Until the dawn: everyday experiences of people living with COVID-19 during the pandemic in Thailand [version 1; peer review: awaiting peer review]

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Abstract
Background: This study aims to understand and analyze the complex experiences of people living with COVID-19 to support future cases.
Methods: Purposive and snowball sampling techniques were employed to collect data through in-depth interviews; the data were combined with non-aggregated behavioral observations. Lived experiences of 15 individuals were collected through semi-structured interviews and analyzed using a phenomenological-hermeneutic approach. We used the thematic analysis technique to analyze the data.
Results: Through analysis, themes of stress, economic impact, social stigma, social support, and unexpected benefits were identified. Participants further expressed economic and social concerns during the interviews.
Conclusion: The identified themes can help develop multidisciplinary treatment strategies that would be useful during a healthcare crisis, establish comprehensive support systems that could address economic and social problems, and provide training for employees for post-COVID-19 assistance.

Keywords
COVID-19, Mental health, lived experiences, phenomenological-hermeneutic approach, stress, economic impact, social stigma, social support, multidisciplinary treatment strategies, multidisciplinary treatment teams
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Introduction

Over 219 million cases of COVID-19 were reported globally until October 10, 2021. With 4.55 million fatalities and threats of new variants, the virus continues to evolve. To control COVID-19 outbreaks, governments and health experts worldwide have been experimenting with various vaccines, treatment modalities, new measures, and preventative strategies within a short timeframe. Lockdowns and lenient curbs have caused turmoil worldwide since the beginning of the pandemic. People have been trying to use several new coping strategies to deal with market turbulence (Nurunnabi et al., 2020). After its rapid spread worldwide, the number of people contracting COVID-19 and succumbing to it reached 512,963,517 and 6,259,611, respectively, by May 25, 2020 (World Meter, https://www.worldometers.info/coronavirus/). COVID-19 outbreaks affect the population’s immediate morbidity and mortality from COVID-19, disrupt the emergency care for non-COVID-19 conditions, change chronic illness care modality, and rapidly escalate the incidence of mental health problems such as stress, depression, and anxiety (Sing, et al., 2021). Approximately 20% of all COVID-19 cases may experience severe symptoms, and require oxygen therapy or other inpatient interventions, and only 5% require hospitalization in the intensive care unit (Wu & McGoogan, 2020). However, studies have reported that COVID-19 has a broader physical and psychosocial impact beyond acute symptoms. Patients with COVID-19 demonstrate various symptoms such as fever, dyspnea, muscle ache, headache, fear, diarrhea, nausea, vomiting, increased systolic blood pressure, and hemoptysis, all of which require invasive and non-invasive therapeutic support during the acute course of the disease (Davis et al., 2019; Huang et al., 2020). The mortality rate of COVID-19 has been estimated to range from 1% to 5%, but this varies depending on patients' age group and the presence or absence of underlying diseases. The epidemiological distribution of mental health problems and associated factors are heterogeneous among COVID-19 patients. The current evidence suggests that a psychiatric epidemic is co-occurring with the COVID-19 pandemic, which necessitates the attention of the global health community (Hossain, 2020). During the COVID-19 pandemic, patients have faced problems such as fear, loneliness, boredom, anger, anxiety, insomnia, and a feeling of taboo. Patients have also been concerned about the effect of being quarantined on their psychological well-being and the risk of infecting family members and community members.

In the initial crisis response to the pandemic, researchers primarily conducted epidemiological studies and clinical trials. However, qualitative research is needed to provide the nuance and detail of COVID-19 patients' lived reality and contextualized experiences. Such rich data can help develop interventions and policies alongside obtaining quantitative data (Tremblay et al., 2021). Besides, a few studies have explored the needs of COVID-19 cases, their stress and adaptation to the disease, and health support. Explaining the perspectives of people living with COVID-19 on their needs and the impact can help improve the quality of care and their quality of life. The study findings can guide policymakers in making public policy decisions and strategic plans for public health organizations, and provide accessibility of assessment and treatment services, thereby improving the quality of care provided to this population and ensuring research subsidy priorities at state, regional, and national levels. The findings can guide public mental health initiatives across multiple ecological levels that can mitigate the toll of COVID-19.

