

The Lived Experiences of COVID-19 Quarantined Omani Adults: A Phenomenological Study

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ABSTRACT

This study aimed to promote an in-depth understanding of lived experiences of Omani adults who were quarantined with COVID-19. Giorgi's descriptive phenomenological qualitative method was used to collect and analyze data from twelve eligible participants, who were selected through purposive snowball sampling. Data were collected from eligible participants using interrogatory statements during semi-structured audio-recording individualized phone interviews. Five general structural descriptions (GSDs) reflected the essence of the lived experiences of Omani adults who had been diagnosed with COVID-19 and experienced home quarantine. The GSDs of their lived experiences represented five phases: (1) before catching the infection ("No way I will get infected"), (2) between catching the infection and the quarantine ("I may be infected"), (3) early in the quarantine ("Oh my God, I am infected"), (4) in the middle and end of the quarantine ("So what? Yes, I am infected"), and (5) after the quarantine ("Praising God because I was infected"). The findings show that they experienced the quarantine period positively, as a time of self-growth and empowerment, highlighting the need to look at the brighter side of life. This qualitative study highlights that a positive outlook will help people regain their balance in any negative situation. It is the mindset that matters, not the situation.

KEYWORDS: Covid-19, quarantine, lived experiences, Omani adults, phenomenology, nursing.

In November and December of 2019, a novel threatening infectious viral disease called COVID-19 was first identified in Wuhan, China. At the beginning of 2020, the World Health Organization (WHO) declared the outbreak of COVID-19 an international public health emergency and a pandemic (Hou et al., 2021). COVID-19 caused very high mortality and morbidity rates worldwide, and almost four billion people were quarantined in their homes because of the contagious nature of this disease (Ferreira et al., 2021; Meo et al., 2020). Isolation and quarantine

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are two of the oldest and most potent instruments for controlling outbreaks of communicable diseases such as COVID-19 (Cetron & Simone, 2004). Although “isolation” and “quarantine” have different meanings, the terms are often used interchangeably to mean separating a person from their loved ones, normal daily life activities, and routines to prevent or minimize the spread of infection (Jassim et al., 2021). In this paper, quarantine during a pandemic means restricting the movement of individuals who are believed to have been exposed to the infectious disease but are not sick, either because they have not been infected or they are still in the incubation period (Cetron & Landwirth, 2005; Usher et al., 2020). Quarantined individuals must avoid physical contact with others both outside and within the household, for a period ranging between ten days and two weeks, which may be spent in either the home or a hotel (Daly et al., 2021). Quarantine durations, locations, and restrictions vary from one country to another worldwide, or even from one province to another within nations; quarantines can be classified as either optional or mandatory (Daly et al., 2021; Ferreira et al., 2021). Because of the international health emergency, all countries have implemented self-quarantine measures for their populations. Other measures were also implemented to control the pandemic, such as school closures, restrictions on social gatherings and traveling, partial closures of workplaces, and mandatory online work and education (Afrin et al., 2022; Flahault, 2020).

Quarantines may be enforced at the individual or group level and typically include restrictions on homes or facilities (Ferreira et al., 2021). All individuals should be monitored for symptoms during the quarantine period. If symptoms arise, they must be treated immediately in a designated center familiar with severe respiratory disease treatment (Wilder-Smith & Freedman, 2020). As soon as quarantine is launched, health care systems should consider various reaction measures where feasible: interventions such as public education, promotion of personal protective hygiene, and preparation of health systems for the emergence of critically ill patients; improved prevention and control of infections in healthcare services, nursing homes, and long-term care services; and postponement or cancellation of important public meetings (Bedford et al., 2020; Ferreira et al., 2021). During a quarantine, people can do most indoor activities, as long as they stay where they are. For example, suppose people are told to stay at home (i.e., home quarantine). In that case, they are given guidance about what to do and not do with family members. They are told to monitor their health condition by taking their temperature, take precautionary measures to lower their risk for other diseases, and regularly report how they feel to health authorities (Jassim et al., 2021; Rothstein et al., 2003). On the other hand, when people are asked to live away from home (i.e., institutional quarantine), they are provided with food, sleeping quarters, and other necessities until their risk of developing or transmitting the disease ends (Rothstein et al., 2003). However, quarantine is an unfavorable decision for most people, and it has adverse psychosocial, physical, and emotional effects on quarantined people and their families (Daly et al., 2021; Giallonardo et al., 2020; Meo et al., 2020).

