Ding et al., 2021). This has meant both periods of relatively few restrictions and periods of full lockdown orders. The Danish population has hence had to live under relatively more fluctuating restriction levels than Sweden, restrictions which for the most part have been mandated by law under the penalty of fines if broken.

In communicating their messages at the start of the pandemic, both Swedish and Danish authorities relied heavily on messages of trust in authorities. The Danish government and health authorities focused on the message of 'standing together - at a distance' to emphasise the need for shared responsibility in following restrictions (Olagnier & Mogensen, 2020). Swedish health authorities, on the other hand, focused rather on a message of personal responsibility in their rhetoric, that while guidelines and preventative measures were in place, it was up to the individual to follow them accordingly (Claeson & Hanson, 2021). Even with the more recent tightening of restrictions and guidelines, the notion of personal responsibility is still part of the overall messaging used by the Swedish Government (FHM, 2021). These differences in rhetoric should also be viewed in the context of how Danish and Swedish authorities have implemented and enforced their approaches. While the Danish strategy has been based on adaptation and steered by a principle of caution (Clotworthy et al., 2021; SST, 2020), the Swedish has mostly centred on stability and been guided by a principle of sustainability (FHM, 2021; McCracken et al., 2020).

Recently Clotworthy et al. (2021) examined the mental well-being of Danish adults during the first year of the pandemic. By using multiple adjusted scales, the study found that though mental well-being remained largely stable, many concerns did arise about both the health consequences of the disease as well as the economic consequences of mitigation policies. Both were understood to contribute to an increased level of worry in most of the examined sample. These results, to a certain extent, stand in contrast to Blom et al. (2021). In their study on mental health and physical activity in Sweden during the country's first and second wave, the authors found a seemingly low prevalence of generalised anxiety and depression symptoms, as well as concerns regarding employment and the economy. Only anxiety towards the health and well-being of loved ones saw a greater increase, similar to the findings of Clotworthy et al. (2021).

Research like this has called for more international comparisons between the mental health outcomes under different countries' mitigation strategies. Whilst this call has begun to be answered by studies such as Ding et al. (2021), which compared 11 countries, a growing interest has also emerged in more small-scale studies that can uncover a more nuanced difference between planfully chosen countries. While such studies are likely underway, there still exists an empirical gap in this regard, one which the present study seeks to help fill. Furthermore, to the best knowledge of the present authors, there are currently no published studies that directly seek to compare Denmark and Sweden in this respect. Given the frequent cultural comparison between the two countries, such a comparison seems apt and is undertaken in this study.

Sociodemographic factors and COVID-19 mitigation strategies

Coping with the great changes a mitigation strategy can bring about, may arguably for many people, mean adjusting to a more restricted life, making it a new 'normal'. Both the finding of Benke et al. (2020) and the stable levels of mental well-being shown by Clotworthy et al. (2021), point towards this normalisation of living under harder restrictions for extended periods. They show to a degree that even if anxiety and panic symptoms see rises during large health crises, many people may, for better or worse, adapt to the circumstances they encounter.

That being said, the list of possible fears and worries that a pandemic may bring are manifold. Whether it be globally (Benke et al., 2020; Ding et al., 2021; Qiu et al., 2020; Rossi et al., 2020) or in Denmark and Sweden (Blom et al., 2021; Clotworthy et al., 2021; McCracken et al., 2020), greater reduction of social contact, sitting at home and thinking about the pandemic and risks of infection, a decrease in perceived self-controllability, economic uncertainty; have all been noted as common sources for these fears and concerns. Lack of social and physical contact can lead to increased feelings of loneliness, isolation, and anxiety. A known protective factor against these is immediate social support (Li et al., 2021).

The relationship between sociodemographic factors, mental health, and country differences during COVID-19 was first investigated by Ding et al. (2021). By comparing effect sizes across eleven different national contexts, the study found sociodemographic factors to be of greater significance than differences between restriction approaches. While the study's findings are based on a convenience sampling and are thus difficult to generalise, it nevertheless found that across national contexts; younger age, female sex, being at risk for a more severe course, and having a history of mental illness all were significant variables to take into consideration when investigating the impact of COVID-19 and restrictions across sociodemographic factors. Other studies (Blom et al., 2021; Clotworthy et al., 2021) have also pointed towards at least increased feelings of worry and despair in the above-mentioned groups. Furthermore, there have also in student populations been measured heightened anxiety and stress symptoms during lockdowns. With educational institutions shutting down and lectures moving online, students do not meet each other in the same way as they did before. This may, for some, cause increased feelings of isolation and mental distress (Rossi et al. 2020; Sun et al., 2021).

The results from the above studies are somewhat consistent with those of Benke et al. (2020). In a similar sampling of a general adult German population, the study pointed towards additional factors such as lower educational level, being unemployed, and living alone as groups

that saw increased levels of anxiety symptoms after more severe restriction measures had been implemented. It is important to note that there was a significantly higher increase in anxiety levels in the face of immediate tightening of restriction measures, rather than living under restriction measures for extended periods. Similar to Ding et al. (2021), though, the sampling of Benke et al. (2020) was based on a convenience sampling and are thus also difficult to generalise to other contexts. It therefore seems fitting to study the differences between sociodemographic groups across a Danish and Swedish context as well.

While the topic of vulnerable sociodemographic factors has been approached by other studies, the discussion of which sociodemographic factors are especially vulnerable during this pandemic in Denmark and Sweden is still relatively open. By comparing individual factors across samples from two countries that are as culturally and historically similar as Denmark and Sweden but responded to the pandemic in such contrasting ways, the importance of sociodemographic factors compared to different mitigation strategies should arguably be assessed in a Swedish and Danish context as well, similar to what was done by Ding et al. (2021). Therefore, a further gap the present study seeks to partly fill is in the ongoing debate of which sociodemographic factors can be considered at an increased risk for negative mental health outcomes during this pandemic, even under different mitigation strategies.

