

Original Research Article

The acceptability of a self-guided psychological intervention for patients with COVID-19 in isolation and quarantine

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ABSTRACT

Background: A significant number of patients not requiring intensive care would experience psychological symptoms and distress. This may necessitate mental health care services which may not be feasible given the number of patients involved and paucity of mental health care workers. An innovative solution for such a scenario may be in the form of a self-guided psychological intervention. The aim of the study was to test the acceptability of a brief self-guided psychological intervention for patients in quarantine and isolation with COVID-19.

Methods: The authors developed a brief, self-guided psychological intervention handout targeted towards reducing psychological distress and enhancing the coping of patients in quarantine and isolation due to COVID-19. This was developed concurrently in English, Hindi and Punjabi languages. This was administered to 60 patients. Assessments were done at baseline and at two weeks.

Results: Assessments were completed in 51 patients (21 isolated and 30 quarantined). A majority of the patients in both groups found the intervention to be appropriate in form and content, relevant to the situation, had a positive emotional impact on them, enhanced their understanding of the situation and was perceived as being useful overall. The intervention was found to be highly acceptable.

Conclusions: The study demonstrates the acceptability and feasibility of using this intervention in patients in isolation and quarantine due to COVID-19. The intervention lends itself to ease of use and can be scaled up at little cost.

Keywords: COVID-19, Self-guided psychological intervention, Psychological distress, Coping, Isolation, Quarantine

INTRODUCTION

The COVID-19 pandemic has affected millions of people around the world. The cornerstone of management of pandemic is based on isolation and quarantine of affected individuals, the cornerstone of management of the pandemic is based on the isolation and quarantine of affected individuals.¹ Isolation is done to prevent the spread of infection by people with confirmed infection to unaffected individuals and quarantine aims to restrict the movement of people who have been exposed to infection to see if they develop the illness. The setting of isolation

and quarantine can be institutional or at home. Different countries and regions have their own protocols depending on various factors. In the initial stages of the pandemic in India, quarantine and isolation were institutional in especially designated COVID hospitals. The initial stage of the pandemic was also characterized by misinformation and panic in the population regarding the nature and outcome of the illness.² Based on current evidence, the psychiatric symptoms associated with acute COVID-19 are likely to be similar to other coronavirus infections. It is expected that there would be a high prevalence of acute psychological symptoms in patients with COVID-19 (who do not require intensive care) and severe mental illness

would be uncommon.³ This is similar to our clinical experience as well. These are different from the psychological aftermath of the illness which may require specialised interventions such as delayed specific neuropsychiatric sequelae of COVID-19 that are as yet not well recognised.⁴ Patients with more intensive needs (due to severity of COVID-19 or psychological symptoms) are likely to be uncommon and may need more specialised care and are also not a subject of this paper. In addition, patients in quarantine (with unconfirmed infection) may also suffer from psychological distress.⁵

In ideal circumstances, mental health services for patients in COVID-19 care settings should be administered by Mental health professionals (MHP). However, there are logistical issues to this approach. Firstly, there is a paucity of trained MHP in many parts of the country. Secondly there are difficulties in direct contact of MHP with patients suffering from COVID-19. Patient selection may be difficult in the absence of triaging and screening and there is also scarcity of personal protective equipment. Finally, the number of patients may be large enough to overwhelm any mental health care team.

Thus, there is a need to develop interventions for psychological distress in patients with acute COVID-19.⁶ Such an intervention should be useful for a majority of patients having psychological symptoms associated with COVID-19 and also bypass the need for direct contact with MHP. In addition, such an intervention would also need to be safe, culturally sensitive, easy to understand and be acceptable to patients, scalable, and finally be easily administered and cost-effective.

A self-help intervention would be a useful method of bypassing the limitations that are mentioned above. Self-help interventions have been based on a variety of theoretical constructs, used in a variety of populations and administered via a variety of methods.⁷ Self-help interventions can be guided in that the client receives support or coaching by a therapist or they can be self-guided in which the intervention does not require a therapist.⁸

The aim of the study was to test the acceptability and perceived usefulness of a non-guided self-help intervention in patients with COVID-19.

