

# Alterations in the Experience of Time, Space, and Intersubjectivity and the Interaction with Pre-Existent Psychopathology during the COVID-19 Pandemic

Inga Lau<sup>a</sup> Laura Melanie Schaefer<sup>a</sup> Stefanie Brons<sup>a</sup> Fabian Koch<sup>b</sup>  
Franca Johanna Utz<sup>a</sup> Stanislav Metodiev<sup>a</sup> Anne-Louise Meyer<sup>a</sup>  
Nathalie Rapp<sup>a</sup> Claas Lahmann<sup>a</sup> Stefan Schmidt<sup>a</sup> Prisca Rachel Bauer<sup>a</sup>

<sup>a</sup>Department of Psychosomatic Medicine and Psychotherapy, University Medical Center Freiburg, Faculty of Medicine, University of Freiburg, Freiburg, Germany; <sup>b</sup>Faculty of Medicine, University Leipzig, Leipzig, Germany

## Keywords

Depression · Anxiety · Psychotherapy · Social distancing · Face masks · Unheimlichkeit · Uncanny

## Abstract

**Background:** The COVID-19 pandemic and the measures to protect the physically vulnerable may disproportionately affect people with mental health vulnerabilities, who receive psychotherapeutic inpatient treatment, as many of these measures impact the (inter)subjective space crucial to psychotherapy. **Objective:** We investigate how people with pre-existing mental health conditions and healthcare professionals experienced changes linked to the COVID-19 pandemic. **Methods:** During the first COVID-19 outbreak and lockdown in spring 2020, we conducted semi-structured interviews with patients and healthcare professionals at a clinic for psychosomatic medicine in Germany and analyzed them following the principles of descriptive phenomenology focusing on social interactions, intersubjectivity, and the therapeutic space. **Results:** We conducted a total of >30 h of interviews with 19 patients and 17 healthcare professionals. Analyses revealed that the COVID-19 pandemic and the related measures have led to a sudden loss of a sense of normality. Par-

ticipants experienced changes in the perception of time, space, self, and embodied interaction with others, resulting in a profound feeling of alienation and “unhomeliness” which seemed to magnify pre-existing psychopathology. The inpatient psychotherapeutic environment provided safety by offering spatial and temporal structures and opportunities for social interaction, supporting people to find new ways to be in a changed world. **Conclusions:** Our study shows that despite the threat of infection, it is vital to continue to provide people with psychological vulnerabilities with a safe therapeutic space in which to regain a sense of safety in a changed world. This is particularly important, as those people seem to suffer intensely from the collateral measures of a pandemic.

© 2022 S. Karger AG, Basel

## Introduction

On 11 March 2020, the WHO declared the COVID-19 a pandemic. Like in many other countries, measures to protect particularly vulnerable members of the popula-

Inga Lau and Laura Melanie Schaefer contributed equally.

tion were implemented in Germany. These measures included the introduction of a lockdown, restricting public life and social gatherings, with policies of social distancing, the avoidance of handshakes as well as wearing face masks [1].

Previous studies suggest that pandemics themselves, as well as protective measures such as quarantine and isolation, have an impact on mental health [2–5]. Social distancing and face masks may also impact mental health as interpersonal distance and facial expressions (including gaze) are central to social interactions [6] and can trigger approach or avoidance behaviors to increase or decrease interpersonal distance [7]. In turn, actions to regulate proximity also seem to influence attitudes and emotions, depending on the context [8]. People with pre-existing mental health conditions may be especially vulnerable to the influence of such effects [9, 10].

Psychotherapy, and its interpersonal space, is important in the treatment of mental health conditions. The patients' psychological phenomena are assessed and processed through the psychotherapeutic relationship for healing to occur [11, 12]. People with severe mental health conditions are usually treated in inpatient or day clinic settings, with intensive multimodal treatment programs [13], offering space for various therapeutic relationships which influence and stimulate each other. These settings also provide social and therapeutic encounters between patients, during or outside group therapy sessions.

The subjective experiences of patients (individually or within the group) and therapists (individually or within their team) influence each other, creating a clinical environment, which is different but not separate from the extra-clinical environment. As embodied, nonverbal processes are key in interpersonal interactions, the clinical environment and psychotherapeutic encounter may be especially affected by social distancing and face masks [12].

In this qualitative study, we explored if and how the pandemic and protective measures influenced the experiences of people with pre-existing mental health conditions in a clinical environment. We interviewed people who received inpatient psychotherapeutic treatment for mental health conditions, and healthcare workers involved in their care, during the first 4 months of the COVID-19 pandemic in Germany. The inpatient setting provided the opportunity to study the experience of people who received extensive diagnostic work-up and who were severely affected by their mental health issues. In such a setting, changes to the intensive psychotherapeutic relationship and environment were expected to be

perceived quickly, mirroring general changes in perception and interaction outside the clinical setting. Staff members working in psychotherapeutic settings are likely to be sensitive to such changes in intra- and interpersonal processes. The inclusion of patients with different diagnoses and staff members with various backgrounds and patient contacts enabled us to investigate the experiences of pandemic-related changes from different perspectives.

## Material and Methods

### *Participants and Recruitment Procedure*

Participants were recruited from the Department of Psychosomatic Medicine at the University Hospital Freiburg, Germany. The department consists of inpatient (17 beds) and outpatient clinics as well as a day clinic (14 places) and provides a liaison service for other departments. This psychosomatic setting offers multimodal care with a psychodynamic focus for people with different acute and chronic mental health conditions including depression, anxiety, eating disorders, somatoform disorders, trauma-related disorders, and personality disorders. Therapeutic programs include individual and group psychotherapy, art, music, body, relaxation, and sport therapy, physician rounds, educational elements, and, if needed, support by a social worker, therapy sessions with family members, general medical care, and/or psychopharmacology [13]. The standard duration of in-patient treatment is between 4 and 12 weeks. Patients were informed about the study during group sessions and through written notices published in the department. In the written and oral information, it was made clear that participation was entirely voluntary. If patients were interested in participating, they were invited to contact one of the members of the study team to receive more information. Members of staff were informed about the study and invited to participate through a general email list from the department.

### *Interviews*

Semi-structured interviews (see the questions in online suppl. S1; see [www.karger.com/doi/10.1159/000522345](http://www.karger.com/doi/10.1159/000522345) for all online suppl. material) [14] were conducted in-person or by telephone by physicians and psychologists in the department (I.L., L.M.S., S.M., F.U., N.R., A.-L.M., P.R.B.). This ensured that potential difficult emotions and any distress that emerged in study participants during or after the interviews could be contained. Patients were given the choice of whether they wished to be interviewed by their treating therapist or by another member of the study team. Staff members were also given the choice among the team members. This allowed participants to find a trusted partner to share their experiences with, with as much openness as possible. Interviews focused on the personal experiences of the participants during the first COVID-19-related lockdown, including their feelings in daily personal life and in the therapeutic setting.

