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Psychosocial experiences of patients diagnosed with COVID-19 at a teaching hospital in Ghana

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Abstract

Objectives: The number of people affected with COVID-19 keeps rising globally resulting in increasing fear and anxiety among patients and their families. However, literature on the psychosocial experiences of these patients with COVID-19 in Africa is limited. Hence, this research explored the psychosocial experiences of patients infected with COVID-19 and undergoing treatment.

Methods: The study employed a qualitative phenomenological approach. The sampling technique chosen for this study was purposive with a sample size of 34 determined by data saturation. Participants were selected from Korle-Bu Teaching Hospital, Ghana, and were interviewed face-face using a semi-structured interview guide. Data were analyzed using Interpretive Phenomenological Analysis.

Results: Two main themes and seven sub-themes were generated from this study. The two themes included emotional burden of COVID-19 patients and effects of COVID-19 on patients and relatives. Sub-themes formulated under the emotional burden were reactions to COVID-19 diagnosis, suicidal thoughts, and sadness by fear of the unknown. Social restriction/isolation, stigmatization and disclosure, effect of COVID-19, and positive attitudes of staff emerged under the effect of COVID-19 on patients and relatives.

Conclusion: Even though the recovery rate of COVID-19 has improved since the introduction of the COVID-19 vaccine, there is generally a global surge with respect to the incidence of the condition and an increasing number of patients on admission. Most interventions are targeted at the prevention of the disease than the effect of the psychosocial experience on the quality of life of the individuals affected which is equally essential. It is therefore recommended that current studies focus on improving the quality of life of those affected.

Keywords

Psychosocial experiences, COVID-19 patients, Ghana

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Introduction

The number of people affected by COVID-19 keeps rising globally resulting in increasing fear and anxiety.[1] It continues to present a devastating effect on individuals and the world economies.[2] COVID-19 victims and their families experience social, emotional, physical, and psychological problems.[1] Moreover, this pandemic has also led to severe restrictions on the free movement of human beings, and the lockdown of almost all countries across the world, affecting socioeconomic activities.[1] In addition, fear has crippled several individuals worldwide due to the increasing outbreak

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and the stigma associated with it.[3] Recently, a study conducted in Ghana established that stigmatization is still a problem in Ghana at the workplace, in the family, and in public places.[4] The result was similar to a study done in China which found that stigma is still a prevalent problem that patients diagnosed with COVID-19 face.[5] The psychological stress associated with COVID-19 is as a result of social isolation, the cost of treatment, and uncertainties about the future. The condition is also found to cause emotional distress to patients and families affected by it with the fear of contracting the infections from the affected relatives.[6] The patient may also go through psychological trauma due to the fear of transmitting the infection to their loved ones and the vulnerable individuals in their family as well as their community.

The psychological disturbance associated with COVID-19 constitutes uncertainty, ambiguity, and loss of control, leading to stress and emotional distress.[7,8] Researchers have ascertained that the isolation or quarantines related to COVID-19 have resulted in a decline in the psychological health of individuals and their families.[9–11] However, the real-life experiences of the patients admitted to the COVID-19 wards and their well-being in the COVID-19 era are largely neglected.[1]

The first two cases of COVID-19 were recorded in March 2020 in Ghana.[12,13] Since then, efforts have been made and are still ongoing to help reduce the incidence of COVID-19 and its stigma. However, little has been known about the prejudice, discrimination, and the experiences these patients face on a daily basis as many of such incidents are either underreported or not reported at all, making it more difficult to deal with these shortfalls.[14] Stigma faced by COVID-19 patients and their family is still a challenge despite the increasing knowledge about the situation, leading to mental distress among affected individuals.[15] Hence, the study recommended that the COVID-19 National Response Team in Ghana must institute a robust psychosocial intervention for affected individuals. It is therefore imperative that this study explores the lived experiences of these individuals and makes them known to the world, especially from the Ghanaian perspective. The focus however will be on the psychosocial experiences of these patients as they battle in their lives with the highly stigmatized COVID-19 infection.

Methods

Research design

The study employed a qualitative phenomenological approach. This is an approach in research that focuses on the commonality of a lived experience within a particular group with its fundamental goal of arriving at a description of the nature of the particular phenomenon.[16] The researchers chose this design because of the sensitivity of the research question and their quest to dig deeper into the issues. The study population comprises both male and female patients who were isolated and undergoing treatment for COVID-19 at the Korle-Bu Teaching Hospital (KBTH) COVID-19 treatment center (Ghana's biggest and highly advanced teaching hospital in Accra).