Theoretical perspective

The theoretical framework of this study will help deepen our understanding of the lived experiences and the impact of COVID-19 on patients. The Roy adaptation model (Roy, 2001, 2009, 2011) states that the three elements are coping processes, adaptive modes, and adaptive levels. Coping processes are primary elements of understanding individual COVID-19 cases, their adaptation, and their life strategies for enhancing adaptation. Furthermore, the adaptive modes classify COVID-19 case data and help us understand this population's daily life and experiences of people living with COVID-19.

Methods

Design

This research applies narrative-based data collection procedures (NbDC). NbDC (Kirkpatrick, 2008), underpinning the phenomenological-hermeneutic approach, allows researchers to listen to and understand human experiences and contribute to planning quality of care in the future.

Participants

Fifteen participants were selected through purposeful sampling. As per the inclusion criteria, participants included COVID-19 survivors who had been discharged from the hospital and provided written consent for participation. COVID-19 cases that experienced stress or mental health problems were prevented from giving informed consent, and their participation was thus excluded.

Procedures

The phenomenological-hermeneutic approach was applied through discussions after examining and interpreting lived experiences and perceptions related to the COVID-19 pandemic (Al Kalaldeh et al., 2018; Graor & Knapik, 2013; Kvale
Dialogical conversations were conducted with participants who were in a vulnerable state. During the interviews, the interviewer used a checklist to report essential aspects of the research team, methods, context, findings, analysis, and interpretations (Tong et al., 2007).

**Data collection**
We recruited participants through the nursing offices of a hospital in a different location in Thailand. First, participants' willingness to participate was sought through phone calls. Second, the nurse apprised the participants of the interview. Third, semi-structured individual in-depth video interviews were conducted via Microsoft Teams in a time slot of the participants' preference after explaining the research goals and acquiring their verbal and written consent. The sampling process continued until data saturation, and the researcher, a psychiatric nurse, took on the role of interviewer to maintain a professional relationship with the participants. The duration of the interviews was between 25 and 60 minutes. Data were anonymized. In the final step, the transcripts were returned to participants for comment and/or correction.

**Ethical approval**
Ethical approval was obtained from the Ethics Review Committee for Research Involving Human Research Participants (COA No. 119/2563) on 20 October 2020.

**Consent**
The research scope, risks, and benefits were explained to the participants; they were assured that anonymity and confidentiality would be maintained. They were informed that their participation in the research was voluntary (Imkome & Moonchai, 2022). We confirm that we obtained written and verbal consent to use data from the participants included in this study. The interview duration was determined based on the participants' preferences, patience, and experiences. All interviews were recorded on video.

**Data analysis**
Interviews and data analysis were conducted simultaneously using the phenomenological-hermeneutic method (Kvale & Brinkmann, 2014). The three levels of description and interpretation were processed. The first level was self-understanding, wherein in the first readings, the authors created the narrative, summarized all the participants' experiences, and protected data anonymity. The second level was structural understanding, as several readings of the transcription constructed general themes, and we named and interpreted the central theme. We analyzed the data using SPSS Modeler software (RRID:SCR_002865) for qualitative data analysis. The third level was a structural understanding that was extended through theoretical interpretation. The Roy adaptation model (Roy, 2011) was applied.

**Results**
This section describes the participants' understanding through a structural account of the findings, followed by a theoretical interpretation of the results.

**Level 1: Participants' demographic data and their self-understanding**
Out of the 15 participants, 11.33% were unemployed, and 62.5% had an insufficient family income per month (Table 1). The data analysis led to four themes (Figure 1).

**Level 2: Structural understanding**
These early findings highlight how the comprehensive theme shaped by the participants' structural understanding brings attention to their perceptions of experiences and the impact of COVID-19. Major themes derived from content analysis were evident across interviews and included stress, economic and social impact, social stigma, and the concept that bad luck occasionally brings good luck, which was described in all interviews. Positive experiences of "feeling good" and "social support" were also emphasized throughout the transcripts (Figure 1).