All interviews were audio-recorded and transcribed verbatim (by I.L., L.M.S., S.M., F.U., N.R., A.-L.M., S.B., F.K., and P.R.B.). To ensure confidentiality, staff members' interviews were transcribed and anonymized by the interviewer, and staff-interviewees were given the possibility to read the transcripts.

### Data Analysis

Analysis was conducted using a group-oriented qualitative methodology and inspired by a phenomenological approach [15–17]. Phenomenology is rooted in the philosophy of Edmund Husserl and aims to reveal features of human existence from individual (first-person) narratives [18]<sup>1</sup>. In every qualitative approach, the disentanglement between our own lived experience and that of study participants is a major concern. In the pandemic, this was especially crucial as the pandemic affected all of us at the same time. Throughout the study, we were aware of this and took care of this fact in several ways: during the data collection phase, we wrote diaries, in which we recorded our own observations and experiences. For each interview, we wrote a memo recording our own impressions. We held weekly meetings as a research group to discuss the interviews and our own observations. By doing this, we discovered how helpful it was to reflect on the interviews in the group, as it helped to bring to the fore collective experiential features and observations, while helping us to reflect and to contextualize our own. Like others [17], we felt that this group approach, although uncommon in qualitative research, was promising for the data analysis, as it could help us to not overinterpret data and distance ourselves from our own subjective experiences. It was an attempt to suspend our own preconceptions, views, and judgments, and to try to uncover the structures of experience in the descriptions of participants. As both patients and staff members were affected by the pandemic, we analyzed the interviews without a priori differentiating between these groups but followed a data-driven approach comparing emergent themes between the groups.

Data analysis and interpretation were thus conducted as follows: first, the team read all interviews in their entirety. A sub-team (I.L., L.M.S., F.U., S.M.) identified and selected passages that were broadly pertaining to social interactions, (inter)subjective space, and therapeutic space. In a second step, the entire research team reread the selected passages and took notes about important passages, themes, and ideas. These were discussed thoroughly in weekly meetings involving the whole research group. In our discussions, we followed similar approach to our clinical team meetings in which we discuss clinical cases: by looking at the words from the participants from different perspectives (different members of the group), we tried to understand their meaning. Members of the group had different personal and professional backgrounds (psychology, medicine, students, living alone, with partners, with children). Each member of the group had an equal say, and all perspectives of members were considered equal. Two team members (F.K. and S.B.), who did not know the interviewees and thus had more distance to the data, proceeded to inductively generate content-describing units/codes for the entire body of interviews based on these discussions. In a circular, iterative process, intuitions that emerged in the group discussions were verified in the interviews through the coding process and fed back into the group by I.L., L.M.S., F.K., S.B., P.R.B. In a third step, which started when no new viewpoints emerged from the group discussions, we summarized the descriptions into categories with thematic or narrative similarities. This step of “condensing” data to the most concise and representative thematic fields of participants’ narratives relating to the

<sup>1</sup> We are aware of the widely diverging methods in the field [16], especially regarding the use of the epoché and reduction; see for example [42–44].

research question was done by I.L., L.M.S., F.K., S.B., P.R.B. Finally, we put these identified theme fields in the context to each other, again by discussing this within the whole group. Repeatedly discussing different interviews helped us to collectively come to an interpretation and to identify structural commonalities in the interviews. All analytical steps were conducted in German. The manuscript was written by I.L., L.S., and P.R.B. All authors were involved in the interpretation of the data and the selection of representative quotes from the interviews. Emerging categories and quotes were translated into English for the purpose of publication. Analysis was supported by ATLAS.ti software (version 9 for Mac; ATLAS.ti Scientific Software Development GmbH, Berlin, Germany).

## Results

### Participants

The interviews were conducted between April 24 and July 26, 2020. This was during the time that the protective measures and lockdown were in place. Nineteen patients and 18 staff members participated in the study. Some participants, especially patients, immediately volunteered. For staff members, we practiced purposive sampling and invited specific people in order to gather information from as many different groups as possible regarding age, sex, and profession or social status. The first staff interview was not completed due to technical difficulties and was excluded, leaving 36 interviews for analysis. Interviews lasted between 30 and 75 min. In total, >30 h of interviews were recorded.

Patients ( $n = 19$ , 11 females, 8 males, aged between 20 and 73 years [mean = 39 years]) had different ICD-10 diagnoses including affective disorders ( $n = 14$ ), anxiety disorders ( $n = 7$ ), eating disorders ( $n = 6$ ), somatoform disorders ( $n = 5$ ), and personality, posttraumatic, and autism spectrum disorders ( $n = 1$  for each). Most of them had more than one diagnosis. The health workers (13 women) were psychologists ( $n = 7$ ; 2 in training), a body psychotherapist, a music psychotherapist, a physician, nurses ( $n = 5$ ), a physiotherapist ( $n = 1$ ), and an administrative worker with daily patient contact.

### Interviews

Three thematic areas emerged from the interviews, in which changes within and outside the clinical environment were closely intertwined: (1) societal changes due to the pandemic and protective measures, (2) the influence of public lockdown, distancing rules, and face masks on interpersonal interaction, and (3) psychopathology and the therapeutic space. An overview is shown in Table 1. Below, we describe each area and subthemes.

**Table 1.** Emergent themes and subthemes

1. Societal changes due to the pandemic and the related protective measures	
A. The pandemic itself	Finitude of life and overall loss of control
B. Protective measures	Measures: protection versus restriction
C. Changing normality	Loss of familiarity, alienation
2. Interpersonal interaction	
A. Lockdown measures	Changes of daily structure and role, loss of routines Fewer appointments: freedom versus oppression Changes in perception of time: slowing down Changes in perception of space: constricting Relationships becoming more distant versus closer or too close Coping strategies: nature induces feeling of freedom
B. Distancing rules	Insecurity how to deal with rules in social contact Feeling guilty if not cautious enough Change of personal comfort zone Lack of embodiment, in case of psychopathology Feeling rejected due to physical distance Missing physical contact for showing emotions
C. Face masks	Telecommunication: insufficient surrogate Association with Medical terms and danger Foreign cultures Changing (self-)perception Missing facial expressions: hindering communication and synchronization
3. Psychopathology and therapeutic space	
A. Patients	“Magnifying glass” on psychopathologies
B. Healthcare workers	Work more challenging versus more gratifying
C. Therapeutic space	Changes within the hospital mirror changes outside Therapeutic encounter as a room of shelter offering structure and social interaction

### Societal Changes due to the Pandemic and Protective Measures

Changes in society were described by many participants and were usually mentioned early in the interviews. These descriptions revealed a sense of all-pervading anxiety of a threat that is unknown, unavoidable, and uncontrollable.

