

# The Prior-to-isolation Psychosocial Experiences of COVID-19 Diagnosed Patients: An Interpretive Phenomenological Analysis

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## Abstract

**Background:** Changes that occurred during COVID-19 pandemic have caused people to have various responses when receiving a diagnosis of COVID-19; among others are stigma in society, lack of knowledge, various social media news that affect people's beliefs, and mental health during the pandemic.

**Purpose:** The purpose of this study was to explore the psychosocial experiences of patients before and when they were first diagnosed with COVID-19.

**Methods:** Using a phenomenological approach, we involved 19 COVID-19 survivors who were medically diagnosed and confirmed positive for COVID-19 in the first 6 months of the pandemic entering Indonesia, located in Madiun Regency, East Java Province, Indonesia. We conducted face-to-face semi-structured interviews with health protocols and analyzed using the 6-step of Interpretive Phenomenological Analysis (IPA) method.

**Results:** Three themed-findings illustrate patients' psychosocial experiences before being diagnosed: 1) cooperative behavior during the pandemic (with sub themes: recognizing symptoms and looking for medical help); 2) Navigating feelings when first received a diagnosis (with sub themes: being worried about the diagnosis, suspecting infection based on exposure history, and acknowledging the existence of COVID-19); and 3) Early psychosocial responses (with sub-themes: psychological response, cognitive response, behavioral response, family responses, and social response).

**Conclusion:** Exploring the experiences of patients with confirmed COVID-19 before and undergoing the isolation period can provide opportunities to improve the quality of physical and psychological services starting from prevention and assistance when receiving a diagnosis so as not to experience a worsening of the condition during treatment. Recommendations are for further study about COVID-19 survivors among children and adolescents who have been treated in the intensive care unit.

**Keywords:** COVID-19; first time; patient; phenomenology; psychosocial

## Introduction

Corona Virus Disease-19 (COVID-19) has caused a global health crisis since 2019. Until January 2021, the spread of COVID-19 occurred in 223 countries in the world including Indonesia (WHO, 2020). Indonesia experienced an increase in COVID-19 cases, or what is known as the first wave, from January to March 2021 (Joyosemito & Nasir, 2021). This disease spreads quickly so that it has an impact on physical, psychological, economic, and social health (Hossain et al., 2020). People experience disturbances in sleep patterns,

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eating patterns, decreased immune systems, and worsening of comorbid diseases (CDC, 2020; Deng & Peng, 2020). The community's inability to cope with symptoms and changing conditions during the pandemic causes anxiety (Arora, Jha, Alat, & Das, 2020), fear, panic, paranoia (Dubey et al., 2020), stigma (Ying et al., 2020), restlessness, depression (Loades et al., 2020) and anxiety (Hyland et al., 2020). The pandemic changes social life in society such as social restrictions (Dubey et al., 2020), closure of schools or public facilities (Loades et al., 2020), social isolation and loneliness (Krishnamoorthy, Nagarajan, Saya, & Menon, 2020). People also experience negative behavior changes such as hoarding of necessities and negative stigma toward someone diagnosed with COVID-19 (Dubey et al., 2020). The opposite situation is a change in preventive behavior, and filtering information from various social media (Shiina et al., 2020). The COVID-19 pandemic has impacted various aspects of people's lives and caused behavioral changes in everyday life.

People diagnosed with COVID-19 are declared based on positive Real Time Polymerase Chain Reaction (RT-PCR) test results so that therapy will be carried out according to the protocol (Ministry of Health of the Republic of Indonesia, 2020). Treatment of COVID-19 patients is carried out in isolation according to their physical condition (Regulation of the Minister of Health of the Republic of Indonesia, 2020). Physical and psychological care for patients in isolation rooms is carried out by nurses in collaboration with other medical teams and they cannot meet with families directly (Djalante et al., 2020). The findings reported in the community are high stigma toward confirmed positive patients (Ying et al., 2020). The unequal level of public education affects the level of trust in COVID-19 and its prevention (Mohamed, Solehan, Mohd Rani, Ithnin, & Isahak, 2021). Public distrust is also affected because the news in the media is not true and filtered properly (Melki et al., 2021). Changes that occurred during this pandemic caused people to have various responses when receiving a diagnosis of COVID-19. Existing research has not discussed the meaning of psychological, social, and behavioral experiences in society when first diagnosed with COVID-19. Therefore, exploring the meaning of psychosocial becomes very important to overcome the psychosocial problems experienced by patients when they are first confirmed positive for COVID-19. The results of the study are also expected to improve nursing services ranging from prevention to the community to assisting when confirmed. Thus, the purpose of this article is to explore the psychosocial experience of patients when they were first diagnosed with COVID-19 before undergoing isolation and to conceptualize the experience using Interpretive Phenomenological Analysis.