Criteria for inclusion and exclusion

The study included COVID-19 patients who were not critically ill and undergoing treatment at the KBTH COVID-19 treatment center who were 18 years and above since they were eligible to give informed consent, but it exempted recovered COVID-19 patients and those who were unwilling to participate in this study.

Sample size and technique

The sample size was determined by saturation. Saturation refers to the point at which no additional information is collected since data keeps repeating, indicating an adequate sample size has been reached, thereby making the data collection robust and valid.[17,18] With this, the researchers considered saturation as the point at which no additional data was required from the data collection and this was reached at the 34th participant. All participants who were contacted agreed to participate in the study without dropping out.

A purposive sampling method also known as judgmental, selective, or subjective sampling was used by the researchers.[19] This is a non-probability sampling technique in which the researchers relied on their own judgment when choosing members of a population to participate in a study. In using a purposive sampling technique, only participants who were diagnosed with COVID-19 and receiving treatment at Korle-Bu Teaching Hospital, and who were willing to partake in the treatment, with no hindrance to their condition were used. This method permitted the researchers to recruit participants whose conditions were milder or moderate and excluded those whose illnesses were severe. It also permitted researchers to recruit patients who were due for discharge.

Data collection instrument and procedure

A face-to-face interview was conducted guided by a semi-structured interview guide developed by all the researchers. This approach was considered because it allowed in-depth coverage of the experiences of COVID-19 patients undergoing treatment. Ethical clearance was sought from the Institutional Review Board in Dodowa with a protocol number DHRCIRB 028/03/21 following which an introductory letter was sent to the head of Korle-Bu COVID-19 treatment center expressing interest in conducting such a study within the facility. The researchers together with the help of the nurse-in-charge of the treatment center purposively identified the participants relevant to the study after written informed consent was sought from them. The researchers

introduced themselves to the participants, established rapport, and explained the study's purpose to them. The interviews were conducted at a convenient private place and at participants' convenient time, which were audio-recorded with permission from the participants. This continued until data saturation was reached. All the participants were contacted at the selected facility; however, some of the interviews were done in the homes of participants following discharge. Strict adherence to COVID-19 protocols on hygiene and social distancing, and wearing of masks were ensured throughout the interview process. With this, participants were provided with alcohol-based hand sanitizers before and after the interview. Mandatory wearing of the mask was also enforced at all times during interview sessions. A reasonable distance of at least two meters apart was ensured throughout the interview process. The interviews lasted for 40–60 min, the data collection span was 2 months in March and April, and the whole study commenced in May 2020 and was completed in May 2022.

Trustworthiness

The concept of methodological rigor is the thoroughness and accuracy with which research is conducted to ensure confidence and trustworthiness.[20] The processes that contribute to rigor in qualitative research was first described as credibility, confirmability, dependability, and transferability. And this was strictly followed to ensure reliable and credible results.[21]

The authors achieved credibility by collecting in-depth interviews, ensuring that all the authors were involved in the data analysis to ensure rigorous results, and contacting participants for ambiguities following transcriptions of recorded data. This was also achieved by pretesting the interview guide designed by the researchers among six patients diagnosed with COVID-19 and detained at the Korle-Bu Teaching Hospital Polyclinic. Dependability was achieved by allowing other and colleague researchers to review the manuscript for their inputs and revisions where appropriate. Also, the research design was described in detail indicating the rationale for selection.

With transferability, the authors described in detail the methods for this study including the sampling technique and size, the instrument for data collection, and the data collection procedure as well as ethical considerations. Finally, confirmability was achieved by taking field notes during the data collection and describing the data analysis in detail.

Data processing and Analysis

The data analysis was done by all the researchers. The current study was analyzed with an Interpretive Phenomenological Analysis. This approach is used when examining lived experiences of individuals.[22] The data analysis was done by all the researchers. The following are steps followed when using IPA; familiarization, categorization, developing emergent themes, condensation, connecting, and organizing the themes to generate sub-themes. Prior to the analysis, the responses of the participants were transcribed verbatim. The interviewee transcripts were then examined in totality, to obtain an overall sense of the content of the responses by the participants to various issues by reading through the transcripts by the process known as familiarization.