General anxiety and interpreting GAD-7

General anxiety is a complex phenomenon. When referring to anxiety, what is meant is "an emotion characterized by apprehension and somatic symptoms of tension in which an individual anticipates impending danger, catastrophe, or misfortune. The body often mobilizes itself to meet the perceived threat" (Anxiety, 2021). As may be gathered from this understanding general anxiety covers a broad range of somatic and cognitive-emotional symptoms, a matter which has led to some debate of how to best represent anxiety.

The present study uses the GAD-7 scale for generalised anxiety disorder, GAD. The instrument is based on the DSM-V's criteria for GAD, with each item inquiring about specific aspects or symptoms of generalised anxiety (Spitzer et al., 2006). A GAD-7 score should therefore be considered a composite score of different items that represent the symptoms of GAD. In terms of interpreting the scale, there has been found good support for the use of either a unidimensional or one factor structure or for a two-factor structure (Beard & Björgvinsson, 2014; Rutter & Brown, 2017). In a unidimensional structure, all of the GAD-7 items are computed as a single total score.

While in a two-factor structure, items are split into two separate factors, representing the cognitive-emotional experience of GAD and the physical experience of GAD (Beard & Björgvinsson, 2014).

Where the two structures differ is in how they represent GAD. Whilst a two-factor structure allows for an interpretation of general anxiety that focuses on how the anxiety is symptomatically experienced, a unidimensional structure instead focuses on general anxiety as a whole (Beard & Björgvinsson, 2014; Rutter & Brown, 2017). Though the use of a two-factor structure certainly invites a discussion of the nature of general anxiety during the pandemic, it is beyond the central aim of this study to examine the exact symptomatic experiences of general anxiety in Denmark and Sweden during the pandemic. It is rather to examine differences in mental health outcomes between different mitigation strategies and sociodemographic factors, for this general anxiety serves as a means of comparing those outcomes.

Terror management theory

To help guide our interpretation of these results, we use theoretical concepts drawn from terror management theory, in short, TMT (Greenberg et al., 1986). TMT posits that all human beings are instinctively driven by a need for continued existence and survival (Ahmed et al. 2020), but as an inherent consequence of our refined cognitive abilities, we have an innate awareness of our mortality (Pyszczynski et al., 2020). The constant awareness of one's own mortality, knowing that death can occur at any time for any reasons you can never control or foresee, gives rise to an ever-present potential for anxiety and existential terror. The desire for eternal life and the painful thoughts of the finitude of life create an existential dilemma, which causes anxiety and terror (Florian et al., 2002). This terror is controlled by an anxiety-buffer system consisting of three elements; *cultural worldviews*, *self-esteem*, and *close interpersonal relationships*. When confronted with death or reminded of death (mortality salience), these three elements become more prominent and work as death-denying defenses. From this theoretical framework, we mainly draw the relationship between mortality salience and the three anxiety-buffers in the face of the pandemic.

Cultural worldviews are shared beliefs about reality and are essential in order to give humankind a sense of meaning and value in a world of order and purpose. They provide a standard for valued behavior and the promise of symbolic or literal immortality (Ahmed et al., 2020). During the COVID-19 pandemic, the world is full of uncertainty and unpredictability; people are losing their jobs and struggle to maintain self-esteem. Daily we are exposed to new confirmed cases and deaths, and with constant reminders to keep physically and socially distant, other people who used to buffer against anxiety in our lives suddenly pose a threat. According to TMT, all of these are

factors that affect our buffers against anxiety and make it difficult for us as humans to cope with mortality, and death that seems just around the corner. The pandemic seems ripe with reminders of mortality and uncertainty, and activates but still deter us from using our anxiety buffers.

With TMT in mind, we might expect two possible scenarios for the country comparison. On the one hand, the Danish mitigation strategy has been relatively more fluctuating and stringent from the beginning of the pandemic. Because of this, the Danish sample has arguably seen stricter control and more sudden disruptions of their daily lives and not been able to use different social relationships as anxiety-buffers to the same extent the Swedish sample might have been able to. Added to this, the sharp rhetoric of physical distancing and isolation from Danish health authorities, as well as the risk of mandatory restrictions serving as frequent reminders of COVID-19's presence and mortality, we could in this scenario expect the Danish sample to score significantly higher than the Swedish sample in generalised anxiety.

Alternatively, due to the higher daily case and death rates seen in Sweden, the threat of the virus and mortality may seem more pronounced. For this reason, the case could also be made for the Swedish sample to report a higher generalised anxiety level. Added to this, the contrast in messages of shared and personal responsibility from Danish and Swedish authorities, respectively. Shared cultural worldviews might not have been as pronounced in Sweden. Because of this, shared cultural worldviews might have served as more of an anxiety buffer for those residing in Denmark than those in Sweden. Despite the likely greater opportunity to make use of more interpersonal relationships as a buffer against this anxiety. We could, therefore in this scenario, expect the Swedish sample to report the highest anxiety scores. This is a point of contention and will be explored further in the discussion section.