## Materials and Methods

### Design

The study employed a qualitative paradigm to explore the experiences of COVID-19 patients when they first received a diagnosis before undergoing isolation. In so doing, in this study, data analysis was carried out using the approach by Smith and Shinebourne (2012) with the method of Interpretive Phenomenological Analysis. Interpretive phenomenology emphasizes giving meaning to a phenomenon that is not only described but also interpreted by the researchers (Creswell, 2012; Polit & Beck, 2014).

### Participant and Setting

Participants in this study were patients with confirmed COVID-19. The sampling technique used was purposive to ensure that the participants met the predetermined criteria. The number of participants until saturation was reached is 19. All participants had undergone isolation at home and had recovered, and were not experiencing severe physical or mental illness. Patients were diagnosed with COVID-19 in the first 6 months of the pandemic entering Indonesia. Participants can communicate well and do not take psycho pharmaceuticals. Information on prospective participants was obtained from the clinic center database. Prior to collecting the data, the study was approved by the National and Political Unity Agency number 072/135/402.301/2021, Madiun District Health Office, and primary health center. This study is situated in Madiun Regency, The Province of East Java, Indonesia, within four primary health centers with the highest COVID-19 incidence. Table 1 showcases participants' demographic information.

### Ethical consideration

This study has obtained ethical clearance from the research ethics committee of Universitas Brawijaya (No. 97/EC/KEPK-S2/03/2021).

### Data Collection

After the participants agreed with the explained consents, in-depth interviews were then carried out. The interview aimed to get an overview of the participants' experiences before being diagnosed until they first received a diagnosis of COVID-19. The results of the depth of the interview are in accordance with the ability and experience of the researchers in developing questions for participants. Researchers used recording devices and field notes in addition to using Personal Protective Equipment (PPE) in the form of N95 masks, gloves, and gowns. All recording devices and notes were used to record all information during the interview (Creswell, 2012). PPE was used as the data collection process was carried out in a face-to-face setting.

**Table 1. Participants' Demographic Data**

Code	Age	Gender	Education	Work
P1	67	Man	High School	Unemployed
P2	39	Woman	High School	Entrepreneur
P3	55	Woman	Undergraduate	Teacher
P4	48	Man	High School	Village apparatus
P5	39	Woman	Diploma	Private sector employee
P6	27	Man	Diploma	Nurse
P7	32	Woman	Undergraduate	Nurse
P8	56	Man	High School	workshop
P9	70	Man	High School	Unemployed
P10	41	Man	Undergraduate	Bank employee
P11	53	Woman	Undergraduate	Civil servant
P12	35	Woman	Undergraduate	Bank employees
P13	31	Woman	Undergraduate	Nurse
P14	38	Woman	Master's	Civil servant
P15	47	Man	High School	Indonesian National Military
P16	40	Man	High School	Indonesian National Military
P17	34	Man	High School	Health center employee
P18	61	Man	Undergraduate	Unemployed
P19	46	Woman	Undergraduate	Employee

**Table 2. Theme's Distribution**

Themes	Sub themes
Cooperative behavior during a pandemic	Recognizing symptoms Looking for medical help
Navigating feelings when first received a diagnosis	Worried about the diagnosis Suspecting infection based on exposure history Acknowledging the existence of COVID-19
Early psychosocial responses	Psychological response Cognitive response Behavioral response Family response Social environment response

