MENTAL HEALTH IMPLICATIONS OF ISOLATION DURING HOSPITALIZATION FOR COVID-19: SELF-PERCEIVED VARIATIONS IN EMOTIONS

by

Rebekah Ruth Jones

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

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Abstract

Forced isolation due to the COVID-19 pandemic has resulted in numerous mental health consequences. Individuals who have required hospitalization due to contracting the illness are at an increased risk of developing potentially harmful mental health concerns resulting from the emotional distress of forced isolation. Families separated from one another experience anxiety and fear due to helplessness fostered by the separation. Furthermore, medical caretakers are placed in the position to make life-altering decisions for their patients, increasing their stress and anxiety levels. Therefore, it is imperative that hospitals provide adequate mental health support for patients and their family members. Furthermore, communities experiencing restricted freedom or lockdowns may benefit from increased access to mental health services.

Keywords: COVID-19, Hospitalization, Emotional Distress, PTSD, Corona, Isolation

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Table of Contents

List of Tables

List of Figures

List of Abbreviations

PTSD- Post Traumatic Stress Disorder

HIPAA-Health Insurance Portability and Accountability Act

IRB- Internal Review Board

EFT-Emotion Focused Therapy

Chapter One: Introduction

Overview

The presentation of symptoms of emotional distress in relation to a period of forced isolation during hospitalization for Covid-19 presents a problematic scenario that may impede the appropriate management of mental health concerns. Therefore, it is necessary to identify specific mechanisms which aggravate and promote maladaptive coping skills and emotional distress. Through the process of identification, it is possible to develop appropriate strategies for intervention that will reduce the experience of emotional distress during periods of isolation related to inpatient treatment for Covid-19.

Background

In order to develop a deeper understanding of how to mitigate the emotional distress experienced during hospitalization for COVID-19, it is essential to identify the degree to which isolation alters emotional stability and to determine specific mechanisms for future intervention. Therefore, it is proposed that a phenomenological method is utilized to produce a deep body of data in which individual case studies are presented in a manner that facilitates synthesizing the participants' experiences. Conducting a transcendental phenomenological study allows one to focus on participants' personal experiences to such an extent that the interference of external factors is excluded. The phenomenological approach provides an opportunity to engage in a deep examination of the individual experiences of an event or phenomenon, thereby generating a clearer picture of personal truths concerning the experience (Hepner et. al., 2015). In the context of future research, this methodology expands on the potential development of strategies or

interventions through a more thorough conceptualization of the experience of isolation related to hospitalization and treatment of COVID-19.

Problem Statement

The problem is that the presence of a global pandemic has shifted the normative patterns of human connection to such an extent that adequate access to social support networks has been disrupted. As a result, the ability to cope with emotional distress related to high-stress situations, such as hospitalization for COVID-19, has been reduced. Therefore, it is necessary to develop a clear understanding of the severity and mechanisms of this reduction to develop effective intervention strategies. Research conducted by Bossche et. al., (2021) identified social isolation as a contributing factor to the development of increased symptoms of depression in people who had a history positive for psychiatric illness and newly formed symptoms of depression in those without. The presence of increased or newly formed symptomology as a consequence of separation from social support systems indicates the need for further research to better formulates an understanding of the mechanisms of the concern.

Consistent and early interventions provided by trained mental health personnel may reduce the presence of these concerns in communities where mental health workers are easily accessible (Sheek-Hussein et. al., 2021). Reducing isolation-based stress responses is essential in improving mental health in persons experiencing forced isolation during treatment in a hospital setting for COVID-19. The reduction of the presentation of mental health concerns such as depression, anxiety, and suicidal ideation may be accomplished through person-based interactions and support provided to the patient (Bruce et. al., 2004).

Situation to Self

I was motivated to conduct a qualitative research study after witnessing my husband's struggle with isolation and emotional distress during a period of forced isolation in a hospital setting after experiencing respiratory distress due to COVID-19. Throughout his stay, he was placed on various assistive breathing machines, which made it impossible for him to turn his head to see me standing in the hallway on the other side of the glass wall separating us. He lay in bed strapped to machines and heavily medicated without the benefit of family support or a medical advocate. Though he did have his phone on him, he was often too delirious to answer calls and was unable to text. When he returned home, he experienced difficulty sleeping, frequent waking, nightmares, and feelings of dread when one of the children exhibited any symptoms of illness.

This experience influenced my decision to identify the manner in which individuals experience forced periods of isolation during their COVID-19-related hospital stays and how to best support them during their stay so that emotional distress may be limited or alleviated. After we returned home, he expressed the depths of his fear and loneliness to me. He shared that he longed to hear the voices of those he loved and that the only staff who entered his room barely spoke to him and left as quickly as they could, even after two negative COVID-19 tests.

Watching him share the level of distress he experienced and walking with him as he regained his strength physically and emotionally caused me to want to assist others in similar situations. I began to wonder what would have been different if there had been access to facetime technology in the room so that I could have, at least virtually, been present with him. I thought of the other individuals I walked past in the halls, sedated and on ventilators, with no one standing outside their rooms. I recalled the medical decisions we would not have allowed to take place if I

had been asked before they were carried out on my husband, who was too delirious to make decisions for himself. How might the staff have been supported by an informed family member being there to help make these complex and potentially life-altering decisions?

As a licensed professional counselor and researcher, I used the resources available to me to select the phenomenological approach as my philosophical assumption by which my research process is guided. This assumption was selected due to the focus on how a person's individual experiences influence their perceptions of reality and their response thereof. According to Heppner et. al., (2016), the phenomenological approach is a philosophical assumption of how one engages with reality based on the individual's intuitive experiences of an event or phenomenon and that reality is shaped through these experiences. Therefore, I obtained information regarding the individuals interviewed experiences and perceptions to construct a synthesized set of data that concisely presented their experiences and lived realities so that the data was used to better understand and engage with these experiences.

As part of this process, I have selected the top-down and bottom-up frameworks as well as the systems theory to assist in understanding how the individual was affected differently based on their locus of control. The top-down and bottom-up approaches refer to whether an individual's perception of life satisfaction is based on their inward thoughts and experiences or their outward circumstances (Pavot & Diener, 2008). This distinction allows for more focused development of interventions based on the individual needs of the person experiencing distress. Furthermore, the systems theory allows for a broader exploration of how the rules and standard procedure changes within the hospital systems alter the levels of stress and satisfaction experienced by the staff and patients receiving care from the staff. Institutional changes and

alterations in procedures and rules cause disruptions within the system, which may affect the satisfaction and stress levels of those working within the system (Schneider, 2017).

Purpose Statement

The purpose of this transcendental phenomenological study is to develop a deeper understanding of how forced isolation affects emotional and mental wellness in people who have experienced forced isolation due to hospitalization for COVID-19. Hospitalization refers to any period during which an individual is admitted into the care of a hospital system to receive treatment for symptoms related to infection with COVID-19. Furthermore, potential participants in this transcendental phenomenological study have experienced a period of forced isolation in the hospital system lasting a minimum of 3 days with no limit on stay length. Participants must have potentially experienced hospitalization at various times during the pandemic in different institutions.

Therefore, each hospital will have its own set of policies and standards of procedure in place. At this stage in the research, the presentation or increase in the presentation of mental health symptoms such as depression, anxiety, PTSD, and suicidal ideation will be generally defined as emotional distress. The experiences held by the participants have been explored through the combined frameworks of top-down, bottom-up, and systems theory. This has provided the opportunity to explore how a person's locus of control relates to life satisfaction and emotional regulation, as well as how changes within a system, the hospital system, affect those within the system. Through exploring these matters, it is possible to develop appropriate interventions to alleviate the experience of emotional distress.

Significance of the Study

Identifying areas of need and potential strategies for intervention are essential steps in the process of reducing the number of people exhibiting maladaptive coping skills and experiencing disruptions in mental health related to isolation during hospitalization for COVID-19. Through a more thorough synthesis of information concerning personal experiences of emotional distress and resilience during periods of isolation and inpatient treatment for COVID-19, it is possible to identify protective and harmful factors that dictate how the process is experienced. Furthermore, reducing mental health crises or decreasing the severity of mental health symptoms can potentially reduce patient involvement with hospital systems, freeing up hospital rooms and reducing the workload on the medical staff. Patients with higher levels of support and lower anxiety levels may experience shorter hospital stays (Ting et. al., 2020). Additionally, developing adequate mental health support systems and utilizing the support of the previously established social systems is essential to reduce the degree of suffering experienced by community members and medical caretakers. According to Hambisa et. al., (2021), adequate social support decreases the overall risk of experiencing disorientation and anxiety while receiving care in a medical setting.

Further evaluation of the consequences of periods of isolation during high periods of stress, for the purpose of this study, it is hospitalization for COVID-19, is indicated as it provides an opportunity to understand better the emotional process experienced and how to intervene in these processes effectively. Early and effective intervention may prove beneficial in improving mental health outcomes for people who have experienced emotionally distressing situations while seeking treatment for COVID-19 infection. However, suppose the opportunity to intervene in an expedient manner is missed or otherwise prevented. In that case, it is necessary to identify

and implement interventions as soon as feasibly possible in an attempt to reduce the presence of emotional distress.

Research Gap

There are a limited number of current studies that discuss the effects of isolation on families, patients, and medical caretakers during forced isolation from hospitalization for COVID-19. The existing body of research explores the connection between mental health consequences and isolation but is not explicitly related to individuals hospitalized for COVID-19. Additionally, there is research that discusses the emotional toll on medical caretakers associated with the lack of presence of family support but fails to explore how this emotional distress affects the patient's perception of the quality of care provided to them and, therefore, alters their emotional state in conjunction with forced isolation. For this reason, further exploration of individual caretaker experiences is merited. Rosa et. al., (2019), indicated the need to engage in additional research to identify the extent of emotional distress experienced by medical workers and how this interacts with the level of care provided to patients.

Furthermore, an in-depth exploration of the experiences of patients hospitalized for COVID-19 is essential in determining the severity to which life stressors, COVID-19-related concerns, the stress of hospital staff, and the experience of isolation alter one’s ability to self-regulate emotions. For this reason, people who have experienced forced isolation during hospitalization for COVID-19 merit further study. Suppose the mechanisms that interfere with mental wellness and the ability to self-regulate emotional processes can be identified. In that case, it is possible to develop effective interventions to prevent these mechanisms and outcomes.

Theoretical Framework

The theoretical perspectives used to synthesize the information presented are the bottom-up and top-down approaches and systems theories. These perspectives allow information gathered to be broken into data units, which clearly depict the experiences of those who have required in-patient hospitalization for the treatment of COVID-19.

The top-down theory presents the view of personal happiness as something that is developed as a result of an individual's natural predisposition to interact with the world in a way that prioritizes pleasurable or happy experiences with little regard for the number of these experiences compared to unpleasant or harmful experiences (Brief et. al., 1993). For the purpose of this study, this is an essential theoretical perspective as it potentially identifies inherent protective factors against developing symptoms of emotional distress while experiencing a distressing situation or set of circumstances. Suppose an individual is predisposed to notice and interact with tiny bits of joy in a painful setting, such as a positive nurse or a video call from family. In that case, it is possible to develop meaningful interventions using this knowledge. Furthermore, it may be possible to assist those with a bottom-up manner of interaction with the world around them to adopt a top-down approach to their hurtful or unpleasant experiences, thereby potentially affording them some increased level of protection against emotional distress.

The bottom-up theory dictates that an individual's capacity to experience joy and happiness is determined by the number of positive or pleasurable experiences they have compared to harmful or unpleasurable experiences (Brief et. al., 1993). As a result of this bottom-up approach to life experiences, an individual who is experiencing prolonged exposure to harmful or unpleasant stimuli is at an increased risk of developing symptoms of emotional distress that may continue post-hospitalization due to the continued imbalance of pleasant versus

unpleasant life experiences. Therefore, the utilization of identification of pleasurable moments or small moments of joy through present-focused mindfulness may assist individuals with a bottom-up approach to life in learning to shift their focus to the pleasurable moments without weighing them against the harmful or unpleasurable ones.

Bowen's system theory presents the systems theory as a set of natural emotional processes that interact with and shape social groups and families (Jakimowicz et. al., 2021). Systems theory is multidisciplinary by nature and aids in the process of understanding the way in which pieces of an experience or phenomena interact with one another to develop the whole of an experience or construct (Adams et. al., 2014). For the purpose of this study, the use of systems theory has allowed for the marriage of the individual components of the participants' experiences to fully identify how these individual pieces interact with one another to form a whole. Furthermore, the summarization of the individual pieces has allowed for the development of precise interventions aimed at dissecting the experiences and preventing these distressing connections from forming prior to the development of emotional distress or symptoms of prolonged emotional distress. Additionally, systems theory is beneficial in identifying the way organizations interact with complex environments.

Organizations, like individuals, struggle to adapt to complex environments and experience an increase in the risk of expressing distress (Schneider et. al., 2017). During the course of the research, the systems theory has facilitated the assimilation of bits of data into conceptualized bursts of information, which work together to present the story of how institutions and organizations, such as hospitals, adjusted to the sudden increase in complexity due to the presence of COVID-19 and the rapidly changing protocols that the illness

necessitated. It is possible to utilize this information to identify and develop interventions based on an organizational level that will benefit the individuals served by the organization.

Through the careful construction of information concerning the nature of the personal experience, the level of clarity of what constitutes how an individual will perceive an experience or set of experiences increases. According to the bottom-up and top-down theories, it is clear that how a person perceives a situation is heavily connected to that individual's perception of life satisfaction and happiness (Pavot & Diener, 2008). Additionally, the systems theory provides a framework through which the manner in which organizational changes and behaviors interact with individuals may be better understood and interventions developed if required.

Research Questions

In an effort to reduce the gap in existing research, it is necessary to develop a comprehensive understanding of the answers to the following research questions:

RQ1. How does isolation during hospitalization affect self-reported rates of depression and anxiety?

RQ2. How does isolation during hospitalization affect self-reported rates of depression and anxiety in persons previously diagnosed with depression or anxiety?

RQ 3. How does isolation from social support during hospitalization for COVID-19 affect the personal perception of mental health?

RQ 4. How does the patient's perception of the level of stress experienced by caregivers affect the patient's perception of their emotional health during periods of isolation?

Through thorough exploration of these questions, it is possible to develop a more focused view of the necessary next steps in treating those affected by forced isolation during their time

seeking treatment for COVID-19 in a hospital setting. The population sample was intentionally limited to individuals over the age of 18 with a primary diagnosis of COVID-19 during hospitalization.

Definitions

A list of essential terms and definitions is listed below to assist in comprehending the content discussed within this dissertation.

1. *PTSD*: Post-traumatic stress disorder occurs after real or imagined exposure to a life-threatening event and is identified by the presence of intrusive memories, emotional dysregulation, flashbacks, persistent negative emotional state, personalized blame, anger, and/or guilt (5th ed.; DSM-5; American Psychiatric Association, 2013).
2. *Depression*: Depression is characterized by the presence of a depressed mood or anhedonia and exists on a spectrum of severity (5th ed.; DSM-5; American Psychiatric Association, 2013).
3. *Anxiety*: Anxiety is identified by the presence of irrational fear coupled with mental health symptoms or physical presentation of symptoms (5th ed.; DSM-5; American Psychiatric Association, 2013).
4. *Suicidal Ideation*: The presence of suicidal ideation is indicated when an individual is experiencing thoughts consisting of self-inflicted termination of life (5th ed.; DSM-5; American Psychiatric Association, 2013).
5. *Emotional Distress*: For the purpose of this dissertation, emotional distress refers to the presentation or experience of symptoms of emotional dysregulation, anxiety, depression,

PTSD, suicidal ideation, or other distressing emotions that are experienced in excess of the individual's capacity to cope.

6. *Transcendental Phenomenological*: a philosophical approach to understanding the unique understanding of life experiences through the emotions and experiences of the individual (Moustakas, 1994).
7. *Systems Theory*: A framework through which it is possible to understand how changes within the system affect people working in it and served by it (Adams et al., 2014).
8. *Top-Down*: This theoretical framework posits the idea that life satisfaction and emotional responses are dependent upon the individual's perception of events and circumstances (Nakazato et al., 2011).
9. *Bottom-Up*: The Bottom-up theoretical framework presents the idea that a person's life satisfaction and emotional responses depend heavily on their environmental circumstances (Nakazato et al., 2011).
10. *Forced Isolation*: As used in the context of this dissertation, forced isolation refers to a period of time in which an individual is deprived of physical contact with others, with the exception of medical staff, due to the contagious nature of the illness they have.
11. *Quarantine*: According to the Centers for Disease Control and Prevention, quarantine refers to a period of time in which a person exposed to contagion is separated from others to determine if the infection has occurred (Centers for Disease Control and Prevention [CDC], 2014).
12. *Hospitalization*: Admission into a hospital for the purpose of treatment of a medical or psychological need. For the purpose of this dissertation, it refers to the treatment of infection from COVID-19.

Summary

The sudden experience of a global pandemic shifted the established norms within society and in the healthcare systems that serve members of society. As a result of the pandemic, communities entered periods of quarantine in an attempt to slow the spread of the virus. Furthermore, people infected with the virus experienced forced isolation periods while seeking treatment in hospital settings. The presentation of symptoms of emotional distress in relation to a period of forced isolation during hospitalization for COVID-19 presents a problematic scenario that may impede the appropriate management of mental health concerns. Therefore, it is necessary to identify specific mechanisms that aggravate and promote maladaptive coping skills and emotional distress (Moore et. al., 2011). Through the process of identification, it is possible to develop appropriate strategies for intervention that will reduce the experience of emotional distress during periods of isolation related to inpatient treatment for COVID-19 (Tyler et. al., 2014).