**Stress**
In this context, stress refers to how people with COVID-19 perceive the infection and related circumstances as threatening and challenging to manage.

"It is stressful to be alone in the room. It was not easy to go out and find food. The city was locked down; what would happen next? Will our family be okay? Will the people who live in the community hate us? A disease spreading heavily in Thailand is stressful." (Cl. 1)

"Going to the hospital, I coughed a lot the first day and felt stressed, and I did not feel better on the third day. The doctor from the hospital called to check my signs and symptoms, and I felt like I would not survive. After being admitted to the
hospital, I was completely unconscious for about 40 days. What is the difference in oxygen? What is bulking? My family cannot visit, but they can look from outside.” (Cl. 9)

"Covid infection affects health and causes stress.” (Cl. 15)

**Economic and social impact**

The economic and social impact here refers to the physical, mental, social, spiritual, and economic situations that people living with COVID-19 experience that affect their daily lives.

"After being infected with COVID-19 and locked down, I had no job. When there was no job, there was no money. I kept saving money until I could not manage it. Shops were closed, so it was not easy to buy food. My salary was reduced when I returned to work because we were expected to help the company financially. Our expenditures remained the same, but our incomes were smaller, which had a huge impact. But other matters are not affected as much as the finances.” (Cl. 1)

"An essential part of people today is the economy. If the economy is good, mental health is good. I do not need anything; trade does nothing; I do not feel upset and offended; I am already happy. It is a good environment; it is good, I think.

<table>
<thead>
<tr>
<th>Demographic data</th>
<th>N (15)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. &lt; 30 years</td>
<td>2</td>
<td>13.33</td>
</tr>
<tr>
<td>2. 31-40 years</td>
<td>8</td>
<td>53.34</td>
</tr>
<tr>
<td>3. 41-50 years</td>
<td>2</td>
<td>13.33</td>
</tr>
<tr>
<td>4. 51-60 years</td>
<td>1</td>
<td>6.67</td>
</tr>
<tr>
<td>5. &gt; 60 years</td>
<td>2</td>
<td>13.33</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Female</td>
<td>6</td>
<td>40</td>
</tr>
<tr>
<td>2. Male</td>
<td>9</td>
<td>60</td>
</tr>
<tr>
<td><strong>3. Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Single</td>
<td>5</td>
<td>33.34</td>
</tr>
<tr>
<td>2. Couple</td>
<td>4</td>
<td>26.66</td>
</tr>
<tr>
<td>3. Widow</td>
<td>2</td>
<td>13.33</td>
</tr>
<tr>
<td>4. Divorced/Separated</td>
<td>4</td>
<td>26.67</td>
</tr>
<tr>
<td><strong>Level of Education</strong></td>
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<td></td>
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<td>1. Primary school</td>
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<td>6.67</td>
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<tr>
<td>2. Secondary education</td>
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<tr>
<td>3. Vocational Certificate/Higher Vocational Certificate/Diploma</td>
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<tr>
<td>4. Bachelor's degree or higher</td>
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</tr>
<tr>
<td><strong>5. Career</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Government service/state enterprise employee</td>
<td>4</td>
<td>26.67</td>
</tr>
<tr>
<td>2. Trading or running a personal business</td>
<td>2</td>
<td>11.33</td>
</tr>
<tr>
<td>3. Company employees</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>4. Hire</td>
<td>4</td>
<td>26.67</td>
</tr>
<tr>
<td>5. Unemployed</td>
<td>2</td>
<td>11.33</td>
</tr>
<tr>
<td><strong>The family income per month (estimated)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Fair</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>2. Not enough</td>
<td>10</td>
<td>62.5</td>
</tr>
</tbody>
</table>
Everyone has their duties. Why are there so many robbers and thieves? Maybe because they do not have a choice. The whole problem lies in economic and mental health.” (Cl. 3)

“A stupid economy. If we get infected, we cannot work; it affects our family.” (Cl. 5)

“In health, stress, or unemployment, I have no money to spend like this.” (Cl. 6)

“COVID-19 is affecting work. I closed shop; cannot open now; no money.” (Cl. 13)

“I am unemployed, and I have no money.” (Cl. 15)

**Social stigma**

In this study, social stigma refers to how people with COVID-19 are stereotyped and treated with discrimination, dissociation, and loss of certain status due to association with a perceived disease.