Maxfield et al. (2007) used the TMT construct of mortality salience to argue that as we age, we respond to existential threats differently. With reminders of mortality increasing as we age, the exposure to the mortality of oneself and loved ones becomes more salient. Due to these more frequent reminders of mortality in the lives of older people, existential threats might not seem as new as they do for the young. In connection with the pandemic, this could mean that the presence of restrictions as reminders of uncertainty and mortality may affect the anxiety levels of younger age groups more than older ones (Ma-Kellams et al., 2020). Going by TMT, we thus expect to see a lower degree of general anxiety in the older respondents who have likely faced a greater mortality salience previously than the younger respondents. Accordingly, we would also expect to see those who have been around those particularly vulnerable to a more severe course of COVID-19 to be

more often reminded of mortality during this pandemic, and consequently score higher in generalised anxiety scores.

Added to this, the argument used in Li et al. (2021), that as we age, we tend to move from a greater number of distant personal connections to more proximate and intimate relationships. With most restriction measures and guidelines related to COVID-19 indirectly impacting physical, social interactions, such mitigation policies arguably impact the ability of younger age groups to access their usual interpersonal relationships as anxiety-buffers differently than older ones. Following this logic as well, it seems likely to expect younger age to be a significant sociodemographic factor across countries.

Method

Study design

The study was implemented by an online cross-sectional survey with a quantitative approach, using snowball and convenience sampling, which was the safest way under the ongoing pandemic and current COVID-19 related restrictions. A link to the anonymous online survey was shared via the authors' social media, Facebook and LinkedIn, encouraging contacts on these platforms to share the link. The link was also shared on social media groups for Danes living in Sweden and several groups for Swedish and international students.

The dependent variable was general anxiety under restrictions, and the independent variables were living under Danish or Swedish restrictions for the past six months and different sociodemographic factors. We wanted to provide a more detailed picture of this subject by exploring potential interactions or differences according to sociodemographic factors. The survey was kept relatively short to get as many respondents as possible to complete the survey.

Participants

The target population of the current study was a general adult population from 18-year-old and above, who had been living in either Sweden or Denmark for the last six months under restrictions. Of the 503 participants 64.8% ($n = 326$) were living in Denmark, and 35.2% ($n = 177$) were living in Sweden the last six months. Descriptive data of the sociodemographic characteristics of the participants are shown in Table 1.

Table 1.

Sociodemographic Characteristics of participants

Characteristics	<i>n</i>	% of Total
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Gender		
Female	386	76.7
Male	115	22.9
Other	2	0.4
Age Group		
18-24	69	13.6
25-34	139	27.3
35-44	113	22.2
45-54	89	17.5
55-64	54	10.6
65+	45	8.8
Highest educational level		
Elementary school	18	3.6
No schooling completed	1	0.2
Ph.D. or above	11	2.2
Post. graduate/Master's degree	150	29.8
Secondary education/High School/ vocational education	170	33.8
Undergraduate degree	153	30.4
Occupational status		
Employed	288	57.3
Employed, Not employed/looking for work	10	2.0
Employed, Retired	3	0.6
Employed, Student	19	3.8
Not employed/looking for work	37	7.4
Not employed/looking for work, Retired	1	0.2
Not employed/looking for work, Student	2	0.4
Retired	46	9.1
Student	97	19.3
Working/study from home		
No	134	32.0
Yes	285	68.0
Number in household		
1	126	25.0
2	168	33.5
3	79	15.7
4+	130	25.8
Risk group in the household		
No	389	77.3
Yes	114	22.7

Instruments and procedure

The instrument used was an online survey created via the Qualtrics survey software. Versions were created in Danish, Swedish, and English to include as many people as possible living in Sweden or Denmark, who might not have Danish or Swedish as their first language but still wish to participate in the study. Two screening questions were applied at the start of the survey to determine participant eligibility. If a respondent had not lived in Sweden or Denmark for the last six months, or if they were less than 18 years old, the participants were discontinued from the study.

The survey consisted of an introduction to the study, followed by eight sociodemographic questions and questions about personal circumstances during the pandemic. Participants were asked to answer all questions with the last six months in mind. The questions included country of residence, gender, age group, the highest level of completed education, occupational status, if one has had the opportunity to work or study from home, how many occupants have lived together in the primary household, and if anyone in the household could be considered at an increased risk for a more severe course of COVID-19 if infected (Appendix B). After the sociodemographic questions and the questions regarding personal circumstances, the participants were introduced to an adjusted version of the GAD-7. A validated instrument for measuring general anxiety with a good construct, criterion, and factorial validity, which measures symptoms that are related to nervousness, worry, and catastrophic thoughts, short temper, and physical agitation. (Spitzer et al., 2006) (Appendix C). GAD-7 consists of seven items with a high correlation score between the items ($r = 0.75-0.85$) and has a great internal consistency (Cronbach alpha = .92) and a good test-retest reliability (intraclass correlation = 0.83). The obtained Alfa level of GAD-7 from the sample was $\alpha = 0.92$.

Two adjustments were made to the scale for this study. First, in the original GAD-7, the response scale for the seven items consists of a 4-point Likert scale from 0 (*not at all*), 1 (*several days*), 2 (*more than half the days*) to 3 (*nearly every day*), we adjusted this scale to a 6-point Likert scale from 0 (*never*), 1 (*rarely*), 2 (*sometimes*), 3 (*often*), 4 (*very frequently*), to 5 (*almost always*). Second, where the original GAD-7 uses a "two-weeks" reference period, we changed the reference period to a "six-months" reference period from the publication of the survey, October 11, 2020 - April 20, 2021. The extended reference period was put in place to ensure that when respondents considered the GAD-7 items in relation to COVID-19 and related restrictions, they did so with a reference period in mind where they were more likely to have experienced Denmark's or Sweden's respective mitigation strategies. The expanded Likert scale was viewed as a necessary expansion to

complement the adjusted six months reference period since the original four points likely would not have captured the same nuance for a six-month reference period as they would for a two week one.