Chapter Two: Literature Review

Overview

The exploration of personal experiences of individuals who have required in-patient treatment due to an active diagnosis of COVID-19 provides researchers with the opportunity to develop a deeper understanding of the extent to which emotional distress is experienced during hospitalization for COVID-19. Furthermore, this allows researchers and clinicians to create interventions that mitigate the presence of emotional distress in the afflicted population. This is especially relevant in reference to the extent to which isolation is related to the experiences of various forms of emotional distress. Therefore, exploring the personal processes of those who

have experienced isolation due to a COVID-19-related hospital stay is imperative. Through careful exploration of the emotional responses and the increase or decrease in the presentation of symptoms of pre-existing mental health concerns, if there are any present, it is possible to develop a clearer picture of the mental health consequences and processes experienced during COVID-19-related hospitalization.

The deterioration of mental health during forced periods of isolation has been well documented in previous research by identifying altered behavioral states in rats. According to Jahng et. al., (2012), adolescent female rats who were placed in social isolation consistently exhibited symptoms of depressed mood and reduced motivation to engage in life-sustaining activities as well as social activities. The results of this research promote the concept that social, emotional, and mental health are all directly affected by prolonged experiences of loneliness and isolation. Unexpected and prolonged exposure to periods of isolation during times of distress, including distress related to personal health and the health of others, promotes emotional distress and dysregulation. This was further supported by recent studies conducted during the COVID-19 pandemic response. According to Kumar and Nayar (2021), self-reported rates of depression and anxiety increased during forced periods of isolation related to COVID-19.

Although the global pandemic has provided a unique opportunity to study large populations experiencing isolation simultaneously, previous research discusses isolation's potential mental health consequences. As a result of the worldwide pandemic, world populations have been exposed to widespread instances of forced periods of isolation and restricted access to social support systems. Despite the current body of research indicating the negative mental health consequences of forced isolation and quarantine, there is a limited body of research regarding the emotional implications of forced isolation during hospitalization for COVID-19.

There is even less information regarding how to mitigate the emotional distress experienced due to patient removal from social support systems during treatment for COVID-19. Therefore, further research into this matter is strongly encouraged if meaningful interventions and preventative measures are to be developed. As a result of the research process, it is possible to use the information gathered to promote activities and interventions that improve the overall wellness of people afflicted with COVID-19 and various other illnesses requiring periods of isolation.

Social Support Systems

When discussing and exploring the consequences of isolation, it is imperative to examine the importance of support systems and how removal from social support systems may alter a person's ability to cope with stressful situations. Social support systems are integral parts of an individual's overall wellness. The presence of reliable social support reduces the presentation of symptoms of anxiety and depression in individuals with previously diagnosed mental health conditions (Wang et. al., 2020). This is especially detrimental if the patient has a personal history of positive for PTSD or suicidal ideation. According to Menon et al. (2020), suicidality increases in reaction to forced isolation related to COVID-19 for those who have experienced such thoughts previously. This indicates the need to support the continued participation in previously established sources of social and emotional support during treatment and isolation periods. Separation from the individual's support network reduces their capacity to cope with the increased level of distress associated with hospitalization. According to Cacioppo (2008), overall life satisfaction and mental wellness decrease the more prolonged isolation is experienced.

Furthermore, the number of stressors present in an individual's life increases during periods of hospitalization.

Financial support systems and independence are different matters of consideration when assessing overall life stressors for those separated from their typical support systems, as well as when assessing individual levels of accessibility of support systems. According to The Centers for Disease Control and Prevention (2014), over 76.3% of people were concerned about their financial security related to COVID-19. This concern is increased in people who were hospitalized for COVID-19 due to reduced ability to earn income and associated costs of care. As a result of financial insecurity, stress concerning the ability to provide safe housing for self and/or dependents increases, as does the presence of food insecurity. Unstable housing and food insecurity increase the risk of developing or worsening symptoms of depression and anxiety (Wilson et. al., 2020).

The inability to meet one's basic needs for survival substantially decreases their ability to allocate emotional resources to mental wellness and self-care. Symptoms of emotional dysregulation and distress increase as a result of food insecurity and financial insecurity (Wilson et. al., 2020). Therefore, it is essential to factor in stressors not directly related to the presence of the illness within the individual. Such factors increase stress's physical and mental symptoms, further increasing the risk of physical and mental consequences. The presence of high levels of stress increases the risk of developing mental health consequences and decreases the overall prognosis for those hospitalized for COVID-19 (Xu et. al., 2020). Mitigating the financial stressors present during periods of time when the individual is unable to earn an income may decrease the presence of additional stress, which impedes the recovery process and increases emotional dysregulation. Further efforts to determine means of creating financial stability as a

means of supporting mental and emotional wellness during times of health-related stress are indicated as an area for future research.

Interventions

It is for these reasons that identifying appropriate interventions to support the physical needs of those hospitalized for COVID-19 is essential. By reducing the overall stress levels and providing both support for mental health and external needs, it is potentially possible to improve the individual's treatment outcome. According to Sun et. al., (2021), through the use of meaningful mental health interventions, the stress experienced by a patient quarantined with COVID-19 may be reduced, causing an increase in positive emotions and improvement in overall treatment progress. Such measures may include emotional connection with the staff offering them care, the care nurse speaking to them in a kind manner, or bringing in electronic means of contact with the external world by setting up video calls with the patient's support system.

Despite in-person communication and support as the norm in previous years, it is possible to meet the need for social support and interaction via virtual means. Current social norms and means of interaction are such that utilizing technological means of interaction may not deviate from the individual's normal means of communication, or if it does, it may be viewed as a viable alternative to in-person interaction (Grabowicz et. al., 2014). Utilizing social media in day-to-day interactions has allowed individuals to cast a more comprehensive social net and connect with more people. Therefore, it is possible that this assists in developing a more diverse social support network that may be used while seeking treatment for COVID-19. According to Qui et. al.,

(2020), utilizing virtual means of connection with family and social support while hospitalized reduces the patient's experiences of anxiety and depression.

Interventions require early detection of symptoms of emotional distress and adequate social support to meet external needs. This was indicated in research conducted by Sun et. al., (2021), which showed that violations of rights to privacy, loss of independence, and isolation all promoted symptoms of emotional dysregulation; however, these symptoms were alleviated through the use of attentive interventions that promoted management of points of stress and improved mental and physical wellness.

Isolation During Hospitalization

The contagious nature of COVID-19 and the risk of associated loss of health and life created a unique set of circumstances in which society's collective emotional and mental wellness was placed at risk without the ability to rely on previous means of support. To reduce the spread of COVID-19, lessen the risk of loss of life, and decrease the number of individuals seeking care in a hospital setting, hospitals have adopted quarantine protocols for patients seeking care for COVID-19. Although understandable and necessary for the overall physical wellness of others, these changes have resulted in restrictions and isolation, which are detrimental to the patient’s well-being.

In response to the global pandemic, it was necessary for hospitals to alter the longstanding regulations regarding visitation and family involvement. Recently adopted visitation measures restrict the patient’s access to social and familial support and increase the burden of decision-making on the hospital staff. As a result of the restriction of access to support systems, patients experience an increase in self-reported symptoms of depression and anxiety

(Hambisa et. al., 2021). Therefore, it is essential to develop a comprehensive understanding of the various ways that forced isolation alters an individual's capacity to cope with stressors in order to identify ways to support mental wellness during COVID-19-related hospitalization and isolation.

Through an in-depth look at personal experiences during periods of hospitalization, it is possible to develop an improved level of understanding of the emotional consequences of such an experience. Furthermore, providing a platform for this exploration promotes the likelihood that those experiencing emotional distress related to COVID-19 will have access to a higher level of support. Establishing adequate support systems, which the patient may access in a meaningful manner regardless of the presentation of symptoms, is imperative if the hospital systems begin supporting emotional and mental wellness during quarantine periods.

Related Literature

Mental Health Consequences of Quarantine

Although quarantine was experienced differently by each individual subjected to a period of forced isolation in relation to COVID-19, a clear pattern of emotional distress emerged in a significant portion of the affected population. One way that distress may present in a patient is a reduction in the ability to cope with daily life stressors, an increase in symptoms of depression, anxiety, ideation of self-harm, or as loneliness that diminishes the patient's ability to engage with others (Tokur Kesgin et. al., 2022). One such source of distress was the removal from pre-determined sources of support and mental health care.

Vulnerable Populations

Of those affected by quarantine, those in vulnerable populations may experience a higher level of distress related to these disruptions. Inadequate access to mental health care and social support as a result of quarantine increases the risk of suicide in lower socio-economic groups (Singh, 2020). The lack of social support and experiences of isolation are especially detrimental to younger populations. Recent research regarding human isolation in normative social settings is indicative of similar responses to those exhibited in adolescent rats (Jahng et. al., 2012). Studies conducted based on human behavioral patterns during the pandemic, and related isolation showed similar patterns and concerns as what had been witnessed in the rat populations. Elementary-aged children removed from educational facilities and forced into isolation experienced reduced overall physical and mental health (Viner et. al., 2021).

Social Support

The presence of social support serves as a buffer from stress and fear. In the absence of this buffer, it is essential to have adequate coping skills for emotional regulation and management. Common coping mechanisms for loneliness and emotional distress include removing oneself from the situation, going out and enjoying social interactions, talking to others, and attending the gym to mind both one's social needs and physical needs. Unfortunately, many of the traditionally recommended coping skills are not possible in a quarantine setting. Easily accessible coping skills such as quiet space to meditate or engage in mindfulness practices are further reduced during hospitalization due to frequent intrusions by hospital staff, decreased cognitive functioning if oxygen levels are low, and lack of privacy.

Reliance on family members as a support source reduces distress levels for both the patient and the patient's family members (Kosovali et. al., 2021). Promoting social interactions such as texting, phone calls, and video calls may strengthen the degree of support received by the patient. This is particularly important as a lack of social interaction and support correlates with the experiences of hopelessness and helplessness patients feel in an inpatient setting for COVID-19 (Troutman-Jordan & Kazemi, 2020).

Quarantine Risks

Quarantine forcibly removes people from their daily life patterns of behavior. It restricts their ability to access previously successful coping skills, leaving them vulnerable to unmanaged stress and worry associated with the COVID-19 pandemic. In the absence of the ability to rely on predetermined and established coping skills, underlying predispositions to anxiety, depression, and emotional distress were activated, resulting in a cascade of symptomology, further reducing the individual's self-efficacy. Self-efficacy refers to an individual's belief in their own capacity for success. A reduction in self-efficacy results in a lower level of trust in self to develop and implement healthy coping skills, increasing their overall experience of distress and reducing the success of their daily tasks (Godoy Izquierdo et. al., 2021). Thereby reducing their capacity to develop and implement appropriate coping skills for managing extreme life stressors. This is particularly problematic as research has indicated the protective factor resilient coping skills offer individuals with an underlying diagnosis of depression who are exposed to trauma (Sinclair et. al., 2016). Due to the necessity of a period of quarantine, it is not feasible to advocate for the removal of such measures but instead to promote ways to soften the stressors experienced during

these times of quarantine so that social isolation and loneliness need not be part of the experience.

Additional Risk Factors

Additional risks associated with periods of high stress and low ability to engage in coping skills include domestic violence, substance use relapses or episodes, and maladaptive coping skills such as self-harm, overeating, or noncompliance with treatment. Comprehending and reacting to sources of stress as mental health professionals has the potential to reduce the emotional burdens experienced by the community served. According to Rosa et. al., (2019), it is essential to consider the needs of the population served and the manner in which isolation and evolving social expectations affect the individual's ability to access appropriate coping skills when determining the best course of treatment.

Periods of increased stress due to decreased access to social resources and limited or nonexistent capability to earn income during quarantine increase instances of domestic violence, substance use disorder, and incidents of self-harm (Kumar & Nayar, 2021). Identifying populations at a heightened risk of experiencing emotional distress is essential as it may allow professionals to intervene earlier in the treatment and isolation stages, thereby reducing the level of distress experienced and the risk of engaging in problematic or maladaptive coping skills.

Mental Health During Forced Isolation

For specific individuals, forced isolation, or the mandated removal of self from social interactions, may reduce an individual's overall stress, initially causing them to voluntarily prolong their period of isolation that increasing their overall risk of developing mental health consequences such as depression (Kato et. al., 2020). Isolation, chosen or forced, reduces a

person's access to social and familial support, thereby increasing the risk of increased presentation of symptoms of mental illness.

Feelings of loneliness may contribute to thoughts of worthlessness or sadness that, when not interrupted by social interactions or uplifting words, may further contribute to the experience of depression. According to TMGH-Global COVID-19 Collaborative (2021), isolation may initially mitigate stress and anxiety for those with social anxiety; however, prolonged isolation increases the risk of renewed and increased levels of anxiety and depression. Higher levels of anxiety and depression before the onset of illness increase the risk of extreme emotional distress post-onset of illness and for the duration of inpatient treatment for COVID-19. If left uninterrupted, these emotional concerns may result in continued disruptions in patients' daily lives following discharge from the hospital.

Visitation Limitations

In the wake of the COVID-19 pandemic, hospitals have been forced to restrict visitation in an effort to minimize the risk of spreading the illness. The restriction of hospital visitation during the COVID-19 pandemic increased the immediate experiences of stress and fear for both the patient and the family members, leaving the patient in the care of the hospital staff (Moss et. al., 2021). The implementation of strict isolation measures fosters an environment devoid of family support and advocacy. This is particularly concerning for those hospitalized with COVID-19 as this illness can potentially affect respiratory functioning to such an extent that individuals may develop COVID-19 pneumonia, which depletes oxygen in the patient's blood, thereby leading to hypoxia (Somers et. al., 2020). This is particularly concerning as hypoxia restricts cognitive functioning and promotes sensations of fear and distrust. Patients who are experiencing

hypoxia are at an increased risk of also experiencing pain and disorientation that combine to diminish their capability further to make informed decisions regarding fundamental medical care decisions (Somers et. al., 2020). As a result, a patient may fail to adequately convey their level of discomfort leading to the continued use of inadequate or excessive medical interventions and increased emotional distress.

Quarantine

Populations subjected to quarantine regulations reported a significant decrease in overall feelings of happiness and life satisfaction (Chakrabarti, 2021). The sudden and pervasive presence of isolation and loneliness altered the manner in which people interacted with the world around them and how they viewed their function in society. Where routine human interaction and connection had once been the norm in office and social settings, there were now digital meetings and closed facilities lacking the ability to form genuine human connections with others. The sudden disconnect from previously established supportive resources and comfort sources left many without access to adequate coping skills and resources to manage their emotional responses, thereby leading to emotional distress. The severity of the presence of this risk was intensified in patients facing health complications from COVID-19 that required inpatient treatment in a hospital setting (Chakrabarti, 2021). The risk of developing or experiencing anxiety and depression increased for those who lost their means of income or had inadequate support to maintain their responsibilities during hospitalization (Wilson et. al., 2020). Loss of income is especially problematic as it increases the presence of food insecurity and the risk of homelessness and reduces the ability to meet life responsibilities.

Suicidal Ideation

Suicidality is an additional concern when treating people in an isolative environment. Feelings of discomfort related to the sensation of being trapped may be heightened by the risk of developing further physical complications related to COVID-19 infection that may trigger suicidal thoughts during quarantine (Hophing et. al., 2022). Furthermore, the biopsychosocial mechanisms that interact with the COVID-19 virus may increase the potential to develop suicidal ideation in conjunction with organic feelings of loneliness and being trapped. Inflammatory responses in the brain and blood of individuals with COVID-19 have been linked to increased suicidal ideation and disorientation, thereby complicating the treatment process and increasing the need for interpersonal support systems (Menon et. al., 2020). This indicates the need for immediate and effective interventions provided to those seeking treatment and their support networks to reduce the immediate risk of self-harm. At the same time, the body is returned to a state of homeostasis. Returning to a resting state allows the biological mechanisms to increase the patient's risk of self-harm dissipating.

Various mental health concerns are associated with isolation and the treatment of contagious illnesses. Of these mental health concerns that may accompany a period of isolation during hospitalization, suicidal ideation presents as a potentially imminent risk factor that may supersede the presence of COVID-19 as the primary source of danger for the patient. Treatment for an infectious illness increases the risk of developing suicidal ideation in a patient under care in an ICU department from 4.9% in the general ICU population to 7.9% (Botega et. al., 2010). Therefore, it is essential to identify a standard of procedure that allows for supportive care while also meeting the needs for the safety of the staff treating the patient with an infectious illness. Special attention is required when working with patients between the ages of 18–35, who have

an alcohol or tobacco use disorder, or symptoms of depression and anxiety as they experience a higher level of risk for developing suicidal ideation (Botega et. al., 2010). Ideation may occur on a spectrum of severity, from brief thoughts or images of intentional loss of life to the act of completing suicide. Fleeting thoughts are not uncommon in the face of highly stressful situations such as hospitalization. However, they are not healthy and do require proper attention and assessment from a trained professional. Pons-Banos et. al., (2020) discovered that patients who are experiencing symptoms of the suicidality spectrum react favorably to mental health nurse-driven mental health interventions.

Depression

Current data support the supposition that isolation and quarantine have a causal correlation with depression. Patients receiving care in a hospital setting in China reported higher than general population instances of depression with a high enough severity level to produce suicidal ideation (Huang et. al., 2019). The presence of depression creates an additional concern that requires addressing during a period in which survival and treatment are the primary focus points. Furthermore, depression is linked to lower recovery rates and an increased need for invasive medical procedures that further reduce the success rate of patients (Dunstan, 2009). Therefore, it is reasonable to make the assumption that assessing patients for emotional distress and alleviating the causative factors that promote the presence of emotional distress may increase the rates of recovery and decrease the length of stay in a hospital setting. Additionally, depression is not limited to the patient seeking treatment. Family members of patients admitted to the general hospital for treatment of COVID-19 were more likely to exhibit anxiety symptoms

than those who did not have a family member under similar circumstances (Kosovali et. al., 2021).