### Data Analysis

Data analysis uses the approach by Smith and Shinebourne (Smith & Shinebourne, 2012) with the Interpretative Phenomenological Analysis method based on collecting data from verbatim transcription. The researcher read and re-read the transcript of the in-depth interview. Next, initial noting was done by looking for meaningful or interesting texts to produce comprehensive and detailed notes and comments about the data. Then, developing an emergent theme started from looking for keywords and then categorizing them into sub-themes and themes, which were written in tabular forms. Multiple readings were conducted in order to document initial coding from the data. When an emerging theme was obtained, we determined the

categories for the themes. Afterward, we searched for connection in cross-emergent themes, moving to the next cases and looking for patterns across cases. In such a step, we interpreted the themes to explain the participants' psychological experiences. In this explanation, we employed narratives in order to plot structured voices shared by the participants. Trustworthiness is one way researchers can persuade that their data from qualitative research findings are accurate and worthy of attention (Forero et al., 2018; Nowell, Norris, White, & Moules, 2017). Trustworthiness of a study refers to the degree of confidence in data, interpretation, and methods used to ensure the quality of a study (Polit & Beck, 2014). Trustworthiness in this study was obtained by adopting four criteria,

including credibility, dependability, confirmability, and transferability which were later applied in this study systematically. Credibility was carried out by researchers by visiting COVID-19 survivors in 2-3 meetings each to conduct direct interviews and validate verbatim results. Researchers cannot make observations because the process experienced by participants has passed. Dependability was carried out by researchers with prepared detailed drafts of the study protocol throughout the study and they developed a detailed track record of the data collection process. Confirmability was carried out by researchers with implemented reflexive journals and investigators' meetings to discuss about data results. We applied triangulation techniques (data source and theoretical). Transferability was carried out by researchers explaining this study used a purposive sampling technique and quantified data saturation. Researchers made the final report of this research in detail, systematic and reliable.

## Results

Participants in this study were COVID-19 patients who had recovered and had undergone isolation in a referral or emergency hospital. The number of participants in this study consisted of 19 COVID-19 patients who had recovered and had undergone isolation and were willing to conduct in-depth interviews. Participants have an age range of 27 to 70 years. Nine participants were female and ten participants were male. Most of the participants had a diploma to a bachelor's degree. Three participants worked as nurses, two participants did not work and 14 other participants worked as employees in the private sector and the government. The participant demographic data are described in [Table 1](#).

Findings from the study were detailed into three themes: 1) cooperative behavior during the pandemic; 2) navigating feelings when first received a diagnosis; and 3) psychosocial responses that appear early. [Table 2](#) showcases the distribution of theme findings consisting of superordinate and subordinate themes. The first themes composed of sub-theme recognizing symptoms and looking for medical help. Recognizing symptoms from categories was such as identifying the appearance of one or more symptoms before being diagnosed. Looking for medical help from categories was such as looking for traditional medicine and medical service help to treat symptoms. The second theme composed of sub-themes such as being worried about the diagnosis, suspecting infection based on exposure history, and acknowledging the presence of COVID-19. Being worried about the diagnosis from categories was such as doubts about the results of the diagnosis and not believing in the symptoms felt. Suspecting infection was based on exposure history from categories such as travel history, close contact with exposed family or friends and close contact with COVID-19 patients at work. Acknowledging the presence of COVID-19 from

categories was such as knowing the process of transmitting COVID-19, knowing the cause of the patient's death and believing that COVID-19 is true. The third theme composed of sub-themes such as psychological responses, cognitive responses, behavioral responses, family responses, and social environmental responses. Psychological responses were from categories such as stress, shock, confusion, worry, disbelief and depression. Cognitive responses were from categories such as positive thinking and blaming others. The sub-theme behavioral responses was from categories such as try to relax, go to the hospital, self-isolate, contact the closest people. Family responses were from categories ranging from sadness, shock, fear, and blame to use by providing support. Social environmental responses were from categories such as feared and shunned, looks weird, denies, ignores, giving a support.

