International Journal of
Mental Health Promotion

Tech Science Press

DOI: 10.32604/ijmhp.2022.020703

ARTICLE

The Interaction and Life Experiences between the Patient and the Nurse Caring for the Patient with COVID-19 in Turkey: A Qualitative Dyadic Approach

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Received: 07 December 2021 Accepted: 21 February 2022

ABSTRACT

Previous research and observations have shown that COVID-19 affected both patients' and nurses' mental health. Even in the best times, one of the best ways to improve patients' experiences is to improve the health workers' experience. Therefore, it is important to be aware of the patterns of interaction between patients diagnosed with COVID-19 and the nurses caring for them and to help them recognize the strengths of their relationship. In this study, we aimed that purposed to discover the interaction and life experiences between the COVID-19 patients and the nurses who provided care for them in Turkey. With the dyadic approach, a qualitatively descriptive design has been used. The research examples consisted of 12 patients diagnosed with COVID-19 selected by purposeful exemplification and 12 nurses who provided care to them. Semi-structured individual in-depth interviews were conducted with individuals. The study adheres to the COREQ guidelines. As a result of the content analysis, four main themes came forward: life change, pandemic journey, getting strong together, new horizons. Institutions should focus on appropriate psychological interventions in order to fortify the relations and mental health of dyad members. Institutions should focus on appropriate psychological interventions in order to fortify the relations and mental health of dyad members. In our research, it is expected to guide related public institutions and non-governmental organizations on formulating policies related to protecting and maintaining the mental health of nurses and patients, extending the scope of existing information, providing patient-health worker security, to assess the problems on the field through the eyes of patients-health workers and to take necessary precautions. This study, which deals with the interaction and life experiences of patients with COVID-19 and nurses who care for them, will shed light on patients, families, communities, organizations, health policies and systems.

KEYWORDS

COVID-19; patient; nursing; qualitative methodology; dyadic approach

1 Introduction

Coronavirus Disease-2019 (COVID-19) is a public health emergency of international concern [1]. Just like with the COVID-19 pandemic, the members of the health systems fought at the front lines during epidemics that affected the world and caused deaths. In the literature, it is stated that the increasing number of COVID-19 patients, the workload, the rapid spread of positive cases and death news in the media, the lack of specific drug treatment, limited personal protective equipment, and lack of

psychosocial support can increase the mental health burden of healthcare workers and cause psychosocial problems [2,3].

The importance of nurses and nursing, which has played a key role in combating the COVID-19 pandemic, has been felt and continues to be felt intensely in the world, with limited resources and many uncertainties, in the diagnosis, treatment, and care of patients [4]. In the meta-synthesis of 13 qualitative studies which focuses on the experiences of the nurses working at pandemic services, it is emphasized that important psychological problems can be prevented if the nurses are actively supported [5]. Nursing which is a science and art for caring focus on human beings and the caregivers are also humans. At this point, it is important to assess the interaction between the patient and the nurse, to establish the experiences in order to provide qualified and secure health services. In the literature, there are studies that focuses on the experiences of COVID-19 patients [6–11], and nurses who cared for these patients [12–18]. In addition, while there are no studies focusing on the experiences of COVID-19 patients in Turkey, there is only one qualitative study focuses on the experiences of the nurses [18]. Consequently, this study offers important findings as it handles the patient's and the nurse's perspectives at the same time and it was conducted during the peak period of the pandemic in Turkey.

Previous researches and observations have shown that COVID-19 affected both patients' and nurses' mental health. In studies conducted both in the world and in Turkey, it is stated that nurses experience more mental problems during the pandemic process. They also found that nurses experience personal protective equipment use and administrative difficulties [19–21]. In a systematic review, it was stated that nurses need mental health interventions more than other healthcare professionals during the pandemic process [22]. Similar results obtained and determined that receiving mental health support significantly reduced mental illnesses [23]. As mentioned above, although there are many study findings dealing with the life experiences and mental problems of nurses during the pandemic process [12–23], studies on the experiences of patients with COVID-19 in clinics are almost non-existent [6–11]. Even in the best times, one of the best ways to improve patients' experiences is to improve the health workers' experience. What is needed now is studies on both sides that provide evidence of psychosocial interventions to strengthen the interaction between patients and nurses. In fact, the disease causes both sides to attribute new meanings to their relationships. Therefore, it is important to be aware of the patterns of interaction between patients diagnosed with COVID-19 and the nurses caring for them, and to help them recognize the strengths of their relationship. That's why it is important to be aware of the interaction patterns between the COVID-19 patients and the nurses who care for them and to help them to discover the strong sides of their relationships. While the pandemic continues, the only way to discover the interaction between the COVID-19 patients and the nurses who care for them and their life experiences is by using qualitative research. Therefore, it is important to state the interaction between the COVID-19 patients and the nurses who care for them and their life experiences. For this reason, a qualitative type, the dyadic methodology was used in our research in order to handle the two perspectives of the patients and the nurses [24,25].