Anxiety

Although anxiety as an emotional response to stressful stimuli is a normal and healthy component of the human experience, it encourages actions and promotes safety; anxiety as a diagnosis interferes with one's ability to engage in daily life tasks and significantly increases the level of distress experienced by the afflicted individual. Such sources of stress include hospitalization in an intensive care unit (ICU) for an infectious illness, which was found to increase anxiety levels in both the person admitted into the ICU and their family members (Kosovali et. al., 2021). Anxiety occurs when there is an exaggerated response to perceived sources of distress or danger. When a person's parasympathetic nervous system is activated in response to a perceived threat or source of danger, the sensation of anxiety is experienced, which, if there is no clear resolution, leads to emotional distress, reduced ability to function cognitively, and overall feelings of discontent (Sapolsky, 2004). Therefore, identifying and providing potential solutions for the stressors and sources of anxiety may reduce the experience of anxiety for both the individual seeking treatment for COVID-19 and their family members.

Vulnerable Populations

If preventative measures are to be developed to mitigate the risks of developing mental health consequences related to COVID-19, it is necessary to identify the populations most susceptible to these concerns. This is particularly necessary when an at-risk individual enters the hospital for treatment. Through early identification, it may be possible to limit the risk of experiencing treatment-related trauma. Women who developed COVID-19 are at a higher risk of

experiencing detrimental levels of emotional distress than their male counterparts, increasing their risk of developing anxiety and depression (Brivio et. al., 2021). Women who experience emotional distress have higher odds of exhibiting symptoms of depression and anxiety. According to Levers (2012), women have a higher level of activity within the limbic system, which increases their reactivity to emotionally distressing stimuli; however, women are also more likely to recover after the development of trauma-based disorders if they are provided with adequate interventions. For these reasons, it is essential to provide preventative measures such as access to their social networks to the greatest extent possible and be given access to mental health care while receiving treatment.

Geriatric Populations

Additionally, removal from social support systems appears to have an exceptionally detrimental effect on geriatric populations. Elderly individuals whose circumstances required isolation and quarantine, with or without hospitalization, experienced higher rates of emotional distress than their younger counterparts, as indicated by 20% of the American geriatric population experiencing some form of mental health condition during the pandemic (Troutman-Jordan, & Kazemi, 2020). The high prevalence of emotional distress within this population indicates a greater need to explore this correlation and develop appropriate measures to reduce the distress level experienced by removing distressing circumstances and adding effective coping skills.

Socioeconomic Status

Lower socioeconomic status is an additional area of concern when assessing the risk level for poor mental health outcomes for individuals hospitalized with COVID-19. Individuals with

lower socioeconomic status experience higher levels of base stress and receive lower levels of social support. Furthermore, the financial burdens of the inability to work generate increased levels of emotional distress and instability in their personal lives, further interfering with their ability to regulate their emotions due to helplessness and isolation during hospitalization (Wanberg, 2020). People who do not have adequate levels of financial security prior to medical expenses are more likely to lack appropriate resources to rely on during times of increased stress. For this reason, it is necessary to identify supportive means of intervention for clients of lower socioeconomic status upon admission to a hospital.

Previous Mental Health Conditions

Additionally, people with personal histories positive for trauma also present as a high-risk population for the development of psychological or emotional distress. According to Hambisa et. al., (2021), 57.9% of hospitalized individuals with trauma histories reported a significant increase in emotional distress. The risk of emotional distress increases when the individual has a poor social support system. Furthermore, the severity of the infection and perceived risk of loss of life elevate the individual's state of emotional distress (Sommaruga & Carugo, 2021). The presence of a trained mental health team within the hospital system may be indicated as a means of increasing patient levels of emotional regulation and as a means of preventing isolation-related emotional distress.

Women

Women are at a higher risk of developing symptoms of PTSD and GAD that interfere with daily life tasks in relation to quarantine and social isolation enacted due to COVID-19 (Ravaldi et. al., 2020). The daily tasks of caregiving and planning are often the responsibility of

the female head of the home. Furthermore, women receive higher levels of satisfaction from social interactions and more heavily rely on the opinions of their social support systems than their male counterparts (Ajrouch et. al., 2005). This is a further indication of the need to foster social support during hospitalization and to build in added support for those experiencing COVID-19-related isolation. Social support and interactions build resiliency and provide a safe avenue to release emotions and process through difficult experiences. Although virtual means of communication such as zoom video calls and telephone conversations assist in the maintenance of relationships, the level of interactions engaged in on a daily basis is significantly less during a period of quarantine as the individual is not engaged in everyday tasks such as running errands. This impedes their ability to engage in a healthy and robust social support system and degrades the level of support received from micro-social interactions (Ravaldi et. al., 2020).

Women who develop COVID-19 are at a higher risk of experiencing detrimental levels of emotional distress, which increases their risk of developing anxiety and depression (Brivio et. al., 2021). Women who experience emotional distress have higher odds of exhibiting symptoms of depression and anxiety as well. For these reasons, it is essential to provide preventative measures such as access to their social networks to the greatest extent possible and be given access to mental health care while receiving treatment. This may be achieved through the use of assistive technology such as cell phones or laptop computers with access to video technology. Engaging in socially supportive activities via technological means reduces the presence of distress in hospitalized individuals (Wong & Merchant, 2021).

PTSD

Individuals with a previous diagnosis of PTSD are at an elevated risk of experiencing an increase in the severity of symptoms of PTSD as a result of the inability to access previously helpful coping skills due to quarantine restrictions (U.S. Department of Veteran Affairs, 2020). Removal from previously effective coping skills, such as spending time with family and friends, going to in-person support groups, engaging in group activities, and even disrupting in vivo therapy interventions, all increase the risk of a relapse of PTSD symptoms. Increased symptoms place the individual at an increased risk of attempting suicide or experiencing debilitating mental health concerns (U.S. Department of Veteran Affairs, 2020).

Mitigating Factors Against Consequences of Isolation

Financial stability and the development of a new, less stressful daily routine are mitigating factors against the lockdown's potentially negative mental health consequences (Ahrens et. al., 2021). Continued financial stability allows the individual to remain focused on limited sources of stress instead of having their mental resources spent on meeting basic needs and navigating the stressors of quarantine. For those who do not have adequate financial resources, accessing information concerning local assistance is essential to lowering their levels of distress. Pertinent resources may include food banks, rent assistance programs, utility assistance programs, and virtual social support groups.

Mental Health Support

According to Sheek-Hussein, Abu-Zidan, and Emmanuel, the presence of mental health resources reduces the overall level of emotional distress in the communities served by them (2021). Through a combination of meeting basic needs, innovative social support systems, and

mental health resources, the level of emotional distress and the risks of developing mental health conditions may be mitigated. Additional sources of support include houses of worship. Despite the inability to meet in person, many places of worship have developed alternative methods of meeting. This is important as it serves as a spiritual and social support during times of uncertainty and isolation. Continued access to everyday aspects of life routines, such as attending Church, may mitigate the detrimental effects of isolation and the disruption to daily life caused by COVID-19. Furthermore, planned behaviors, such as exercise, reduce individual risk factors of experiencing emotional distress during periods of social isolation (Bird et. al., 2021). Therefore, it is suggested that individuals increase their level of physical activity and adhere to a daily schedule.

Family Involvement in Treatment

Inadequate levels of familial involvement and support during patient hospitalization for COVID-19 are correlated with increased emotional distress in the patient (Sun et. al., 2021). The feelings of helplessness and fear that may be associated with an unknown prognosis and the isolation of a hospital stay are exacerbated by the inability to have loving and familiar faces present while receiving treatment. Positive treatment outcomes are supported by the presence of family and social support during hospital stays (Rosa, 2019). Further research is required to verify the extent of the benefits offered by family support. However, present research indicates the benefit of familial support to such an extent that including it in current interventions is warranted.

Alternative Support Systems

Due to the contagious nature of the illness, isolation and quarantine are necessary components of hospitalization that supersede the emotional need for familial presence (Parks & Howard, 2021). Therefore, it is essential to find alternative methods for providing support and including family in treatment decisions. Video messaging and communication platforms may alleviate some level of stress for the patient during medical interventions and periods of loneliness. This is beneficial in staving off emotional distress, as loneliness may contribute to poorer outcomes in treatment settings. According to Reijinders et. al., (2018), a deficit in social support that leads to loneliness decreases patients' rates of oxygen and overall health of vitals, and higher rates of emotional distress, with 99.4% of patients with COPD. They rated their experience of loneliness as severe experiencing mental health consequences. This dataset is potentially relevant to patients' experiences in treatment for COVID-19 due to the presence of respiratory distress and hypoxia-related mental health concerns.

Medication and Cognition

The combination of isolation from the patient's family and the use of sedative medications in patients with severe medical complications due to COVID-19 results in emotional distress that serves as an impediment to the healing process (Ting et. al., 2020). Though medication management may reduce a patient's psychological distress, it is also potentially distressing when the patient experiences an altered state of cognition without the supportive presence of family. The presence of sedatives further reduces the patient's rate of cognitive function, thereby increasing feelings of confusion and anxiety that may increase their risk of experiencing delirium (Bashar et. al., 2018). Despite the necessity of using such medications, the potential

consequences remain problematic. Therefore, it would be beneficial to identify possible supportive measures to reduce the level of distress experienced while in an altered state of cognitive capabilities. According to Ting et. al., (2020), the use of palliative care has the potential to create a state of confusion and disorientation that is worsened by the lack of familiar sources of support.

Isolation-Related Stressors During Hospitalization

The presence of overwhelming fear associated with contracting COVID-19 has resulted in an increase in depression, anxiety, and suicidality that is directly correlated with limited stress management skills and access to social support (Menon et. al., 2020). Responsibilities did not diminish or cease to exist when the pandemic began. Individuals were still required to provide housing, food, and safety for themselves and any dependents they cared for; however, they were expected to do so with limited or no income-generating activities and severely restricted access to support. The combination of the increase in daily stressors with a decrease in potential coping mechanisms and support created an exceptionally high-stress environment for many people. Those who contracted COVID-19 experienced an even higher level of emotional distress. Developing Takotsubo Syndrome is a potential consequence of experiencing severe emotional distress during hospitalization for COVID-19 infection (Barbieri et. al., 2021).

These concerns are further exacerbated by the loneliness and despair that are experienced during hospitalization. Due to the high level of fear and uncertainty surrounding a hospital stay for COVID-19, familial support would serve as a mitigating factor against emotional distress. However, in an effort to slow or prevent the spread of the virus, visitation is not permitted. The absence of familial and social support fosters an environment in which feelings of helplessness

and anxiety thrive. In an environment devoid of social support, isolated individuals experience an increased probability of developing physical symptoms of anxiety and stress that may exacerbate their level of emotional distress (Menon et. al., 2020)

Mental Health Considerations

Mental health considerations are once more gaining significant consideration after an initial shift toward concerns about physical safety during the COVID-19 outbreak. Individuals were forced into periods of isolation, quarantine, or limited access to social encounters on a global scale. It has been discovered that forceful separation from social support due to COVID-19 lockdowns increases an individual's risk of developing PTSD and experiencing an increase in the severity of preexisting mental health conditions (TMGH-Global COVID-19 Collaborative, 2021). PTSD is a mental health condition that develops after an individual experiences a significant trauma in which a real or imagined risk of death is present, such as during the global COVID-19 pandemic. According to Liu et. al., the presence of loneliness and anxiety during periods of COVID-19-related isolation were indicators of an increased risk of developing PTSD (2020). People who were forcibly removed from their support systems while simultaneously experiencing a risk of death or perceived risk of death are at an increased risk of developing PTSD and other trauma-related concerns. Patients were receiving treatment in a hospital setting for COVID-19 experience significant increases in the risk of presenting clinically significant symptoms of depression and anxiety (Sommaruga & Carugo, 2021). The presence of emotional distress is alarming as it has the potential to interfere with the individual's drive for survival. Loneliness remains an area of concern as it increases the level of emotional distress experienced by an individual, thereby reducing their overall level of resilience (Liu et, al., 2020).

The rates of development of anxiety and depression in previously unaffected individuals rose in connection with the forced removal of social support due to lockdown measures (Nguyen et. al., 2021). This indicates that there is an inadequate level of intervention present in areas affected by lockdown measures, including hospital settings. This is further illustrated by the rise in the number of self-reported symptoms indicative of depression and anxiety. As a result of the COVID-19 pandemic, the rates of self-reported experiences of depression and anxiety have risen by 11% in one year (Abbott, 2021).

Therefore, it is imperative that the level of mental health resources available and the ease of access to these resources be increased. Teletherapy and online support groups are potential options available to close this gap. Accessing mental health resources through teletherapy increases the availability of support without unnecessary exposure to risky settings such as clinics or hospitals. Individuals suffering from depression experienced a reduction in self-reported symptoms of depression and an increase in overall wellness after participating in online healthy lifestyle promotion therapy (Navarro et. al., 2020).

Hospital Regulations and Mental Health

Altering the manner in which hospitals conducted visitation and patient treatment was a necessary response to the global COVID-19 pandemic. Although necessary, these alterations in regulations have not been implemented without a significant cost to the individuals and communities served. Isolation-related anxiety and depression associated with feelings of loneliness may correlate with an overall reduction in emotional wellness. Additionally, medical care providers have also experienced emotionally detrimental consequences related to hospital regulations and procedure alterations. The medical team’s alterations in stress levels and

expectations of care may diminish the level of care provided to patients and could negatively affect the patient's emotional well-being.

Death and Dignity in Isolation

Visitation restrictions enacted in an effort to slow the spread of COVID-19 in treatment centers resulted in elderly patients dying deaths that lacked emotional meaning and support, thereby subjecting the patient and their families to emotional distress (Parks & Howard, 2021). Death is an absolute in life. It is a final movement through the stages of life. When it happens in turn, and with dignity, those left to live can lean into these final experiences for comfort and peace. Dying alone creates an environment devoid of comfort that strips the family of the opportunity to engage in end-of-life remembrance activities furthermore, it has the potential to leave the family with grief that may contribute to the development of complicated grief (Corpuz, 2021).

Bereavement

Moving forward after the loss of a loved one due to COVID-19 may be complicated by the presence of guilt over failure to be present as their loved one died. Guilt and grief may be further complicated if the family member or members also contracted COVID-19 and survived. The risk of experiencing symptoms of complicated grief after a COVID-19-related death is exacerbated by the removal of social support and reduced access to previous sources of comfort (Sani et. al., 2020). Therefore, it is imperative that alternative methods of enduring and honoring the end-of-life process are developed. Potential alternative honorary procedures include video platforms supporting funerals and/or creating books of memories put together by friends and family.

Mitigating Effect of Family on Emotional Distress

The active participation of the family in the process of caring for adult patients during periods of hospitalization has proven to offer support emotionally and physically during the course of treatment, thereby improving treatment outcomes (Mackie, 2018). Due to the contagious nature of COVID-19, family members' active participation in treatment endeavors has proven challenging to encourage or maintain. Family participation in treatment decisions when a patient is incapable of making a decision for the course of their treatment increases the likelihood of the patient's wishes being carried out (Sharma, 2011). Adherence to patient wishes concerning the nature of interventions that are carried out during the course of treatment may lower the level of distress experienced by the patient in part due to preserving the patient's bodily autonomy. Furthermore, patients who hold a high level of value in their familial relationships benefit from the presence of a trusted advocate and support during the course of treatment, which minimizes the experience of stress suffered during their period of hospitalization (Kydonaki et. al., 2020). In the absence of the ability to provide patients with the physical presence of familial support, it may be beneficial to utilize electronic means of involvement, such as video calls. According to Chakrabarti (2021), using electronic means of communication and family involvement in treatment may protect against emotional distress experienced in patients hospitalized for COVID

19.

Mitigating Effect of Family Support on Medical Staff Stress Levels

When it is not possible to have supportive family members and appointed advocates present, medical personnel have been placed in the position to make treatment-related decisions for incapacitated patients under their care. The stress of making such decisions for patients whose treatment-related wishes are unknown increases the levels of emotional distress and work-related stress experienced by medical workers such as doctors and nurses (Hamama et. al., 2021). Therefore, if it is possible to increase the level of involvement of family members, it is reasonable to consider the possibility that the increase in the amount of participation would benefit the medical staff's overall levels of distress. This is supported by the research conducted by Shibily et. al., (2021), which states that an increased level of involvement from family members in patient care reduces the perception of stress in nurses and medical personnel.

COVID-19 Treatment-Related Trauma

As with other mental health-related concerns, early identification and treatment of COVID-19-related mental health concerns may increase the effectiveness of interventions offered. If preventative measures are to be developed to mitigate the risks of developing mental health consequences related to COVID-19, it is necessary to identify the populations most susceptible to these concerns. This is especially necessary when an at-risk individual enters the hospital for treatment. Through early identification, it may be possible to limit the risk of experiencing treatment-related trauma. Furthermore, it may be possible to reduce the rate of exacerbation of preexisting mental health concerns through the use of appropriate and immediate interventions based on client needs.

Previous Trauma

The presence of traumatic experiences during COVID-19 exposure and infection are a risk factor for developing trauma-based disorders. Additionally, people who have personal histories positive for trauma also present as a high-risk population for the development of psychological or emotional distress. According to Hambisa et. al., (2021), 57.9% of hospitalized individuals with trauma histories reported a significant increase in emotional distress. The risk of emotional distress increases when the individual has a poor social support system. Furthermore, the severity of the infection and perceived risk of loss of life elevate the individual's state of emotional distress (Sommaruga & Carugo, 2021). The presence of a trained mental health team within the hospital system may be indicated as a means of increasing patient levels of emotional regulation and as a means of preventing isolation-related emotional distress.