The description text presenting the GAD-7 was thus changed from, "Over the last two weeks, how often have you been bothered by the following problems?" (Appendix C) to "Over the last six months, how often have you experienced the following symptoms?" (Appendix B).

The GAD-7 was retrieved from PsychTests in a Danish, English, and Swedish version. The introduction, the socio- demographic questions, the questions regarding personal circumstances during the last six months, and the outro were translated into Swedish by a relative of one of the present authors, who is a native Swedish speaker. The survey was read through by someone who did not know the project's content to prevent unclear questions and content, and it was tested several times before being shared on social media. It was estimated to take approximately 3-5 minutes to complete the survey. Data were collected between April 11 and April 20, 2021.

Statistical analysis

For the analysis, we used the statistical software Jamovi. Outliers were removed, and homogeneity (Levene's) and normality checks (Shapiro-Wilk) were done, and the data was checked visually in Jamovi with QQ-plots and density histograms. Since the assumption of normality was violated ($p = <.001$) and the distributions had a positive skew, a Mann-Whitney U test was carried out to compare the Danish and the Swedish sample in GAD-7 total scores. In addition, we did Kruskal-Wallis tests and Mann-Whitney U tests to examine the differences in the sociodemographic variables and the total general anxiety score across the countries, and a DSCF pairwise comparison to find out where these significant differences were.

"Other" ($n = 2$) was removed in the analysis of the gender category. In the analysis of the highest level of education completed, "No schooling completed" ($n = 1$) was removed. In the analysis of the occupational status, "Employed/retired" ($n = 3$), "Not employed/looking for work/retired" ($n = 1$), "Not employed/looking for work/student" ($n = 2$) was also removed. These groupings were removed in the analyses since they were considered outliers because of the small sample size. The significance level was set at $\alpha = 0.05$.

Ethical consideration

Before the survey began, the respondents were informed of the study's purpose, that they could withdraw from the survey at any time, and that none of the collected data would be traceable to any individual, thus providing anonymity for any participating respondents. Informed consent

was obtained from all participants in the study, and the participants had to be at least 18 years old to participate.

To minimise the amount of sensitive data collected, general anxiety was chosen as a construct instead of more specific types of anxiety. GAD-7, which we used as an instrument for measuring general anxiety, is a part of a diagnostic procedure but not a confirmatory tool, and the items on the scale do not address more than what people may sometimes experience daily.

As a general proactive measure, we replaced the sentence in the intro text to GAD-7 with a more neutral wording and contact information to the Danish and Swedish support associations AngstTelefonen (<https://angstforeningen.dk/>) and Ångestförbundet (<https://angest.se/>) was provided at the end of the survey for advice and support in case of distress or ill health.

Results

A comparison between the sample living in Sweden and the sample living in Denmark in GAD-7 scores, the Man Whitney U test showed a significant result. Participants who have been living in Sweden for the last six months under restrictions reported a higher level of general anxiety. In general, the GAD-7 scores reported by the sample living in Sweden were a bit higher than the sample living in Denmark. Descriptive data and results are reported in Table 2.

Table 2

Differences in GAD-7 between Denmark and Sweden

	<i>M (SD)</i>			
	Denmark (N = 325)	Sweden (N =176)	Differences test- statistics	Effect-size
GAD-7	10.4 (6.68)	11.9 (7.50)	$U=25395, p =.026$	$r = .12$

In the individual sociodemographic factors, a Mann-Whitney U test showed a significant result in gender, and the Kruskal Wallis tests showed significant results in age-group and in occupational status. In the gender variable, women reported a higher level of general anxiety than men. No significant results or approaching statistical significance were found between GAD-7 scores and educational level, the number of people in the household, the opportunity to work or study from home, or having a person in the household in a risk group. In terms of effect size, age group, gender, and occupational status had the largest of the sociodemographic variables. However, age group had the largest effect size overall.

A DSCF pairwise comparison showed significant differences between several of the age groups. Still, the biggest difference was between the adult groups 18-24 and the 65+, where the 18-24 had the highest scores and 65+ had the lowest scores on GAD-7.

When it comes to occupation, the pairwise comparison showed significant results between "Employed" and "Student" and between "Retired" and "Student". In both cases, "Student" reported the highest level of general anxiety. A significant result was also found between "Not employed/looking for work" and "Retired", where "Not employed/looking for work" has the highest scores in general anxiety of the two groups. Detailed results from the pairwise comparison can be found in Appendix D. Results are reported in Table 3.

Table 3
Differences within sociodemographic groups and GAD-7

	Sub-group	<i>M(SD)</i>	Difference test-statistics	Effect size
Gender	Female ^a	11.3 (7.12)	$U = 19127, p = .024$	$r = .138$
	Male ^b	9.52 (6.44)		
Age	18-24 ^a	15.0 (6.52)	$\chi^2 (5) = 92.5, p < .001$	$\epsilon^2 = .184$
	25-34 ^b	13.5 (6.97)		
	35-44 ^c	10.7 (5.87)		
	45-54 ^{cd}	9.02 (6.48)		
	55-64 ^d	6.98 (6.30)		
	65+ ^d	6.31 (5.72)		
Education	Elementary school	9.72 (7.69)	$\chi^2 (4) = 4.05, p < .399$	$\epsilon^2 = .008$
	PhD, or above	12.6 (6.39)		
	Post-graduate/Master's degree	10.4 (6.96)		
	Secondary education/High School/Vocational education	11.4 (7.06)		
	Undergraduate degree	10.9 (6.79)		
	Employed	9.52 (6.27)		
	Employed, Not employed/Looking for work	12.4 (5.50)		