Following this, similar ideas of the raw data were categorized together by grouping them. Emerging themes were developed by the authors by formulating concise phrases in the margin of the transcripts whilst maintaining the original meaning of the participants. These phrases where further shortened to a few words (2–3) whilst still maintaining the original meaning by participants through the process known as condensation to form codes. The codes were further compared according to similarities and differences to help group codes of similar patterns to develop themes and sub-themes. In all, two themes and seven sub-themes emerged. COREQ software was used to guide the research.

Results

Socio-demographic characteristics of participants

Most of the participants 18 (52%) were between 30 and 39 years of age. Concerning their educational levels, most of the participants 20 (58.8%) were tertiary school graduates, while 9 (26.5%) have had a primary school education. Per their marital statuses, the majority 21 (61.8%) of them were married while the remaining 13 (38.2%) were single. With regards to the number of children, 15 (44.1%) of the participants had 0–1 children, while 11 (32.4%) of them had 2–3 children and 8 (23.5) had 4–5 children. The details of the socio-demographic data of participants are illustrated in Table 1.

Organization of the study. The results of the study revealed two main themes and seven sub-themes as illustrated in Table 2.

Theme 1: Emotional burden of patients diagnosed with COVID-19

This section presented information on the lived psychological experiences of the patients diagnosed with COVID-19 and undergoing treatment. Three sub-themes emerged under this section and presented as follows.

1. Reactions to COVID-19 diagnosis
2. Suicidal thoughts and sadness
3. Fear of the unknown

Sub-theme 1: Reactions To COVID-19 diagnosis

The reaction to situation varies from one person to the other depending on one's demographic characteristics, experiences, and the situation one finds himself or herself in.

Table 1. Demographic characteristics of participant.

Age	Frequency	Percentage (%)
25–29 years	5	14.7
30–34 years	10	29.4
35–39 years	8	23.5
40–44 years	6	17.7
45–49 years	5	14.7
Total	34	100
Sex		
Male	22	64.7
Female	12	35.3
Total	34	100
Education		
Primary	9	26.5
Secondary	5	14.7
Tertiary	20	58.8
Total	34	100
Marital status		
Single	13	38.2
Married	21	61.8
Total	34	100
Children		
0–1	15	44.1
2–3	11	32.4
4–5	8	23.5
Total	34	100
Occupation		
Trading	10	29.4
Public servant	18	52.9
Craftsman	6	17.7
Total	34	100
Ethnicity		
Akyem	12	35.3
Kwahu	4	11.8
Ashanti	3	8.8
Fante	10	29.4
Ewe	2	5.9
Ga	3	8.8
Total	34	100
Hometown		
Kyebi	7	20.6
Accra	3	8.8
Cape Coast	10	29.4
Ho	2	5.9
Oboo	4	11.8
Kumasi	3	8.8
Akyem Oda	5	14.7
Total	34	100
Current location		
McCarthy Hills	4	11.8
Osu	12	35.3
Achimota	3	8.8
Kaneshie	15	44.1
Total	34	100
Length of stay		
Less than a week	21	61.8
1–2 weeks	5	14.7
More than 2 weeks	8	23.5
Total	34	100

Several reactions were exhibited by participants of this study as a result of their diagnosis.

About 16 (47%) of the study participants reported that they were in a state of shock when the news was broken to them.

> It is very shocking and painful to realize you've been diagnosed with COVID-19. Imagine going about your normal and daily activities. . . only to be told that you have COVID-19, hmmm, that's how shocked I was (P 30)

Some of the participants 18 (53%) also recalled how they were in denial and disbelief when the news was broken to them. They had to practice all the recommended protocols to keep them safe from the infection. It was unbelievable for them to have been diagnosed with the disease. One participant shared the following:

> I felt very angry, bitter and mad when I was told I had COVID-19 because I did everything right (paused with a sigh). I was always wearing my face mask whenever I am in a public place, and I wash my hands with soap under running water always and my sanitizer is always in my bag or purse so that if I'm at a place where I cannot get water to wash my hands I use my sanitizer and I always keep my social distance so I was like how can I be diagnosed of COVID-19? (P 34)

Because of the disbelief, some participants 12 (35%) doubted the reality of the diagnosis and went to the extent of seeking a second medical opinion after diagnosis; one participant narrated as follows:

> I was even contemplating having a second opinion on the test by going to a different facility but they told me that the test they did was very reliable and there was no mistake with the result. I would not have believed but because of the symptoms I have experienced for about four (4) days which was unrelieved by over-the-counter drugs, I accepted it in order to get treated and go home. (P.5)

Few of the participants 10 (29%) were furious about their diagnosis and some raised comments of bitterness expressed toward the health workers who broke the news to them; below are some of the comments:

> I was really angry when the public health nurses informed me that I had COVID-19. How could that even be possible for me to contract this condition? I was just sitting there trying to recollect what I did wrong and what safety protocol I omitted for me to be in this situation I find myself, in fact, a whole lot of things were going through my mind at that time and they could see the anger and frustration in my face. (P 2)

Sub-theme 2: Suicidal thoughts and sadness

Suicidal thoughts are ideas of ending one's life when exposed to life-threatening situations or misfortunes. It was therefore surprising that few of the participants 5 (15%) had thoughts

Table 2. Summary of themes and sub-themes.

Themes	Sub-themes
A. Emotional burden of COVID-19	1. Reactions to COVID-19 diagnosis
	2. Suicidal thoughts and sadness
	3. Fear of the unknown
B. Effect of COVID-19 on patients and relatives	1. Social restrictions/isolation
	2. Stigmatization and disclosure
	3. Effect of COVID-19 on the work and family
	4. Positive attitude of staff

of ending their life when they were first diagnosed with the condition.

> Hmmm (sighs), at first, I used to feel like death was better than what I was going through and that was before I was admitted. This was because of the stories I hear on the news about the condition. I wanted to die before it killed me and the death rate was becoming alarming especially when I learned that it did not have a cure. (P 29)

Other participants were thinking of taking an overdose of sleeping pills to end their life to save them from this situation;

> To be honest with you, my symptoms were more intense than I anticipated, especially the cough and chest pain were unbearable and because of that, I thought of ending all this suffering once and for all. (P 20)

According to the participants 14 (41%) upon first time hearing the news of being infected with COVID-19 they couldn't control themselves; some recounted shedding tears immediately after they were informed, others too cried at their various wards. They recounted as follows:

> In fact, I can remember vividly how I cried when I was told by the public health nurses that my results were as positive for COVID-19, they had to calm me down to reassure me that everything will be fine. They encouraged me to express my emotion since I was already tearing and they assured me that it is normal to cry to help me cope with how I'm feeling. (P 25)

> The news of having COVID-19 broke my heart. I was tearing up all along because I did not know how I could have contracted this condition. Sighs! I'm very particular about everything I do especially if it involves my health and lifestyle, so I followed all the COVID-19 protocols to the core you know, hmmmmm, all I could do was just sit there and be crying my eyes out. (P22)

Sub-theme 3: Fear of the unknown

Fear is mostly experienced when one encounters a challenging situation; however, few people may exhibit fear without any specific cause and this was realized in more than half of the participants 25 (74%) as illustrated below.

> I was full of fear because I have heard many people dying from the disease, I was scared of not knowing what the outcome will be for me and I did not even want anyone around me to know that I was on admission for having COVID-19. . . .I was now wondering whether I will be able to survive this condition and that really scared me a lot. (P 3)

> Hmmm.. . . the Doctor could not give me the exact day I will be discharged but he said my discharge will depend on how fast my body responds to the treatment being given me, that scared me and I was afraid of dying. (P 9)

Another participant recounted how scared he was because he was on oxygen since he could not breathe well without the support of the oxygen.

> I was scared I might not get cured and die. These thoughts became worse when I was on oxygen because according to the Doctor my chest sound was bad . . .I was having difficulty breathing as well. . .I was afraid it could lead to my death, it was so scary. (P 7).

One is likely to feel disappointed when unexpected situations happen especially if it's something that could have been prevented. Some participants 15 (44%) were disappointed with themselves since they had the feeling that they brought the condition upon themselves by not strictly adhering to the preventive protocols.

> I felt really disappointed since I knew I could have prevented this from happening but because of my carelessness and carefree lifestyle, see what I have brought upon myself. Moreover, I never believed that this COVID-19 exists so I was living my life like there was nothing at stake and was not following the protocols like I was supposed to. (P 33)

Some health workers 5 (15%) who were on admission narrated how disappointed they were with themselves as follows:

> It is really disappointing as people will think that as a health worker I must know better than anyone else when it comes to safety precautions . . .I have a feeling that they gossip about me. (P 18)

It was realized that most of the participants doubted their diagnosis and became angry as a defense mechanism to cope with the COVID-19 diagnosis. Others were disappointed, and anxious to the extent of shedding tears.