Hospitalization and Coping Skills

Understanding the experiences of patients who require hospitalization and isolation is an essential part of developing effective interventions. Prolonged exposure to critical illness-related stressors significantly increases levels of emotional distress and decreases the presence of effective coping skills (Cox et. al., 2018). Due to the reduction of access to previously established coping skills and the interference presented by the trauma experienced during isolation related to treatment for COVID-19, it is imperative to identify means through which meaningful coping skills may be learned. According to Cox et. al., (2018), the utilization of telephone-based coping skills training reduces the level of distress experienced by people who were hospitalized in response to a critical illness. For those who experienced high baseline levels of distress, improvement began around six months post-training.

In contrast, people who were on a ventilator in excess of 7 days but did not have a high baseline of distress experienced improvement three months post-training (Cox, et. al., 2018). This indicates the potential success of electronic means of intervention. However, the length of time between training and improvement does indicate a further need for exploration and additional support methods to reduce the overall length and severity of the experience of emotional distress.

Risk Factors for Medical Care Workers

Changes in hospital regulations and visitation policies have resulted in additional stress for both those under hospital care and those providing care. Due to an increase in personal responsibility for life-sustaining medical decision-making, the risk of developing trauma-based disorders has increased for medical workers (Rosa, et. al., 2019). Prior to the onset of the pandemic, medical caretakers were not expected to carry the entire burden of decision-making for each incapacitated or cognitively impaired patient under their care. Partly as a result of the onset of the pandemic and its associated changes in regulations, advocates and family members were not readily accessible to make medical decisions for a majority of incapacitated patients. However, with higher workloads and drastically fewer interactions with family members, more and more daily medical care decisions are becoming the medical team's responsibility. Both in regard to what treatment is given and to who receives treatment. These additional responsibilities and stressors have increased the instances of depression and anxiety in medical personnel that may interfere with their ability to provide a high standard of care for their patients (Rosa et. al., 2019). Lower levels of care provided to patients may decrease treatment outcomes and increase patients' emotional distress experiences. Though there is a small body of research concerning the

effect on patients of medical personnel stress, it is suggested that further research into the perceived effect of medical personnel stress on patient care is conducted.

Support Programs for Medical Workers and Patients.

One of the many consequences of inadequate mental health support in areas served by medical personnel is the development of severe emotional distress in the population served and among the medical professionals themselves (Sheek-Hussein et. al., 2021). Locations requiring higher levels of medical intervention but limited access to mental health support are at risk of emotional burnout related to the continuous high stress within their communities. Emotional burnout in medical professionals depletes their emotional stores, reduces their capacity for compassion, and reduces the level of care received by patients under their direct care (Koniukhovskaia et. al., 2021). Therefore, it is imperative that adequate coping skills and social support networks are implemented to the highest extent possible for both community members and the medical team serving them. Improved access to family support and family stability decreases the risk of developing burnout in medical professionals (Koniukhovskaia et. al., 2021). The presence of relative communicators serves as a further protective factor against medical caretaker burnout. Hospital systems that employ relative communicators shift a portion of the stress of reaching out to families and discussing options with the families of patients receiving treatment for COVID-19 away from the medical providers, thereby reducing their risk of burnout and reducing their overall stress load (Ramanathan et. al., 2021).

Mental Health Programs.

The implementation of adequate mental healthcare programs serves as an additional mitigating factor against the development of emotional distress related to COVID-19 in

healthcare settings. The presence of a mental health team greeting medical workers as they entered their work environment reduced the staff members' self-reported feelings of depression and anxiety and reduced their feelings of loneliness (Vanden Bossche et. al., 2021). Supportive members of work and social environments meet the individual's base need for human connection and support during times of stress and fear. The implementation of support programs may mitigate the negative consequences of working in hospitals inundated with patients positive for COVID-19 (Vanden Bossche et. al., 2021). Additionally, utilizing virtual means of interaction and support that allow the medical workers to track and understand their feelings of helplessness reduces the presence of emotional distress by providing an outlet and identifying potential interventions for distress tolerance (Mira et. al., 2020). Through adequate use of interventions and supportive measures, it is possible to ameliorate the distress experienced by hospital staff, thereby reducing the presence of emotional distress present in the patients receiving direct care by affected hospital staff members.

It has become evident that supportive care for medical workers is an essential component of the process of increasing the level of support and standard of care available to the patients. Adequate professional support is essential as they increase the emotional capacity of the staff caring for the patients. Patients who receive personal care from staff, including physical touch, may experience a decline in their experiences of emotional distress (Sun et. al., 2021). Therefore, if medical personnel is expected to provide comfort to patients experiencing fear and distress while under their care, they must first have the emotional capacity to meet their own needs. It is an unobtainable goal to expect a depleted individual to continue to provide satisfactory care to another. Therefore, it is imperative that mental health support is offered to hospital staff as well as patients. More research is indicated in this area as it is necessary to determine the extent to

which hospital staff's levels of stress and distress affect the level of emotional distress experienced by patients. However, it is essential to remain cognizant of the additional stressors placed on medical workers during the process of researching this matter. Even with the family involved in medical decision-making, due to the COVID-19-related visitation restrictions, medical team members are heavily responsible for articulating and guiding the decision-making process, which increases their baseline levels of stress and responsibility related to patient care (Bronsther, 2020).

Effect on the Brain.

Infection with COVID-19 has been linked to inflammation within the brain and alterations in the production of urea nitrogen, cystatin C, and increased reactivity to C-reactive protein, in addition to various other changes that increased the risk of developing psychiatric symptoms including emotional dysregulation, depression, and anxiety (He et. al., 2021;2022). Though this bodily reaction to the presence of the virus is beyond the scope of the study, it is noteworthy in that it may provide additional explanations for the increase in emotional distress and dysregulation. According to Studerus-Germann et. al., (2016), symptoms of brain injuries may include emotional dysregulation, difficulty thinking, reduced capacity to form memories, and an increased risk of depression and anxiety.

Conclusion

In conclusion, the detrimental mental and emotional consequences of forced isolation are exacerbated when an individual requires hospitalization for COVID-19. These consequences include increased presentation of symptoms, or newly developed symptoms, of depression, anxiety, PTSD, and other trauma-related mental health consequences. Those at the highest risk

include individuals without adequate social support networks, people with a history positive for mental health conditions and trauma, women, the elderly, and those in a lower socio-economic class. It is important to note that these populations are at a greater risk of developing emotional distress. However, no group is immune to developing emotional distress as a result of the added stressors associated with life disruptions associated with COVID-19; it is necessary to understand better what factors increase the probability of experiencing emotional distress and to account for additional factors such as the body's response to the virus.

The available research indicates that the risk of developing or experiencing worsening symptoms of depression, anxiety, PTSD, or emotional distress may be mitigated through the use of social support, family support, structure, readily accessible mental health resources, and increased financial stability. During periods of forced isolation, these needs may be partially met by relying on the presence of a caring medical team and virtual means of support from family and friends. Virtual means of support include phone communications, video communications, and consistent contact with family members by the medical staff in an effort to maintain a balance of decision-making between the patient and their family members, thereby reducing the burden of decision-making on the medical staff.

Despite temporary periods of relief being experienced by some people early in the global lockdown, a clear detrimental pattern of emotional distress has been identified as an overall consequence of forced periods of isolation. There is a limited body of research on the experiences of individuals hospitalized for COVID-19. Current research regarding emotional distress during hospitalization promotes the assertation that isolation interferes with the development of beneficial emotional and mental responses to high-stress situations. Therefore, it is essential to identify further measures of intervention that decrease the risk of continued

heightened levels of distress during treatment for COVID-19. Furthermore, identifying sources of stress for patients in a hospital setting benefits not only the patient but also the staff treating them and the patient's family members. Therefore, this population must receive a higher level of attention and research to develop and implement effective interventions.

Medical and mental health professionals have widely recognized the support offered by family members and friends as beneficial during periods of stress related to medical treatment and illness. Despite the acceptance of the assistive nature of familial support, the role of the family and social support systems as mitigating factors to alleviate emotional distress during treatment has not been fully explored. It, therefore, is not adequately promoted as a beneficial measure during hospitalization. Furthermore, the presence of a contagious illness additionally complicates the ability to benefit from family support in a hospital setting by increasing the risk of harm to others. It is essential to operate in a way that reduces the risk of harm to everyone involved, which often includes restricted access to the individual seeking treatment. Nevertheless, recently this has shifted due to the advent of virtual social interaction as a viable option of support has changed the feasibility of bringing family support into an isolated setting such as a quarantined hospital setting. Additional research is indicated in this area to identify further the benefits of family support, means of providing support from a distance, and to develop meaningful ways to implement these strategies in medical settings without compromising the level of care or safety of the patients being treated or the communities in which they live.

Chapter Three: Methodology

Overview

The desired information was gathered through the use of a qualitative transcendental phenomenological study. The transcendental phenomenological study format allows for a deeper conceptualization and synthesis of individual experiences concerning the study content matter (Creswell & Poth, 2018). Participants were gathered using a suitability survey administered through online means. Potential participants were searched for via social media-based clinical mental health and social worker groups and social media platforms for the general public. Facebook is the platform selected for the purpose of participant recruitment. Information concerning the nature of the research was clearly provided in the request for participants. Information concerning the extent of involvement required of the participants was openly included in the initial request for participants. The survey is not a data-gathering tool but instead a suitability measure to determine if the potential participants meet the basic criteria to engage in the study. Potential participants are eligible for participation if they were hospitalized after a COVID-19 diagnosis and experienced a period of isolation during hospitalization, are over the age of 18, and agree to complete the necessary stages for the research process. After the initial survey, three individual sessions were conducted to provide information concerning the specifics of the research and what to expect during the process to each participant and to begin the data gathering process. Five total participants were selected for continued participation in the study. A series of three interviews were conducted via Theranest, a HIPAA-compliant telecommunications platform.

The interviews were undertaken remotely once every two weeks over a four-week period. Participants were each provided with contact information for a therapist should the need be indicated, allowing the participants who experienced emotional distress an opportunity to process their experiences during the course of the study. The participants' names have been altered to protect their confidentiality and anonymity. In a further effort to preserve the confidentiality of the information gathered, data is being stored under pseudonyms in a locked file on a locked computer that will remain behind a locked door in the researcher's office. Protecting the confidentiality of participants is an essential component of research ethics (Hepner et al, 2015).

In order to develop a deeper understanding of how to mitigate the emotional distress experienced during hospitalization for COVID-19, it is essential to identify the degree to which isolation alters emotional stability and to determine specific mechanisms for future intervention. Therefore, a transcendental phenomenological method was selected in an effort to produce a deep body of data in which individual experiences and reactions to isolation during hospitalization are synthesized into data sets that promote the development of effective strategies for intervention. Information gathered through the process of discussing personal experiences with research participants has been presented in a manner that facilitates synthesizing the participants' experiences. Conducting a transcendental phenomenological study offers the opportunity to focus on participants' individual experiences to such an extent that the interference of external factors is excluded. The transcendental phenomenological approach provides an opportunity to engage in a deep examination of the individual emotional experiences of an event or phenomenon, thereby generating a clearer picture of individual truths concerning the experience (Hepner et. al, 2015). In the context of the prospective research, this methodology expands on the potential development of strategies or interventions through a more thorough

conceptualization of the experience of isolation related to hospitalization and treatment of COVID-19. Furthermore, this design method allows for the exploration of how secondary sources of stress interact with the experience of hospitalization, such as food insecurity and financial instability.

Design

The desired information was gathered through the use of the transcendental qualitative phenomenological method of research. The phenomenological format allows for a deeper conceptualization and synthesis of individual experiences concerning the studied content matter (Creswell & Poth, 2018). Participants were each gathered using a suitability survey administered through online means. Potential participants were searched for and collected via social media and professional social worker and therapist groups. The survey is not a data-gathering tool nor a standalone measure. Instead, it is a suitability measure to determine if the potential participants met the basic criteria to engage in the study: 18 years of age or older, experienced hospitalization for COVID-19, and were isolated. The survey was part of the announcement-seeking participants. Potential participants were required to self-respond instead of using a measure that records responses.

The participants each self-affirmed that they met the requirements and submitted contact information via the announcement to be considered for the study. After the initial survey, an individual interview was conducted to further determine suitability, provide information concerning the research process, and begin the data gathering process. After reviewing contact information and conducting a live interview, five participants were selected for participation in the study. A total of six people contacted the researcher for participation one was ineligible due

to not having been hospitalized but instead having been isolated at home. A series of three interviews were conducted with each participant via Theranest, a HIPAA-compliant telecommunications platform. The interviews were conducted once every two weeks over a four-week period. Participants were provided with contact information for a therapist as a protective measure for them as they discussed potentially emotionally tumultuous content.

Furthermore, each participant was provided with time to process their experiences during the course of the study if necessary, allowing for a more in-depth understanding of the emotional and mental experiences. The names of participants were altered in an effort to protect their confidentiality and anonymity, and ages were reduced to ranges. In a further effort to preserve the confidentiality of the information gathered, data has been stored under pseudonyms in a locked file on a locked computer that will remain behind a locked door in the researcher's office. Protecting the confidentiality of participants is an essential component of research ethics (Hepner et. al., 2015).

Research Questions

RQ 1. How does isolation during hospitalization affect self-reported rates of depression and anxiety?

RQ 2. How does isolation during hospitalization affect self-reported rates of depression and anxiety in persons previously diagnosed with depression or anxiety?

RQ 3. How does isolation from social support during hospitalization for COVID-19 affect the personal perception of mental health?

RQ 4. How does the patient's perception of the level of stress experienced by caregivers affect the patient's perception of their emotional health during periods of isolation?

Through careful exploration of the identified research questions, it is possible to develop a clearer understanding of the individual experiences of the study participants. It is in this way that the phenomenological method promotes a narrow but deep understanding of the human experience (Creswell & Poth, 2018).

Setting

As was initially proposed, initial participant selection occurred by utilizing a self-answered survey as part of the announcement for the study to determine suitability via social media, posting on a Facebook clinical mental health workers and social workers support group, the platform on which this advertisement was listed is Facebook due to a pre-established presence in professional groups and knowledge of use by the researcher. To diminish the risk of transmission of COVID-19 and increase the participant pool, interactions were conducted via electronic communications such as email and Theranest, a HIPAA-compliant teletherapy platform. Participant emails were individually gathered when the participants responded to the research announcement requesting participants in the research process. An initial meeting with participants was held via a virtual program, Theranest, in an individual setting to discuss the research procedure and answer any participant questions. All interactions were conducted via telecommunications. Participants were also provided with the option of selecting written correspondence through email as a means of responding or asking questions instead of additional individual meetings in which they answered or asked the questions verbally to the interviewer/researcher.

Participants

Selecting suitable participants for the study was a crucial component of producing accurate data. Therefore, rigorous steps needed to be set in place to identify suitability for participation in the study (Creswell & Poth, 2018). Criteria for involvement in the study include being 18 years old or older, having a history of hospitalization exceeding three days for treatment of COVID-19, and experiencing isolation during their hospitalization. Participants need not have experienced distress as a result of this isolation to qualify for participation in the study. All participants must meet participation requirements of being 18 or older, having experienced isolation in a hospital setting after receiving a diagnosis of COVID-19, and for treatment of the same.

Procedure

A need for a deeper understanding of the mental health consequences of isolation during hospitalization for COVID-19 was identified while working with clients experiencing emotional distress after leaving the hospital and witnessing friends, and family members experience similar responses. In order to engage in the process of researching these concerns, it is necessary to obtain permission from the internal review board for the University (IRB) through the process of submitting the research procedure to the IRB along with the required request form. A list of basic research questions was designed and used in an attempt to develop a deeper understanding of the emotional toll of such an experience.

An introductory survey was intentionally built into the research announcement as part of the process of determining potential participant suitability for the study. The questions asked on the request for participation announcement determine whether the individual is 18 years old or

older, tested positive for COVID-19, and required hospitalization for this infection. It also inquired if the person experienced forced isolation or quarantine during this experience. It was necessary that all questions were answered affirmatively for the potential participant to qualify as a candidate for continued participation. Furthermore, the participants were each provided with consent forms. They were individually informed on the depth of involvement requested of them, how the information would be used, and any potential risks to their well-being as a result of participation, as well as potential benefits of the research.

The initial phase of research required the selection of qualified participants. A simple self-filtering survey determining if the individual had been hospitalized and received treatment for COVID-19 in an isolated hospital environment for a minimum of three days was administered via online communications. Qualified potential participants were contacted via email to determine their continued willingness to participate in the research; if they did want to continue, then an individual follow-up session was scheduled to review the requirements of the study and begin the data gathering process. Data collection was accomplished through the use of three semi-structured interviews. The use of semi-structured interviews allows the participants to provide open-ended responses that produce meaningful units of information (Creswell & Poth, 2018).

Once potential participants indicated a desire to participate in the study and stated that they met the study requirements through an initial email from them to the researcher, a follow-up email was sent by the researcher requesting to schedule an interview. A follow-up email would have been sent if a response had not been received after seven days. If no response were received three days after the follow-up email, an email thanking them for their preliminary participation in

the research would have been sent, and they would have been removed from the research. This situation did not occur.

The collection of data was accomplished through the use of written interviews and telecommunication-based interviews. During this process, data concerning the affirmative experience of being hospitalized for COVID-19 was recorded as well as data indicating the number of potential participants who chose to complete the research process after being provided with information detailing the necessary steps and research process. Data collected will continue to be stored on a locked computer in a locked office space, with all identifying content removed from participant responses. Pseudonyms will be assigned to further protect participant anonymity.