#### *The Pandemic Itself*

The COVID-19 pandemic outbreak was a sudden and unforeseen occurrence, bringing about a collective experience that was described as frightening and threatening. Life as it was known ended abruptly and confronted people with the finitude of life. Although most of the participants did not have a personal experience of war, they associated this sudden feeling of threat and insecurity with a war, in which the virus was seen as the enemy: “I mean, it is a kind of war [...] It’s going to cost many, many lives worldwide.” (Interview 11, man with depression) “It’s such an invisible enemy.” (Interview 21, female staff member)

The situation seemed to awaken precise visions of what a war could be like. In our German sample, this could be linked to a collective memory of the Second World War.

The worst-case scenarios that participants described triggered anxiety as people got prepared for a possible catastrophe, resulting, for example, in panic buying. “I’ve seen people fight over food or toilet paper. And that just reminded me of war. This scarcity, although it is not there. So, everyone is afraid they won’t get anything and for me that was bad.” (Interview 9, woman with eating disorder)

#### *Protective Measures*

The measures put in place to limit the spread of the virus (lockdown and social distancing) had a profound impact and affected most participants more than the fear of the virus itself. On the one hand, people reported feeling protected, possibly because the measures helped them to regain a sense of control over an uncontrollable situation. “I actually feel safe with the measures that have been taken, both family-wise and professionally.” (Interview 21, female staff member)

Yet, the measures were continuously changing according to incidence rates and changing knowledge, supporting the feeling of the situation being continually “out of control,” rather than offering stability and security. “Suddenly something big falls away, when you no longer know where you’re headed. [...] the uncertain-

ty makes me restless.” (Interview 10, woman with eating disorder)

On the other hand, the measures led to feelings of being restricted and controlled by the authorities, which in turn led to fear and anger – not toward the virus, but toward authorities. “Being patronised (by the authorities) makes me angry. Scared and angry. Through fear comes anger.” (Interview 11, man with depression)

Here again, the specific sociohistorical context and past experiences with authorities may be important and influence how people perceived the measures.

### Changing Normality

The topic of a changing normality and the feeling of losing something important was brought up frequently. “Something was taken away from us and the soul, it doesn’t want that. When you take something away you have to put something back...” (Interview 02, woman with depression)

While some wished to go back to the “old normality,” many described the wish for, or the development of a “new normality.” “This is of course a state in which one does not know [...] but one must invent like a new normality for oneself.” (Interview 19, female staff member)

Most interviews reflected profound and destabilizing changes caused by the pandemic. Life as it was known had suddenly stopped and people seemed to feel lost in the midst of the changes. Descriptions carried a sense of loss and missing of former normality, which was replaced by unfamiliarity and disorientation. At the same time, some described feeling increasing solidarity and closeness to other people. “There is a sense of responsibility towards others. [...] I am part of a community, and I am developing responsibility for fellow human beings.” (Interview 06, man with depression)

This sense of solidarity and shared experience in the pandemic has been described before [19–21]. Almost all participants described feeling responsible for others, echoing previous descriptions [22]. This may be seen as a way to find some stability and support while trying to retrieve some feeling of familiarity. In the next section, we explore the direct impact of these wider societal changes on people’s lives.

### Interpersonal Interaction: The Influence of Public Lockdown, Distancing Rules, and Face Masks

We identified three domains of people’s lives that were particularly affected by the pandemic: (1) the lockdown measures and their ensuing changes in routines, (2) dis-

tancing rules and the resulting challenges in distance regulation, and (3) face masks and their influence on (self-) perception and communication. We will show how these three domains are tightly connected to existential themes including temporality, spatiality, embodiment, and intersubjectivity [16].

### Lockdown Measures: Loss of Routines and Structure

The closing of institutions, schools, and offices restricted possibilities to meet others. Home-schooling and home-office led to a collapse of routines, intensifying the feelings of loss, destabilization, and disorientation. “There is no more routine, there is somehow no more support. [...] It is totally completely gone. Instead, everything is completely in turmoil, everything is so unclear.” (Interview 07, woman with anxiety disorder)

Several participants reported that roles within the family had changed. Especially parents needed to adapt to the needs of their children and provide stability in an ever changing situation while also fulfilling expectations to continue to work normally. “The children are totally unbalanced, restless. And all this comes together in the situation like under a magnifying glass, when you are at home all the time and you are supposed to do something for school, and actually as a mother or father you have no time to be with them because you are supposed to work at the same time, that was quite difficult.” (Interview 31, female staff member)

The loss of daily structure and routine was felt as a reorganization of time. Mostly patients, but also several staff members, reported boredom and temporal emptiness linked to a feeling of oppression. “No meetings with friends, no cinema, no theatre, no sports. [...] So a certain monotony, I must say. [...] And that [...] is burdensome and restricting [...]. So maybe I would call it emptiness [voice breaking] yes, like that. Something oppressive [...]” (Interview 19, female staff member)

This was connected to a change in the perception of time. People perceived themselves as slower, more undefined, and passive. “I have more time and the danger, [...] for me is that I fall into a lack of drive. That I, as I have fewer appointments, lie down too much [...] The danger is greater, that one has dull thoughts. [...] It’s a struggle against passivity.” (Interview 06, man with depression) “Everything takes longer. So, I think that’s one aspect that’s really important. [...] I perceive myself as much slower. Everything takes longer. Everything is tougher.” (Interview 19, female staff member)

Interestingly, clinical depression has been linked to similar felt changes in temporal experiences [23]. Time

has also been conceptualized as an intersubjective phenomenon [23], in which the synchronization and desynchronization with others are fundamental. This can be on a person-to-person level, but social life with its recurring events and rituals is another level on which people synchronize with each other [24]. During the lockdown, all social life was suspended, leaving people with few possibilities to synchronize with others. It might well be that these changes in temporal experience have contributed to the profound feeling of alienation.

A few participants – mostly staff members – described the emptied calendars as liberating. They could enjoy the calm and found time for meaningful activities. The perception of time slowing down was perhaps valued differently due to more inner flexibility to adapt to changes in temporal structures. *“On the positive side, [...] you can now do nothing for a longer period of time with a clear conscience. So that’s this general feeling of deceleration. I also notice that, somehow a diffuse feeling of calm, deceleration, contemplation, too.”* (Interview 17, male staff member)

Structures of life also have a spatial aspect, which was also affected by the pandemic. International borders were closed, separating some participants from their loved ones for several months. The living environment was narrowed as travel was restricted and social interactions were concentrated on the personal household. Interactions with “close” family members, friends, or flat mates became closer, which most felt was positive, even if sometimes this was experienced as too much. *“It’s important for me to be close to my family. And I’m experiencing that very differently right now, or in this whole phase that I’m in now, I’m much more at home anyway. The children appreciate that. It is extremely good for me, yet I also notice that we are reaching our limits.”* (Interview 05, man with depression and anxiety disorder)

This could be interpreted as a constriction of both physical and intersubjective spaces. Outside their homes, participants recounted how the usually busy places became eerily quiet, which they associated with emptiness, oppression, and death. *“It was weird that you partly had people there who avoided you or so, but I felt this emptiness, this silence as strange, that the city was totally dead.”* (Interview 24, man with depression) *“It’s oppressive because it’s not a nice atmosphere. People are avoiding each other, yes, which is as it should be. It’s just an oppressive mood.”* (Interview 11, man with depression)

These descriptions of spatiality are reminiscent of agoraphobia, in which wide open spaces bring a bodily feeling of constriction, uneasiness, and disease. Similarly, the

collapse of life rhythms, temporal and spatial structures, leads to a bodily feeling of constriction and heaviness.