### Theme 1: Cooperative behavior during the pandemic

This theme the participant has a cooperative behavior during the pandemic means the participant being alert to the effect of the pandemic such as recognizing symptoms and looking for medical help.

#### Recognizing symptoms

Based on this theme, participants expressed cooperative behavior toward prevention before being diagnosed with COVID-19. The cooperative behavior carried out includes being alert by recognizing the symptoms that appear then being alert to seek health help before being diagnosed with COVID-19. The following are excerpts from participants that describe cooperative behavior in the form of being alert to the symptoms that appear:

*"Yes, actually the symptoms are only cold, the first one doesn't want to eat and then cold sweat comes out, then after that, the body doesn't feel good"* (P1)

*"Then on Friday, the sense of smell went away, the head was dizzy, breathless, choking, couldn't sleep, Miss, Saturday morning, the feeling was getting worse, the taste was getting worse, I was getting dizzy"* (P5)

#### Looking for medical help

The behavior of participants on standby to seek medical help to overcome the symptoms they feel is illustrated in the following quote:

*"Ask the chaplain, you're smart, Ms we're not the original sick..., I'm feeling bad, I'm just sending it, I'm not happy with you, so it's very illness. Yes, there are those who send them because they don't like it so it hurts like that... well, it's true that this is the one who blames the poor people, the goods come to visit... yes, maybe there is a use for someone else... Yes, finally I prayed a lot, then was given prayers too"* (P4)

*"Even on Thursday, Mrs. P, I'm afraid that I don't want to check directly, I was told tomorrow to*

go to the clinic, then the clinic was advised... Even the clinic was afraid, didn't you hold it too, didn't you... just asked, where did that come from, then On Thursday, it is recommended that the swab be referred to the hospital C, on Friday the swab, right, I asked Ms" (P2)

## Theme 2: Navigating feelings when first receiving a diagnosis

This theme finding was because of the participants, when first confirmed COVID-19, feeling worried about the diagnosis, suspecting infection based on exposure history, and acknowledging the presence of COVID-19.

### Worried about the diagnosis

Based on this theme, participants revealed that, after being diagnosed with COVID-19, they first experienced bargaining, namely feeling hesitant when receiving a diagnosis, then having suspicions about history of transmission to admit that COVID-19 is indeed true. Worrying about the diagnosis is illustrated in the following excerpts from participant interviews:

"Yes, if I think about it, yes, believe it or not, my pain is not COVID-19, Ms. I was sick at the beginning, it was just a little stomach, Ms. It's like that, Ms, yes, for treatment, we will recover, thank God, that's the proof" (P10)

"Hey, I can't believe it, when I was sick, I was crushed it seems the common cold, I lost my sense of smell but I kept quiet about it, I was afraid that my friends would think of it as COVID, so I don't think of it as a common cold, right sometimes if we have the flu, it's clogged, right? Never mind" (P12)

### Suspects infection based on exposure history

Participants revealed that they suspected that they were confirmed positive for COVID-19 due to exposure from other people or travel from epidemic areas. Participants guessed based on the history of exposure as illustrated in the following quotes:

"But I have an indication that I have a stomach, because that's what my stomach is... it's reoccurring... that's where I met a lot of people... then I went home and I checked it right" (P3)

"Actually, since this pandemic, I have been asked by the office to pick up and pick up COVID-19 patients and send them to D and continue to pick up those who are declared cured while on the road, maybe because of that, where did I come from, I don't want to know" (P17).

### Acknowledging the existence of COVID-19

Participants acknowledged that COVID-19 existed based on the information and experience they had obtained. Participants still believe that COVID-19 exists even though they still do not believe that they have been diagnosed with COVID-19. The following are excerpts from participant interviews:

"Yes, I believe in COVID-19, it's said that

sometimes in schools there are lectures, they say that COVID-19 can be transmitted through the air" (P11)

"There is an original that there is COVID-19 but I believe that because of the loss of smell, it's true that if you lose your sense of smell and your body is half dead, you know, right from there, I came out asking, Mrs. Your husband died yesterday? Yes Sir. What's his complaint? When he get home, his body is half hot and then it's taken to the hospital, how come COVID-19" (P4)

## Theme 3: Early psychosocial responses

The theme early psychosocial responses composed of meaningful participant answers about psychological responses, cognitive responses, behavioral responses, family responses, and social environment responses when confirmed COVID-19 positive.