“It is stressful that people around you have to be poorly judged by society, such as when someone was evicted from their condo when it was learned that he had infected a friend with COVID-19 even though he had a young child. Some people know that it is my friend in the condo. So many people push them away from their homes. I told him to go elsewhere for 14 days and then return.” (Cl. 5)

“An infected friend posted a picture on Facebook. There will be a team to hunt him. This is a true story.” (Cl. 5)

“Do you not understand? Are you disgusted or not? My mother told a group friend that her daughter was infected with the coronavirus. My mother gave them a gift and souvenir, and they returned it as if afraid it was infected with COVID-19.” (Cl. 8)

“I had to stop work. I had to take a break from work first. It was too bad. My friend is a football coach, and he has COVID-19. Parents do not let their children learn football from him. The room was locked when he returned to his condo; the owner had kicked him out.” (Cl. 11)

“You will be stigmatized by society as an infected person. You have to go somewhere else. Those who are infected or have a friend who is infected are disrespected and bullied. Let us go together and not live in a normal society.” (Cl. 13).
Social support

In various fields, social support involves purposeful interactions that bring about help. For those infected with COVID-19, cultivating concrete and abstract assistance, such as recognizing, understanding, and responding to emotions, providing information, giving objects, and being accepted as part of the group, affects how a person perceives social support. Individuals are perceived as being loved, cared for, valued, and positively affected by their physical and mental health. This enables a person to face life-threatening events more effectively.

"I call home every day, and I jog to my room to watch television." (Cl. 2)

"During stressful times, listening to music, reciting the prayers, doing housework, and watching TV with my girlfriend can relieve stress." (Cl. 4)

"I was infected, and therefore [my] friends were exposed. They only have sympathy for us. We called to apologize. He said hey, it is okay. You can take care of yourself. It is not a problem. He wanted to encourage us and not make us more stressed." (Cl. 5)

"I have a neighbor who acts as if she is his older sister and consults about dealing with COVID-19." (Cl. 6)

"Luckily, most people are encouraging, and those around sick people are worried. They will never bully or scold." (Cl. 1)

"When stressed, I listen to music and watch TV." (Cl. 4)

"Doctor and his teams were highly qualified, and people received good treatment; they felt confident, and their health status gradually improved." (Cl. 1)

"The health team from the hospital that has taken care of me since I was discharged still contacts me to ask about my symptoms, invite me to work, become a lecturer, and sometimes get a job. Recently, the agency made an appointment for an interview. If anything could help, such as providing information about COVID-19 or others, I would be happy to help. The hospital produces an application called Clinical App to track the symptoms of COVID-19 patients. So we do not have to go to the hospital. You can ask for advice in the app. There will be a team that takes care of coordinating." (Cl. 1)

"Bang Khae Health Center contacted and coordinated care such as home visits and consults. They gave good help." (Cl. 2)

"During the treatment, the medical team was excellent and did not show disgust. The doctors and nurses took good care of the patients, spoke well, cared for them, and encouraged them. They gave us medicines, checked the temperature and pressure, and always called to tell us. They provided detailed treatment care. The medical team is perfect." (Cl. 4)

"At that time, I was in an intensive care unit. The healthcare team provided a PPE gown. All the care and treatment procedure was done quickly so that I could get out of the intensive care unit faster." (Cl. 5)

"I was very well taken care of. The doctor would video call and ask about my condition. Then, a doctor would check the fever in the morning and evening. Everything about the food was good. I got lung x-rays, and they took blood samples. When I came out of the hospital, I called to ask, but I did not come to visit because it was difficult. After all, I was staying at work—I called to ask." (Cl. 6)