Although quarantine is a necessary health measure to reduce the spread of pandemic diseases, many studies recommend that authorities and policymakers think wisely before applying it to their citizens (Brooks et al., 2020; Webster et al., 2020). Researchers have illustrated a wide range of negative effects on those deprived of their freedom of movement (Daly et al., 2021; Nkengasong & Mankoula, 2020; Rubin & Wessely, 2020; Wang et al., 2011). The adverse effects of quarantine have been studied for both mandatory and voluntary isolation, in the home and in institutional settings (Desclaux et al., 2017; Gray et al., 2022; Webster et al., 2020). Most of the literature on this topic reports findings focused on the emotional and psychological impacts of quarantine, including feelings of anger, fear, stress, anxiety, restlessness, agitation, helplessness; loss of interest in usual activities; depression; insomnia; development of obsessive-compulsive symptoms such as repeated temperature checks and sterilization; increased risk for violent behavior

(Brooks et al., 2020; Caleo et al., 2018; Daly et al., 2021; Giallonardo et al., 2020; Hou et al., 2021; Jeong et al., 2016; Pellicchia et al., 2015; Wang et al., 2011). There is even an increased risk of suicide in many affected cases (Barbisch et al., 2015). Quarantined individuals during the COVID-19 pandemic showed higher levels of stress and depression and lower rates of health-related quality of life (HRQoL) (Ferreira et al., 2021). The literature reports that fear of death or mental illness was increased among symptomatic and asymptomatic quarantined people (Son et al., 2021). Globally, COVID-19 restrictions and quarantine policies caused many people to feel bewildered, apprehensive, and doubtful about their leadership (The Lancet, 2020). People were shocked by the alarming spread of the pandemic, the escalating number of deaths, the nature of the quarantine system, and the consequences of COVID-19 on their lives (Son et al., 2021).

Quarantine leads to significant long-term effects, challenges, and stressors for those quarantined and their families. Often, they become increasingly aggravated and frustrated with the duration of their quarantine and the lack of sufficient information from public health authorities about the disease (Center for the Study of Traumatic Stress [CSTS], 2020; Gray et al., 2022). Studies have found many lasting effects on quarantined individuals, such as avoidance behaviors with respect to social contact, avoiding enclosed or public spaces, fear of returning to work, and excessive concerns with hygiene and hand-washing (Regehr et al., 2021). Those who did not comply with quarantine instructions reported feeling shame due to social stigma (Brooks et al., 2020; CSTS, 2020).

Some other adverse consequences of quarantine relate to financial loss (Kavanagh et al., 2012), especially for those who depend on part-time jobs or run small/home businesses (Jeong et al., 2016). Some quarantined people also experience fear related to a lack of necessary supplies (Brooks et al., 2020; Teh et al., 2012; Webster et al., 2020), such as water, nutrition, and home services, as well as fear of monopolization of goods/services and increased prices. These fears drove many people to panic shop and empty market shelves (Teh et al., 2012; Zhou et al., 2020). Daly et al. (2021) reported that suicide rates increased worldwide during the COVID-19 pandemic because of the economic consequences of lockdown and unemployment. They also found that quarantined people were at higher risk for suicidal ideation and harming themselves.

In their review of previous studies, Regehr et al. (2021) found that quarantined individuals showed increased alcohol consumption and exacerbation of physical health conditions. The impact of quarantine on individual physical health includes restriction of movement and exercise, which could lead to serious health problems, such as weight gain, sleep disturbances, appetite changes, increased tobacco and alcohol use, and worsening chronic health problems such as cardiovascular diseases (Gilchrist, 2020). Moreover, quarantined individuals reported that they were bored and frustrated due to the change in their lifestyles from active to sedentary (Jeong et al., 2016).

The disruption of everyday life due to the COVID-19 panic occurred worldwide, including in Oman. Oman first encountered the COVID-19 crisis when its first two cases were reported at the end of February 2020. These cases were linked to individuals who had recently travelled to Iran. COVID-19 cases increased steadily in Oman, causing great distress among both the citizens and the government. Unfortunately, most of the new cases reported were contacts of previous positive cases. In early 2020, Oman's Ministry of Health (MOH) began taking step-by-step preventative measures, announced through the media. The first restrictions, before COVID-19 began to spread rapidly, were focused only on travel to affected countries, requiring 14 days of quarantine after a person returned from any of the listed countries. Subsequently, all schools and universities were closed for students, unnecessary movements were restricted, working from home was encouraged, and all types of gatherings were prohibited. As cases increased, individuals with

COVID-19 were asked to self-quarantine in their homes, with strict isolation procedures followed by all members of the household (MOH-Oman, 2020).

Omani culture is among the warmest in the world. Omani families are known for their frequent gatherings and extensive socialization. They share a constant need to be together and revive connections and family ties. Given this social context, it is imperative to explore the lived experiences of Omani adults and their families during this compulsory isolation imposed due to the COVID-19 crisis, thereby affording nurses and healthcare providers a fuller understanding of the stressors experienced and the coping strategies used by this population. Because there is a dearth of knowledge about COVID-19 quarantined Omani adults' experiences, this study aimed to promote an in-depth understanding of these lived experiences, and the study was designed to answer the following research question: What is the meaning of the lived experiences of Omani adults during their COVID-19 quarantine period?