The Researcher's Role

Throughout the process of completing research, the researcher is involved. They form the idea for the material being reviewed and explored; they determine what previous research needs exploration and inclusion in the development process of the current research; they gather participants, work with them, and synthesize the information received from them into meaningful bits of data. According to Friber & Öhlén (2010), the researcher is a vital component of the research process whose personal perceptions of life experiences influence the manner in which the data gathered is presented; therefore, it is essential to have measures in place to ensure the accuracy of data presentation.

In regards to the emotional experiences of those who have undergone isolation during a period of hospitalization for COVID-19, as the pandemic changed the social norms of the society I lived in and altered how people received medical care, I became aware of the feelings of

discomfort and suffering that others were experiencing. I witnessed my husband's battle with emotional distress during his time in the ICU with COVID-19. He struggled with nightmares and slept disruptions for months after returning home. I was aware of a friend who gave birth via C-section while she was in a coma breathing only because of the help of ventilators. She would not meet her child for nearly two months. I myself experienced loss, and I witnessed my friends and clients mourn as they lost loved ones due to the virus, or to the lack of access to medical care, or even untreated mental illness. We were left unable to attend funerals or to gather and mourn. These experiences caused me to want to study the emotional distress and the perception of events from the patient's point of view. Perhaps if I could understand what caused them suffering, then we could develop coping skills and interventions to minimize this suffering and improve their outcomes.

Data Analysis

After the completion of the interview process, the data gathered was broken into meaningful quotes from the participants. The researcher then sorted these quotes into subclasses and assigned personal interpretations of the meaning of the data collected. Before moving on with the data interpretation and synthesis process, the participants were each given an opportunity to review the selected quotes and verify that the interpretation of the information provided was accurate. This information was then synthesized into a clear and coherent article discussing the human experiences of isolation during hospitalization for COVID-19. Next, the data was used to determine what, if any, interventions may require future research to determine if the experiences of emotional distress may be mitigated during periods of isolation and hospitalization.

According to Creswell and Poth (2018), involving the participants in the process of interpreting data provided aids in minimizing the risk of researcher bias. A necessary component of the process of data collection and interpretation is the process of gathering data that clearly defines the aspects of the participants' experiences that contribute to the presentation of symptoms of emotional distress. Points of consideration include whether the individual experienced financial burden due to medical bills, loss of wages or work opportunities, loss of security financially or inability to provide for dependents. It is necessary to identify if these additional sources of stress were present, whether they contributed to the severity of symptom presentation, and whether additional social support would mitigate these concerns.

Interviews

Through careful evaluation of related literature, the following interview questions were developed. It is imperative to select interview questions that further the process of gathering data and answering pertinent questions that will contribute to developing meaningful interventions moving forward. These questions produce information that provides a deep and personal understanding of the individually lived human experiences during isolation and treatment for COVID-19.

Interview One

1. Describe your emotional process after learning that you were positive for COVID-19.
2. Describe the emotional experience of isolation during treatment.
3. Describe the progression of your emotional state throughout your treatment period.
4. Describe your state of mental clarity during your stay.
5. Describe the perceived effects of treatment on your mental state.

6. Describe the perceived effects of treatment on your emotional state.

7. Describe the perceived effects of isolation on your emotional state.

8. Describe the perceived effects of isolation on your mental state.

Interview Two

1. Describe your personal history of mental health.

2. How, if at all, did your experience in the hospital alter the presentation of symptoms of mental health concerns?

3. Describe sources of comfort during this period of isolation during hospitalization.

4. Describe your perception of the overall experience of isolation during hospitalization for COVID-19.

5. Describe your perception of stress during your treatment period.

6. How did your perception of the level of stress experienced by the medical staff providing care affect your emotional state?

7. How did financial concerns interact with your emotional state related to COVID-19?

Interview Three

1. How did external stressors such as financial considerations related to hospitalization and inability to work affect your mental health?

2. How did your inability to access previous sources of comfort, such as familiar faces, affect your perception of the treatment you received?

3. Describe external stressors such as financial instability or food insecurity and how they interacted with stress levels.

4. Describe the extent to which external sources of stress affected your ability to remain focused on treatment and recovery.

5. Identify sources of hope for the future related to managing external sources of stress.

6. Identify sources of hope related to the recovery of your physical health while in the hospital.

7. Describe mitigating factors that alleviated symptoms of emotional distress, if any were experienced.

Questionnaires

During the course of recruiting potential participants for the research topic, a simple but effective questionnaire was included in the announcement portion of the process. Simple yes and no responses were used to determine suitability for participation in the research procedure. Potential participants self-administered this instrument. Questionnaires provide essential data during the participant selection process, which allows for the appropriate selection of participants.

Trustworthiness

The presentation of accurate and trustworthy information is a foundational component of credible research. As such, data that is presented in the research include direct quotes from participants, which were verified for accuracy by the source prior to inclusion in the synthesized data. Once the data collection and verification processes were completed, participants were provided with the portion of the research, including their quotes and data sets for verification of interpretation. According to Heppner et. al., (2016), the interpretation of data in a manner in which meaningful interpretations may be formed is possible through the use of balanced checks with the source of the data in qualitative research.

Credibility

As part of the process of producing trustworthy and credible research, it is essential to implement the use of research-based and evidence-supported methods of synthesizing and collecting data. The transcendental phenomenological method of research provides the necessary framework to produce such research. In an effort to develop an inclusive set of data concerning emotional responses to isolation during hospitalization for COVID-19, between five and seven participants were sought, with five being selected. Each participant engaged in the same set of interviews and onboarding process to provide an equal representation of participant information. Achieving credibility is possible through careful filtration of participant information that preserves the original intent of the message shared by the participant (Morse, 2015).

Dependability and Confirmability

Dependability and confirmability are essential if the credibility of the research is to be preserved. For the purpose of this research, dependability will be achieved through the minimization of researcher bias and the preservation of the original meaning of the information gathered. In an effort to minimize bias, epoch and bracketing were used. Epoch refers to overcoming one's own perceptions and biases so that one may immerse oneself into the participant's lived experiences (Creswell, 2018). Additionally, participants' responses were recorded in a written record for review during the interpretation period of the research. Furthermore, the participants were asked to review the interpreted data for accuracy of interpretation. Thereby increasing the level of dependability and accuracy.

Transferability

Though this research focuses purposefully and entirely on the experiences of patients infected with COVID-19, it is reasonable to assume that the emotional experiences are transferable to other contagious illnesses requiring treatment. Therefore, it is rational to consider that this information may be easily transferable to other populations who may benefit from the knowledge gathered. These assumptions are supported by research conducted by Hall et. al., (2008), during the Ebola outbreak in 1995 that showed that shame and isolation were companions to transmittable illnesses that interfered with adequate engagement in medical treatment and produced emotional distress.

Ethical Considerations

In an effort to present ethically sourced and synthesized data, potential ethical considerations have been made. According to Munn et. al., (2014), protecting participant data and confidentiality is a critical component of ethically produced research. Therefore, client interviews will be conducted via Theranest, a HIPPA-compliant teletherapy platform, through secured email communication, or via in-person meetings. Participants will be assigned pseudonyms and gathered data would continue to be kept in a locked office space on a password-protected electronic device. Furthermore, protective measures were set in place to navigate concerns related to mental health considerations. Heppner et. al., (2016), discussed the potential for emotional reactivity to the process of sharing personal information within the context of research and data gathering. In an attempt to mitigate the potential for emotional reactivity of the exacerbation of mental health concerns, information for qualified therapists who are currently

accepting clients was provided to participants. Additionally, withdrawal from participating in the research process was not in any way discouraged.

Summary

The purpose of the transcendental phenomenological study was to produce synthesized bits of data regarding the experience of emotional distress during periods of forced isolation related to in-patient treatment for COVID-19. The event of a global pandemic altered the social structures and norms established over the previous generations that led to the experiences of isolation and loneliness in at-risk or vulnerable populations. This was especially true in those who were infected with the illness. The primary goal of this research was to identify and discuss these experiences in a meaningful manner that may produce effective interventions or present data which may be used in future research to produce effective interventions for those experiencing emotional distress during medical-related periods of forced isolation.

Chapter Four: Findings

Overview

The purpose of this transcendental phenomenological research is to develop an understanding of the lived experiences of people who experienced isolation while seeking treatment for COVID-19 in an inpatient hospital setting. Throughout the course of the study, key themes began to emerge. Through careful study of the data gathered during the interview process, it was found that forced periods of isolation during treatment for COVID-19 resulted in an increase in feelings of loneliness, increased presentation of symptoms of depression and anxiety in both participants with a previous diagnosis of depression or anxiety, and those without a previous diagnosis. Participants indicated loneliness as their primary concern and source of distress, followed by fear-based emotional dysregulation. Participants in hospital settings with lower levels of restrictions showed a decrease in symptoms of loneliness, anxiety, and depression though these concerns were still present.

Participants

Participants were selected via a request for participation on Facebook in which participants were asked to affirm that they were 18 years old, had tested positive for COVID-19, and experienced a period of isolation during hospitalization for a period of three or more days as a result of COVID-19. Five participants were selected after determining suitability during initial interviews. One ineligible potential participant contacted the researchers. This potential participant had self-isolated at home under medical supervision but not in a hospital environment. The individual participants provided unique insights into their lived experiences. Participants received treatment in various hospital settings, each with its own set of visitation

regulations and hospital protocols. The researcher contacted the hospitals to determine the protocols in place during the time period in which the participant was treated in that specific hospital setting. The interviews were conducted using Theranest, a HIPPA-compliant virtual meeting/therapy software system. Additional questions and communication were conducted via email, including questions from the researcher seeking clarity on previous interview responses to determine the accuracy of interpretation. As an additional measure to assess accuracy, participants were provided with the interpretation of the interview questions and allowed an opportunity to make corrections concerning interpretation when needed. Each participant engaged in three interviews. A synthesized compilation of the data gathered from these interviews per client is presented below. Pseudonyms were used to provide additional anonymity to participants.

Table One

Participant Demographics

Gender	
Male	2
Female	3
Age	
20–30	2
30–40	2
70–80	1
Pre-existing Depression	2

Table One

Pre-existing Anxiety	3
No Pre-existing Mental Health Diagnosis	2

Alberto

Alberto was the first participant in the study. He reported having a personal history positive for depression and anxiety. He is a 30-40-year-old married male from a rural setting in Texas. Alberto was infected with COVID-19 in the summer of 2021. Alberto remained hospitalized for 9-days. He was somber about participating in the research process but was determined to discuss and share his lived experience of becoming infected with COVID-19 and the subsequent necessity of hospitalization. He discussed feeling indifferent about the diagnosis when he first tested positive, stating, "I didn't care much. I expected a flu-like experience." Within a week of infection, he had developed pneumonia in both lungs despite being on medication prescribed by his physician. He shared feelings of shock and fear of "dying alone" as his wife drove him to the hospital. He shared that the experience felt disconnected and frightening, as though he was "going into the dark alone." There was a persistent theme of fear of being alone throughout the content shared by Alberto. His voice changed, and his eye contact became less consistent, often breaking and looking down and to the side as he shared. He shared that he had been married for "nearly two decades; we've been together since we were kids" and expressed separation from his spouse and children as particularly distressing.

Alberto shared that he did not trust the treatment team due to his state of "confusion from the drugs and had no one with whom I had an actual relationship. I felt like a lab rat." This lack of trust fed into his experience of fear and intensified previously diagnosed mental health

concerns of depression with a history of suicidal ideation without intent to act. He expressed an intensification of the suicidal ideation that included intent and a plan “I was extremely paranoid of everyone to the point I considered suicide to get relief.” He continued to share, stating that his inability to receive comfort and reassurance from his wife regarding their financial security and ability to continue meeting their financial obligations caused the anxiety and suicidal ideation to continue to increase. “I was very concerned… I considered suicide to help ease the financial burden on my family.”

Alberto discussed feeling “insane to the point of wanting to die” and discussed his belief that he was “just another patient waiting to die alone” to the staff at the hospital. He shared that he was only bathed once during his nine-day stay “that was the only time I felt human in that place.” He shared that the hospital staff “allowed my wife to stand in the hall some on the other side of the glass that helped me push through.” He shared that for the majority of the stay, his wife was not allowed to visit and that phone calls were helpful but challenging as he could not talk but only listen to her and the children read and share about their day. Alberto stated that his perception of the staff was that they were “overworked and tired, making my trust in them nonexistent. I thought they only did the least they had to do, so I almost hated them.”

In reference to points of hope, Alberto shared that he focused on returning home to his family "I was worried about my family if I died what kind of an effect it would have on them." He shared that this kept him from acting on the suicidal ideation that he stated included the plan to "just crush the oxygen tube so I couldn't breathe. They let the machines scream for a long time before checking; I know I could have died before they arrived." Furthermore, he expressed a sense of hope gained from relying on his spiritual beliefs and connection to God. "God and family are what got me through." He shared that his faith in God gave him the strength to fight to

be with his family. "I wanted to be home with my family, so I pushed hard to get up and move once they let me do so. It helped me focus on recovery." He stated that he was expected to be in the hospital for two months but that he fought to recover and "pushed them to keep lowering my oxygen intake even if it hurt to breathe." He stated that he prayed consistently and relied on God throughout this period of treatment. "They had stopped letting my wife come and stand outside my room. I was desperate to go home."

Shantelle

Shantelle was the second participant in the study. She is a 20-30-year-old married female from a large city living in Pennsylvania. She reports a personal history of positive for depression and anxiety. Shantelle was infected with COVID-19 in the Spring of 2022. Shantelle was hospitalized for 6-days. She was excited to share her experience and eagerly discussed her emotional responses to her stay in a hospital for COVID-19. Shantelle freely shared her emotional reactions to receiving the positive results of her test.

"I was terrified. I didn't want to die." She shared instantly, feeling lonely and fearful. "I started crying and just wanted a hug, but my wife wouldn't come near me. She said she couldn't afford to miss school so that she couldn't get sick." She shared that her symptoms rapidly progressed and required hospitalization within a few days. "I was just scared. I hate COVID-19. I have anger toward COVID-19; it brought me anxiety and isolation. It took my family from me." Shantelle processed feeling victimized by the illness and personally harmed by the isolation she was subjected to. She shared feeling guilty for exposing her caretakers to the illness in the hospital but shared feelings of resentment that her family did not care for her during her time at

home. She questioned whether or not she would have required hospitalization if she had received care at home. "It hurts that my family was focused on not getting sick instead of helping me."

During her stay in the hospital, Shantelle shared that she experienced intense waves of depression and anxiety “I felt like a virus in an isolation tank. I felt guilty, like I was dangerous.” She shared feeling shame and sadness when others had to enter the room that caused her to have suicidal thoughts “I kept thinking it might have been better if I was dead. I wouldn’t feel so scared, and they wouldn’t get sick.” When asked about her level of trust and her perception of the medical team treating her, she stated, “I didn’t trust anyone anymore; they treated me like a disease. I was fully vaccinated and boosted and wore a mask, but I still ended up so alone.”

Shantelle stated that her mother and aunt visited virtually via face time and that this provided her with some support and comfort; however, she stated, “as much as I wanted them in the room with me, I would rather suffer than get them sick.” She also shared that her faith was a source of hope. Shantelle shared that she is “a practicing Catholic. I trust God in my suffering, but I still felt so alone.”

In reference to concerns regarding financial security or additional external sources of stress, she shared, "people seem to care more about how me being sick affects them and not me," but continued to tearfully discuss her guilt and fear over not being able to work during her sickness and treatment "I am the sole provider. I wasn't able to fulfill my duties to my wife." She shared fear over being unable to pay her bills and fear that she would interfere with her wife's educational process.

Ashley

Ashley is a 70-80-year-old single female living in a mid-sized city area in Texas. She denies a personal history of mental health diagnosis. Ashely was infected with COVID-19 in the Winter of 2020. Ashley required hospitalization for six weeks. Ashley was kind, but reserved, speaking in a voice reportedly made "raspier by the illness." She shared her experiences as though telling a story, pausing when a more substantial wave of emotion crossed her face. She shared feelings of "disbelief and disappointment" when she was diagnosed as well as fear as she had just met her great-grandchild three days prior. She shared frustration that she was not told how to help prevent herself from needing hospitalization "I was just told to take medicine and stay home. It wasn't until the hospital that I learned I should have been laying on my stomach and making sure to walk." The participant shared feeling shame for requiring hospitalization and an intense longing for her family. She shared that she was able to text and receive calls throughout her hospital stay "I was tired and couldn’t talk back some of the time but hearing my daughter read the messages from loved ones and friends helped me feel less lonely.” However, she stated that her overall mood declined rapidly in the hospital setting “the calls were precious, but they were not enough.”

Ashley shared feeling uneasy with the hospital team due to the limited time they spent in the room and the rushed nature of the interactions “the procedures and medications were not fully explained to me. I was expected to quickly do what I was told so they could leave.” She shared that, though the hospital staff treated her with kindness, she could sense their discomfort treating her, and that increased her feelings of shame and isolation. “I don’t blame them. I did not want to be sick either.” Through tears, Ashley stated, “I was afraid I was going to die or go crazy. I laid on my stomach for 10 hours at a time with nothing to do but try to breathe the

oxygen being forced up my nose through those tubes.” It was during these times that the sensations of helplessness and loneliness were most severe “I would just cry off and on.”

The use of social media served as an outlet for Ashely, allowing her to see pictures of her grandchildren and children and read messages from friends and old students “it was touching to see how many people were praying for me and sending me well wishes. I read them all.” Although, she shared that she was unable to use social media for long periods of time due to the manner in which the level of exhaustion she was experiencing interfered with her ability to use her phone. “The times when I desperately needed that connection but couldn’t even lift a phone long enough to message someone was the loneliest. I had never felt that level of despair.”