METHODS

This study was carried out in a multi-specialty tertiary teaching hospital in North India. A separate wing of the hospital has been designated a COVID hospital for the district and the participants were recruited from the patients admitted in this facility. A few patients were recruited from home-based quarantine as well.

The protocol was approved by the institutional review board. This was a non-funded study. The following procedure was followed. The first step was the

development of the intervention. We decided that the most practical way of administering the intervention would be through reading material that patients could refer to and practice. The reading material had to be brief, easily readable and portable. We also wanted it to be available in the commonly used languages in this region. Using the inputs of all the authors (based on their experience of working with patients diagnosed with or suspected of suffering from COVID-19) and a review of the literature, we developed two initial drafts, one each for quarantine and isolation. We followed an eclectic approach and incorporated components that the authors agreed would be most useful and an existing resource⁹.

The drafts included the following headings. The content was formatted in the form of bullet points for ease of reading and assimilation. There were some differences in content with relation to isolation and quarantine (Table 1)- (a) face COVID-19 with facts not fear-information about COVID-19 disease. This was done to counter the misinformation that we encountered commonly in patients; (b) why are you in isolation/quarantine- explanation regarding the reason for isolation/quarantine. This was primarily based on existing literature; (c) anticipate your emotional reactions, handle it better- information about the potential emotional issues that may emerge during the period of stay and how to handle them. This was based on instilling hope and emphasizing the transitory nature of the psychological symptoms; (d) what you can do to help?- this was based on practical tips dealing with how patients could help themselves and also the treating team, thus raising their self-esteem and also giving rise to feelings of altruism; (e) if you are feeling stressed, you can practice the breathing exercise steps as given below- a procedure of brief self-guided breathing exercise to be done twice a day, every day; and (f) there was also an option of getting in touch with comments and queries through e-mail/Whatsapp/call.⁵

These drafts were concurrently written in English, Hindi and Punjabi (in Gurmukhi script) languages using Microsoft word software. We designed the material so as to fit on opposite sides of an A4 sized sheet of paper (in font size 11). This would enable easy printing and dissemination. These drafts through a process of editing and proofreading for accuracy, weeding out of errors and syntax. At each step, we also made corrections in each of the versions.

We also asked colleagues familiar with all languages to read the versions for equivalence. Their suggestions were also incorporated. We piloted these documents in volunteers drawn from the non-medical staff drawn from the department for comments regarding understandability and flow. The suggestions were incorporated. We thus generated 6 documents in form of handouts (3 each in English, Hindi and Punjabi for isolation and quarantine respectively). The Flesch-Kincaid reading level for the english version was 7th grade (11-13 years). We also made electronic copies of the documents in the form of

slideshows saved as portable document format that could be sent electronically through a messaging app (Whatsapp). Participants were drawn from the patients admitted in quarantine and isolation wards of the COVID hospital. The inclusion criteria for intake into the study were that the participants had to be at least 18 years of age, were isolated or quarantined in context of COVID-19, able to give informed consent, able to read Hindi/ English/ Punjabi, medically stable (i.e.; able to communicate on phone without any discomfort), have access to a smartphone with Whatsapp application to receive the digital version of the intervention if needed. 60 consecutive patients fulfilling the inclusion criteria were provided the self-administered psychological first-aid tool depending upon their COVID-19 status and language preference by their primary treating team. Patients were contacted via a mobile phone by the research team. Baseline assessments included socio-demographic details and cross-sectional patient perceived measurement of holistic distress (distress thermometer) on a scale of 0-100 (where 0 signified no distress and 100 signified maximum distress) within a few hours of the document being provided to them. The

patients were assessed at the end of 2 weeks at which point we enquired about the acceptability of the intervention and patient perceived cross-sectional assessment of distress as explained earlier. The questions asked regarding the acceptability of the intervention were based on a validated resource which has subsequently been used successfully in other settings.^{10,11} The questions regarding acceptability of the intervention material included inquiries with regards to its form and content, relevance to their situation, perceived improvement in their understanding as a result of the intervention, and the perceived emotional impact of the intervention. As the assessments were being carried out on phone, we eschewed the use of Likert type scoring in favor of simple yes/no responses. We also recorded (in written form) some relevant comments that were made by the patients regarding the intervention material (how it had helped) and also how it could be improved. We also asked the respondents to score the intervention material from 0-100 (completely useless to highly useful). Assessments were included for analysis only if participants had been assessed on both occasions.