Reflexivity Statement

The research team has reflected on how our sociodemographic, cultural, and educational backgrounds may influence our data collection and interpretation. The lead author is a bicultural (Canadian/Arabic), doctorally prepared qualitative and quantitative researcher currently working as a professor at Cape Breton University in Canada. He has conducted many qualitative studies and published a long list of qualitative and philosophical methods. During the data collection and analysis for this study, the lead author worked as a faculty member at the College of Nursing at Sultan Qaboos University in Oman. The second author is a bicultural (Canadian/ Arabic), doctorally prepared qualitative and quantitative researcher, currently she is working as a health researcher for Nova Scotia Health in Nova Scotia, Canada. The third author is a doctorally prepared Indian researcher and educator in mental and community health nursing at Sultan Qaboos University in Oman. All of the other rest authors are Arabic, worked as lecturers in the community and mental health nursing field at Sultan Qaboos University-Oman. During the COVID-19 pandemic, most health researchers worldwide postponed their research projects and prioritized working on topics related to the pandemic. The first and the second authors took full responsibility for training other authors on conducting and mastering qualitative data collection and analysis before recruiting participants for this project. All of the authors were interested in this topic because it is related to community health nursing and because there was a dearth of knowledge about it. During the data collection and analysis, none of the authors experienced quarantine related to COVID-19 infection. Interviews and data analysis were conducted by all of the authors, who maintained ongoing discussion and reflection on how their sociodemographic, educational, and cultural backgrounds may influence their interpretations of the data.

Methodology

Participants

The study was conducted in the Sultanate of Oman. All Omani adults who had experienced home quarantine due to COVID-19 infection were eligible to participate. A purposive snowball sample was used for this study, consisting of 12 COVID-19 quarantined Omani adults who volunteered to participate. There were eight males and four females, whose ages ranged from 18 to 65, and all were quarantined at home. All participants were married and educated (one had some high school education, two had high school diplomas, seven had bachelor's degrees, and two had master's degrees), and they all worked full-time. Their average monthly income was US \$3,750.

The participants reported living in big houses, with an average house area of 420 square meters. Their average family size was nine people, and ten participants said they lived with multigenerational families. Participants for this study were recruited through social media (Facebook, Instagram, WhatsApp) over a period of seven months (May-December 2020). A research poster was shared with different groups on social media for participant recruitment. The poster recipients were asked to share the poster with their social media contacts to reach the maximum number of people. Potential participants who contacted the researchers were checked for participation eligibility and offered an information sheet providing a brief explanation of the research study's nature. Then, the researchers arranged an initial online meeting with participants interested in participating in this qualitative study. The university's Research Ethics Board approved this study, and all participants provided online informed consent.

Design

Phenomenology is a rigorous, critical, systematic, investigative research methodology to study human lived experiences (Cilesiz, 2011). Giorgi's (1970, 1985, 2009) qualitative descriptive phenomenological methodology was used to understand the lived experiences of COVID-19 quarantined Omani adults. This method helps to portray and understand the meaning of a phenomenon as described by those who have lived the conscious experience (A. Giorgi, 2012; A. Giorgi & Giorgi, 2008). The essence of the experience represents the nature of the phenomenon being studied and is generally experienced by people who encounter the phenomenon (Finlay, 2009). Neubauer et al. (2019) reported that phenomenological research is conducive to examining meaning in participants' individually perceived and interpreted lived experiences. Giorgi's descriptive phenomenological method can be applied to any discipline in viewing the phenomenon (Giorgi, 2012). This qualitative descriptive phenomenological approach was the best method to deepen our understanding of the whole new phenomenon of life during a pandemic that suddenly struck humanity by surprise. Achieving data saturation was beyond the aim of this study; instead, our focus was on understanding the complexity of the phenomenon being investigated. This qualitative inquiry brought new knowledge to the scientific world about the overall experiences of COVID-19 quarantined Omani adults. This knowledge can help the government and healthcare providers envisage appropriate healthcare facilities and develop policies to face similar situations in the future.

The descriptive phenomenology method can be used in different human/social sciences, such as nursing and health sciences, to understand various phenomena with a health and social disciplinary lens or focus (Giorgi, 1970, 1985, 2009). The Health Promotion Model (HPM), developed by Pender et al. (2011), was used to understand how Omani adults lived their experiences of COVID-19 quarantine. Understanding their experiences from the lens of this theoretical perspective helped in data collection and analysis, to understand the participants' experiences in a meaningful and useful way for the nursing profession and other health science disciplines. The HPM focuses on three primary areas: (1) individual characteristics and experiences, (2) behavioral-specific knowledge and effects, and (3) behavioral outcomes (Pender et al., 2011).

Procedures

The researchers conducted unstructured, in-depth one-on-one interviews with all participants via telephone for 45 to 60 minutes, in order to understand participants' experiences with home quarantine. Participants were permitted to share their experiences in an open-ended but focused manner, at a comfortable pace. Therefore, each interview ended when the participant felt they had told the interviewer everything they wanted to tell. The interviews were recorded on a digital recorder. Participants were asked to respond to the following open-ended statement: "Would you please describe your lived experiences throughout your quarantine during your infection with COVID-19?" Other probing questions were asked throughout the interview to keep the participant focused on the topic. After the interview, each participant filled out a demographic data sheet. All interviews were conducted in Arabic, then transcribed by the researchers and translated into English by a bilingual, culturally sensitive translator. Data were collected between May and December 2020.