Turkey has shown unparalleled efforts to control the infection and prevent the ways of transmission. These days, the mental havoc individuals have experienced is ignored as only the physical symptoms of COVID-19 are focused on. Many writers have also underlined the psychological first aid for patients that were admitted in pandemic wards [26,27]. In all pandemic wards, individuals should be monitored by mental health professionals in addition to receiving treatment. Also, mental health specialists should be ready to deal with the post-COVID-19 mental health consequences [28]. In our research, it is expected to guide related public institutions and non-governmental organizations on formulating policies related to protecting and maintaining the mental health of nurses and patients, extending the scope of existing information, providing patient-health worker security, to assess the problems on the field through the eyes of patients-health workers and to take necessary precautions. As a result, the purpose of this study is to

discover the interaction and life experiences between the COVID-19 patients and the nurses who provided care for them in Turkey.

2 Methods

2.1 Study Design

A qualitative descriptive design with a dual approach was used to fully explore the perspectives of patients diagnosed with COVID-19, and the nurses who care for them, the relationship between them, and how the COVID-19 experience is experienced, perceived and affected. The dyadic approach was used because it provides rich and in-depth data, deals with the phenomenon from a two-sided detailed perspective, and is widely used patient-nurse relationships [24,25,29,30]. In addition, this study is suitable for the Consolidated Criteria for Reporting Qualitative Research (COREQ) [31].

2.2 Settings and Participants

The research was carried out in the pandemic clinic of a state hospital in Mersin in December 2020. The research examples consisted of 12 patients diagnosed with COVID-19 selected by purposeful exemplification and 12 nurses who provided care to them. Data collection continued to a point of saturation the repetition of responses to research questions [32]. The criteria for the patients to be included are these: being 18 years old or older, volunteering for the research, diagnosed with COVID-19, and admitted to a COVID-19 ward. The criteria for the nurses who care for COVID-19 patients are: being 18 years old or older, volunteered for the research, cares for patients diagnosed with COVID-19. Exclusion criteria for nurses are physical or mental disability, physical or psychological symptoms that may interfere with interviews. Exclusion criteria for patients are the same as for nurses, in addition to being in the terminal stage of the disease.

2.3 Data Collection

Data collection was done separately by the researchers using "Personal Information Forms" and "Semi-Structured Individual In-Depth Interview Forms" (Table 1) prepared in line with the literature from patients and nurses [10–12,15,18]. Data that is related to socio-demographic characteristics such as age and gender were collected with the personal information forms. The interviews were done virtually via mobile phones or computers of patients and nurses due to pandemic conditions and infection risk. Before interviewing the patients, an assessment to decide if the patients are available was done with their clinical nurse. The patients were informed by their clinical nurse before the virtual interviews. In the first five minutes of the interview, the researcher introduced themselves and explained the purpose and the method of the research, and explained that the interview would be recorded. Since one of the researchers worked as a nurse in the clinic where the research was conducted, it became easier to meet patients and nurses online. It was paid attention that the participants freely express their opinions and do not affect the nature of the patient-nurse relationship, which is in the roles of caregiver and field. Data were collected through semi-structured individual in-depth interviews. Patients were matched with the caregiving nurses and the interviews were done individually. During the analysis, in order to protect the binary perspective, the interviews were done by the same interviewer, and the same questions were asked to the matches. In this way, by analyzing the similarities and differences between the couples, the relational perspectives were understood [24]. According to the purpose of the study, as there was enough in-depth data, repetitive interviews were not needed. The approximate duration of the interviews was 16 min for the patients and 25 min for the nurses. None of the participants denied participating in the data collecting process and the researcher took field notes about the important parts during the interview. The pre-application was made to a patient diagnosed with COVID-19 and a nurse caring for this patient. These interviews were checked by two experts to be evaluated in terms of quality and quantity, and no change was made in the questions after the feedback.

Table 1: The semi-structured interview questions

Main questions for patients	Main questions for nurses
• What have you experienced from the time you were diagnosed until now? • What could the nurses who care for you have experienced? • How would you evaluate your relationship with your caregiver nurse during this period?	• What did you experience during the period you started working with patients diagnosed with COVID-19? • What could your patients have experienced? • How was your relationship with your patients affected in this process? How would you evaluate your relationship?