Theme 2: Effect of COVID-19 on patients and relatives

This theme revealed the social challenges or experiences patients in this study encountered after being diagnosed with

the condition. Four sub-themes emerged and were analyzed under this theme and they are presented as follows;

1. Social restriction/isolation
2. Stigmatization and disclosure
3. Effect of COVID-19
4. Attitude of frontline nurses.

Sub-theme 1: Social restrictions/isolation

Individuals are often isolated when they are at risk of transmitting infectious diseases to help control outbreaks. COVID-19 is one of the infectious diseases that lead to isolation among those affected. As a result, many of the participants 28 (82%) in this study bemoaned feelings of being restricted and cut off from their family and friends as depicted in the statements below:

> it is very difficult to be here not knowing anyone and whom to chat or talk with all because I have tested positive for COVID-19 and they are afraid I could spread it to more people, I miss chatting with my friends and family as well as going to social functions, in fact, being here without having the chance to see other people is very difficult but what can I do? (P 13)

> My lifestyles have really been affected ever since my admission and confinement at this center, I am not able to do the usual things I liked doing when I was home, I cannot even go to church or work and because of that I am really feeling lonely and can't wait to get home. (P 14)

Some participants also expressed their views about how the routines here are different from their own normal routines due to the restrictions at the center.

> So many things have been affected in my daily routines, now we can't go to the shop like we used to. Movement and activities are even restricted such that we are not supposed to leave our surroundings to any place and my family cannot come and visit me, if they bring stuffs I need, they have to leave it with the nurses since they can't deliver it personally. (P 11)

Sub-theme 2: Stigmatization and disclosure

People will usually want to have some information about themselves kept confidential due to the apprehension of having their secrets being shared with others. A similar feeling was exhibited by some participants 20 (59%) of the study who were scared of being stigmatized even after they would have fully recovered.

> I live in a community where nothing is kept a secret so I am very careful not to let anyone in the community know of my current situation to avoid any stigmatization or discrimination after my discharge. (P 8)

Some also said that apart from their close relations nobody knows they were on admission and they thought it was good to keep it that way to prevent any sort of stigmatization against them or their family.

> I have told my wife and children not to tell anyone including my extended family and close friends since I don't know how they will take the news, what if they end up spreading it and my family is ignored or stigmatized because of that. (P 25)

Some participants 15 (44%) said that they only broke the news to their close relatives and friends since they were scared of being discriminated in their community. They recounted as shown below:

> I have only disclosed my COVID-19 status to a few people around me, those that I can trust and know will not discriminate against me. No one in my neighborhood even knows I'm receiving treatment at this center and I live alone as well, it's only my parents, siblings, some few friends, and my pastor who knows I'm receiving treatment here. (P 26)

> Since I was told of having COVID-19, I have been very conscious of who I can trust to tell them that this is what has happened to me and because of that just a few know that I have COVID-19 and receiving treatment here. (P 19)

Some participants commented on how some family members spread the news to others even though they warned them to keep it to themselves and how displeased they were because of that.

> My brother really got me angry when he told some neighbors and friends that I was on admission for COVID-19, I strictly told him not to tell anyone but he did not listen to me. (P 10).

Sub-theme 3: Effect of COVID-19

COVID-19 causes a significant effect on all individuals worldwide due to the restrictions and the deaths associated with it. Participants of this study also recounted how they were affected by this pandemic as follows:

> My mother is taking care of my child for me in my absence and she has prepared food and put it in the fridge for my husband so that he can only heat them to eat when he is hungry, I have told my husband to leave our son with my mum until I am discharged but he prefers to go for him after work at my mum's place and take him home every day. (P 30)

Others also recounted on how their families are affected emotionally because of them being admitted at the treatment center.

> In fact, my mum and my sister were so worried when they heard I had tested positive for COVID-19 and was on admission, they told me on phone they could not sleep or eat because they thought I was going to die and were so scared for me especially when they heard that there was no treatment for this condition, whenever they call me on the phone, I have to assure them that

> I am fine and recovering, they're always sending me motivational quotes everyday smiles. (P 15)

Work-related issues are problems encountered by individuals at their workplace.