Data Analysis

The research team did a verbatim transcription of each interview after it was finished. After all the interviews were transcribed and translated, the text was ready to be analyzed. Data analysis and synthesis were conducted using Giorgi's method (Giorgi, 1985, 1992, 1997, 2012; Giorgi et al., 2017), which involved the following steps:

- Each participant's transcript was read freely and openly many times, to gain an overall sense of the whole statement. The researchers assumed the attitude of phenomenological scientific reduction.
- The meaning units (MUs) were identified. These are text passages expressing the meaning in the participant's own words.
- The researchers transformed the MUs into focal meanings (FMs). The participants' language (MUs) was transformed into scientific expression (researchers'/disciplinary language, which in this case was the Health Promotion Model language).
- The FMs were transformed into situated structural descriptions (SSDs) describing each participant's specific situation. The SSDs represented the meaning of the experiences from each participant's perspective.
- General structural descriptions (GSDs) of the research participants' lived experiences were synthesized from the SSDs. The GSDs represent the experiences of all the participants. Therefore, the GSDs are more general than specific.

Trustworthiness

Credibility, transferability, dependability, and confirmability criteria developed by Guba and Lincoln (1985) were used to ensure data collection and analysis trustworthiness. In this study, credibility was achieved by consulting with peer researchers. All researchers in this project worked together in a collaborative, integrative manner throughout all research steps. They pursued ongoing discussions, consultations, brainstorming sessions, and feedback from each other. For dependability, the data were analyzed using Giorgi's method, and any differences in opinion were discussed and addressed to ensure consistent results between researchers. Confirmability was achieved by using the same interview guide for all interviews and documenting the research process

in detail, including descriptions of data collection and analysis-synthesis methods. For the sake of transferability, comprehensive descriptions and quotations were collected from the participants, to ensure that the results from this study are meaningful to others who live the same experiences in a similar context.

Results

Five general structural descriptions (GSDs or themes) reflect the essence of the lived experiences of Omani adults who were diagnosed with COVID-19 and experienced home quarantine. The GSDs can be categorized into five phases:

- Phase 1: Before catching the infection (“No way I will get infected.”)
- Phase 2: Between catching the infection and the quarantine (“I may be infected.”)
- Phase 3: Early in the quarantine (“Oh my God, I am infected.”),
- Phase 4: In the middle and end of the quarantine (“So what? Yes, I am infected.”)
- Phase 5: After the quarantine (“Praising God because I was infected.”)

Although the transition from one phase to the next was not fully described (represented with bend arrows), the participants described each phase's characteristics clearly. These five themes (phases) and their subthemes are presented as a comprehensive scheme organized in an interactive structure in Figure 1 (the curvy arrows represent the nonlinear transition from one phase to another). However, the subthemes will be merged in subsequent sections to describe each theme.

Figure 1

Conceptual Representation of the Five Themes (Phases) and Subthemes



Phase 1 (GSD1): Before Catching the Infection (“No way I will get infected.”)

Omani adults who experienced home quarantine lived through some of the pandemic before they got infected with COVID-19 and quarantined themselves. The participants described mixed feelings of fear about diseases and their consequences and carelessness to comply with full preventive precautions. Some participants thought they would be immune to the disease. Others reported that they were anxious about getting infected with COVID-19; they were convinced that the virus was incurable and caused death. Although participants reported practicing the recommended measures to prevent COVID-19 infection because they had some fear of getting the infection, they did not take these measures seriously and did not follow the regulations strictly. Two participants spoke of this matter as follows:

I was living in a panic because of the nature of this killing disease and because there is no vaccine or known treatment for it; you know, the terrifying TV news and unreliable social media posts about COVID-19 provoked my fear of this vague disease... Actually, I was afraid that my kids and family [would] get the infection. (Salwa)

I did not take COVID-19 seriously. I thought it was an untrue, faked political game; I even did not believe in it... I was practicing the preventive measures because I did not want others to point at me as an odd person, but from inside, I was not convinced that these measures would prevent the infection... It was my fault that I dealt with COVID-19 carelessly. (Fadi)

Phase 2 (GSD2): Between Catching the Infection and the Quarantine (“I may be infected.”)