Ashley smiled when discussing financial concerns outside of treatment “that is a benefit of being my age, I am retired, and I was tenured. I did not have to worry with finances.” She shared that concern about not being able to watch her grandchildren continue to grow and build their families was a more significant source of sadness and stress than financial concerns. However, she stated that her "faith in God kept me going. Even if I had left this life, I knew I would see them again. I can trust in God." Additional sources of hope were the continued messages from loved ones through social media and the eventual ability of her daughter to visit. "Everything changed when they said I had been negative long enough and my daughter could come to sit by the bed with me. I felt like a weight lifted off my chest. Just having her there gave me the strength to know I was going to make it home."

Sierra

Sierra is a 30–40-year-old married woman living in a midsized city in Texas. She reports the absence of a mental health diagnosis. She was infected with COVID-19 in the summer of

2021. Sierra required hospitalization for 14 weeks. She shared openly, frequently touching the prominent scar on her throat while discussing the more emotionally challenging parts of her story. Sierra shared that she gave birth to her third child shortly before becoming infected with COVID-19. "My baby had down syndrome that we didn't know before she was born because we didn't do any testing. We wanted her to be a complete surprise." She shared that she initially excused her symptoms as postpartum aches and pains and then as allergies "it wasn't until a friend told me to check my 02 levels that I realized I was 95%, and then I tested, and it was determined that I had COVID-19" she shared instant fear and heartache "I went to the doctor, and they sent me to the hospital immediately I didn't get to say goodbye to my kids or husband." Sierra shared feeling guilt for missing the early newborn stages of her daughter's life and for leaving her husband, also COVID-19 positive, to care for all three young children. She stated she felt devastated and panicked.

Sierra shared that she deteriorated quickly and required intubation within 48 hours of hospital admission. "I was intubated my second day of being there and placed on an ECMO machine not long after that. I don't know exactly how long." She shared that she was sedated for the majority of her early treatment but would "wake up screaming desperate to find my children. I thought I had been kidnapped. Anytime they tried to wake me up, I'd get so panicked that I would start pulling on wires and screaming, so they had to sedate me again." She stated that she eventually required a tracheotomy.

During her brief periods of wakefulness, Sierra explained feeling lost and alone "I needed my husband there to help me understand what was going on." She discussed believing that if he had been allowed to be with her, she would not have required the extensive intervention that she did. "They said being sedated caused my lungs to deteriorate even more and that I almost did not

survive." Sierra expressed anger and resentment toward the hospital for their visitation policy "why couldn't he be there with me? Was he sick too? Even when I wasn't contagious, they waited weeks to let him be with me. I was there for a month before they started letting him visit."

She stated that she remained in a state of "total terror and agony" for the majority of her stay "the final four weeks I was there, I was lucid enough to hear my husband's voice and trust that I was safe. That's when I started recovering." She stated that once she was able to feel "anything but terror," she began to worry about her family's finances "what was keeping me alive costing my family? Would we ever be okay?" and to long for her children. "Would my baby even remember me? Would we bond like I did with my older two?" She stated that these questions intensified her feelings of depression and anxiety.

Timothy

Timothy is a 20-30-year-old single male living in a large city in California; he reports a personal history positive for anxiety. He was infected with COVID-19 in the winter of 2021. Timothy required hospitalization for four days. He shared feeling shocked and guilty when he received his diagnosis "I had just spent the night with friends. I thought it was allergies until the next morning when I started to run a high fever" he recalled sending a message to his friends informing them of their exposure "I was sweating I was so nervous they would hate me or that one of them would get sick and die." He discussed his sadness and fear related to potentially harmfully impacting his friends and their families.

Results

For the purpose of this research, a transcendental phenomenological approach was chosen, and data gathered were processed and synthesized using bracketing and epoch to

minimize the researcher's biases and preserve the trustworthiness and credibility of the information produced through the study. Bracketing requires the analysis of the entirety of the interview transcripts so that information may be broken into meaningful quotes that create themes between the lived experiences of the participants (Creswell & Poth, 2018). Clear themes began to develop related to participant experiences as the bits of data were separated into sections created through the use of lumping similar content together.

Theme Development

Theme development occurred in response to the process of answering the research questions of the study. Through the process of sifting through and organizing participant responses, clear themes became identifiable in relation to each research question.

Theme one: reaction to infection showed that a majority of people responded with guilt and anxiety about infecting others to the diagnosis of COVID-19. This was intensified by the perceived stress of health professionals treating the participants. Therefore, this theme partially responds to research question four: How does the patient's perception of the level of stress experienced by caregivers affect the patient's perception of their emotional health during periods of isolation?

Theme two showed a correlation between the presentation of anxiety, depression, and in some instances, suicidal ideation with isolation from social supports. This theme relates to research questions one, two, and three. Research question one: How does isolation during hospitalization affect self-reported rates of depression and anxiety? Research question two: How does isolation during hospitalization affect self-reported rates of depression and anxiety in persons previously diagnosed with depression or anxiety? Research question three: How does

isolation from social support during hospitalization for COVID-19 affect the personal perception of mental health?

Theme three occurred in response to the exploration of research question four: How does the patient's perception of the level of stress experienced by caregivers affect the patient's perception of their emotional health during periods of isolation? However, participants deviated unilaterally from the intended content of this question and instead discussed their own stressors related to outside influences. This theme was unexpected. It showed that external factors that existed beyond the hospital setting were overwhelming to such an extent that current treatment was not the primary focus; instead, it was the presence of financial insecurity and the health of their families that occupied their thoughts. Though one participant expressed that the stress of the attending medical personnel "made me feel like they were overworked and they didn't have the energy to care about me."

Theme four was developed in response to the first three research questions. Research question one: How does isolation during hospitalization affect self-reported rates of depression and anxiety? Research question two: How does isolation during hospitalization affect self-reported rates of depression and anxiety in persons previously diagnosed with depression or anxiety? Research question three: How does isolation from social support during hospitalization for COVID-19 affect the personal perception of mental health? This theme showed that access to supportive social and familial supports reduced the overall experiences of emotional distress and dysregulation.

Theme One: Reaction to Infection

As the initial reaction to infection was explored, it became apparent that fear and guilt were the primary emotional reactions of the participants. However, a single participant expressed an outlying experience of indifference and lack of concern. Despite the initial reaction, all participants expressed experiencing symptoms of anxiety and depression. Receiving a diagnosis of an infectious illness that requires a period of isolation to protect others from infection is linked to strong emotional reactions such as shame and guilt that increases the risk of symptoms of depression and anxiety (Hall et. al., 2008). Participants shared that the sudden way that COVID-19 altered their lives caused a sense of upheaval emotionally. Each participant cited this sudden sensation of loneliness associated with diagnosis as a significant source of emotional discomfort.

Alberto

Alberto shared feeling indifferent when he received his initial diagnosis "I felt rough, but I expected it to be more like the flu. I thought I would get better quick." However, within 3-days of diagnosis, Alberto was admitted to an ICU with an oxygen level of "84 on the pulse ox. I felt lost and scared when they wouldn't let my wife go with me," he shared, feeling more alone and helpless at that moment than any other time in his life. "I kept thinking I didn't want to go into the dark alone. I thought I was dying." Although the initial reaction was that of indifference, once the reality of the severity of the diagnosis set in, he quickly experienced fear and feelings of helplessness.

Shantelle

Upon first discovering her positive status for COVID-19, Shantelle stated that she felt “guilt… I couldn’t eat. I was so scared.” She stated that fear and guilt were her initial emotional

reactions but that she quickly developed feelings of anxiety and loneliness. The prospect of potentially exposing others to the virus was a primary source of fear and guilt for her. “I work in the public; I wear two masks, but I still got sick. What if someone got sick and died because of me?.” She shared that these fears continue to plague her and have become intrusive thoughts that she “can’t push out of my head.”

Ashley

Ashley stated that she was embarrassed when she first began to feel sick and that the embarrassment turned to guilt and fearfulness immediately after learning she had tested positive for COVID-19. “I had just met my great-grandchild and spent the weekend with my daughter and grandchildren. I was terrified. What if I got the baby sick?” she shared, feeling guilt over being sick “what if they got me sick and I died? They would have to live with that guilt.” She expressed experiencing waves of emotions ranging from feeling encouraged and knowing that “it would be okay no matter what because of my faith in God” to feeling “scared that I had either hurt someone else or that they would feel responsible for my illness.” She shared, “I am grateful to God that my great-grandchild did not get sick.”

Sierra

Sierra shared that when her doctor notified her that she was positive for COVID-19, she was frightened for the health of her newborn child and her older two children. “I was scared that it would hurt the baby, and I was ashamed that I hadn’t protected them better.” She shared feeling guilt and regret for allowing others to meet her baby “I kept thinking, what if I killed my child by celebrating her birth?" Sierra began crying while discussing this experience. She shared that the guilt and regret were made worse by the way in which others responded and "asked

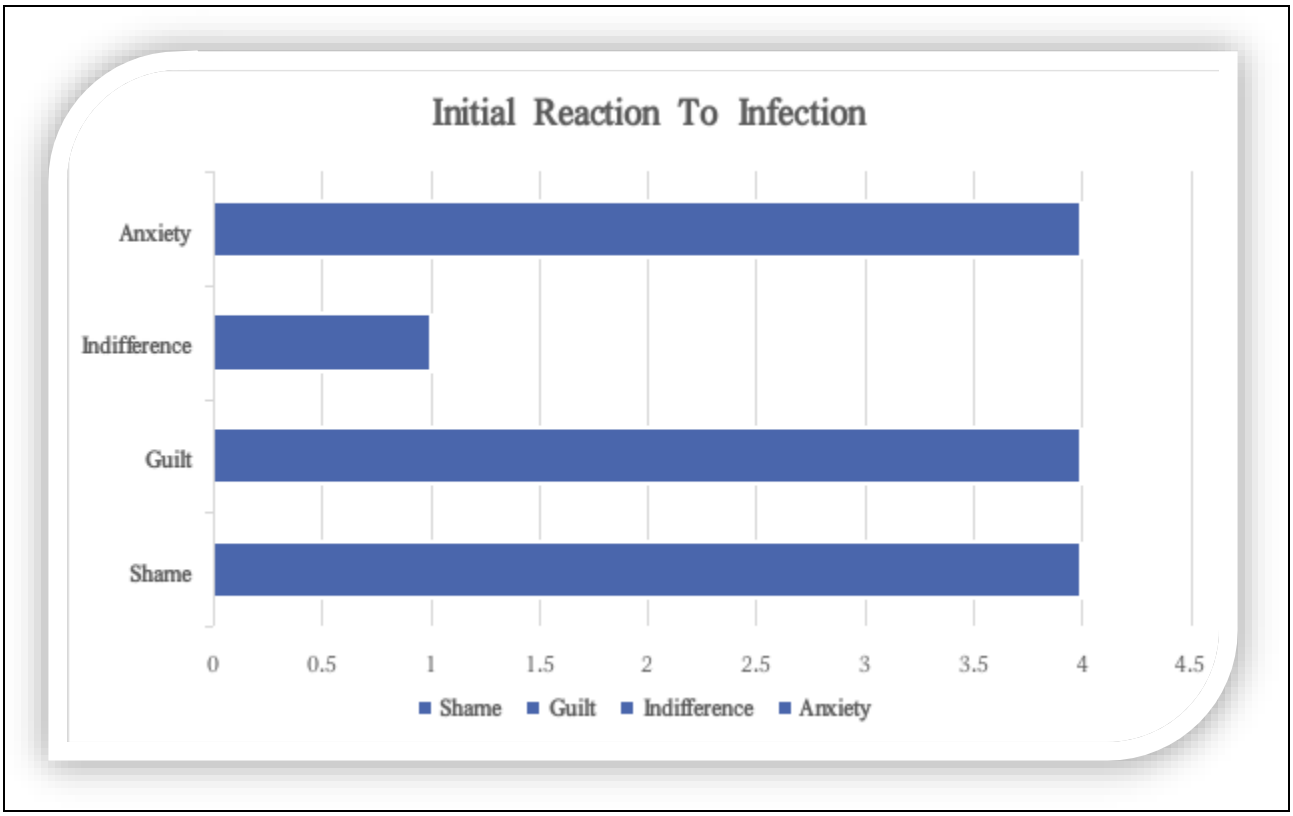
questions about how I got sick so quickly after having a baby." She shared feeling intense fear of dying and "not seeing my children grow up and guilt over leaving my husband with them alone."

Timothy

Timothy discussed his reaction to discovering that he was positive for COVID-19 instead of simply being tired and having allergies. “I was immediately remorseful and guilty. I had just spent the night with friends. What if I got them sick?” he shared feeling embarrassed as well. “I had to call everyone and inform them, and that did not feel good.” He shared feeling similar to “Harry Potter when he was caught outside after sneaking the dragon out. It was scary and embarrassing.” Timothy discussed his experiences using movie quotes and pop-culture references but was able to provide emotional terms when asked for clarity.

Figure One

Initial Reaction to Infection



Theme Two: Emotional effect of COVID-19 Related Isolation

A common set of experiences shared by all the participants in the study were those of sadness, loneliness, anxiety, and fear. Several participants also reported experiencing symptoms of depression and suicidal ideation. However, the presence of suicidal ideation was not a common theme across all participants. According to Cox et. al., (2018) prolonged periods of isolation are associated with an increase in experiences of anxiety and loneliness.

Alberto

Alberto shared an overwhelming sensation of anxiety and depression related to his period of isolation. He shared significant and distressing emotional dysregulation, including a strong desire to end his life. "I was so lonely and scared… I felt like the only people who actually cared about me were being turned away and left in the dark about my condition." Alberto began to shift in his seat and break eye contact as he shared his experiences of loneliness. He shared that the inability to have his wife present was exceptionally painful for him and added to his fear and suicidal ideation "I paranoid and thought the nurses were out to get me. The doctor was just a floating head on a screen. I needed my wife… it made me want to die to escape it all." Alberto reportedly found the experience of isolation particularly distressing. The inability to visit with his wife and children was reportedly a key component in the sudden increase in his symptoms of anxiety and depression that led to the development of suicidal ideation and emotional dysregulation. These symptoms increased as the period of isolation and inability to see his family increased, cumulating in Alberto developing a plan for suicide and having the intent to act on that plan.

Shantelle

Shantelle was tearful while sharing her incredible longing to be with her mother, “I just wanted a hug,” and expressed that the experience of loneliness during her hospitalization harmed her relationship with her wife. Shantelle shared feeling ashamed and stigmatized by others for having contracted COVID-19 "my wife acted like it was something I had done on purpose to her." She wept while sharing that she "needed support and love more than anything, and I was completely alone." Shantelle stated that even after returning home, "empty walls make me feel

like I am going to cave in on myself. I feel so lonely looking at them" she shared that this was because they reminded her of the hospital walls. According to the participant, her overall experiences of anxiety and depression increased beyond her baseline levels and exceeded her levels upon initial diagnosis with COVID-19. These increases in symptoms reportedly increased the participants' experience of emotional dysregulation and discomfort that continue to interfere with the participant in daily life, as indicated by her reference to discomfort and emotional distress related to triggers such as "empty walls".

Ashley

Ashley discussed the manner in which isolation interacted with her feelings of guilt and fear related to having become infected with COVID-19 "I didn't have anyone to help break my thought pattern. I couldn't check and see if my family was safe. It was just me and my thoughts" she shared the feelings of being trapped and helpless came in waves. "When I was able to pray and lean into my faith, I did better, but sometimes my mind wasn't fully there, and all I could feel was the emptiness of the room around me." The interactions with staff members and the times that they assisted her physically in moving reportedly helped ease this loneliness "they may have only been helping me roll over but just having physical contact with someone helped" she shared an almost "burning sensation" when being touched because of her desperation for physical contact. Ashley shared an increase in feelings of anxiety related to the health of her family due to the inability to verify their well-being.

Sierra

The loneliness was described as a crushing sensation for Sierra, “it was total and complete blackness.” She described her hospital stay in short bursts apologizing when she

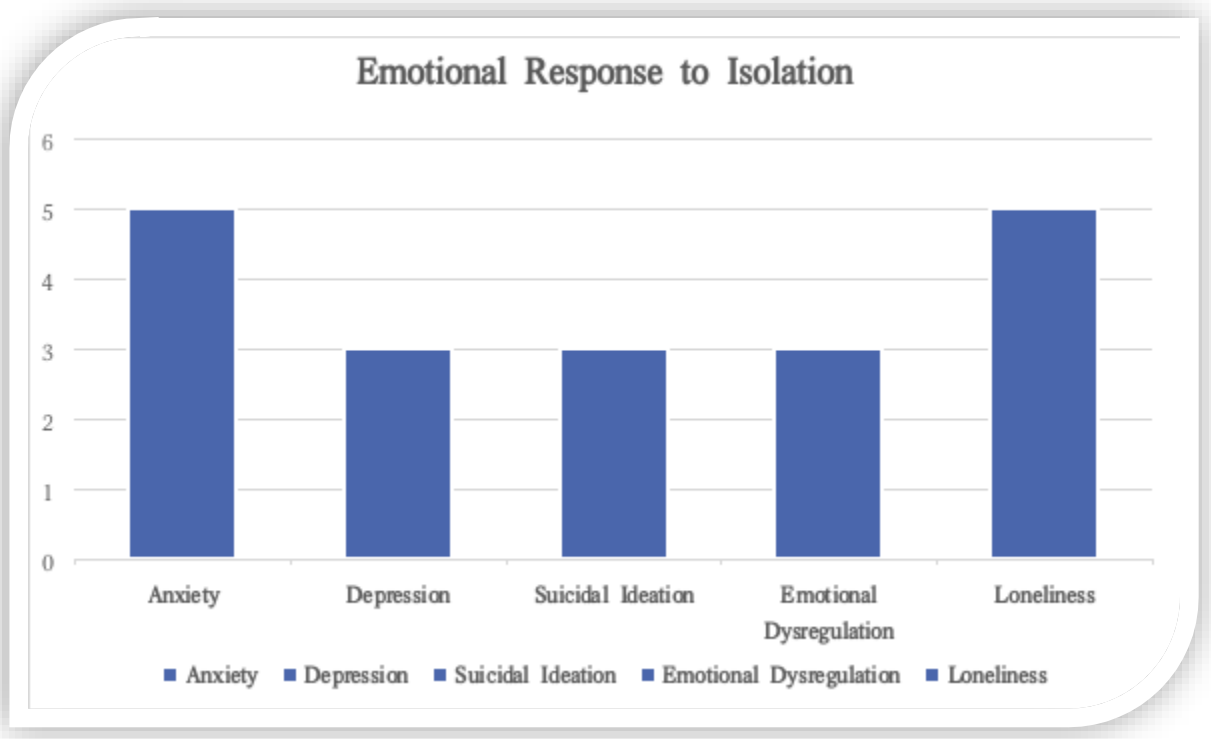
needed to pause and gather herself again. “It is hard to remember those places; emotionally, I wanted to die.” She shared feeling fear to the extent that she had never experienced, “I was alone. I did not know anyone and was in so much pain.” Sierra stated that the pain and lack of supportive family increased her anxiety to the extent that it “crossed into psychosis. I thought they had kidnapped me. I thought they were torturing me.” She expressed a deep longing for her husband and children, “I needed them more than anything, and I couldn’t have them.” Sierra became tearful while discussing the depths of loneliness she experienced while in the hospital. “I have never felt that before.” Sierra expressed a sudden and severe increase in symptoms of depression, anxiety, and suicidal ideation in relation to the loss of contact with her family.