Occupational status	Employed/Student	12.1 (6.40)	$\chi^2 (5) = 64.1, p < .001$	$\epsilon^2 = .129$
	Not employed/Looking for work ^b	12.8 (7.06)		
	Retired	7.70 (6.78)		
	Student ^a	15.4 (7.04)		
Number in household	1	11.1 (6.90)	$\chi^2 (3) = 2.21, p < .530$	$\epsilon^2 = .004$
	2	11.1 (7.67)		
	3	9.76 (5.98)		
	4+	11.2 (6.76)		
Work/study from home	No	10.3 (6.49)	$U = 17372, p = .136$	$r = .090$
	Yes	11.5 (7.11)		
Risk group in household	No	10.9 (6.92)	$U = 21955, p = .873$	$r = .009$
	Yes	11.1 (7.30)		

Note. Different superscripts in the sub-group column indicate the significant difference detected in post-hoc pairwise comparison at $p < .05$. Detailed results from the pairwise comparison can be found in Appendix D.

Discussion

Since the spring of 2020, Denmark and Sweden have used various mandatory restriction measures and guidelines to curb the spread of COVID-19. From mainly mandatory restrictions as part of a strategy of adaptability and caution in Denmark to mainly voluntary guidelines as part of a strategy of stability and sustainability in Sweden. This study sought in its first research question to investigate the differences that such two COVID-19 mitigation strategies might have on the general anxiety in the two countries. In its second research question, which sociodemographic groups might see a higher negative mental health outcome during prolonged restriction measures and health emergencies such as the current pandemic was investigated. The third question asked about the relationship between sociodemographic factors across Denmark and Sweden and their respective mitigation approaches. In doing so, we have sought to fill an empirical gap of direct comparison between COVID-19 and restriction related anxiety in Denmark and Sweden, contribute to the ongoing debate about which sociodemographic groups are at an increased likelihood of having heightened general anxiety levels during COVID-19, and what the relationship between them is.

In the present sample, respondents who lived in Sweden scored only slightly higher in GAD-7 scores than those residing in Denmark. Generally, mean differences between scores and effect sizes tended to be small between country samples. This finding is comparable to previous mental health studies conducted in Danish and Swedish contexts, respectively (Blom et al., 2021; Clotworthy et al., 2021; McCracken et al., 2020). In line with previous literature on the topic (Benke et al., 2020; Ding et al., 2021; Li et al., 2021; Sun et al., 2021), we found that generally, female gender, younger age, being unemployed/looking for work, and being a student were significantly associated with a higher generalised anxiety score. Though effect sizes tended to be small, variables related to gender, age, and occupational status had a greater effect size than the country variable and other individual factors. We also tested to see whether other factors that had been previously associated with an increased anxiety level under restriction measures; lower educational level, belonging to a risk group, and living alone, could also be associated with higher levels of general anxiety, but no such association was found in the cross-country comparison.

That the Swedish sample scored higher than the Danish sample in general anxiety must be seen in the light of the last few months' surges in daily new cases in Sweden. The slight difference can be due to a number of factors. If taken into consideration the finding of Benke et al. (2020) that anxiety can rise in the face of immediate restrictions. Sweden's recent gradual increases in mandatory restrictions may be contributive to the slightly higher anxiety scores seen in the Swedish sample, compared to the Danish sample who have lived with mandatory and often fluctuating restriction measures since the beginning of the pandemic. Because of this, a more restricted daily life has likely become more part of normal everyday life in Denmark, while this normalisation has likely not taken place in Sweden yet.

Added to this the substantially greater number of daily cases and deaths found in Sweden, the reminders of mortality, and as a result, mortality salience may seem greater overall. As was argued in the introduction section, the Swedish sample may have had wider opportunities to be around different interpersonal relationships to act as anxiety-buffers, yet changes in restrictions and surges in cases and deaths during the country's third wave might have affected the generalised anxiety levels in the Swedish sample in a very immediate way, despite the availability of anxiety-buffers.

Despite the stricter restriction measures used by Danish authorities, in the light of TMT, one can argue that the Danish authorities' rhetoric has been more beneficial for mental health outcomes. It has been an attempt to balance out the anxiety that fluctuating lockdowns have given rise to, in

the absence of daily social contacts, and uncertainty concerning what is announced at the next press conference of new restrictions and the risk of financial uncertainty. The Danish rhetoric has spoken to unity (Clotworthy et al., 2021; Olganier & Mogensen, 2020) and thereby shared cultural worldviews. Although it can be argued that the Danish population has not had the same access to interpersonal relationships as their Swedish neighbours, the shared cultural worldviews in the rhetoric of Danish authorities may have acted as an activation of anxiety buffers. Buffers, which may have created a perceived social connectedness and created order in a seemingly unpredictable everyday life for those living in Denmark.

The mitigation strategies of the Swedish authorities, with fewer mandatory restrictions, and thus less uncertainty about disruptions to everyday life, and the relatively stable approach, have all created less unpredictability and the opportunity to make greater use of close interpersonal relationships outside of one's immediate household as an anxiety buffer, to a greater extent than the Danish. One can argue the Swedish strategy has been gentler in terms of mental health. The high mortality rate, on the other hand, may have fertile ground for greater perceived general anxiety. In the end, it can be argued that both the Danish and Swedish authorities had mental health in mind with their strategies, and this may explain why there have generally been small differences and low scores in general anxiety in both countries in this study.

Looking at anxiety scores of individual factors across Denmark and Sweden. In terms of differences in age groups, the biggest differences were between the youngest and oldest age groups, 18-24 and 65+. Generally, retirees and the 65+ age group scored significantly lower than other subgroups. Conversely, students and those in the age group 18-24 scored significantly higher than any subgroup. This matches the argumentation posed by TMT. With older respondents likely having been exposed to more reminders of mortality throughout their lifetime, the 65+ age group and retirees may, according to TMT, be generally more used to mortality salience, and consequently less affected by the mortality salience presented by the pandemic (Maxfield et al., 2007; Mackellams et al., 2020).