Table 1: Examples of content included in the intervention (isolation version and quarantine version).

Headings	Examples of content
Face COVID-19 with facts not fear	COVID-19 is a pandemic and is caused by the SARS-CoV-2 virus
	COVID-19 spreads when you cough or sneeze close to someone, touch a contaminated surface and then touch your mouth, nose or eyes with those contaminated fingers
Why are you in isolation	You have been diagnosed with COVID-19 and may be symptomatic
	You are in isolation, to prevent you from encountering others who may get infected in turn by you and so that your clinical state can be monitored closely
	Your treating doctor can tell you how long this admission may last
Why are you in quarantine	You are suspected to have been exposed to Coronavirus and may be infected but asymptomatic
	You may in this state inadvertently pass on this infection to others
	You are in quarantine to prevent you from encountering others who may get infected in turn by you
	Your treating doctor can tell you how long this admission may last, however you will in all probability need to be tested to confirm that you are not infected
Anticipate your emotional reactions, handle it better (isolation)	Isolation entails mandatory admission in a ward specially designed to take care of you. However, it also means that you will have to be separated from your family and friends until you are ready to be discharged
	Separation and isolation, adverse emotional reactions combined with ill-health can be detrimental to your psychological and physical well being
Anticipate your emotional reactions, handle it better (quarantine)	Quarantine entails mandatory admission in a ward specially designed to take care of you. However, it also means that you will have to be separated from your family and friends until you are ready to be discharged
	You are doing a great service to your community and loved ones by being in quarantine and playing an important role in the prevention of further infections. Thank you!!
	Cooperate with your doctors/ staff, they are all trying their best to help you
What you can do to help	Eat healthy
	Sleep adequately (7-8 hours)
	Drink plenty of fluids
	Maintain personal hygiene, wash your hands with soap and water frequently. Keep in touch with family at regular intervals but avoid excessive use of social media
If you are feeling stressed, you can practice the	Sit comfortably, with your eyes closed and back reasonably straight
	Bring your attention to your breathing
	Put your hand on your abdomen and feel it rising with each in-breath and falling with each out-breath

Continued.

Headings	Examples of content
breathing exercise steps as given below	

RESULTS

51 patients completed all assessments and were included in the study. Out of these, 21 patients were in isolation and 30 patients were quarantined. The mean duration of isolation and quarantine at first assessment was 4.28 days (SD=2.68) and 5.66 days (SD=1.91) respectively. The mode (most common day of assessment) was 2nd day for isolation (N=8, 38.09%) and 4th day for the quarantine group (N=13, 43.33%). The second assessment was completed before discharge of the patients or end of quarantine. There were no statistically significant differences across different groups on basis of isolation versus quarantine or gender. Table 2 presents the sociodemographic details of the patients in the isolation and quarantine groups. The two groups were not statistically different on measured parameters. Table 3 presents the responses of the patients towards their assessment of the acceptability and utility of the intervention at two weeks after initial assessment. 1 patient each in isolation and quarantine group (4.76% and 3.33% respectively) thought that the font size could have been smaller while 2 patients each thought that the font size could have been bigger (9.52% and 6.66% respectively). 2 patients each in isolation and quarantine groups thought that the length of the intervention material could have been shorter (9.52% and 6.66% respectively).

Participants thought that addition of pictures (N=19; 37.25%), motivational quotes (N=2; 3.92%) and religious quotes (N=1; 1.96%) might make the intervention material more useful.

In addition to the above, the most common factors perceived to be most helpful by the patients were as follows. Clear-cut information from a legitimate source in a formal written medium was appreciated as being most helpful and reassuring. This was especially so as most patients were alone and did not have any communication with the doctors or staff. Their phones enabled them to be in contact with their families.