"When my symptoms improved and I woke up in the hospital, the doctor took good care and was friendly." (Cl. 9)

"The healthcare team at the Tambon health-promoting hospital providing care is outstanding, so I call and ask about health issues when I get any problem. They support me when I get a problem by providing information and medicine." (Cl. 10)

"During the hospital stay, we would talk on the phone. He would call to check the fever, check here and there, and check every time there was a headache and fever. Ask how we were feeling. Check in the morning and at noon. If we had a fever, we called via Line and told him. There was a blood test and heart rate measurement. Since I coughed a lot, I had many medicines but no side effects. As soon as it got into my lungs, I suffered for 4–5 days, but now my lungs are normal, and I only had medication." (Cl. 14)
"I wish there were a cure for the disease. It is essential for life because it is not only in Thailand; it is worldwide, and I want it to be researched quickly." (Cl. 11)

"At first, I was worried because it was a new case. I do not know what the symptoms of COVID-19 are. Believing in the craftsmanship of Thai doctors and their teams, I felt that it was not scary, and I was fortunate to be taken care of by a hospital that felt that it was a leading hospital, so I was not worried." (Cl. 1)

**Sometimes, bad luck brings good luck**

Good luck in unfortunate situations means someone with COVID-19 has symptoms and needs to be treated in a hospital. There are various consequences, but one can get through that period.

"It was good luck in bad luck. Our bad luck is being infected with COVID-19, but good luck is learning things that we did not know before, such as knowledge of the disease and, most importantly, society. Encouragement and being a spokesperson. We felt lucky because we could not find an experience like this. Advertising for life insurance companies and interviews with other agencies, including this interview and conducted research, is something that other people cannot do because they have not been infected. I am fortunate in the misfortunes that I have to face in this life." (Cl. 1)

"When I found out that I was infected, I felt unlucky. There was a feeling of 'why so unlucky.' But I was lucky enough to enter the treatment process until finally recovering and going out to live a normal life. I think that COVID-19 also brings good things, such as getting to know the medical system in Thailand. There is a line between the patient group and doctors in the medical personnel and equipment system. I will ask a lot because I want to know and check it out on Facebook. We will ask and check with the doctor. After getting the information, try to share it on Facebook with some friends. This infection was helpful. It is not just a punishment. It allows us to spread good things and benefit others after we are infected with COVID-19. We are lucky to be able to benefit society." (Cl. 5)

**Level 3: Theoretical interpretation**

Adaptation is a concept that has been used to understand participants' experiences, and further illumination can be gained through the Roy adaptation model (Roy, 2001, 2009). Based on this model, the participants' stress, economic and social impact, social stigma, social support, and a sense that sometimes bad luck brings good luck can be interpreted.

This model is based on the four dimensions as the person submitted to a scheme, including the stimulus, which generates the coping mechanisms and results that make up the individual, family, and community response. This scheme focuses on three stimulus types: 1) focal stimuli, which require stimulation, including fatigue, dyspnea, high fever, and cough, i.e., the signs and symptoms of COVID-19; 2) contextual stimuli, which can be defined as comorbidities; and 3) residual stimuli, which are described as internal and external factors, such as stress from unemployment, viral infodemic, financial problems, social stigma, and lack of appropriate Personal Protective Equipment (PPE).

Adaptive behavior is assessed in four modes: physiological, self-concept, role function, and interdependence. Additionally, the subdivided models are regulators, including the physiological mode, which we describe as the situation and function of people infected by COVID-19. This is pertinent since the body's homeostasis is directly related to the lower probability of worsening symptoms. Secondly, the cognate coping mechanisms are self-concept, role function, and interdependence. The self-concept mode defines coping and highlights psychological and spiritual aspects. Indeed, considering the context of stress generated by this pandemic, asking for emotional support in chaotic times eases anguish and favors psychological well-being. The coping mechanism that complements the role function mode refers to the individual's ability to understand their role in the world and the self-knowledge of their role in society. During the pandemic, this acknowledgment is necessary because the population does not participate in essential services; instead, it supports control measures when it fulfills social isolation measures such as visiting the hospital after an appointment.