### Psychological responses

Based on this theme, participants revealed that, after receiving a confirmed diagnosis, they had felt changes in their psychological condition, thoughts, behavior, family and social environment even though the isolation period had not yet started. Participants said that they felt psychological changes such as stress, shock and fear during the time they tested positive for COVID-19. The following are excerpts from participant interviews:

"It so... stress, stress is really stressful, where is the stress, I don't know how, I don't know. All this time I'm also not going anywhere" (P1)

"Yes, his mind is messed up, we're going nowhere, I'll do it later, I'll think there, why, why, on social media on television, the news is like this, the direction stays that way" (P18)

### Cognitive responses

Participants said that, when they tested positive for COVID-19 for the first time, they started thinking about blaming other people so they tried to realize and think positively about the conditions they were currently experiencing. This statement is illustrated in the following quotes:

"My husband is still holding my cell phone. I thought that at that time I was positive, yes, it's okay, it's okay, it's okay, I really have to be destined to accompany my father here, the important thing is that I don't have any symptoms, God willing, I'm safe" (P7)

"Stress stressful my head is dizzy... ooohhh crying loudly, blame she, he, and another one until you blame my boss why I was moved to this part why? I was given this task to go to groceries; It used to be impossible to get hit on a computer... I said so... it's a pity" (P5)

### Behavioral responses

Participants said that, after being tested positive, they immediately took actions they could do for themselves and their families regarding their

current condition. This statement is illustrated in the following quotes:

*"After I was positive, I immediately went home with self-isolation in my room, this is also my own initiative to keep this virus from spreading to others, because there are old people at home"* (P3)

*"When the environment was hit, it was certain to stay away from it, but I also didn't cover it up, so when I confirmed I told the neighbors of the head of the Neighborhood to stay at home for isolation, asking residents not to visit our house because we are in isolation at home. So yes, for the neighbors, please accept the news well"* (P13).

### Family responses

Participants when confirmed positive for the first time received different responses from their families, ranging from sadness, shock, fear, and blame to use by providing support. This statement is illustrated in the following quotes:

*"But if my family panics and cries, especially my brother and the children, that makes me even more worried"* (P19)

*"Your family is blaming me.... I mean, how come because of you, how come you can't go out in the end, you own this business, so you can't sell it, you can't do it"* (P12)

### Social environment responses

Participants said they received various different responses such as being feared and shunned from society when they were first diagnosed with COVID-19. This statement is illustrated in the following quotes:

*"If you know, it's okay, madam, if you don't know, you're confused, confused like this, someone said how come the situation here seems to be worrying about this... so neighbors already know, right, so they just walk away on their own, basically no one comes close"* (P17)

*"This environment, yes, ma'am, the name is ordinary people, yes, it's so excited that it's okay, until it's shared in the village and then everyone knows... I'm okay, I'm not really okay, it's true, sickness, it's okay, it's not a disgrace, isn't it?"* (P9)

## Discussion

Individual awareness in recognizing early symptoms when sick is one focus of behavior seeking health help (Saah, Amu, Seidu, & Bain, 2021). The behavior of seeking medical help in a developing country like Indonesia varies from doing nothing, self-medicating, seeking treatment from traditional services and seeking treatment from professional services (Siswanto, 2018). This is influenced by various factors, one of which is knowledge in understanding the disease and the signs and symptoms that appear. Result of the study found 11 participants had undergraduate education and other high school, thus this correlated with their behavior on standby to seek medical help

to overcome the symptoms. Someone who has a level of knowledge and understanding regarding COVID-19 will be more alert to changes in their physical condition during a pandemic (Saah et al., 2021). This knowledge affects how patients behave in seeking health behavior (Saah et al., 2021). Other factors which influenced the participants' health-seeking behaviors are health status changes, financial or socioeconomic, a desire to live, socio-cultural, structural environment and health system (Musinguzi et al., 2018; Ogunkorode et al., 2021). There were medical teams participating in this study who had more knowledge and understanding regarding the disease and its management so that the attitudes and behavior when confirmed would be different from the general public. So, when someone knows the concept of disease and knows what signs and symptoms might appear, they will be more alert when there is a change in their health condition.