Following the logic of TMT and Lie et al. (2021), another difference between students and retirees, between the 18-24 age group and 65+ age group, may also in part stem from the socially restrictive dimensions of many mitigation policies. Consequently, disrupting the daily life of the 18-24 age group and students, who may be more reliant on interpersonal relationships outside of the household as part of their anxiety-buffer system, than older and retired groups who generally tend to focus more on intimate and close social bonds.

Notwithstanding, this is one interpretation of the results based on TMT. An interpretation that does not take into account that, as the survey was conducted online, we did not reach older age groups without an internet connection or social media accounts. This arguably slants this interpretation of the result towards older age groups who have access to social media, where they can stay well-connected even during periods of physical isolation. Those without this opportunity for distant social connectedness are arguably not able to use interpersonal relationships outside the household as anxiety buffers to the same extent. Because of these potentially lacking buffers and the particular vulnerability for severe COVID-19 outcomes, those over the age of 65 without access to social media are likely affected in terms of general anxiety in similar ways to other risk groups, as argued by Benke et al. (2020) and Ding et al. (2021). The interpretation that 65+ and retired demographics are less affected by the circumstances of the pandemic than younger groups should thus arguably not be generalised. Yet that the 18-24 age group and student demographics were in their own right affected by mitigation strategies should not be taken for granted.

Though mean differences were small, the results of this study in part confirm the results of previous studies (Benke et al., 2020; Ding et al., 2021; Qiu et al., 2020), that especially younger age groups, females, and students have tended to see more negative mental health outcomes during this pandemic than other groups tested in the present study. These groups seemingly mattered more than which country, and thereby type of restriction measures, they had lived under. What is implied here is that no matter whether a country makes use of gradual lockdowns and reopenings or a stable level of restrictions and prohibitive guidelines; younger people, females, and students are at an increased risk of negative mental health outcomes, like feelings of anxiety, worry, and fear. Thus, emphasising the necessity to target especially younger and student populations in mental health efforts during not only the current pandemic but in future health crises as well that create similar challenges. This argumentation is in line with that of Ding et al. (2021) that country-level differences in restriction levels can, in the face of certain sociodemographic factors, seem relatively less powerful. What the present study has added to this ongoing debate is an indication that while mitigation strategy certainly matters, especially when discussing relatively different ones as the Swedish and Danish approaches, individual factors such as gender, age, and occupational status may go beyond national contexts.

Limitations and areas for future research

The present results should be viewed in hue of the following limitations. While other studies (Benke et al., 2020; Clotworthy et al., 2021; Ding et al., 2021; Sun et al., 2021) found that the

individual factors; being part of or knowing someone in a risk group and living alone to be significant factors in terms of anxiety during the pandemic, the present study did not. This may be due to a number of reasons. The items in the survey used to represent these two factors, "number of people in household" and "risk group in household", did arguably not cover all possible facets of these factors. While the number of people in a household does report whether a respondent lived alone or not during the six-month reference period, it does not touch upon other possible social connections a respondent might have benefitted from outside the household. For the "risk group in household" item, while this item did serve to capture both whether a respondent was or is in a risk group, and if they have had a risk group close by in their immediate household, it did not account for respondents having loved ones in risk groups outside of the household. A future study covering the same area as the present one should accommodate these two shortcomings by posing questions that also ask about respondents' social connectedness to others outside of their primary household.

In the survey item concerning occupational status, allowing respondents to choose multiple groupings may have resulted in a lower internal validity for that item. Though this item was shaped as such to allow respondents to more readily account for their varied circumstances through the six-month reference period, the item has also resulted in groupings too ambiguous to interpret in comparison to other groupings within that same individual item.

Furthermore, with a generally young sample, a far larger number of females, and a greater number of respondents living in Denmark, the data gathered for this study had a positive skew, meaning a lack of normally distributed data. Though this may partly be considered a consequence of the sampling method, the study has sought to adjust for this by using nonparametric models in the statistical analysis of data. Using nonparametric models for part of our analysis may have heightened the chance of Type 2 error in our analysis.

No baseline anxiety score was measured prior to the onset of the pandemic and the introduction of various restrictions and prohibitive measures. Consequently, the anxiety scores gathered in the present study may not only reflect anxiety related to COVID-19 and restrictions, but simply indicate a difference in the general tendency towards feelings of anxiety in the individual respondents. Additionally, while the reason for asking people to think back to the COVID-19 related restrictions they might have experienced over the past six months, for the adjusted GAD-7 scale, was to have respondents consider the various mitigation measures used by Denmark and Sweden, it also made the study vulnerable to a response bias in the form of recall bias.

The sample for the survey was drawn by convenience and snowball sampling, making generalisations based on the sample difficult and thus lowering the study's external validity. Added to this concern of lower validity is the use of an adjusted GAD-7 scale. While extending the number of possible values in the response scale was deemed necessary to better accommodate the extended reference period the survey encompassed, this arguably changed the documented validity of the scale to a certain extent as well. Nevertheless, the relatively large sample size of 503 respondents arguably does allow these results at the very least to point towards some differences in general anxiety between Denmark and Sweden and different sociodemographic factors.