Taken together, the descriptions of our participants point to a disruption of a lifeworld that previously was familiar, revealing spatial and temporal emptiness that was previously not directly experienced. This sudden confrontation led to a feeling of uneasiness and anxiety. The most fitting term for this is probably the German word “*Unheimlichkeit*,” which carries both the notion of “not feeling at home” (“unhomeliness”) and the revelation of something that is not hidden or secret (*heimlich*) anymore. It is often translated as “uncanny” [25].

In the midst of this, many participants described that it was helpful to be in nature. It was easier to meet others outside where rules and measures felt further away, leading to a general feeling of freedom. It seems like the nature experiences helped to reduce the feelings of heaviness and oppression described above. *“Every Friday we went into the forest, collected wood and made a big fire and barbecued and had such a nice feeling of being away from it all. [...] That was so very nice, this feeling of freedom.”* (Interview 22, female staff member)

#### *Distancing Rules and Distance Regulation*

In direct social encounters, many felt insecure about how to handle the safety measures. This led to a feeling of uneasiness in relationships. *“It’s just that there’s so much uncertainty in dealing with others, how to behave now, what closeness, what distance, so that was a bit confusing.”* (Interview 20, female staff member)

Others, interestingly almost all patients with eating disorders, described feeling safer due to the increased physical distance to others, changing the socially accepted and expected comfort zone. *“Less than 1.5 metre proximity is unpleasant. That has nothing to do with physical contact; only with proximity. [...]”* I: *“Does that feel uncomfortable now then, when they’re too close?”* P: *“Yes, with strangers in stores or so. And then I also avoid them.”* (Interview 13, woman with eating disorder)

For most, following the distancing rules was a sign of respect, solidarity, and responsibility toward others. Some participants described a sense of guilt if they felt they did not act cautiously enough. *“I’m rather afraid of being a carrier [of the virus] together with my children.”* (Interview 32, female staff member)

In contrast, several patients but not staff members reported feeling rejected by others due to the distancing rules. In this case, the physical distance was understood as an emotional distance. *“You also feel bad, you go shopping and you can’t keep the distance and you’re looked at*

as if you were [...] sick and this distance immediately has an emotional effect [...] simply this fear and I also notice it in myself: I don't want to get too close to him, to maybe not infect them but also otherwise, and there is always this fear, respect, distance, rejection." (Interview 05, man with depression and anxiety disorder)

One patient (with an eating disorder) described a change in self-perception due to others keeping their distance. "I find myself kind of disgusting and toxic [when people keep distance]." (Interview 08, woman with eating disorder and trauma related disorder)

It appears that for people with some form of psychopathology it is especially difficult to separate the outer and inner world. External distance leads to strong affects and changes in self-perception, increasing the feeling of alienation and separateness from others. Similarly, several participants also remarked how difficult it was for them to share their emotions without being able to recur to nonverbal ways of communicating, underlining the crucial link between the body and emotions. "Talking about feelings is even harder than showing them. [...] You have to compensate a lot more verbally. To say, 'Hey I feel for you.' [instead of] 'Come here, let me give you a hug.' That's even more detached. [...] You have to verbalise it. Often it may not be verbalisable." (Interview 05 man with depression and anxiety disorder)

Social distancing reveals the tension between different aspects of the body and embodiment in the pandemic. On the one hand, there is the wish to be in contact with others, and on the other hand, there is the fear of not being responsible enough. At the same time, there is a confusion between distance in internal and external spaces, and the breakdown of nonverbal communication to express feelings and closeness. It is striking that this aspect of embodiment is especially problematic for people with psychopathologies. Physical distance seemed to be a great challenge, affecting the regulation of inner psychic distance. Participants were forced to find new ways of feeling connected to others. This was especially important because social support and feeling close and connected to others seemed to be an important way to deal with the insecurity and disorientation.

#### *Face Masks: Change of Communication and Embodied Synchronization*

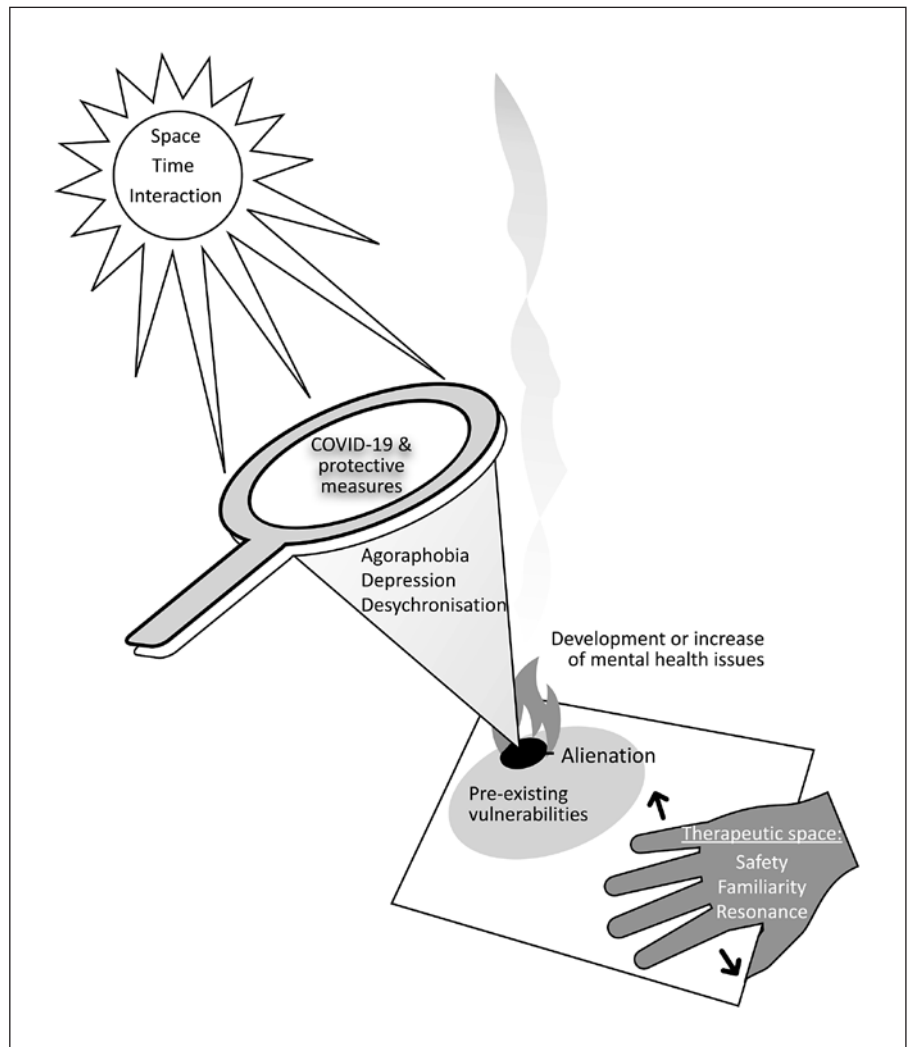
Most participants associated masks with "intensive care," "being infectious," "disease," or "danger." For others, the masks symbolized the social restrictions and were linked to southeast and east Asian societies (where face masks had been more common before the COVID-19