This section is centered on the impact of being diagnosed with COVID-19 on participants' work.

> My work has really been affected and I do not have anyone to look after my shop for me because I am on admission here, there is no one I can trust to look after my shop too since the last time I tried that they stole from me, I'm sure by the time I leave here. I might have lost all or most of my customers so my shop is closed until I will be discharged. (P 10)

Some of the participants were also enthused because of the love and affection shown by their bosses when they were on admission. Some recounted as follows:

> I am lost for words and surprised at the love and affection shown to me by my boss at work, she is always calling me on the phone to check up on me and to know how I'm faring, and she also sends some of my colleagues to bring me some stuff at the center to make me feel at home and feel relaxed, I'm really grateful for that and I am really grateful to have someone as caring as her as my boss, may God bless her. Smiles. (P 22)

Sub-theme 4: Positive attitudes of staff

Positive attitudes of health workers at a hospital or health facility count in the recovery of patients on admission; it makes patients feel relaxed and believe that they are getting the best care available to them. Some participants had this to say.

> The staffs have really exceeded my expectations and given me the best of care, thus, making me feel more relaxed and comfortable. They are always there to listen to our complaints and address them accordingly and they are very friendly making sure we lack nothing, even when it's not yet time for them to come and give us our medications or check our vital signs, they call us on the phone to find out if we are fine and whether we need anything. God bless them for the wonderful work they are doing. (P 1)

Some recounted on the fact that though most of the staffs discharged their duties exceptionally well with the speed of light and in a culturally sensitive manner, there were some few ones whose attitudes were abysmal as recounted by them.

> I must say I'm very impressed with the attitude of the staff at this treatment center but there are a few among them whose behaviors are very appalling, there's this particular nurse that is very disrespectful and keeps her distance from us even when she's wearing all the protective equipment's and that makes us feel really bad and certain gestures she makes when attending to us will make you not to dare ask her a question even if you wanted to and that is very bad. (p 33)

Majority of the study participants have concerns about being restricted from participation in social activities, and being stigmatized. Moreover, they express concerns about challenges at work and in their family as a result of their diagnosis.

Discussion

Shock, disbelief, and denial are some notable expressions health workers noticed among patients after breaking unpleasant news to them. The participants of this study were of no exception. Shock, disbelief, and denial were some of the key experiences participants of this study were identified with. This is consistent with a study that argued that shock accompanied by disbelief and denial are some of the initial reactions people diagnosed with certain conditions experience.[23] The consistency was as a result of the intrinsic nature of the human response to external and unexpected stimuli which might be the same or similar everywhere and exhibited in every situation. This is mostly experienced when people are exposed to situations they are not expecting, especially when they feel they have done all that is expected of them to prevent the disease from occurring. Appropriate counseling should be given to newly diagnosed patients by a clinical psychologist during the declaration of test results.[24] Also, for the avoidance of doubt, test results should be shown to the patients only and if they insist, another test should be carried out for confirmation.

Expression of anger is another psychological experience of being diagnosed and treated for COVID-19 by some participants in this study. Participants expressed so much anger at the health workers, their families, and loved ones as a reaction to the feeling of disappointment after contracting COVID-19. Anger can be shown in different ways through either violent or physical outbursts upon hearing the news of the diagnosis. Similarly, it was identified that anger toward self and others is some of the outward expressions among people diagnosed with COVID-19.[1] The expression of anger may result from fear of being depressed and being stigmatized even though one might have adhered to the safety protocols of COVID-19 prevention.[25]

Most participants who shared their experience stated that they broke down emotionally and, in some cases, shed tears at the news of having contracted the virus. Shedding tears is a way some people use to express their emotions depending on the situation they find themselves in. This is consistent with the discovery that there are diverse ways in which individuals react to bad news of which crying is a part.[26] The majority of the participants of this study were overwhelmed by the news and the only way to express their emotions was through crying. Psychologically, it is advisable for one to express themselves through crying if that is what will make the individual

cope with what they are going through.[27] Participants complained about feeling sad, shedding tears, and worrying about the outcome of their condition which is consistent with a study where the expression of shedding tears was considered as reflecting depression among people who had undergone quarantine.[28] This may be that there is an anticipated level of feeling of loneliness and fear of the unknown as a result of some reportage about the mortality rate of COVID-19. This call for intensive and extensive public education on COVID-19. There is also the need to provide infected patients with the needed psychological and social support.