2.4 Ethical Consideration

Institutional approval from the Ministry of Health and the state hospital administration where the study was conducted, and ethical approval was received (Approval No. 2020/25/783). Also, verbal consent from the participant patients and nurses were recorded.

2.5 Data Analysis

The togetherness of the patient-nurse relationship was interpreted as a whole and a case. Relationships and dynamics between dyads represent all the meanings, positive and negative, as it put forth those phenomena in depth [24]. The data were analyzed by inductive content analysis. First of all, online interview records were transcribed *verbatim*. Subsequently, the interviews that were written down were transferred to the MAXQDA 20.0 statistical software package program by the researchers, and they were repeatedly read and verified by the first and second researchers. These two researchers independently read and encoded the interviews several times in the MAXQDA 20.0 program. These codings, which are called adding a third dimension to the dual perspective, enriched by the emergence of the similarities and differences of the couples, were carried out by the researchers in two stages: (1) individual coding of the answers given by the patients and the nurses, (2) specification of the similarities and differences between the couples [24]. The researchers came together after the analysis was completed independently to discuss the themes created both within and between the pairs and agreed on the themes that best represent the data for the research purpose. The researchers are all women who were experts in psychiatric nursing and trained in qualitative research. The first researcher works as a Specialist Psychiatric Nurse at the institution where the research was done. The third researcher who is a specialist is a Professor in a government university and the second one works as a Research Assistant. They have also worked as nurses in hospitals in the past. One of the researchers received training in psychodrama, the other two in cognitive behavioral therapy, conscious awareness, and motivational interview techniques.

3 Results

The average ages of the patients and nurses were 48.4 ± 11.05 and 35.91 ± 7.56, respectively. Four of 12 patients were female, eight were male, and 10 of 12 nurses were female and two were male. Five of the patients and 11 of the nurses are graduated from universities. The average time passed after the COVID-19 diagnose is 19.33 ± 9.98 days, the average duration of their stay in the hospital is 11.75 ± 10.93 days. Nurses' average care giving duration to COVID-19 patients is 4.45 ± 2.11 h, their time spent with a COVID-19 patient in a 24-h turn of duty is 7.50 ± 3.34 h (Table 2). As a result of analysis of the interaction and life experiences of patients diagnosed with COVID-19 and the nurses who care for them, four main themes come forward: life change, pandemic journey, getting strong together, new horizons. The categories, codes and sample quotations determined for each theme are presented in Table 3.

Table 2: Characteristics of the dyads

Dyads No.	Age (year)	Gender	Marital status	Having a child	Education	According to income expense	Chronic illness	Chronic illness in the family	Diagnosed with COVID-19	Diagnosed with COVID-19 in the family	Length of hospital stay (day)	Length of time after diagnosis (day)	Duration of caregiving (month)	Length of time spent together in 24 h (hour)
P1	44	Male	Married	Yes	University	Much	Yes	No	Yes	Yes	1	10	–	–
N1	46	Female	Single	No	2-year university program	Equal	No	No	No	Yes	–	–	3	12
P2	38	Female	Single	Yes	Primary	Equal	No	No	Yes	Yes	4	14	–	–
N2	43	Female	Married	Yes	Master	Equal	No	No	No	No	–	–	2.5	4
P3	31	Female	Single	Yes	2-year university program	Low	No	Yes	Yes	Yes	6	21	–	–
N3	40	Female	Married	Yes	University	Equal	No	No	No	Yes	–	–	7	6
P4	56	Female	Married	Yes	Primary	Low	No	No	Yes	Yes	6	16	–	–
N4	30	Male	Married	Yes	University	Equal	No	No	Yes	Yes	–	–	2	4
P5	43	Female	Married	Yes	Primary	Equal	Yes	Yes	Yes	Yes	17	20	–	–
N5	48	Female	Married	Yes	2-year university program	Equal	Yes	Yes	Yes	No	–	–	6	6
P6	40	Male	Married	Yes	2-year university program	Low	Yes	No	Yes	No	3	11	–	–
N6	26	Female	Single	No	2-year university program	Low	No	No	Yes	No	–	–	7	6
P7	56	Male	Married	Yes	Primary	Low	Yes	Yes	Yes	Yes	40	40	–	–
N7	39	Female	Single	Yes	University	Low	No	Yes	No	No	–	–	3	5
P8	71	Male	Married	Yes	Primary	Equal	Yes	Yes	Yes	Yes	20	23	–	–
N8	30	Female	Married	Yes	University	Equal	Yes	Yes	No	Yes	–	–	1	6
P9	52	Male	Married	Yes	University	Equal	No	No	Yes	Yes	10	17	–	–
N9	29	Male	Single	No	Master	Equal	No	Yes	Yes	No	–	–	5	15
P10	60	Male	Married	Yes	High school	Equal	Yes	No	Yes	Yes	10	20	–	–
N10	40	Female	Married	Yes	High school	Much	No	No	No	No	–	–	3	8
P11	48	Male	Married	Yes	High school	Low	Yes	No	Yes	Yes	5	5	–	–
N11	31	Female	Single	No	University	Low	No	Yes	Yes	Yes	–	–	6	10
P12	42	Male	Married	Yes	University	Equal	Yes	No	Yes	No	19	35	–	–
N12	29	Female	Single	No	Master	Equal	No	Yes	No	Yes	–	–	6	8