Following their admission, once patients realized that they were not worsening, and in fact had mild to no symptoms combined with information about the course and prognosis was reassuring. Some patients also appreciated the information about the course and transitory nature of most psychological symptoms. Most patients were able to carry out the activities in the section titles 'what you can do to help'. Many patients also appreciated the relaxation exercises and found their practice useful.

Finally, the mean self-perceived distress score at the follow-up assessment was reported as 0 in both groups.

Table 2: Socio-demographic details of the isolation group and the quarantine group.

Socio-demographic parameters	Isolation group (N=21)	Quarantine group (N=30)
Mean age in years (SD)	36.23 (13.35)	34.03 (7.07)
Mean years of education (SD)	12.52 (5.36)	13.06 (2.86)
Mean distress score at intake (0-100) (SD)	16.16 (23.44)	7.23 (13.79)
Females [N (%)]	9 (42.85)	17 (54.83)
Married [N (%)]	14 (66.77)	24 (80)
Nuclear family [N (%)]	7 (33.33)	17 (56.66)
Earning member of family [N (%)]	12 (57.14)	28 (93.33)

Table 3: Acceptability and utility of the intervention material.

Variables	Isolation group (N=21)	Quarantine group (N=30)
	Yes responses [N (%)]	Yes responses [N (%)]
Form and content of the intervention material		
Did you read all of it	21 (100)	30 (100)
Was it easy to read	21 (100)	30 (100)
Was it easy to understand	21 (100)	30 (100)
Was the colour scheme appropriate	21 (100)	30 (100)
Was the font size appropriate	18 (85.71)	27 (90)
Was the length of the material appropriate	19 (90.50)	28 (93.30)
Was the intervention material relevant to the situation in your opinion	21 (100)	30 (100)
Did the intervention material make a positive emotional impact on you	20 (95.23)	28 (93.33)

Continued.

Variables	Isolation group (N=21)	Quarantine group (N=30)
	Yes responses [N (%)]	Yes responses [N (%)]
Did the intervention material help in improving your overall understanding of the situation around you	21 (100)	30 (100)
Mean usefulness score (0-100) (SD)	76.42 (23.98)	78.00 (26.96)

DISCUSSION

The COVID-19 pandemic is a global challenge. It has affected the psychological health of the general population, people with the infection and in all likelihood will have long term consequences as well.¹² Each of these populations would require dedicated methods of countering the ill effects of COVID-19. In this study we describe the acceptability of a non-guided, self-help psychological intervention for patients in isolation and quarantine with COVID-19 who do not require intensive care.

The number of people with confirmed or suspected COVID-19 are likely to increase with time in many parts of the world. Epidemiological studies show that most patients with COVID-19 remain asymptomatic or have mild symptoms and do not require intensive care.¹³ However, most countries around the world advocate institutional or home base isolation and quarantine for confirmed and suspected cases with COVID-19. It is also likely that this group would suffer disproportionately with various transitory but significant and distressing psychological symptoms.³ With the overwhelming of health care systems, it is more than likely that mental health services may be relegated to a lower priority. Many hospitals or facilities may not have mental health professionals. There are also logistical and safety issues in the accessibility of patients to mental health professionals. Psychological therapies are focussed towards single diagnoses rather than general psychological distress as is likely to be encountered in this patient group.¹⁴ Thus, there is a need for innovative solutions to this impasse.

Self-guided interventions can be an innovative method of bridging the gap in this population. Self-guided interventions have been used effectively for many indications, in a variety of settings, employing various modalities and based on different conceptual frameworks.^{8,15} However, while there has been some attempt made to enable people in the general population and the health care providers to help themselves cope with the psychological impact of COVID-19, this is not the case with patients suffering from COVID-19.^{9,16} Self-guided psychological interventions have been found to be modestly effective for depressive symptoms.¹⁷ They have also been effectively administered via the internet.¹⁸ As reviewed recently, quarantine and isolation are stressful experiences and factors such as longer quarantine duration, infection fears, frustration, boredom, inadequate supplies, inadequate information, financial loss, and stigma have a deleterious effect on patients.⁵ It has also been suggested that patients in quarantine and isolation be informed about

their status, provided clear rationale for protocols and procedures, and appeals to altruism are made.⁵