In contrast, in the scope of essential services, health professionals, for example, legitimize their functional importance when they perform their duty with technical skills and humanity. The coping mechanism of the interdependence mode includes the affective demands of everyone. In fact, with a social distancing policy, it is common to observe anguish in the community, which has a particular need related to complete well-being. However, information and communication technologies can be alternatives to increasing physical distancing and its repercussions on the population's biopsychosocial health. For the interdependence mode, social support from family and multidisciplinary treatment teams can decrease the experience of fear around the transmission and conditions related to COVID-19. Social stigma increases the participants' stress, which increases the severity of COVID-19 (Sing et al., 2021).
In conclusion, the theoretical interpretation of COVID-19 case perceptions showed that participants experienced stress, economic and social impact, stigma, and social support during the global COVID-19 pandemic. The participants' adaptive process promoted their mental integrity and positively affected their health. Nonetheless, they discussed their existential perceptions during the interviews, raising questions about work and the future during crises. Knowledge gathered from this point of view will help plan to fight such crises in the future.

Discussion
An interest driving this study was to 1) describe the stressful experiences of life during the COVID-19 pandemic and 2) describe the impact caused by the COVID-19 infection on those infected during the global COVID-19 pandemic.

Stressful experiences in life caused by the COVID-19 pandemic
People with COVID-19 were stressed by being in lockdown and quarantined. Difficulty finding food sources and disgust from the community exacerbated the symptoms of the disease.

Social stigma toward people with COVID-19 existed among people such as relatives or neighbors who feared infection. People with COVID-19 were severely judged by society and experienced situations such as being hunted by a group of citizens who came to find them, who then publicized infection information, meaning that there was no safe place in society. The owners locked rooms and stopped renting to patients. Patients were kicked out of their place (Tsai & Wilson, 2020) and were insulted and bullied. Anyone who had an infected friend was stigmatized by society, meaning they could not stay together and not live in a typical community. Shreyaswi & Shashwath (2020) reported that reducing stigma and providing mental health services is a necessary public health response to COVID-19. Challenges related to the spread of COVID-19, stigma, and discrimination can affect patients diagnosed with COVID-19 and those who are quarantined. Effective communication is both accurate and timely. It positively affects coordination and community involvement and is a cornerstone for reducing stigma and promoting mental health. Besides, an integrated psychosocial rehabilitation program to reduce social stigma and improve the resilience of COVID-19 patients is needed (Son et al., 2021). While several steps are required to address stigma and promote mental health, a clear strategy to integrate mental health services into meeting public healthcare needs becomes necessary during the pandemic; for example, elaborating on possibilities to deliver mental health care through technology.

Additionally, participants mentioned the impact of stigmatization and discriminatory experiences on physical and psychological health during the pandemic. This situation has increased discrimination against East and Southeast Asians, with reports of anti-Asian harassment and attacks rising globally (Lee & Waters, 2021; Chen et al., 2020; Dhanani & Franz, 2020; Hahm et al., 2021; Noel, 2020).

Among those infected with COVID-19, social support was received during the COVID-19 outbreak, including treatment and assistance, information, and material provisions. For example, the landlord and neighbors showed no disgust when accepted as a part of society. Receiving love, care, appreciation, and acceptance from friends and family, such as encouraging calls during treatment, friends that did not mind doing activities with family members, such as exercising, listening to music, or watching TV, and consulting trusted people, such as a family member, and a health team that provided good care was also experienced. Hospitals produced an app called Clinical App to track the symptoms of COVID-19 patients, coordinate care, ask questions, help people receive care at home, and give advice; on this app, the medical team was beneficial and did not show disgust. Nurses took good care of the patient, unconditioned positive regards of care, encouraged (Galehdar et al., 2020a), (Galehdar et al., 2020b) and made video calls to ask about patients' symptoms. Nurses checked their temperature in the morning and evening. Lung X-rays were obtained. A study by Rathnayake et al. (2021) examined nurses' perspectives on caring for COVID-19 patients; their phenomenological study found that nurses were willing to provide care for COVID-19 patients because it was their duty and responsibility as well as a humanitarian issue. In the beginning, infected people always thought they were unlucky because of the infection's severe economic, social, health, and mental impacts. However, after entering a good treatment regimen, symptoms improved, and they found themselves fortunate to be cured of this disease. Many established friendships with the health team. They acquired good morale and the ability to educate and share experiences during treatment to benefit society.