The notion that COVID-19 is a deadly virus made some participants contemplate suicide. In reporting their experiences, some participants viewed the diagnosis as a "death sentence" and would do anything to hasten it to escape the challenges that come with it. This finding aligns with a study where many of the participants seriously considered suicide in the past after being diagnosed with COVID-19.[29,30] This suicidal ideation may stem from some social effects as a result of the psychological distress that they may encounter during and after treatment. This is in line with a study that stated that the isolation or quarantines related to COVID-19 have resulted in a decline in the psychological health of individuals and their families diagnosed with COVID-19.[9] People with suicidal ideations should be given close monitoring and social support from both families and friends. Also, another way to help these people is to provide them with clinical counseling on the need to live again.

Findings from this current study revealed that most of the participants feared dying from the virus due to the exponential mortality rate reported worldwide. The continuous administration of oxygen therapy also imposes a lot of fear in some of the participants making them think they were nearing death; others also verbalized how uncomfortable they felt with the oxygen delivery devices. This is consistent with the study conducted on the outbreak of the coronavirus disease which revealed a sharp increase in fear and worries relating to the virus.[31,32] However, it was expressed that fear of the unknown is one of the emotional responses experienced by people with chronic illness or diseases.[33] The inconsistency may be due to the intensity of the havoc that can be caused by the virus and also the over-exaggeration on the death toll reported by the media. Hence, well-informed media reportage should be encouraged among the media houses concerning the fear caused by the media on the management of COVID-19.

Another central finding was disappointment toward self. The occurrence of coronavirus has caused a lot of disappointment to people, especially those who were infected by the virus. The findings of this study revealed that most of the participants felt disappointed in themselves when they were diagnosed with the virus. Their disappointment can be attributed to non-adherence to the safety protocol as a result of ignorance and negligence. This could also be that most people were misinformed about the spread of the disease and the cloudiness of the mind with myths can also be a contributing factor. This is similar to a survey about the misinformation of COVID-19 causing disbelief and doubt in some people through conspiracy theories and the motivation of preventive measures like vaccination, social distancing, and face mask and this caused a lot of disbelief in some people worldwide.[33] For effective management and prevention of COVID-19, proper mass and media education should be carried out throughout the country not neglecting any single village. People should be educated that it is a natural phenomenon that can occur to anyone. Hence, blaming oneself or another entity is not the ideal way to deal effectively with the virus.

One of the key concerns of the participants was the restrictions imposed upon them by their admission or quarantine and treatment. The majority of the participants felt they have been ostracized from the world due to the quarantine and the fact that they are on admission also poses a certain level of restrictions on them. They felt homesick, with limited access to recreational activities, and deprived of social contacts with friends and family. These experiences were consistent with the findings of the Center for Disease Control which found that isolated people displayed physical distancing which affects their ability to socialize with friends and families in-person to celebrate many significant life events. To some, the inability to perform their usual activities of daily living such as going to church, shopping, and even working makes them so unhappy. The safety measures like self-isolation and quarantine negatively influence the usual activities, routines, and livelihood of people.[34] Similarly, a researcher opined that this pandemic has led to severe restrictions on the free movements of human beings resulting in detrimental effect on socioeconomic activities.[1] These experiences may trigger the elevation in negative mood and low self-esteem among such isolated people and most of the participants were in low spirits as a result of that.

Another important finding identified in this study was about work-related issues. The study identified that the majority who are of the working class were the breadwinners of their families and their absence affected their families. The greater proportion were by virtue of their admission not able to resume work to make some living. This is consistent with a study that revealed that some hotel workers were unable to resume their jobs due to being quarantined.[35] This could be due to the fear of infecting other workers and the strict restrictive measures put in place that prevents a worker from contracting COVID-19. Hence, appropriate measures should be taken to help affected employees work electronically from the treatment center so they become beneficial to their employers. This will bring some level of job security to the patients. Affected entrepreneurs should be supported financially so they can carry on with their business even after discharge from the isolation or treatment center.[36]

The perception of stigma and discrimination among participants was also identified in this study. Most of the participants perceive themselves being stigmatized by family and

their community if their status is made known to them. Participants expressed difficulty returning to the social circles due to the potential of being stigmatized. A researcher demonstrated that quarantined participants were significantly more likely to report stigmatization and rejection from people in their local neighborhoods.[37] Inconsistent to the finding of this study is a survey that revealed that affected people do not fear to be stigmatized but are rather only withdrawn from families and others out of the fear of infecting them.[38] The inconsistency can be attributed to a lack of better understanding of the mode of transmission and education on how to be properly integrated into the uninfected people. Stigmatization can only be resolved upon a better understanding of the disease. When people are better off in knowledge concerning the causes, transmission, treatment, and prevention of the disease, it eliminates their ignorance and helps boost their confidence on how to stay and accept individuals who were once affected by the virus.