Keeping all the above factors in mind, we developed a brief, multi-lingual, eclectically based intervention material in printed format to enable patients with or suspected to be suffering from COVID-19 in isolation and quarantine respectively to cope with their psychological distress. The authors in the study involved in the development of the intervention are involved in the day-to-day care of patients in the COVID hospital where this study was carried out and are experienced in the issues and concerns of these patients. The version of the intervention that was used in this study involved many rounds of discussion and consensus.

The development of the intervention was guided by the following considerations. The intervention had to be relevant to the situation and the consumer. All the authors agreed that the intervention material accurately reflected the major concerns of a typical patient in the COVID hospital and that the intervention was relevant to the same. The second consideration was that of the ease of the intervention. A conscious decision to keep jargon to the minimum and use simple sentences was made. Thus, we used bullet points instead of paragraphs and used simple language. A special emphasis on ease of readability was kept at all stages. We tried not to delve too deeply into psychological concepts but keep the content of the intervention more instructional and at the same time keep the option open for a consumer to find more personal meaning in case required. We also developed the language versions concurrently rather than translating an original copy for this reason. A major concern was the cost, ease of distribution and the scalability of the intervention. Thus, the choice to have the intervention printed on both sides of a single sheet of paper was made. A sheet of paper can be given as a hand-out as a part of the intake of any patient into a healthcare facility or a COVID hospital. A sheet of paper is portable, can be carried out in a pocket, can be referred to at any time and is thus handier than a book or a pamphlet. Also, many copies can be made using a printer or a photocopier in a short duration of time. It can be transmitted electronically with ease. We also developed an electronic version for transmission via messaging apps in smartphones.

The patients included in the study were asymptomatic or mildly symptomatic and did not require intensive care. As indicated by the distress score, they had psychological symptoms but by the time of the second assessment these had resolved. Thus, the participants are representative of the intended consumers for this intervention.

The results of our study indicate that the participants in the study found the intervention to be acceptable across both the groups. With regards to the form and content of the intervention, the following results were noted. All of the participants were able to read all of the material, found it easy to read and understand and aesthetically pleasing. Most participants found the font size and length of the material to be appropriate. Similar results were had for the patient perception of the relevance of the material, positive emotional impact, understanding and usefulness.

The limitations of the study were as follows- we did not attempt at this stage to formally validate the intervention material. We also did not make any formal pre and post assessments of knowledge, attitude and practice with regards to COVID-19 or indeed the intervention material in the participants. We also did not make detailed evaluations of the different sections of the intervention.

CONCLUSION

We believe that the results indicate that the intervention material was well received and was considered acceptable by the participants. This could be attributed to the form and content of the intervention material. The results indicate that at the time this study was carried out, most participants needed easy to understand information from legitimate sources instead of misinformation on social media. Many participants were reassured by the legitimacy of the information regarding the course and prognosis of the illness. The importance of countering misinformation in the COVID-19 pandemic has been stressed time and again.¹⁹ While simple misinformation regarding the facts of COVID-19 may be easier to tackle (as in this case), misinformation and conspiracy theories may be more difficult and require more specialised culture specific interventions.²⁰ Another important attribute was the readability of the intervention. We made our material so that it would be easily understandable to a functionally literate person with at least primary schooling (upto 8 years of education). Thus, it would be understandable and readable by a majority of patients as indicated by their mean years of education. The use of simple language makes it more likely for a written resource to be read and understood by the reader.²¹ Another important aspect was the avoidance of technical terms and jargon as far as possible. This enabled the intervention material to be more readable.²² Many participants made suggestions. Some suggested the incorporation of religious or quotes from scriptures which we avoided to keep the document as neutral and as acceptable as possible. Motivational quotes were also not incorporated keeping in mind that finding a quote that is acceptable to everyone may be difficult. Pictures and illustrations were not included keeping in mind the space constraints.

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