pandemic). In the narratives, this was also associated with reduced freedom of expression. Other participants had an association with head coverings worn in the Middle East, contributing to the feeling of alienation. For many, the mandatory wearing of face masks was uncomfortable as they had an unpleasant smell, were sweaty, made glasses foggy, hurt behind the ears, and impeded breathing. This altered self-perception and influenced the perception of others. Face masks also complicated communication in multiple ways: participants reported difficulty in reading facial expressions, voice volume was reduced, and people felt that they were not properly understood by others, leading to insecurities in interpreting and anticipating others' reactions, emotions, and thoughts. "You also get much less feedback, which is also important. Especially in my case, where my perception was completely different and maybe still is in parts, than what people have reflected to me and that is so important. I don't get a mirror anymore. [...]" (Interview 02, woman with depression)

Patients had difficulties showing their feelings behind their face masks, which was felt as hindering the building of a trusting therapeutic relationship. "I think it was the first time [a therapy session] with a mask and yes, that makes a big difference. So, I think that also feeds my fears a bit more because I'm afraid that my points or how I feel right now won't come across. [...] Now you have to do everything more verbally; what was normally non-verbal you now have to express with words. [...] To express your current state of mind is often difficult enough anyway and that is difficult for me even without a mask." (Interview 03, man with depression)

And the responses of the therapists were less perceptible beneath the face masks, also triggering insecurities in psychotherapy. "I mean, you talk about incredibly personal things. And I think it gives me a lot when you also get a human response, and faces say so much. And when I'm talking to two-thirds wall (laughs) somehow yes, it also has a bit of a bizarre quality." (Interview 12, woman with bulimia)

These quotes underline the role of the body, and especially the face, in communicating feelings and emotions in interpersonal interactions. One staff member summarized the process of such interactions as follows: "Our facial expressions react to the other person's facial expressions, and I take over something and that also guides me. And from such facial expressions I get signals for myself, yes. And in the beginning I was completely like behind a curtain [...] I had the impression I was frozen. And when I'm frozen, I can't get access to myself anymore. Or to what



**Fig. 1.** The pandemic as a magnifying glass. This figure illustrates how the different thematic fields that emerged from the interviews may be related to each other. The former normality with its familiar experience of space, time, and interaction has changed due to the pandemic, causing a sense of depression (slower time, heaviness), agoraphobia (oppressive spaces), and desynchronization (not being able to attune with others). This intensifies a feeling of alienation and might, depending on pre-existing vulnerabilities, lead to the development or increase of psychopathologies. The therapeutic space seems to offer a feeling of safety, familiarity, and resonance, opposing the destructive power of the pandemic-induced alienation.

*is happening now. And the contact to the other. Or to the group. I didn't find myself completely blocked, but as I said, like behind a veil maybe or a bit befuddled.*" (Interview 16, female staff member)

This quote is an explicit description of interpersonal synchrony or the breakdown thereof. Interpersonal synchrony is defined as the temporal coordination of people's mutual behavioral, physiological, and neurological functions [26, 27]. When two people interact, also in a clinical context, synchrony is a widespread phenomenon. Crucially, movement synchrony during psychotherapy sessions may predict the quality of the therapeutic alliance between psychotherapist and client and symptom reduction (outcome) at the end of psychotherapy [28–30]. The reduction of interpersonal synchrony described above may thus negatively impact the therapeutic rela-

tionship and outcome. In the next section, we explore the impact of the pandemic on psychopathology and the therapeutic space.

### Psychopathology and Therapeutic Space

All the issues described above had an impact on the development and persistence of psychopathologies, the interpersonal space, and thus also the therapeutic setting. Regarding pre-existing mental health issues, it was mentioned by several participants that the pandemic functioned like a magnifying glass intensifying people's vulnerabilities: "*Corona functions like a magnifying glass in the political sphere, or in society. Or a catalyst. So, this one patient who got terribly confused because of all these*



rules, [...] but got through it very quickly like in the pressure cooker, through this phase, and is now cooler than ever.” (Interview 22, female staff member)

The metaphor of the pandemic as a magnifying glass has also been used by others [20]. We suggest that the emergence or intensification of psychopathology is linked to the changes in perception of time, space, and interaction as shown in Figure 1.

Some clinical psychopathologies have a marked overlap with the feelings reported linked to the societal changes due to the pandemic (feeling of emptiness, oppression, or constriction). It is therefore easily conceivable that pre-existing mental health issues like depression and anxiety disorders were enhanced by the pandemic and its effects on experiences of time, space, and embodied interaction. Most patients, but also staff members, reported an increase in depressive mood. Anxieties were intensified, especially for people with pre-existing anxiety disorders and participants with social anxiety described an increased threshold to get in contact with other people. Also, patients with somatoform disorders, who find it difficult to separate their outer somatic and inner psychic worlds, seemed especially challenged by distancing rules and altered ways of communication, whereas anorexic patients tried to compensate for the feeling of loss of control by controlling food intake or weight.

Generally, pre-existing mental health conditions can be seen as maladaptive, yet known and familiar patterns, and their intensification may in certain cases also be an attempt to restore familiarity in the midst of the pandemic-induced alienation. Healthcare workers also had to deal with personal challenges related to the destabilization caused by the pandemic. In addition, most of them also experienced an increased workload due to the change of structures, insecurities about work procedures, and moral conflicts about how to handle them. Patient care became more intense and demanding because of the aggravated pathologies, but it was also described as rewarding. *“I’ve got a lot more to do, even though we have fewer patients on ward. They need so much more [...] The nice thing is, they are so much more motivated, they show more initiative than before. [...] I enjoy coming here every day for work. I am glad, that I can work.”* (Interview 14, male staff member)

Especially at the beginning of the pandemic, the rules within the hospital changed often, contributing to the general disorientation experienced by patients and health workers. Just like outside the hospital, there were strict rules, for example, regarding the maximum number of people in each room. Social interaction with other patients,

which is important for the therapeutic process, was restricted. Group therapies had to be conducted with fewer participants. While some patients felt insecure in bigger groups and welcomed this, others missed the variety of exchanges. Wearing face masks was mandatory in the hospital and, for 1 week during our study period, also during therapeutic sessions. As described above, the face masks hindered the building of a trusting therapeutic relationship.