Most people have the severity of the disease ranging from asymptomatic, mild, moderate and severe symptoms (Esakandari et al., 2020). COVID-19 not only affects the respiratory tract resulting in pneumonia, but can also affect the gastrointestinal, neurological, or cardiovascular systems (Tali et al., 2021). The better a person's perception and level of knowledge in recognizing the symptoms of COVID-19 can speed up the medical treatment process and prevent wider transmission. Society gets information about COVID-19 but has a different perception or does not believe. Based on the study some participants had not believed, so they searched for information in the non-medical service. Thus, this condition causes changes in compliance behavior so that an increase in cases occurs. The increase in cases can be suppressed if the society has the knowledge to be able to prevent, has the right attitude and follows the procedures for handling COVID-19 when symptoms appear (Bhagavathula, Aldhaleei, Rahmani, Mahabadi, & Bandari, 2020; Tali et al., 2021). Collaboration between the community, health workers, and the government is needed to increase knowledge, change beliefs and behavior in recognizing symptoms to follow COVID-19 management procedures.

The behavior of seeking health help increases during the pandemic, people are more active in seeking information and carrying out activities to maintain health. A person who already has a risk of frequent visits to health services increases alertness by conducting regular check-ups (Abdulkareem, Augustijn, Filatova, Musial, & Mustafa, 2020). On the contrary, people choose traditional medicine to prevent COVID-19 because it is believed to be a natural treatment and easy to do independently (Subagyo & Irwansyah, 2021). Based on the result this study, participants choose health seeking behavior in the religious leaders and non-medical service. Participants also use herbal remedies to reduce symptoms and help the healing process from COVID-19. In another study, people use traditional medicine, reflecting various cultural beliefs in

the community and believe that natural herbal materials are less harmful and more effective than conventional medicine (Hasan, Stanmore, & Todd, 2021). Some people who believe in COVID-19 and recognize the signs and symptoms choose to seek medical help from relatives, medical personnel in the community or pharmacies instead of going to a hospital or laboratory (Saah et al., 2021). The community tries to stay healthy by conducting examinations to seek clarity about their condition, hoping for appropriate treatment and care. People who work as a medical team will be more responsive and looking for professional health services. This is different from the general public who choose to try to self-medicate, use traditional medicine and go to professional health services after the condition does not recover.

Results of this study show participants do not believe and doubt COVID-19, because in the beginning stomach illness is the same with common cold. In another research, patients feel doubtful about the diagnosis results based on RT-PCR test, resulting in feelings of rejection and fear (Sun et al., 2021). Initial rejection in COVID-19 patients is the same as in Ebola patients (James, Wardle, Steel, & Adams, 2019). Based on the result of this study, participants are stressful, mind is messed up, blame others, are worried and self-isolate. Self-isolation is because neighbors stay away from and stigmatize COVID-19 patients. The initial attitude of the patient after being diagnosed with COVID-19 is fear, denial and strong stigma from the community (Sun et al., 2021). Feelings of doubt that arise in patients because they do not get an explanation are related to the examination. Some of the participants when experiencing symptoms did a rapid test with a negative result and when it was validated with a swab, it became positive. This makes the patient doubtful about the diagnosis received. The high social stigma and danger of this disease can cause death, making feelings of denial appear as an initial response when receiving a diagnosis.

Individuals who have a history of exposure from epidemic areas express fear when showing clinical symptoms such as cough with fever (Asmundson & Taylor, 2020). Living with family members carrying SARS-CoV-2 in the home environment and interacting together for a long time causes a higher risk of exposure to COVID-19 infection (Chen, Wang, Zhu, & Hu, 2020). History of exposure to COVID-19 can also occur in health workers who have a high risk; until now many health workers have been exposed to death (Iswanti, Ilimi, & Syafwani, 2021). Individuals who have vigilance, are able to recognize symptoms, and have good knowledge so they can guess the origin of a history of exposure to COVID-19. Another thing that can happen is when individuals do not know the history of exposure because they feel they have complied with health protocols but have a lot of activities outside the home.