Disclosure means to reveal or expose information that has previously been kept secret and in this study, participants were asked to whom they disclosed their status after they were diagnosed with COVID-19. Most of the participants said that they only revealed it to their close relatives and friends since they were scared of being discriminated against in their community while some also stated that they did not disclose their status to anyone because of fear of being stigmatized by others and none of their family or friends have any idea that they are even on admission at the treatment center. Consistent with the finding of this study is a survey that opined that disclosure of health status carries several risks which include stigmatization, discrimination, social marginalization, and violence.[39] A researcher further noted that the disclosure of the negative health status caused by the infection not only destroys social relationships but negatively affects the quality of life of the discloser and discourages disclosure.[40] The negative consequences that follow disclosure of health status may come as a result of inadequate knowledge about the infection. The public should be educated in order to reduce the negative consequences that follow a disclosure. This will help encourage people not to hide in their homes and resort to inappropriate treatment at home but move out to seek treatment to help control the spread of the virus.

It was found that the staff at the facility had a positive attitude toward the patients. Attitudes of health workers at a hospital or health facility also aids in the recovery of patients on admission; it makes patients feel relaxed and believe that they are getting the best care available for them, and therefore, they are in capable hands and nothing will happen to them; this confidence alone boosts their chances of recovering early. Most of the participants appreciated the care they received and spelt out that they were content with the way the nurses and other health workers were attending to them; some even said they thought that the staff would not want to be closer to them because of their condition but they later realized that the staffs were friendly and gave them the needed attention without any discrimination. This is consistent with a study revealing that most nurses had a positive attitude by supporting and advocating for the COVID-19 patients and their families despite the heavy workload.[41] This may be due to the high level of knowledge the healthcare professionals have on the protective measures in order not to contract the infection.

Limitations

The major limitation encountered during the study was procurement and access to personal protective equipment (PPE) for data collectors since the period coincided with a shortage of resources for providers.

Conclusion

Even though the recovery rate of COVID-19 has improved since the introduction of COVID-19 vaccine, its incidence is still rising globally with an increasing number of patients on admission. The study found varied psychosocial experiences including shock, denial, anger, stigmatization, and impact of COVID-19 diagnosis on work and family. Also, the attitude of staff caring for these patients was unveiled. More attention is geared toward its prevention than the quality of life of individuals affected. It is therefore recommended that current studies focus on improving the quality of life of those affected as well as the coping strategies used by patients diagnosed with COVID-19.

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Author contributions

EA contributed to the conceptualization, data collection and analysis, data interpretation, and manuscript drafting for publication. EO contributed to the conceptualization, writing the manuscript, drafting the manuscript for publication, and reviewing the manuscript. JA contributed to the reviewing, editing, analyzing, and drafting of the manuscript for publication. EH contributed to the conceptualization, writing the manuscript, drafting the manuscript for publication, and reviewing the manuscript. BO contributed to the conceptualization, writing the manuscript, drafting the manuscript for publication, and reviewing the manuscript. JA contributed to the conceptualization, writing the manuscript, drafting the manuscript for publication, and reviewing the manuscript. RE contributed to the conceptualization, writing the manuscript, drafting the manuscript for publication, and reviewing the manuscript. All authors read and approved the final manuscript.

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The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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The Dodowa Health Research Centre Institutional Review Board (DHRC-IRB) granted the permit for this study to be conducted with the ethical approval number DHRCIRB 028/03/21.

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Informed consent

Written informed consent was obtained from all subjects before the study.

Consent for publication

Written informed consent was sought from the participants and they were also made aware that content may be published for learning purposes without revealing their identity.

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Data availability

All supporting data have been made available as supplementary files.

Supplemental material

Supplemental material for this article is available online.

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