The changes within the hospital thus mirror the alteration of familiar structures of space and time and the restriction of interactions in the general society described above. In spite of these difficulties, patients expressed much gratitude for the therapeutic offer. Throughout these challenging times, the clinic continued to provide stability and the possibility for real-life embodied interactions with others. *“So, the stay in the day clinic is definitely a very big chance for me. I am very grateful to be able to be here. [...] The relief and the gratitude that business is maintained here in the day clinic is by far greater than the frustration of having to wear a mask.”* (Interview 06, man with depression) *“Well, if I hadn’t been lucky enough to come here to the clinic, where you sit with people every day, it would have been much less otherwise. [...] I joined a great group [...] And yes, that it is possible to build up social contacts despite this pandemic. I would not have thought that possible.”* (Interview 34, man with autism and depression)

Although the daily routines and structures in our psychotherapy department changed, they did not collapse. This was essential for patients and for staff members, as it offered a rare space where it was possible to experience safety and familiarity (see Fig. 1).

## Discussion

We examined the impact of the beginning stages of the COVID-19 pandemic and the protective measures on the experience of people with mental health vulnerabilities and staff engaged in their care. Three overarching themes emerged: (1) the experience of societal change due to the pandemic and protective measures, (2) the interpersonal interaction influenced by public lockdown, psychosocial distancing, face masks, and (3) psychopathology and therapeutic space. The changes outside the clinical environment had a major influence on, and could not be separated from, changes within the clinical environment. Our main finding is that the changes brought about by the COVID-19 pandemic intensified pre-existing mental health issues, resembling a magnifying glass effect.

The COVID-19 pandemic and the related measures have led to a sudden loss of taken-for-granted beliefs and assumptions about the world and human life [20]. While the protective measures were established to protect against this global threat, they also induced the loss of personal routines and structures of daily life such as work, social gatherings, and leisure activities. These three effects (the virus, the protective measures, and changes to social routines) all threatened the “lived space” of people [12].

The experience of life rhythm and structure was disrupted affecting the sense that life is coherent, meaningful, manageable, and comprehensible [25, 31]. The measures “forced” people into a “deceleration” [19]. In line with other studies, our participants report a sudden expansion of time [32]. The slowing of time during the pandemic was previously linked to disorientation [22] and correlated with symptoms of anxiety and depression [33]. In our sample, there were no reports of acceleration of time, as was reported by others [34]. Empty spaces evoked feelings of agoraphobia. The restriction of individual possibilities and social contacts constricted the (life-)range to the immediate environment, home, and the closest people [21], which has a more claustrophobic flavor. Both agoraphobic and claustrophobic changes were felt as oppression and loss. Psychopathology has previously been associated with constriction of lived space [35], and we hypothesize that this constriction, imposed by the pandemic, intensified and magnified pre-existing psychopathology. We have illustrated this magnifying glass effect in Figure 1. Participants described feelings of constriction, oppression, emptiness, and lethargy, which seem to have led to an embodied and all-pervading sense of anxiety and depression.

The protective measures profoundly affected the experience of being-in-the-world with others. Interpersonal distance is an essential feature of individuals’ social behavior in relation to their physical environment and social interactions [36], and this varies among cultures [37]. Actions to regulate distance also seem to influence attitudes and emotions, depending on the context [8]. However, the ability to regulate distance is a challenging inner psychic process that is often disrupted in psychopathology. The intersubjective transference of empathy and reassuring physical touch was restricted. Masks changed the embodied perception of others. Thus, fine attunement of embodied interaction became more prone to desynchronization which led to a feeling of insecurity, unfamiliarity, and a loss of trust, which may be linked to increased anxiety [38]. As shown in Figure 1, this desynchronization may thus be an aspect of the magnifying glass effect that has contributed to intensifying psychopathologies.

Beyond synchrony, relationships between self, others, and the environment have been described as a vibrating system in which both sides mutually stimulate each other in three ways: (1) horizontal resonance between two (or more) people, (2) diagonal resonance with things and activities, and (3) vertical resonance with nature, art, history, or religion [39]. In all these things, people can experience life as an intensive encounter or relationship for its own sake. Crucially, resonance emerges spontaneously; it cannot be forced. Through desynchronization of embodied interactions with the self, the world, and others, the experience of stimulation in general, and of resonant relationships in particular, was disrupted [12]. The loss of structures, norms, ideal realities, and forms of being-in-the-world brought about by the COVID-19 pandemic has previously been called a collective experience of “monstrous unavailability” [36]. The breakdown of social synchrony and the loss of possibilities for interpersonal interaction and leisure activities such as sports and music can be understood as a loss of opportunities for resonance [21], contributing to feelings of disconnection and meaninglessness [12].

People have had to become more self-reliant, develop their own routines, and seek new ways in a changed world to facilitate resonant experiences and encounters. The major difference between the experience of staff members and patients in our sample was that staff members seemed more creative and flexible in facilitating resonant and meaningful encounters and experiences, whereas patients seemed more rigid and did not have such resources, as if they had less inner space to process their experience of alienation. Psychopathologies were previously conceived as a disturbance of bodily and intercorporeal existence [12]. Our results seem to indicate that people with pre-existing psychological vulnerabilities were overburdened by the pandemic and thus even less able to find possibilities for resonance than in pre-pandemic times.

At the heart of the pandemic experience is the “loss of normality,” as a fundamental all-embracing change of interpersonal reality [22]. This feeling of alienation, probably linked to the changed experiences of time, space, and embodied resonance (shown in the sun in Fig. 1), was reflected in the vocabulary of the participants, who used words like strange, foreign, bizarre, and scary to refer to public places, empty supermarket shelves and streets, strangers wearing masks, and people avoiding each other. Aho described the COVID-19 pandemic as a collective uncanny experience which “shattered (this) global sense of being at home: we suddenly found ourselves in a situation in which things no longer mattered in ways they

used to” [22]. Referring to Heidegger and Freud, the breakdown of stability and routines through the COVID-19 pandemic could remind us of the uncanniness of our existences, which are always “pervaded by homelessness” or otherness, by something I cannot control, like others, death and birth [40]. The experience of anxiety and the fear of the unknown [41] could be the consequence of this uncanniness. While being confronted with the unknown could make us curious, losing too much control or familiarity is experienced as an existential threat. More importantly, the feelings of emptiness and meaninglessness aroused or perpetuated a sense of loss and depression in participants.