Impact of the COVID-19 pandemic
People were unhappy during the COVID-19 lockdown. The physical, mental, social, spiritual, and economic impacts experienced by people with COVID-19 affected their daily lives, such as having no job and using their savings instead of their salary. Unbalanced trade led to more robbers and thieves and increased stress and depression (Joo et al., 2021). This is consistent with a study by Hertz-Palmor et al. (2021) that examined the relationship between income loss, financial strain, and depressive symptoms during COVID-19. Moreover, according to research by Lei et al. (2020), stress during COVID-19 impacted the participants, and individuals with no psychosocial support were highly vulnerable to anxiety and
depression during this pandemic (Hossain et al., 2020). Moreover, Nicola and research teams (Nicola et al., 2020a) (Nicola et al., 2020b) reported that social support was associated with a lower risk of mental health problems and correlated with another study of emotion regulation growth during the pandemic (Cuan-Baltazar et al. 2020; Dhanani, & Franz, 2020). Post-traumatic growth, psychological conditions, and both hopeless and post-stress growth were reported during the COVID-19 pandemic (Qi & Sheng, 2022; Gutiérrez-Cobo et al., 2021; Hu et al., 2021).

Limitations
The interview was conducted during community quarantine and after the participant was discharged from the hospital. The participants may have had stress and anxiety about their health status, long COVID, work, and economic problems; this may have prevented the authors from fully understanding the studied phenomena. In addition, the research consisted of a homogenous population of only 15 participants. Thus, a similar study that included these participants might have revealed different perceptions of experiences. The small sample size also increased the risk of bias.

Conclusions
This research explores the impact of COVID-19 on patients by analyzing their lived experiences. The data show that COVID-19 patients were psychologically, physically, socially, economically, and spiritually affected by the disease. Therefore, healthcare staff and other support systems should be comprehensively maintained by offering economical, employee-oriented, or occupational therapy and establishing a new career that includes providing training for post-COVID-19 treatment.

Implications for nursing and health
Policy implications
- The research shows that stress, economic and social aspects, social stigma, social support, and the concept that sometimes bad luck brings good luck have impacted COVID-19 cases. We recommend that the government provide a policy to support the incomes, employment, and training of this new era's career in the new generation.
- Understanding the challenges that the COVID-19 cases faced in these outbreaks (stress, economic and social aspects, social stigma, social support, and the concept that sometimes bad luck brings good luck) will advance hospitals and nurses to prepare better for the future.

Nursing interventions
- Social stigma is the factor that influences COVID-19 cases to worsen and leads to mental health problems. Media can efficiently decrease social stigma in the community via social media and gain more cooperation from the healthcare unit in the community.

Nursing research
- There is a need for a more exhaustive holistic assessment, including return-to-work strategies for future research studies.
- This research depicts the impact of stigmatization and discriminatory experiences. This increase in discrimination and harassment has important implications for health care/nursing care.
- Considering the limitations of this study, other researchers should use larger sample sizes or conduct research in other regions of the country.

Ethical approval
Ethical approval was obtained from the Ethics Review Committee for Research Involving Human Research Participants (COA No. 119/2563) on 20 October 2020.

Consent
The authors obtained written and verbal informed consent from all participants to use their data in this study.

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Data availability

Underlying data


The project contains the following underlying data:

- Demographic questions
- Field notes
- Participant information
- Semi-structured interview questions
- Raw data

Data are available under the terms of the Creative Commons Attribution 4.0 International license (CC-BY 4.0).

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References


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