As noted earlier, the use of a one-factor interpretation of GAD-7 scores was preferable for the present study as the central issue that was sought to be addressed were differences in general anxiety between Denmark and Sweden and across sociodemographic groups. Nevertheless, while this may be the case for this study, the use of a two-factor interpretation does present itself as a good area for future research on the topic. In a study with a more specific focus on how anxiety is symptomatically experienced during epidemics, a two-factor structure may bring different insights than are implied in a unidimensional structure. For such a study, a two-factor structure of the GAD-7 scale, where symptoms are divided into physical and cognitive-emotional symptoms (Beard & Björgvinsson, 2014), may contribute to a better understanding of how anxiety is experienced under different public health emergency responses, by telling which specific aspects of GAD symptoms are most prominently experienced (Beard & Björgvinsson, 2014; Rutter & Brown, 2017). This could at least in a theoretical sense further expand upon the empirical gap of direct comparisons between the mental health outcomes under the Danish and Swedish mitigation strategies, which this study has sought to partly fill.

Concluding remarks

In this study, we compared differences in general anxiety after having lived under, respectively, the Danish and Swedish mitigation strategies for the past six months. We examined these differences in general anxiety in light of sociodemographic factors across both countries. The two levels of analyses were done to explore and discuss the relationship between two different ways of handling the COVID-19 pandemic with sociodemographic factors, which have previously been suspected of having an increased risk of negative mental health outcomes under different restriction measures. While country differences in generalised anxiety scores were small, it does seem that a messaging which seeks to address the uncertainty that the pandemic brings has been a beneficial choice for mental health. In Denmark, this was a message of not only connectedness despite

physical distance but of cohesion in the middle of uncertainty, a matter which the Swedish approach arguably did not address to the same extent. Conversely, based on different sociodemographic factors, this study has also pointed towards groups that are affected beyond national contexts. Young, female, and student groups were found to be at risk of general anxiety regardless of the mitigation strategy they lived under. The present study could not determine whether this is a general tendency towards anxious feelings of individual respondents in the sample or a reaction to the widespread uncertainties and unpredictability the pandemic brings regardless of mitigation strategy. Nevertheless, it seems prudent to keep these groups in mind when balancing the adverse effects of restriction measures with other public health needs, such as mental health.

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Appendix A.

Daily new confirmed cases and deaths per million people

Daily new confirmed COVID-19 cases per million people

Shown is the rolling 7-day average. The number of confirmed cases is lower than the number of actual cases; the main reason for that is limited testing.



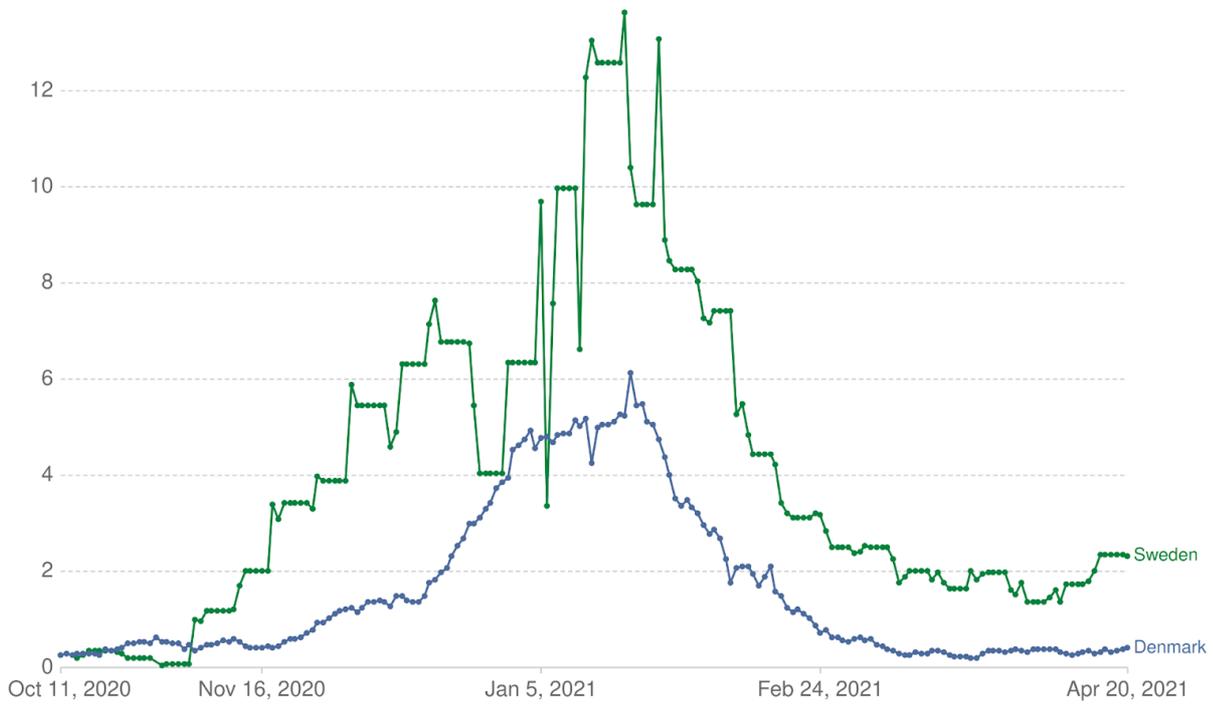
Source: Johns Hopkins University CSSE COVID-19 Data

CC BY

(Our World in Data. Daily new confirmed cases per million people)

Daily new confirmed COVID-19 deaths per million people

Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.



Source: Johns Hopkins University CSSE COVID-19 Data

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(Our World in Data. Daily new confirmed deaths per million people)

Appendix B.

Survey

Welcome!

This survey is part of a bachelor's project at Lund University.

The COVID-19 pandemic and the restrictions imposed to contain it has impacted the lives of us all in different ways. In this survey, we are interested in the connection between general anxiety levels, and COVID-19 restrictions.