Svenaesus explored illness through the concept of “*Unheimlichkeit*” [40]. People with pre-existing illnesses who are already not at home in their minds and lives [40] might therefore experience double alienation: once through their illness and once through the pandemic. Our findings stress the importance of psychotherapy in times of pandemic. The inpatient setting provided safety, familiarity, and opportunities for embodied resonance by offering spatial and temporal structure and social interaction. We could not agree more with Svenaesus when he writes: “the mission of health care professionals must be not only to cure diseases but actually, through devoting attention to the being-in-the-world of the patient, also to open up possible paths back to homelikeness.” This is even more crucial in the pandemic. Our setting may have provided people with such opportunities to find new ways to feel at home in a changed world.

### *Strengths and Limitations*

Our study was conducted during the first wave of the COVID-19 pandemic in Germany. As rules differed over time and across countries, not all findings will be applicable to all situations. The core themes however, such as dealing with insecurity, face masks, distancing, feelings of alienation, loss of opportunities for resonance, expansion of time, and constriction of lifeworld, will probably be relevant to future outbreaks of COVID-19 and other contagious diseases.

It is unusual to conduct a qualitative study with such a large group of researchers, yet we feel that it was beneficial for this study, which was conducted under exceptional circumstances for several reasons. First, patients, therapists, and researchers were (and are) all affected by the pandemic. We kept field diaries about our own experiences, and debriefing sessions with the diverse study group helped us to disentangle our own experiences from those of our participants. Second, the pandemic was associated with in-

creased professional and personal burdens. Distributing the workload enabled us to carry out this work. Engaging with the interviews and the regular peer debriefing sessions were sources of support to cope with the changes the COVID-19 pandemic brought about.

## **Conclusion**

People with mental health problems were particularly challenged during the pandemic because pre-existing vulnerabilities were intensified through a “magnifying glass effect” consisting of constricted life space and desynchronization which led to loss of resonance and enhanced feelings of alienation. Restoring a sense of safety, familiarity, and possibilities for resonance through inpatient psychotherapeutic care was crucial to cope with the strains of the pandemic. Our study shows that despite the challenges and threat of infection, it is vital to continue to provide people with psychological vulnerabilities with a safe therapeutic space in which to regain a sense of safety and resonance in an alienated world. This is particularly important, as it is especially those people who seem to suffer intensely from the collateral measures of a pandemic.

## **Acknowledgments**

The authors thank the participants for sharing their experiences, Francesca Brencio for her advice on earlier versions of the manuscript, and the two anonymous reviewers for their constructive comments that helped improve the manuscript.

## **Statement of Ethics**

The study protocol was approved by the local Ethics Committee (nr 174/20) and registered in the German Clinical Trials Register (DRKS00021395). All patients who received inpatient or day clinic care at the psychosomatic clinic at the University Medical Center Freiburg between April and July 2020, and all staff members in the department received a written letter inviting them to participate in the study. Participants provided written informed consent prior to study participation.

## **Conflict of Interest Statement**

P.R.B. and A.-L.M. receive honoraria from Novocure for courses and lectures. C.L. received speaker fees from Hexal, Lilly, Novocure, Roche. The chair of S.S. is an endowed chair funded by the Luisenlinik Bad Dürrenheim, Germany. He has an additional employment at the Institute of Frontier Areas of Psychology and Mental Hygiene. He received royalties from Springer, Elsevier,

Thieme, Cotta'sche Buchhandlung, Verlag das Netz, Herder Verlag, and Hogrefe. He received honoraria for lectures, seminars, and reviews from tandem Praxis und Institut, Freiburg; Evangelischer Oberkirchenrat, Karlsruhe; Volkswagen; Wolfsburg; ZAYT, Freiburg; SWR, Freiburg; Ministry of Education and Cultural Affairs, Youth and Sport of Baden-Württemberg, Stuttgart (all Germany); and Bial Foundation, Portugal. He received grants from the German Research Council, Bial Foundation, Portugal, and Cogito Foundation, Switzerland. The other authors have no conflicts of interest to declare.

## Funding Sources

P.R.B. is funded by a Berta Ottenstein Fellowship from the University of Freiburg, Germany. The funding source had no influence on the preparation of data or the manuscript.