This phase encompasses the participants’ experiences of the early signs and symptoms of COVID-19 infection and how they got it. They reported being doubtful and unsure whether these signs and symptoms were from COVID-19 infection. Participants lived in uncertainty at two key points. The first time of certainty was related to diagnosis, and this period extended from the moment they developed signs and symptoms until their diagnoses were confirmed. The second time of living in uncertainty was related to the treatment and consequences of COVID-19, and this period extended from when their diagnoses were confirmed until they recovered. Participants reported feeling embarrassed and stigmatized because of testing or confirming a positive COVID-19 test. However, the first action by each of the participants was to quarantine at home voluntarily. Participants knew that stopping the infection chain starts with self-quarantining and stopping all interactions with others. This was the first step they took after they noticed the early signs and symptoms of COVID-19. The following participant quotes exemplify this issue:

I was working in my office when I started to feel tired and could not concentrate. I made many work mistakes during that day, then I left the office early and went directly to bed. After I had slept deeply for three hours, I got up dizzy, my body became warmer and warmer, and my throat became itchy ... Next day, I started coughing. I could not catch my breath...It was not until I lost the taste of my coffee...that I began to feel panic and discomfort because I thought it would be Corona [COVID-19], but I tried to convince myself it was a cold... (Sa’ad)

I engaged with my aunt and ate with her a Ramadhan breakfast. Later on, I knew she had asymptomatic COVID-19. After four days, I got [an] unreasonable high temperature; the first thing I thought about it and came to my mind [was] I have to quarantine myself to protect my kids and [my] pregnant wife. I chose to be quarantined in another apartment away from my family before even being sure whether it was COVID-19 or not; you know, their safety was a priority for me. (Salem)

When I went to the health center for the COVID-19 test, I was hesitant to make it; I did not want anybody to know I was there for the test. I put on a mask and thick black eyeglasses so that no one could distinguish me... I felt timid after knowing the positive result, and I imagined ... people were staring at me and pointing at me... I wished I got other diseases but not this disease [COVID-19]. Before I got to know my diagnosis, I kept going back and forth between many ideas. I was not sure what my diagnosis would be; I was stressed out and could not focus; I could not sleep, and I could not find anyone who can answer my concerns, I searched many websites, asked many people to find an answer... Waiting for the result was the most stressful time I have lived ever; I felt like I was carrying all the world over my head.(Marwa)

Phase 3: Early in the Quarantine (“Oh my God, I am infected.”)

Participants reported living in shock after their infections were confirmed. They described the beginnings of their quarantines as stressful because their routines had been dramatically changed. The transition period from regular, everyday life to living in quarantine was tough. They found themselves fighting the signs and symptoms of COVID-19 using all possible treatments. During this phase, the participants' primary concern was to protect their families and loved ones from getting infected. The following quotes exemplify the participants' experiences:

In the beginning, it was difficult for me to adapt to the new situation, especially since I [did not have] a full, clear image of the disease and its consequences. It was tough and stressful to be quarantined; it seems like you lost your freedom... Exactly, it looks like you live in prison without guards except yourself. My life and daily routine suddenly changed. Oh my God, I could not believe what [had] happened to me. (Jamal)

The terrifying moments of the quarantine were when I heard my kids' voices, but I could not hug or kiss them; watching them from behind the glass was not enough. The difficulty of breathing, coughing, the high temperature, and the inability to perform my daily activities made me hate the quarantine; it was an unbearable time. All the time, I was anxious about how to protect my wife, kids, parents, and brothers. We all live in a big house, and I did not want to infect them. As you know, this is a destroying virus, and it has no mercy over anybody. If anyone [in] my family got infected because of me, I would not forgive myself. This is why I worked very hard to keep the virus inside the room. I kept everything sterilized and

clean; my family put the food and other stuff at the doorstep using disposable materials. I strictly isolated myself inside the room. (Sameer)

It was a life or death issue. I was alone in the middle of the battle, confronting a hidden enemy without a known effective weapon. I had only two choices: to live or die. The high temperature and tiredness were the biggest challenges for me. I used all the medications prescribed for me, and the family supported me with healthy food to keep my immunity—such as yogurt and milk, fresh fruit juice, honey, and black seeds—blessing olive oil (verses of the Holy Quran were recited on it).[I took] many cold showers to decrease the temperature. I used frankincense and frankincense water to gain my body power again. (Iman)

Phase 4: In the Middle and End of the Quarantine (So what? Yes, I am infected.)

In this phase, starting about midway to the end of the quarantine period, participants started to accept themselves as COVID-19 patients. This became easier for them as they were able to manage the intensity of their symptoms. After the participants could control their body temperatures, and once their symptoms started to improve, they regained their self-confidence and convinced themselves that they were strong enough to eradicate the virus from their bodies. After managing and controlling their infections, the participants found themselves with ample free time; therefore, they engaged in many health practices to kill time and decrease boredom. They indicated that the social support they received from their families, friends, and healthcare providers was beneficial to managing their infections and regaining their health. At the end of their quarantine periods, the participants felt more knowledgeable about COVID-19. They felt more powerful, in control, and resilient. The following participants' quotes illustrate these experiences:

Defeating the disease starts once you accept the truth about your illness, to tell yourself, "Okay, I am sick now, but what do I have to do next..." Although I felt a little bit confident after my body temperature returned to normal, I kept working to raise my self-confidence to the optimum, because I believed that high self-confidence helps a lot to control the disease. (Mashal)