Timothy

Timothy described being alone while hospitalized as a "physically uncomfortable sensation. It was like that scene in *The Fantastic Beasts* where she is sinking into the memory pool… my best memories were being used to hurt me." He expressed an intense desire to "break out of the hospital bed and run" in order to reconnect with his family and friends. However, Timothy expressed feelings of "guilt over even thinking it. I was a typhoid Mary. I couldn't be out in these streets shedding like that". The experience of isolation reportedly increased the amount of anxiety experienced "my thoughts were racing like I've never experienced. I was so anxious I couldn't tell if I was sick from the vid (COVID-19) or from feeling anxious." The overall presentation of symptoms of anxiety were reportedly increased during the participants period of isolation when compared to his baseline and to his level of anxiety upon initial diagnosis.

Figure Two

Emotional Response to Isolation

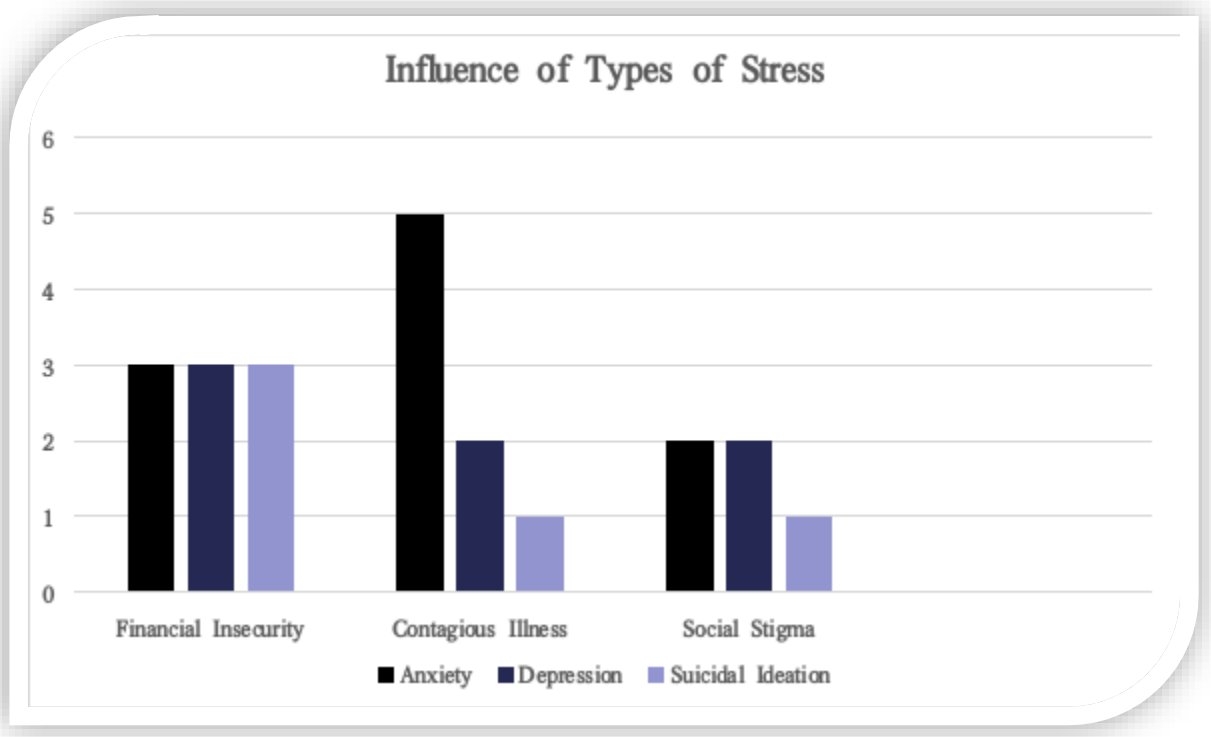


Theme Three: Influence of Stress

External sources of stress, such as financial concerns, concerns of having exposed others to the illness, and social stigma of having contracted COVID-19, contributed to the presence of anxiety and guilt in participants. External sources of stress may increase the presence of anxiety and emotional dysregulation in people experiencing hospitalization (CDC, 2020). Those concerned about financial security reported experiencing anxiety, depression, and suicidal ideation at higher rates than those who did not report such concerns. Economic insecurity caused an increase in symptom presentation across all measures.

Figure Three

Influence of Types of Stress



Alberto

Alberto expressed distress related to external concerns and sources of stress. “How was my family going to pay for my treatment? I felt like every day I was there was one more day I was heaping debt on their heads.” He shared that he had been informed that a government program covered his stay but that he had “forgotten because I was so out of it. I needed my wife there to remind me.” Alberto shared that the stress of worrying if his family was safe and if they had food to eat “made me want to die. I just kept thinking I should go ahead and die. It was horrible.”

Shantelle

Shantelle shared that her anxious thoughts moved from the fear of dying to the fear of not being able to provide for her wife. “I am the sole provider. Every day that I was not there working was a day that bills were falling behind. I cried all the time over it.” She shared that thoughts and stress related to being able to afford treatment and pay her normal living expenses “made everything worse.” Shantelle expressed fear and emotional distress related to her financial situation and her wife being home alone “she had to go to school and take care of the dogs alone. I left her to do everything.”

Ashley

Ashley shared that her fear and stress concerning outside matters were limited to her fear of having infected her great-granddaughter or her grandchildren with COVID-19 "I am blessed that at this stage of life, I don't have to worry about bills or finances, but I was very worried about my family." She discussed feeling distracted and anxious about thoughts concerning the health and wellness of her family but that these things "were easier to manage because they didn't get sick, and I could see that on Facebook."

Sierra

Sierra shared that she was in and out of consciousness and that her primary experiences were firmly founded in the terror and fear of being “held against my will.” However, she shared that once she was “more aware,” she began to feel intense fear and trepidation concerning the ability to pay the hospital bills. “I was in an ICU room for months. I knew I would never be able to repay those bills. Not only was I out of work, but I was spending thousands every single day.” She shared that her family started a fundraiser and used local resources to help meet their daily

needs. “Money and the debt I had caused my family were significant sources of stress and fear for me.”

Timothy

Timothy expressed concern about how his illness may have influenced the lives of others “what if I got them sick and they didn’t tell me?” He shared feeling nervous about his social structure but not about finances. “I was scared that people might not want to be around me anymore, but that wasn’t the case.” Timothy shared that he did not have to worry about financial concerns due to having “good insurance and family that would be there to support me even if I lost my apartment.” These sources of reassurance allowed the participant to remain focused on his treatment instead of worrying about external factors.

Theme Four: Emotional Response to Access to Social Support

Each participant reported feeling as though they would have benefitted from the presence of friends and family during their treatment period. Those who were able to have visitors after they tested negative but continued to require treatment expressed significant emotional benefits from the presence of supportive loved ones. Contact with supportive loved ones produced an overall reduction in the sensation of fear. Participants who were unable to have visitors enter their room at any point during their stay reported intense longing for their loved ones.

Alberto

Alberto shared that his primary source of distress was his inability to see his family “I just wanted them there with me. My wife would call and read stories to the kids with me on the phone, and it hurt so bad to not be able to reach out and touch them.” He shared that he wanted

to hear her speak to him over the phone but that it was also painful and would “make the thoughts of wanting to die stronger sometimes.” He reported feeling ashamed of this response. However, Alberto stated that when his wife was allowed to stand in the hall and call him from the other side of the glass ICU room wall that he felt safer and calmer “I knew she was there, and it was okay that she wouldn’t let anything happen to me.” He reported that she was only allowed to do this for a few days before “the hospital stopped letting her come. They changed their rules.” He stated that at this point, he began fighting their protocols and “pushing hard to go home. I started demanding that they lower my oxygen and let me try to stand. I went home a few days after that even though they said it would be months.” Alberto reported requiring ongoing oxygen and medication once he returned home.

Shantelle

Removal from her family unit was a particularly distressing component of her experience of having COVID-19 for Shantelle. She reported a "spike in depression, anxiety, and crying. I cried all the time, which was scary because it made it hard to breathe. I just wanted my family." Shantelle stated that her mother and aunt were allowed to sit outside her room and talk to her on the phone for "three days, and it was amazing. I felt so loved, but I cried a lot because I wanted one of my mom's hugs." She shared feeling "worthless and dirty because my wife still wouldn't come to sit outside; she was too upset with me for getting sick and risking getting her sick. Even though I got sick at work providing for her." Shantelle stated that the presence of her family and the phone calls she received from her cousins "kept me going. I don't know how I would have done that without them. The anxiety and racing thoughts were much lower when they were there." She reported an overall reduction in fear due to the presence of family.

Ashley

Ashley shared that she struggled with laying on her stomach due to being unable to see the room around her. “I would get bored stuck on my stomach, but I had to stay there for hours every day. Once I was strong enough to use my phone, that was my saving grace” she shared that her faith was her primary source of support, but that reading messages from friends and loved ones via Facebook was “a wonderful encourager for me. Seeing all of those old students and my family and friends lift me up in prayer helped me know I could fight hard enough to go home.” She stated that although social media helped her she still felt lonely and experienced racing fearful thoughts, “I was angry at myself for not knowing what to do to keep myself from ending up that sick. I was scared that I had hurt my family.” She shared that once she was negative for COVID-19 but still recovering from the damage, it did to her lungs that her daughter was allowed to visit her in the room “having her there with me changed everything. I felt joy for the first time the entire stay when she walked through that door and sat beside me.”

Sierra

Sierra shared that her stay in the hospital was marked by “terror and loneliness. I wanted out. I didn’t understand what was happening to me, and I needed to find my children” she shared that she had been sedated due to the severity of her illness and placed on an ECMO machine. “They would try to wake me up, and I didn’t know anyone. It was just people in masks. I’d start fighting and screaming.” Sierra shared that her medical team had to slowly lower the dosage once she had tested negative for COVID-19 and her husband was allowed to be with her. “He would sit beside me and sing while they brought me out. It helped, but I would still sometimes start to panic, and they’d have to put me back under. This went on for three weeks.” She stated

that when her husband was able to bring their then two-month-old daughter in to see her “that’s when I felt safe again. I needed to know she was still safe.” Sierra stated that she did not believe she would have survived treatment without her family. “I barely survived with them. I know I would have died without them. The staff could never have brought me back out of sedation. How many people died like that?” She became tearful while sharing her sadness over others who experienced something similar to her and lost their lives.

Timothy

Timothy remained bubbly and laughing throughout his interviews, rarely breaking his composure to show sadness or discomfort. One such instance of sorrow occurred when he was discussing his period of isolation in the hospital “it was like the death eaters had me. All the joy was sucked out of me, and all that was left were the worst things I have ever felt. I was so lonely and scared." He stated that his family and friends were unable to visit with him during his hospitalization and that visitors were not allowed to stand outside of the room. "I felt like I was in a *Black Mirror* episode; it was awful." He did state that phone calls and text messages "helped me ground back in reality. It was my tether in space. I could drift, but I wasn't going to drift off and get lost in space." He shared feeling elated when he was able to be picked up by his friend. "My best friend came and got me when I was released. It felt so good to hug him."

Summary

In total, five participants engaged in this study in which they expressed their lived experiences of contracting COVID-19 and subsequently requiring isolation in a hospital setting while receiving treatment. Research participants came from different backgrounds, were of different ages, and genders, and had different marital statuses. Participants expressed their

experiences of emotional dysregulation, guilt, loneliness, the effect of external stressors on their emotional state, and the effect of familial or social support during their period of treatment. Data points were gathered via three live virtual interviews per participant. Responses were separated into themes, and meaningful quotes were selected to represent the participant's experiences within the research. Each participant was given the opportunity to review data points for accuracy of interpretation. Through the course of the research and interview process, four key themes evolved 1.) Reaction to infection 2.) Emotional effect of COVID-19-related isolation 3.) Influence of stress, and 4.) Emotional response to access to social support.

The developed themes provided insight into the lived experiences of people who required hospitalization and isolation for the treatment of COVID-19. It became apparent that anxiety, fear, and loneliness were common experiences with suicidal ideation, and depression also occurred for some respondents. Furthermore, financial insecurity and concerns about meeting financial obligations presented as stress sources for participants affected by these matters. Concerns about how the illness had affected others and guilt regarding the contagious nature of the illness were additional sources of stress.

The presence of social support from family and/or friends proved useful in mitigating the symptoms of anxiety, guilt, fear, and stress. The physical presence of family had a more significant impact on reducing emotional dysregulation than virtual means of contact. Still, all forms of communication reduced the overall presence of uncomfortable emotions. Participants expressed a shared belief that the presence of support and as close to physical contact with loved ones as possible was an imperative part of their healing process.

Chapter Five: Conclusion

Overview

Since the onset of the COVID-19 pandemic, an abundance of research has been conducted on the mental and emotional responses to the pandemic and the treatment of those who have become ill. Additionally, previous outbreaks of contagious illnesses have provided reference materials to better understand the impact of isolation as a necessary component of a treatment protocol. It has been established that patients who require isolation experience increased rates of depression and anxiety, which also increases the risk factor for suicidal ideation (Hophing et.. al., 2022). The findings of this research study are consistent with previously published research in that the data support the supposition that forced periods of isolation during treatment of COVID-19 in a hospital setting increase the risk of experiencing emotional dysregulation, anxiety, depression, and suicidal ideation.

Summary of Findings

Through the process of live virtual interviews conducted by the researcher, the lived experiences of five individuals who required hospitalization and isolation for the treatment of COVID-19 were gathered and used to identify common themes within these lived experiences. In the course of this research process, it was determined that participants experienced a similar set of emotions with some variation in severity and initial reaction to learning that they were positive for COVID-19. The study showed that guilt and fear were common themes for all participants, as was anxiety. However, the source of anxiety varied between participants. It was also discovered that financial security had a mitigating effect on the degree to which external sources of stress affected the participants. Those with limited or insecure financial resources

reported anxiety and stress focused on bills and financial responsibility. Whereas participants with secure finances reported experiencing a higher degree of anxiety and stress related to potential social or familial consequences of infection. An additional commonality that was discovered during the research process was that of the benefits of having supportive family or friends present during the treatment process. It was also found in this group of participants that in-person visitation offered more benefits than virtual visitation or phone calls. These patterns were identified while answering the selected research questions.

Research Question One

How does isolation during hospitalization affect self-reported rates of depression and anxiety? As participants responded to questions associated with this research question, it became apparent that isolation during treatment for COVID-19 increases the presentation of symptoms of depression, anxiety, and potentially suicidal ideation. These concerns were self-reported and not indicated through the use of professional measures.

Research Question Two

How does isolation during hospitalization affect self-reported rates of depression and anxiety in persons previously diagnosed with depression or anxiety? As indicated while sorting answers to research question one, the instances of anxiety and depression were increased due to isolation. This was especially true for individuals with a history positive for anxiety and or depression. Participants with a history of both anxiety and depression indicated suicidal ideation, whereas only one participant who did not have a history of either indicated having suicidal ideation. This appears to indicate a connection between worsening symptoms of preexisting conditions and isolation during hospitalization for COVID-19.

Research Question Three:

How does isolation from social support during hospitalization for COVID-19 affect the personal perception of mental health? Each participant reported sensations of anxiety and loneliness in varying degrees. The presence of supportive family and friends mitigated the severity of the experience of both anxiety and loneliness. Three participants reported experiencing anxiety, depression, loneliness, and suicidal ideation partly due to isolation. The level of these concerns reduced the more contact the individual had with supportive loved ones.

Research Question Four:

How does the patient's perception of the level of stress experienced by caregivers affect the patient's perception of their emotional health during periods of isolation? The response to this question was surprisingly different than anticipated. Participants shifted their responses to include external sources of stress or to discuss how witnessing staff whom they perceived to be stressed caused an increase in focus on their own sources of stress. With the exception of one participant who stated that staff behaviors and perceived stress levels were directly distressing to them, participants chose instead to discuss their own levels of stress and outside sources of stress. Two primary sources of stress discussed were financial and the fear of infecting someone else, including hospital staff.