The level of trust and knowledge of COVID-19

is related to the response and the impact felt by the patient (Sembiring & Meo, 2020). Patients with a good level of knowledge are more ready to accept a diagnosis, while patients who have low confidence have a negative psychological impact (Alkhamees, Alrashed, Alzunaydi, Almohimeed, & Aljohani, 2020). People need to have proper knowledge about this disease so as to be able to have attitudes and follow the right practices to prevent transmission (Nwagbara et al., 2021). Knowledge, belief, attitude and behavior are interrelated. This is because knowledge forms one's beliefs and then becomes the basis for determining behavior and making decisions, including belief in COVID-19.

Someone who gets a stressor can manifest an assessment mechanism for the stressor, which includes cognitive, affective, physiological, behavioral and social (Stuart, Keliat, & Pasaribu, 2016). The pandemic impacts the mental health of the global population and causes negative psychosocial effects, which can lead to a psychological crisis (Wu, Chen, & Chan, 2020). Psychological responses that appear when a patient receives a confirmed diagnosis of COVID-19 for the first time are feelings of anxiety, panic, paranoia, depression, fear of death, frustration (Brooks et al., 2020), stress, anxiety, and sleep disturbances (Liu et al., 2020; Wei et al., 2020), aggressive and delusional behavior (Xie et al., 2020), guilt, fear of transmission (Ibáñez-Vizoso, Alberdi-Páramo, & Díaz-Marsá, 2020) as well as anger (Sun et al., 2021).

At first receiving the diagnosis, the patient will feel a psychological burden that becomes a burden during isolation. These feelings can encourage the patient to take both positive and negative actions. Psychological and behavioral responses by patients are influenced by social responses, namely from family and society. The response of family, work friends, and community environment affects the patient's coping ability to deal with the burden felt after being diagnosed. The amount of support can reduce the patient's burden and increase readiness to undergo a period of isolation. The opposite happens when the patient does not have a good source of coping when he gets a stressor, which can cause psychological disorders. Therefore, psychological assistance is needed starting from the initial diagnosis until the patient returns to the community.

### Limitations

Although our study has shared findings from a phenomenological interpretation, some limitations may exist. First, the study did not exclude patients who have jobs as medical personnel as they may have different views and readiness from the community when facing receiving a diagnosis. Second, the study did not cover all patients throughout the first or second wave of the pandemic. Lastly, since the study recruited a small number of participants, its results cannot be generalized to wider people in the region.

## Conclusion

This study reveals that the participants encountered multiple psychosocial responses and conditions when they were first diagnosed with COVID-19. The focal participants in the study have tried to implement a pattern of behavior that is in accordance with what the government has conveyed during the pandemic. Efforts are being made in the forms of being alert to the symptoms that appear and trying to seek health help when experiencing changes in conditions that lead to signs of COVID-19 symptoms. This shows the need to improve preventive behavior and adherence to the application of health protocols in new normal conditions. Participants also experienced bargaining or felt doubts when receiving a diagnosis. Participants were worried when they were confirmed for COVID-19 for the first time and had suspicions about a history of transmission. Transmission can come from traveling from a pandemic area or close contact with a confirmed patient. COVID-19, which is caused by a virus that cannot be seen directly by the eyes, with rapid transmission and can cause death, makes people feel rejected when they experience it. Participants feel confident in the existence of COVID-19 but do not believe if they are confirmed positive until repeated diagnostic examinations and information from medical personnel can convince the patient. Feelings and thoughts of not accepting this condition can worsen the patient's psychological condition, which can hinder the physical healing process during isolation. Thus, the importance of psychosocial health interventions ranging from prevention to assistance before undergoing isolation.

## Declaration of conflict of interest

The authors declare that there is no conflict of interest.

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