There was ample time, and I had to plan to fill my time with something beneficial not to feel bored. I had enough time to pray and recite the Quran, call old friends and family members, watch television, read books and news websites, do sports and exercise, and contact others through social media. I could also reflect on my life and plan for my future. I aimed to benefit from each quarantine moment and not waste my time doing nothing. (Rania)

Social support was one of the positive memories...My family provided unconditional social support; they kept encouraging me and pushing me toward recovery. They showed me their sympathy and empathy during that period. They were also ready to help me anytime and took care of me. They respected my choices and encouraged me to bear the quarantine. My friends kept calling and contacting me through social media, offering me

help and support. The healthcare providers from the Ministry of Health kept calling me regularly to follow up on my health status and provide me with...information. Without their support, I would [have struggled] alone with COVID-19. (Salwa)

Before ending the quarantine, I started to feel better physically and emotionally; I felt stronger and confident and could manage things in a better way. I could control things; it seemed like life was granted to me again, and I [was] a newborn. I looked at life in a more positive [way], and I was thrilled I passed the difficult period of this killing disease and achieved a lot toward recovery. (Enad)

Phase 5: After the Quarantine (“Praising God because I was infected.”)

This phase represents the time after the quarantine period when participants reflected and looked back on their quarantine experience. Participants indicated that their COVID-19 infections and their quarantines were gifts from God that He must be praised for. They reflected that their quarantine periods gave them time to converse with themselves and reflect on their actions, past deeds, and plans. Quarantine gave them a feeling of empowerment and an opportunity to look positively at themselves and their lives. The following participants’ quotes illustrate these perspectives:

When I reflect on the quarantine period and the infection time, I praise Allah...for giving me this opportunity to live the experience of disease and the quarantine. This experience left me powerful, with no fears about this disease or other diseases. I feel like I know myself and my abilities better; it was a positive experience so far. (Raed)

Coronavirus was a terrifying thing; however, I passed it successfully. Although the COVID-19 experience had many negatives, I learned many positive lessons from it for life. Now I feel more optimistic; I can accept anything as it comes right now. I believe that we cannot stop bad things from happening, but we must know how to deal with them. I believe things happen for a reason, and Allah...always chooses the best for us. (Salwa)

In summary, participants reported their quarantine experience during the COVID-19 pandemic through five different phases, representing different times before, during, and after their quarantine periods. Although the transition between these phases was not linear, and there is a lack of information on how the participants moved from one phase to another, this study's findings provide an understanding of the participants' lived experiences during the quarantine.

Discussion

Five general situated descriptions (GSDs) reflect the essence of the lived experience of Omani adults who have been diagnosed with COVID-19 and experienced home quarantine. The GSDs of their lived experiences represent five distinct phases. These findings are discussed next.

The sudden changes in movement and freedom resulting from quarantine have psychologically affected the present study participants. The present study identified that participants were anxious about contracting COVID-19 and worried that it would be fatal to themselves and their families. This supports the existing reports on fear as a significant phenomenon in a pandemic. Fear accentuates anxiety and stress levels in individuals and increases them in those with pre-existing psychiatric disorders during pandemics (Bai et al., 2004; Daly et al., 2021; Jeong et al., 2016; Hou et al., 2021; Shigemura et al., 2020). A dearth of reliable information about causative factors of COVID-19 infection, its geographic reach, the number of infected people, and the actual mortality rate has led to a lack of confidence and fear among the people (Cascella et al., 2022; Malta et al., 2020; Peeri et al., 2020).

The current study revealed that although participants practiced the suggested preventive measures for COVID-19, they did not take it seriously; however, at the same time, they were anxious. In Oman, family relationships are solid, and family social gathering is almost a daily practice. Many Omani individuals live with multigenerational and extended families in the same big house, making family gatherings unavoidable. Although having large homes helped the participants keep their social distance and accommodated them well for the quarantine, living with extended families was a two-edged sword. On the one hand, the participants' extended families provided social support. On the other hand, the unavoidable social interaction with the family in Omani culture accelerated the infection's spread among family members. Mohammadpour et al. (2020) reported that people less afraid of COVID-19 are more likely to not observe self-care behaviours like social distancing. Additionally, Muruganandam et al. (2020) revealed that people who lacked knowledge about the seriousness of the pandemic were not worried about getting COVID-19 and did not take preventive measures against COVID-19 seriously.

Participants in the current study were doubtful about the initial manifestations of their COVID-19 infections. They reported physical symptoms such as tiredness, increased temperature, dizziness, throat irritation, cough, and dyspnea, as well as psychological symptoms such as difficulty concentrating, discomfort, and anxiety. Their physical symptoms matched the typical symptoms reported earlier in China by Wang et al. (2020). Fever, cough, fatigue, myalgia, diarrhea, and headache were common symptoms at the beginning, worsening to dyspnea, hypoxia, leukopenia, lymphocytopenia, and neutropenia. Our study participants' psychological symptoms were also on par with the significant psychological distress reported by hospitalized COVID-19 patients in China, who had shown depressive features. It was assumed that these psychological symptoms might be related to inflammation markers in those patients (Guo et al., 2020).