Discussion

It is the purpose of the discussion section to find correlations between the existing data gathered in the literature review section located in chapter two with the research data produced during the course of this research. This research utilized the bottom-up and top-down theoretical framework that identifies how the orientation of the locus of life satisfaction interacts with

experience of life satisfaction and situation satisfaction (Brief et. al., 1993). The systems theory also helped shape the framework of this research as it highlighted how the changes within the systems interacted with the individual units in the system (Pavot & Diener, 2008).

Of the five participants, three reported an increase in symptoms of anxiety that interfered with their ability to think clearly and engage in decision-making while in the hospital. In contrast, two reported an increase in anxiety levels that caused discomfort and fear but did not interfere with decision-making. Those with lower levels of anxiety reported higher levels of financial stability. Suicidal ideations were reported by two of the participants, who also reported developing worsening symptoms of anxiety and depression coupled with concerns about financial security. Both participants who reported suicidal ideation had previous diagnoses of depression and anxiety. It appeared that the presence of financial insecurity was nearly as distressing as the experience of isolation. However, all five participants expressed distress and loneliness that interfered with their ability to remain recovery-oriented due to the absence of the physical presence of friends or family. This appears to indicate that although financial stability is important, isolation is a more significant factor in the development of emotional discomfort and dysregulation. Isolation from previously established sources of support during times of heightened stress is linked to an increase in emotional dysregulation (Hophing et.. al., 2022).

Virtual means of social support appeared to have offered varying levels of comfort to participants and elicited a variety of emotions ranging from gratitude to sadness and frustration. Though each participant voiced a strong desire to have their loved one physically present with them. Furthermore, levels of feelings and safety were higher for participants whose family members were present or involved in the treatment process. Participants who were allowed visitors in their rooms post-negative test results reported a drop in emotional discomfort and a

rise in feelings of security and determination to continue recovering. Therefore, it appears as though the involvement of a trusted friend or family member is beneficial in the maintenance of emotional wellness during people undergoing medical interventions that require in-patient treatment coupled with a period of isolation. This is supported by research that indicates that social support during medical interventions reduces the presence of anxiety and increases the overall outcomes of treatment (Sun et. al., 2021).

Of the five hospital systems in which the participants were treated, four allowed visitations in the hallways outside of ICU rooms for the duration of the patient stays; one discontinued these visitations mid-stay for the fifth participant. The four hospital systems that allowed hallway visitation also allowed visitors in the room once the patient had two consecutive negative COVID-19 tests. Whereas the hospital that discontinued hallway visitations also denied visitors post-negative COVID-19 tests. The hospital with the highest degree of visitor limitations had the participant with the highest reported level of emotional distress, dysregulation, and suicidal ideation, including a plan and intent to act on the plan while in the hospital system.

Implications

The implications of this study are theoretical, practical, and empirical in nature. The information gathered through the lived experiences of the participants benefits people who have experienced periods of forced isolation in a hospital setting as it creates a clearer picture of their experiences, thereby allowing for more informed decision-making by their treatment team and family members during the process of mentally recovering from the experience. It also benefits future and current patients experiencing forced isolation as it identifies potential support and

areas of lack within the hospital support systems. These findings make it possible for changes to be made, if necessary, within the treatment systems.

Theoretical

The theoretical framework of this study was based on the assumption that people are partially comprised of the experiences that they have, and therefore, understanding these lived experiences is an essential component of understanding an individual's personal reality. Malpas (2022), posited that a person's lived experiences shaped the reality within which they existed. Thereby it is required that one understands the circumstance a person has endured to fully understand the person. This shaped the manner in which participants were listened to and treated during the research process, as it was apparent to the researcher that they were sharing pieces of themselves as they shared their stories. By sharing personal information concerning their lived experiences, the participants provided a window into the lived realities of those undergoing treatment for COVID-19.

Practical

The themes that were revealed during the course of this study lend themselves to the process of developing protocols that may further support the emotional and mental wellness of patients requiring treatment in a hospital setting for contagious illnesses. Participants reported feeling uncertain about their treatment protocols, which intensified feelings of fear and loneliness. These concerns may be mitigated through the use of virtual communication with supportive family or friends during discussions regarding medical decisions (Rosa et al., 2019). Increased support and frequent review of visitation policies are required to continue to improve patient experiences.

The information produced in this study further supports the preexisting data that states that family or friend involvement in treatment is beneficial to patients and that isolation during the treatment of a contagious illness is linked to the development or worsening of symptoms of depression and anxiety. In some cases, the increase in symptoms of anxiety and depression coupled with isolation was sufficient to produce suicidal ideation. In one participant, it was suicidality with a plan and intent to act on their plan. Participants shared that they would have benefited from an increase in the involvement of trusted family and friends as well as an increase in communication from hospital staff. Informed care reduces feelings of anxiety and discomfort in patients in hospital settings (Rosa et. al., 2019).

Empirical

The global nature of the COVID-19 pandemic was unlike anything experienced within the last 100 years. Government systems and hospital systems were ill-equipped to respond to the need created by the occurrence of a global pandemic. Although data exists concerning the effects of isolation on mental wellness and on the effects of contagious illnesses on mental health, it is within the last two years that research has been produced concerning the effect of a global pandemic and the response to such a phenomenon. This study aimed to add to the growing body of research that explores the effects on the levels of depression and anxiety as well as emotional regulation of COVID-19-related isolation during in-patient treatment in a hospital setting.

Delimitations and Limitations

Delimitations and limitations refer to the boundaries of the study set by the researcher and the ways in which the researcher has accounted for natural limitations of the study so that data gathered may be useful when applied to a broader population than the participants of said

study. Identifying the delimitations and limitations of the study assist in the development of validity (Theofanidis & Fountouki, 2019).

Delimitations

Delimitations in this study were set using the selected theoretical framework so that the research questions and objectives were easily identifiable and ensured that they were met. Some of the delimitations of this study were that all participants must have undergone a period of isolation lasting three or more days as a result of medical complications related to COVID-19 that required hospitalization. Furthermore, all participants must have been 18 years old or older. These boundaries assisted in the development of validity within the study as they allowed for the measurement of emotional responses to similar lived experiences in an adult population.

Furthermore, the design for the research conducted also acts as a delimitation. For the purpose of this study, a transcendental phenomenological approach was selected as this allows for a narrow and deep look at the individual lived experiences of the participants' emotional and mental reactions to life experiences (Lossky, 2016). The information provided during the interview process was sifted through carefully so as to identify and group answers into common themes. The terms used to describe the participants' experiences provided the necessary information required to break their experiences into themes which assisted in the development of a clearer picture of their individual experiences that may be applicable to a larger population.

Limitations

As is the case with any qualitative transcendental phenomenological study, there were a number of limitations that must be identified and discussed. The data presented in this study is representative of the lived experiences of five participants, all of whom lived in the United States

of America. Therefore, it is not feasible to generalize the information gathered to populations outside of the United States. Furthermore, the first-person nature of phenomenological research is in itself potentially limiting within a healthcare setting. Phenomenological research presents first-person-oriented data in a third-person environment that requires a careful marriage of the individual needs and the needs of the illness being treated. These may be in conflict with one another, which limits the applicability of the data to real-world situations (Gergel, 2012). In reference to this study, having supportive loved ones present reduced the experiences of stress and emotional distress; however, that is not feasible as an intervention due to the contagious nature of the illness.

Further limitations included the bias of the researcher conducting the study. In an effort to reduce the effect of personal bias on the data gathered, bracketing and epoch were utilized during the study process, and participants were allowed the opportunity to review their individual data to ensure accuracy of interpretation. These steps act as preventative measures against researcher bias within the study.

Recommendations for Future Research

Despite a growing body of research regarding COVID-19, there is a limited amount of information concerning the lived experiences of people undergoing isolation in a hospital setting during their treatment course for COVID-19. The data gathered and results of this transcendental phenomenological study provide context to these lived experiences that may improve the treatment options and support systems available to others undergoing similar circumstances. Identifying the necessary steps to reduce mental and emotional distress during treatment is imperative to the overall wellness of those requiring treatment. Furthermore, identifying the

manner in which these experiences affect mental wellness may also allow for more targeted interventions by therapeutic staff after treatment.

Future research could benefit from the use of small focus or support groups for participants using an emotion-focused therapy (EFT) approach similar to that used in the treatment of eating disorders. Using an EFT-based treatment option may allow the participants to regain a healthy connection with their bodies and physical sensations. The use of EFT has been proven effective in the treatment of eating disorders as it is beneficial in assisting the participants in reconnecting with their physical body through the use of identifying emotions and integrating them back into their lived experiences (Glisenti et. al., 2021).

It would also be beneficial to conduct more research regarding the way in which supportive family involvement in the treatment process may affect treatment outcomes for patients in isolation. How might staff-facilitated virtual contact with family impact the experience of isolation during treatment, and would it have a mitigating effect? Would allowing visitors in the hall within view of the isolated patient positively impact emotional well-being on a larger scale than the small population interviewed in this study? These are questions that future research may be able to explore in a way that promotes the development of meaningful interventions for those undergoing COVID-19-related isolation in a hospital setting.

Furthermore, it is recommended that future research continue to explore the correlation between isolation for a contagious illness and the experience of suicidal tendencies or ideation. Would daily assessments assist in reducing these concerns or reducing the risk of patients potentially acting on these thoughts? Is there an intervention within the hospital system that would be feasible to implement to reduce the occurrence of suicidal thoughts or actions? These concerns and questions could be explored using mental health personnel in a hospital setting to

interact with patients and assess for suicidality, as well as provide mental health first aid to determine the effectiveness against suicidal thoughts and actions.

Summary

The identified purpose of this transcendental phenomenological study was to identify the lived experiences of participants who were 18 or older and had experienced a period of forced isolation in a hospital setting that lasted for three or more days in relation to the treatment of COVID-19. During the course of this study, it was determined that isolation during hospitalization for a contagious illness appears to result in increased experiences of anxiety, depression, emotional distress, and dysregulation. Furthermore, participants with previous mental health diagnoses of anxiety and depression appeared to be at an increased risk of developing suicidal thoughts. Participants who were also experiencing external stressors related to financial concerns appeared to be at an increased risk of developing higher levels of emotional distress, including all the measures used: anxiety, depression, suicidal thoughts, emotional distress, and emotional dysregulation.

The presence of supportive loved ones offered a protective measure against the increases in anxiety, depression, and suicidality. Although virtual support did appear to offer comfort to most of the participants, the physical presence of a loved one, even removed by a glass wall, offered a higher level of support and reduced overall symptoms of emotional distress to a higher level than virtual means of communication. The assistive nature of visitation was further increased when in-the-room visitation was allowed for participants whose hospital's allowed in-person visitation following two negative tests for COVID-19. Therefore, it is feasible to draw the conclusion that isolation during hospitalization for COVID-19 is detrimental to mental and

emotional health and that this detriment is mitigated by the presence of supportive family or friends.

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Appendix A

Suitability for Participation and Recruitment Announcement

Please respond to each question with a singular response

1. At any time have you tested positive for COVID-19?

Yes

No

2. Did you require hospitalization?

Yes

No

3. Did you experience mandatory isolation or quarantine for three or more days during your period of hospitalization?

Yes

No

4. Are you over the age of 18?

If you responded affirmatively for each of the above criteria, you may be eligible for participation in a research study.

The purpose of the research is to develop a more in depth understanding of the emotional and mental effects of isolation during hospitalization for treatment of COVID-19.

Participants will be asked to engage in one initial online individual meeting to discuss the research process and three interviews through electronic means via live virtual meetings.

Participants will be provided with a $20 dollar visa gift card.

If you would like to participate, please send an email indicated desire to participate in the research study to [redacted]

A consent document will be provided to you immediately prior to the initial individual meeting for personal review.

Rebekah Ruth Jones, a doctoral candidate in the Doctorate of Education Community Care Counseling: Traumatology program Liberty University, is conducting this study. Please contact Rebekah Ruth Jones at [redacted]

Appendix B

Interview Questions

Interview One.

1.Describe your emotional process after learning that you were positive for COVID-19.

2.Describe the emotional experiences of isolation during treatment.

3.How did your inability to access previous sources of comfort, such as familiar faces, effect your perception of the treatment you received?

4.Describe your personal history of mental health.

5. How, if at all, did your experience in the hospital alter the presentation of symptoms of mental health concerns?

6. How did external stressors such as financial considerations related to hospitalization and inability to work affect your mental health?

7.Describe external stressors such as financial instability or food insecurity and how these interacted with stress levels.

Interview Two.

1. Describe the progression of your emotional state throughout your treatment period.

2. Describe your state of mental clarity during your stay.

3. Describe the perceived effects of treatment on your mental state.

4. Describe the perceived effects of treatment on your emotional state.

5. Describe the perceived effects of isolation on your emotional state.

6. Describe the perceived effects of isolation on your mental state.

7. Describe sources of comfort during this period of isolation during hospitalization.

Interview Three.

1. Describe your perception of the overall experience of isolation during hospitalization for COVID-19.

2. Describe your perception of stress during your treatment period.

3. How did your perception of the level of stress experienced by the medical staff providing care

effect your emotional state?

4. Describe the extent to which external sources of stress affected your ability to remain focused on treatment and recovery.

5. Identify sources of hope for the future related to managing external sources of stress.

6. Identify sources of hope related to the recovery of your physical health while in the hospital.

7. Describe mitigating factors that alleviated symptoms of emotional distress if any were experienced.

Appendix C

Consent

Title of the Project: Mental Health Implications of Isolation During Hospitalization for COVID-19: Self-Perceived Variations in Emotions

Principal Investigator: Rebekah Ruth Jones, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must be 18-years-old or older, had a previous diagnosis of COVID-19 that required hospitalization, and were required to undergo isolation during your stay in the hospital. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of this transcendental phenomenological study is to develop a deeper understanding of the ways in which forced isolation effects emotional and mental wellness in people who have experienced forced isolation due to hospitalization for COVID-19. Through the exploration of these matters, it is possible to develop appropriate interventions to alleviate the experience of emotional distress.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following things:

1. A virtual individual meeting will be held to review the research procedure and respond to questions from participants. This meeting will be recorded.
2. Participants will engage in three individually scheduled virtual meeting or will be provided a list of the questions via email to respond to interview questions. The virtual meeting will be recorded and the written responses will be maintained in an electronic file. Both will be protected via electronic and physical locks.
3. Participants will be provided with written interpretations of the information they shared during interviews and will be asked to verify accuracy of researcher interpretation.

How could you or others benefit from this study?

The direct benefits participants should expect to receive from taking part in this study are

1. A $20 Visa gift card.
2. Ability to share your experiences.

Benefits to society include

1. Increased awareness of consequences of isolation in medical settings.
2. Increased ability to alleviate emotional distress in hospital settings.
3. Develop effective interventions for people experiencing isolation related emotional distress.

What risks might you experience from being in this study?

The risks involved in this study include emotional discomfort while recalling distressing memories. The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

Further risk includes my status as a mandatory reporter of child abuse, neglect, elder abuse, or intent to harm self or others. Should this information be disclosed during the course of the research process, I will file a report with the appropriate agency.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records. Data collected from you may be shared for use in future research studies or with other researchers. If data collected from you is shared, any information that could identify you, if applicable, will be removed before the data is shared.

- Interviews will be conducted via an online platform Theranest which is HIPPA compliant. Participant responses will be stored using pseudonyms and all identifying information will be removed.
- Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted.
- Interviews will be recorded and transcribed. Recordings will be stored on a password locked computer for three years and then erased. Only the researcher[s] will have access to these recordings.

ow will you be compensated for being part of the study?

Participants will be compensated for participating in this study. Participants will be provided with a $20 Visa gift card after completion of the interview and review processes. Email addresses will be requested for compensation purposes; however, they will be pulled and separated from your responses to maintain your anonymity.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Rebekah Ruth Jones. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at

[redacted]. You may also contact the researcher's faculty sponsor, Dr. Molly Boyd, at [redacted]

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at [redacted].

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record/video-record/written record me as part of my participation in this study.

_____

Printed Subject Name

_____

Signature & Date

Appendix D

IRB Letter

March, 2022

To Whom it may concern,

IRB request

Internal Review Board

Green Hall 2845

Lynchburg VA 24501

Dear Internal Review Board,

As a graduate student in the Department of Community Care and Counseling at Liberty University, I am conducting research as part of the requirements for a Doctorates of Education Community Care Counseling: Traumatology degree. The title of my research project is Mental Health Implications of Isolation During Hospitalization for COVID-19: Self-Perceived Variations in Emotions and the purpose of my research is to develop a deeper understanding of the ways in which forced isolation effects emotional and mental wellness in people who have experienced forced isolation due to hospitalization for COVID-19. Through the exploration of these matters, it is possible to develop appropriate interventions to alleviate the experience of emotional distress.

I am writing to request your permission to conduct my research in a virtual format after gathering participants through use of Facebook.

Participants will be asked to provide an email when volunteering to participate so that they may be contacted to schedule a series of three interviews either through virtual meetings or through email correspondence in which the interview questions are provided. Method of interaction will be based on participant preference. Participants will be presented with informed consent information prior to participating. Taking part in this study is completely voluntary, and participants are welcome to discontinue participation at any time.

Thank you for considering my request. If you choose to grant permission, please respond by email to

Sincerely,

Rebekah Ruth Jones

Appendix E

IRB Approval

June 7, 2022

Rebekah Jones

Mollie Boyd

Re: IRB Exemption - IRB-FY21-22-1051 Mental Health Implications of Isolation During Hospitalization for COVID-19: Self-Perceived Variations in Emotions

Dear Rebekah Jones, Mollie Boyd,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:104(d):

Category 2.(iii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:

The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

Your stamped consent form(s) and final versions of your study documents can be found under the Attachments tab within the Submission Details section of your study on Cayuse IRB. Your stamped consent form(s) should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document(s) should be made available without alteration.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,

G. Michele Baker, MA, CIP

Administrative Chair of Institutional Research

Research Ethics Office