## References

- 1 Robert Koch-Institut. [Ergänzung zum Nationalen Pandemieplan – COVID-19 – neuartige Coronaviruserkrankung](#). Berlin; 2020. Available from: [https://www.rki.de/DE/Content/InfAZ/N/Neuartiges\\_Coronavirus/Ergaenzung\\_Pandemieplan\\_Covid.pdf?\\_\\_blob=publicationFile](https://www.rki.de/DE/Content/InfAZ/N/Neuartiges_Coronavirus/Ergaenzung_Pandemieplan_Covid.pdf?__blob=publicationFile).
- 2 Petzold MB, Bendau A, Plag J, Pyrkosch L, Mascarell Maricic L, Betzler F, et al. Risk, resilience, psychological distress, and anxiety at the beginning of the COVID-19 pandemic in Germany. *Brain Behav*. 2020;10(9):10.
- 3 Pakenham KI, Landi G, Boccolini G, Furlani A, Grandi S, Tossani E. The moderating roles of psychological flexibility and inflexibility on the mental health impacts of COVID-19 pandemic and lockdown in Italy. *J Contextual Behav Sci*. 2020 Jul;17:109–18.
- 4 Brooks SK, Webster RK, Smith LE, Woodland L, Wessely S, Greenberg N, et al. The psychological impact of quarantine and how to reduce it: rapid review of the evidence. *Lancet*. 2020 Mar;395(10227):912–20.
- 5 Holmes EA, O'Connor RC, Perry VH, Tracey I, Wessely S, Arseneault L, et al. Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science. *Lancet Psychiatry*. 2020;7(6):547–60.
- 6 McCall C. [Mapping social interactions: the science of proxemics](#). In: Wöhr M, Krach S, editors. *Social behavior from rodents to humans*. Cham: Springer; 2015. Vol. 30. p. 295–308.
- 7 Elliot AJ, Eder AB, Harmon-Jones E. Approach-avoidance motivation and emotion: Convergence and divergence. *Emotion Review*. 2013;5(3):308–11.
- 8 Centerbar DB, Clore GL. Do approach-avoidance actions create attitudes? *Psychol Sci*. 2006;17(1):22–9.
- 9 Skoda EM, Spura A, De Bock F, Schweda A, Dörrie N, Fink M, et al. Change in psychological burdens during the COVID-19 pandemic in Germany: fears, individual behavior, and the relevance of information and trust in governmental institutions. *Bundesgesundheitsblatt - Gesundheitsforsch - Gesundheitsschutz*. 2021;64(3):322–33.
- 10 Schlegl S, Maier J, Meule A, Voderholzer U. Eating disorders in times of the COVID-19 pandemic-Results from an online survey of patients with anorexia nervosa. *Int J Eat Disord*. 2020;53(11):1791–800.
- 11 Pap G. [Das Gemeinschaftsgefühl aus der Sicht der Intersubjektivität: Philosophische, psychoanalytische und entwicklungspsychologische Wurzeln](#). Wiesbaden: Springer-Verlag; 2017.
- 12 Fuchs T. The interactive phenomenal field and the life space: a sketch of an ecological concept of psychotherapy. *Psychopathology*. 2019;52(2):67–74.
- 13 Zipfel S, Herzog W, Kruse J, Henningsen P. Psychosomatic medicine in Germany: more timely than ever. *Psychother Psychosom*. 2016;85(5):262–9.
- 14 Englander M. The phenomenological method in qualitative psychology and psychiatry. *Int J Qual Stud Health Well-being*. 2016;11(1):30682.
- 15 Flick U. [An introduction to qualitative research](#). London: Sage; 2018.
- 16 Köster A, Fernandez AV. Investigating modes of being in the world: an introduction to phenomenologically grounded qualitative research. *Phenomenol Cogn Sci*. 2021 Feb.
- 17 Halling S, Leifer M. The Theory and Practice of Dialogal Research. *J Phenomenol Psychol*. 1991;22(1):1–15.
- 18 Moustakas C. [Phenomenological research methods](#). Thousand Oaks, CA: Sage Publications; 1994.
- 19 Zipf J, Liebold B. [Inne halten: chronik einer Krise. Jenaer corona-gespräche](#). Jena: Theater der Zeit; 2020.
- 20 von Thadden E, Fuchs T. Wie soll man mit dieser psychischen grenzsituation umgehen? In der corona-krise sind viele gewissheiten plötzlich aufgehoben, sagt der psychiater und philosoph thomas fuchs. [Wir gehen aus einer kollektiven Manie in den Entzug](#). Available from: <https://www.zeit.de/kultur/2020-04/krisensituationen-coronavirus-grenzsituation-karl-jaspers-philosophie>.
- 21 Rosa H. Path dependency, bifurcation points and the role of sociology. A sociological attempt at interpreting the corona crisis. *Berl J Soziol*. 2020;30(2):191–213.
- 22 Carel H, Ratcliffe M, Froese T. Reflecting on experiences of social distancing. *Lancet*. 2020;396(10244):87–8.
- 23 Fuchs T. Temporality and psychopathology. *Phenom Cogn Sci*. 2013 Mar;12(1):75–104.
- 24 Lin Y. [The Intersubjectivity of Time: Levinas and Infinite Responsibility](#). Pittsburgh, PA: Duquesne University Press; 2013.
- 25 Aho K. The uncanny in the time of pandemics. *Gatherings Heidegger Circ Annu*. 2020;10:1–19.
- 26 Scheidt CE, Pfänder S, Ballati A, Schmidt S, Lahmann C. Language and movement synchronization in dyadic psychotherapeutic interaction: a qualitative review and a proposal for a classification. *Front Psychol*. 2021 Oct;12:696448.
- 27 Koole SL, Atzil-Slonim D, Butler E, Dikker S, Tschacher W, Wilderjans T. [In sync with your shrink: grounding psychotherapy in interpersonal synchrony](#). In: Forgas JP, Crano WD, Fiedler K, editors. *Applications of social psychology*. New York: Routledge; 2020. p. 161–84.
- 28 Wiltshire TJ, Philipsen JS, Trasmundi SB, Jensen TW, Steffensen SV. Interpersonal coordination dynamics in psychotherapy: a systematic review. *Cogn Ther Res*. 2020 Aug;44(4):752–73.

## Author Contributions

Study design and conception: P.R.B., C.L., and S.S. Data collection (interviews and transcription) and analysis: I.L., L.S., S.M., F.U., N.R., A.-L.M., P.R.B., S.B., and F.K. Data interpretation: I.L., L.S., S.M., F.U., N.R., A.-L.M., P.R.B., S.B., and F.K. Writing draft manuscript: I.L., L.S., and P.R.B. Editing and approving final manuscript: I.L., L.S., S.M., F.U., N.R., A.-L.M., P.R.B., S.B., F.K., C.L., and S.S.

## Data Availability Statement

The data that support the findings of this study are not publicly available due to the personal nature of the interview data, and the ethics approval does not allow the public sharing of these data. Anonymized data are available from PRB upon reasonable request.

- 29 Altmann U, Schoenherr D, Paulick J, Deisenhofer A-K, Schwartz B, Rubel JA, et al. Associations between movement synchrony and outcome in patients with social anxiety disorder: evidence for treatment specific effects. *Psychother Res*. 2020 Jul;30(5):574–90.
- 30 Reinecke KCH, Joraschky P, Lausberg H. Hand movements that change during psychotherapy and their relation to therapeutic outcome: an analysis of individual and simultaneous movements. *Psychother Res*. 2021 May;32(1):117–27.
- 31 Schumacher J, Wilz G, Gunzelmann T, Brähler E. Die sense of coherence scale von antonovsky - teststatistische überprüfung in einer repräsentativen bevölkerungsstichprobe und konstruktion einer kurzskala -. *Psychother Psychosom Med Psychol*. 2000; 50(12):472–82.
- 32 Grondin S, Mendoza-Duran E, Rioux PA. Pandemic, quarantine, and psychological time. *Front Psychol*. 2020 Oct;11:581036.
- 33 Ogden RS. The passage of time during the UK Covid-19 lockdown. *PLoS One*. 2020 Jul; 15(7):e0235871.
- 34 Wittmann M. Subjective passage of time during the pandemic: routine, boredom, and memory. *KronoScope*. 2020 Nov;20(2):260–71.
- 35 Fuchs T. Psychotherapy of the lived space: a phenomenological and ecological concept. *Am J Psychother*. 2007;61(4):423–39.
- 36 Hayduk LA. Personal space: where we now stand. *Psychological Bulletin*. 1983 Sep;94(2): 293–335.
- 37 Sorokowska A, Sorokowski P, Hilpert P, Cantarero K, Frackowiak T, Ahmadi K, et al. Preferred interpersonal distances: a global comparison. *J Cross Cult Psychol*. 2017;48(4): 577–92.
- 38 Fischer WF. The psychology of anxiety: a phenomenological description. *Humanist Psychol*. 2000;28(1–3):153–66.
- 39 Rosa H. *Resonanz. eine soziologie der weltbeziehung*. 3rd ed. Berlin: Suhrkamp Verlag; 2018.
- 40 Svenaeus F. Das unheimliche: towards a phenomenology of illness. *Med Health Care Philos*. 2000;3:3–16.
- 41 Freud S. Das unheimliche. 5th ed. *Gesammelte Werke: XII: Werke aus den Jahren 1917–120*. Frankfurt am Main: S. Fischer; 1978. p. 227–68.
- 42 van Manen M. Phenomenology in its original sense. *Qual Health Res*. 2017 May;27(6):810–25.
- 43 Zahavi D. Getting it quite wrong: Van Manen and Smith on phenomenology. *Qual Health Res*. 2019 May;29(6):900–7.
- 44 Zahavi D. Applied phenomenology: why it is safe to ignore the epoché. *Cont Philos Rev*. 2021 Jun;54(2):259–73.