Participants quarantined themselves as soon as they experienced the earliest signs and symptoms of COVID-19. Our findings resonate with Lu et al.'s (2020) report that home self-quarantine is associated with a lower rate of depression and increased happiness compared to community-level quarantine. Furthermore, our findings support the results of a survey conducted in two megacities of China on the psychological impacts of mandatory quarantine, which found that people in Wuhan, who experienced mandatory quarantine, had higher rates of Posttraumatic Stress Disorder and associated sleep disorders compared to people in Shanghai, who were not required to quarantine (Wu et al., 2020). This shows that forced confinement can be harmful to people's mental health. In contrast, our participants' voluntary quarantine positively contributed to their early acceptance of illness and their development of resilience.

The present study's findings show that the participants lived in uncertainty twice. First, they were unsure about their signs and symptoms until their diagnoses were confirmed. Then, they experienced uncertainty about the treatment and consequences of COVID-19. This finding supports Guo et al.'s (2020) report that viral disease progression uncertainty was one of the main concerns expressed by COVID-19 patients. The uncertainties about transmission, mortality rate, treatment,

and control measures have had consequences in all sectors of life, with direct repercussions for the population's daily life and mental stability (Li et al., 2020; Ornell et al., 2020).

The social stigma was one of the main concerns expressed by COVID-19 patients in China (Brooks et al., 2020; Guo et al., 2020). Some participants in the present study were reluctant to undergo the diagnostic test for COVID-19, fearing the embarrassment a positive result could cause them in society. Surprisingly, the stigma experience continued even after they completed their quarantines (Brooks et al., 2020; Cava et al., 2005; CSTS, 2020; Desclaux et al., 2017; DiGiovanni et al., 2004; Hawryluck et al., 2004; Pan et al., 2005; Pellicchia et al., 2015; Reynolds et al., 2008; Robertson et al., 2004).

Participants in the present study were shocked by their diagnoses and experienced stress during the early parts of their quarantines. Adapting to the drastic shift from everyday life to quarantine was challenging for them. This finding confirms existing reports on elevated stress and anxiety among people exposed to risk for infection (Bai et al., 2004; Cava et al., 2005; Desclaux et al., 2017). According to Jeong et al. (2016), people with increased stress are likely to be more burdened by physical symptoms. Mazza et al. (2020) reported that COVID-19 patients with comorbidities or other disorders are at an increased risk of experiencing severe stress.

Participants in the present study tried hard to fight the signs and symptoms of COVID-19 during their quarantines, using all possible medical and traditional interventions. Dong et al. (2020) reported patients using similar coping strategies to fight COVID-19, such as performing infection control protocols; staying positive and accepting the risks; minimizing worry and focusing on other things; practicing a healthy lifestyle; and using vitamins, herbs, and other beneficial substances. Participants in the present study were concerned about their loved ones' safety and took all possible precautions to avoid spreading infection. Similarly, clinical staff working in high infection risk areas worried about passing the infection to their loved ones (Chen, Q et al., 2020). These and other reports (Barzilay et al., 2020) indicate that COVID-19-affected individuals tend to be more concerned about others than themselves.

Phase 4 in the current study is characterized by the participants' acceptance of their infection. The participants improved their self-confidence by convincing themselves that they were strong enough to eradicate the virus from their bodies. Similarly, Dong et al. (2020) reported that COVID-19-infected individuals with positive mindsets coped better due to their psychological and emotional well-being.

Participants in the current study found ample time during quarantine for endeavors other than their health maintenance. They engaged in many different activities to kill their boredom. This supports the existing studies on negative emotions such as distress, boredom, social isolation, and frustration in quarantined individuals. Their confinement lowers their social or physical interaction with others, resulting in the alteration of typical routines (Desclaux et al., 2017; DiGiovanni et al., 2004; Reynolds et al., 2008).

In this study, participants reported receiving adequate social support from their families, friends, and healthcare providers. This supports existing studies by Lee and You (2020) and Son et al. (2021), in which most participants reported they received help from others when they were in COVID-19-related isolation and rediscovered meaningful relationships through the support of their family and friends. The perception of increased social support reduces the probability of developing emotional distress and mental disorders (Serafini et al., 2020). Strong social support from friends, relatives, and families is a normal, expected practice in Omani culture. At the end of their quarantine periods, present study participants felt they were more powerful and confident. They felt that their experiences with COVID-19 was a God-given opportunity to grow. Their experiences

support Barzilay et. al (2020)'s findings that more resilient people experienced fewer worries, anxiety, and depression during the COVID-19 pandemic.