You will be presented with questions that ask you to describe yourself and how you have felt through the past 6 months under your country's imposed restrictions. Please be assured that your responses will be kept completely confidential and cannot be traced back to any individual.

To participate in this study, you must be at least 18 years of age and have lived in Denmark or Sweden for the last six months.

The survey should take you around 3-5 minutes to complete. Your participation in this research is voluntary. You have the right to withdraw at any point during the survey for any reason.

If you have any questions about the project or survey, please e-mail us; Matt Erritsø Cottrell (ma5452co-s@student.lu.se), Sara Bach Christensen (sa5772ch-s@student.lu.se), or our project supervisor Yunhwan Kim (yunhwan.kim@psy.lu.se)

By pressing the button below, you acknowledge that your participation in the study is voluntary, you are at least 18 years of age, and that you are aware that you may choose to terminate your participation in the study at any time and for any reason.

I consent, begin the study

Please select country and age group.

Which country have you lived in for the past 6 months?

- Denmark
- Sweden
- Other country/countries

Age group

- Younger than 18
- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65+

Thank you for your interest in our survey!

However, in order to participate in this survey, one must both be over the age of 18 and have lived in either Denmark or Sweden during the past 6 months.

In order to better understand the differences in personal circumstances during the pandemic, we would like to ask you a few questions about you and your circumstances during the 6 months of the pandemic.

Please answer the following questions in the way that best describe you and your circumstances during the past 6 months of the pandemic.

Gender

- Male
- Female
- Other

What is your highest level of completed education?

- No schooling completed

- Elementary school
- Secondary education/High School/Vocational education
- Undergraduate degree
- Post-graduate/Master's degree
- PhD, or above

Which of the following categories best describes your occupational status during the last 6 months?

(Multiple answers are allowed)

- Employed
- Not employed/Looking for work
- Retired
- Student

Have you been able to work/study from home?

- Yes
- No

How many occupants have lived together in your primary household during the past 6 months, yourself included?

3. Worrying too much about different things

4. Trouble relaxing

5. Being so restless that it is hard to sit still

6. Becoming easily annoyed or irritable

7. Feeling afraid as if something awful might happen

Thank you for your participation in this study!

If you experience any distress or ill health, we would like to let you know that help is just around the corner. Please feel free to contact AngstTelefonen +45 70 27 13 20 (if in Denmark), or Ångestförbundet +46 031-13 70 91 (if in Sweden) for advice and support.

This survey was conducted by two bachelor students at Lund University and has no connection with the above support organisations.

Please press continue to end the survey.

Appendix C.

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Not being able to stop or control worrying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Worrying too much about different things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Trouble relaxing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Being so restless that it is hard to sit still	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Becoming easily annoyed or irritable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. Feeling afraid as if something awful might happen



Appendix D.

Pairwise comparisons

Pairwise comparisons – GAD-7 Age groups

		<i>W</i>	<i>p</i>
18-24	25-34	-2.299	0.582
18-24	35-44	-6.170	< .001
18-24	45-54	-8.043	< .001
18-24	55-64	-8.484	< .001
18-24	65+	-8.958	< .001
25-34	35-44	-4.382	0.024
25-34	45-54	-7.077	< .001
25-34	55-64	-8.086	< .001
25-34	65+	-8.417	< .001
35-44	45-54	-3.423	0.149
35-44	55-64	-5.508	0.001
35-44	65+	-6.128	< .001
45-54	55-64	-2.904	0.312
45-54	65+	-3.519	0.128
55-64	65+	-0.544	0.999

Pairwise comparisons – GAD-7 Educational level

		<i>W</i>	<i>p</i>
Elementary school	PhD, or above	2.165	0.542
Elementary school	Post-graduate/Master's degree	0.911	0.968
Elementary school	Secondary education/High School/Vocational education	1.838	0.692
Elementary school	Undergraduate degree	1.426	0.852
PhD, or above	Post-graduate/Master's degree	- 1.788	0.713
PhD, or above	Secondary education/High School/Vocational education	- 1.207	0.914
PhD, or above	Undergraduate degree	- 1.499	0.827
Post-graduate/Master's degree	Secondary education/High School/Vocational education	1.860	0.682
Post-graduate/Master's degree	Undergraduate degree	1.094	0.938
Secondary education/High School/Vocational education	Undergraduate degree	- 0.743	0.985

Pairwise comparisons – GAD-7 Occupational status

		<i>W</i>	<i>p</i>
Employed	Employed,Not employed/Looking for work	2.194	0.631
Employed	Employed,Student	2.528	0.474
Employed	Not employed/Looking for work	3.719	0.090
Employed	Retired	-3.107	0.239
Employed	Student	9.836	< .001
Employed,Not employed/Looking for work	Employed,Student	-0.685	0.997
Employed,Not employed/Looking for work	Not employed/Looking for work	0.000	1.000
Employed,Not employed/Looking for work	Retired	-3.409	0.153
Employed,Not employed/Looking for work	Student	1.796	0.802
Employed,Student	Not employed/Looking for work	0.380	1.000
Employed,Student	Retired	-3.802	0.078
Employed,Student	Student	2.472	0.500
Not employed/Looking for work	Retired	-4.819	0.009
Not employed/Looking for work	Student	2.628	0.428
Retired	Student	8.289	< .001

Pairwise comparisons – GAD-7 number in household

		<i>W</i>	<i>p</i>
1	2	-0.5741	0.977
1	3	-1.8963	0.537
1	4+	-0.0956	1.000
2	3	-1.3949	0.757
2	4+	0.5950	0.975
3	4+	1.9558	0.510