Consistent with previous literature (Sahoo et al., 2020; Shaban et al., 2020), participants in the present study reported experiencing a mix of negative and positive feelings throughout their quarantine time. Participants considered the time after their isolation as a reflection period, where they critiqued and shared their experiences during isolation. Participants reflected that after the quarantine, they became psychologically calmer, as they had passed the quarantine period peacefully and felt safe and secure. This finding is consistent with the existing literature on the post-quarantine lived experiences of COVID-19 patients (Chen, D et al., 2020; Shaban et al., 2020). In addition, they found that the time after quarantine was a satisfying period. Participants reported being happy that God had provided them with a new opportunity to plan for the future in a better way. Some participants stated that they had utilized the extra time during the quarantine to revisit their plans, reframe their agendas, and prioritize their goals in life. Therefore, they felt optimistic and in control. This indicates that providing COVID-19 patients with resources related to effective planning strategies might help them feel more informed and empowered.

The current practice in the Sultanate of Oman focuses mainly on managing the physiological symptoms of COVID-19 while patients are quarantined. However, based on the findings of this study, which are consistent with existing international literature, psychological and mental status require equal—if not more—attention. It is highly recommended that healthcare providers consider spiritual and psychological support for patients during their quarantine as part of each care plan. Quarantined people would greatly benefit from the creation of programs or workshops to promote their mental health, help them reflect on their experiences positively, and ultimately ease their fear.

Implications of the Study

The authors of this study suggest that this study has implications for the following domains: administration, clinical practice, education, and research.

Administration

- It is critical for the government to develop long-term policies and protocols on infection control in all areas of life and work.
- Establishing tracing for all of each infected individual's possible contacts and facilitating contact testing will be a useful strategy to control the spread of COVID-19 infection.

Community

- Awareness can curb the stigma in society. Informational pamphlets and booklets about signs and symptoms and preventive measures against COVID-19 infection should be published in the community's local language.
- Mental health services must be established in the community (Li et al., 2020).
- Vulnerable groups such as the elderly, pregnant women, children, people with chronic illness, etc., require additional care from their families and healthcare agencies.
- Social workers and community health nurses need to be in constant contact with quarantined people, offering them medical, informational, psychological, and social support.

- Telephone help lines should be made available for people in need.

Clinical Practice

- COVID-19 testing needs to be made available to all those exposed to infection and all those with symptoms.
- Healthcare providers should offer adequate clinical facilities and personal protective devices.
- Mental health and counseling services should be made available to affected people, caregivers, healthcare providers, and all those in need during the pandemic.
- Integrative healthcare practices and telehealth services should be made mandatory in all healthcare settings.

Education

- Pandemic response strategies need to be taught in colleges of nursing and other healthcare education programs.

Research

- The impact of the services mentioned above can be tested through innovative research projects.
- Further study is recommended on the long-term impact of COVID-19 on Omani families.

Limitation

People's lived experiences are impacted by socio-cultural practices and environmental supports, which differ from one area to another. The timing of assessing post-quarantine experiences was not consistent across all study participants. Some were interviewed one week post-quarantine, while others were interviewed a month after quarantine. The interview's timing might change the individual's perceptions and feelings after the quarantine period (Phase 5). The context of the study was very specific to Omani culture, which could be a limitation; however, the applicability and transferability of the findings to audiences outside Oman in contexts similar to Omani Arabic/Islamic culture are still promising.

Conclusion

The aim of this study was to provide an in-depth understanding of the lived experiences of Omani adults who had been infected with COVID-19 and home quarantined. Giorgi's descriptive phenomenological approach was used. Twelve participants were interviewed. This study concluded that home-quarantined persons lived their quarantine experience through different phases, starting with fear and denial and ending with self-empowerment and positivity towards the self and life. The transition from one phase to another was not fully clear. Participants all had different perspectives and outcomes, because each phase had its own unique factors and contexts for each participant that shaped their experience. It is evident from the findings that, although the participants experienced considerable stress during the initial period of infection, they recovered quickly due to their strong support systems.

Furthermore, the participants' lived experience during the pandemic showed that physical distancing does not mean social distancing; instead, they reported that social support and communication were crucial in their acceptance of and psychological adaptation to the infection. Interestingly, we found that self-esteem and resilience were factors that enhanced adaptive coping with COVID-19 infection. Because Oman is a highly spiritual country, participants were able to overcome the negative impacts and self-stigma of infection effortlessly. This finding reaffirms the importance of spiritual values and positivity among people and nations. The participants experienced their quarantine periods positively, as opportunities for growth and empowerment, highlighting the need to look at the brighter side of life. This qualitative study highlights how a positive outlook in life will help people regain their balance in any negative situation. It is the mindset that matters, not the situation.

Based on the insights obtained from this study, the authors recommend that nurses and the general population become knowledgeable about both the appropriate precautions and their consequences during a pandemic. This enhanced awareness will hopefully increase the preventive action of every citizen. Everyone needs to share the responsibility of maintaining physical distancing and thus breaking the chain of infection. The general population needs to be trained in emergency preparedness for potential future pandemics and crises. Mental, physical, and medical preparedness can reduce the population's shock, disbelief, and anxiety in such a situation. Further quantitative and qualitative research studies are needed involving both Omani and non-Omani people to understand how contextual factors influence lived experiences during home quarantine.

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