Note: P = Patient; N = Nurse, COVID-19 = Coronavirus Disease-19.

Table 3: Themes, categories, codes and sample quotations identified in interviews with patients and nurse

Themes	Sub-theme	Codes	Quotations
Life changes	Changes in social life	Social isolation, Stigma, inability to fulfill family roles, increased interaction, socio-economic difficulties	P3: "…no one wants to get close, they are scared. They don't want to get close to a normal, healthy person, too because they are too scared. N3: "As we are nurses, people outside treat us like we are suicide bomber, inevitably. P4: "I didn't do any chores at home. I couldn't do it, my mental health wasn't great." N4: "They were thinking about their families the first times, especially women were thinking about their kids at home, who would feed them. They were thinking about their families more than themselves." P9: "They are really understanding with their dialogues, practices, when they are informing us, as I said I have been content and happy ever since I was admitted." N9: "I can say that interaction is more. There is more interaction, communication with the patients." P11:" …Our financial situation affected us the most rather than the illness. Believe me, what we have earned in 20 years, we spent me, what we have earned in 20 years, we spent bad, but it is even more important to bring bread to your house because we live, we use electricity, we use natural gas, our children study, we need money. Of course, in this process, the state did not help us a lot. " N11: "…We do not have the right to leave, we do not have the right to resign, we do not have the right to retire or these wear us out too much. … We are very tired, worn out, we want to take leave. In addition, our salaries are the lowest public salaries, not being given a single item in order not to enter the tax bracket, and our salary changes according to the number of patients. We suffer from these a lot."
	Changes due to hospital environment	Difficulties of using equipment, taking more precautions, different opinions about the negative effects of communication caused by the hospital environment negative emotions arising from the hospital environment	P12: "I recovered from COVID once. The nurse caring for me recovered from it maybe two three times, maybe never but she wears a mask in order not to catch the disease, that must be hard." N12:" It was a very difficult process and it took me months to wear and take off that equipment constantly. We were working for hours with equipment… for example, I want to go to the patient's room right away but it's hard to put on that equipment, I was open at that moment I will eat my meal, but when something urgent happens to the patient, it is a waste of time for me to wear that equipment. I thought I could not intervene immediately, this upset me a little. It takes me 1.5–2 min to put on overalls, equipment, goggles, and visors. Which I think is a very serious and vital time. … After a while I realized that I was sitting dressed all the time. Here, if something happens to the patient, I am running. One day I realized that I could not drink any water. I noticed that I skipped my meals. … Going to the toilet in overalls was like torture. " P6: "Nurses are aware of everything, they take precautions, wear masks. After all they are trained for this." N6: "I started washing my hands with every little thing, I started not to let anyone close to me, I started to say stop at the slightest thing, even to my family. Then the smallest thing caught my attention, especially I check to see if something is clean, I try to wash it immediately……when my hand touches the slightest thing, and things like that" P3: As these are hard times, they are smiling all the time, they try to make us talk which is better for the patient's mental health." N3: "We cannot get in contact with the patients much. I cannot show my nursing skills. I cannot listen well or I cannot even stay in the room for long, I treat them and leave quickly in order not to catch it. Patients think we do not take care of them and this makes me uncomfortable."

(Continued)

Table 3 (continued)

Themes	Sub-theme	Codes	Quotations
	Mental changes	Burnout, tiredness, need for psychological support, not enjoying life	P2: Of course, you get affected a lot, psychologically. I saw the funeral cars and how they left silently. When I saw the crowd here I was affected by it because everyone had COVID and then I felt alone because you cannot get help from anyone." N2: "Here, maybe I need psychological support, too. Everyone is worried in this process. Our concerns can be reduced a little more and our institution can develop more effective activities on behalf of employees in this process. Because we wear out a lot here."
Pandemic journey	Emotions	Disease transmission anxiety, Fear of infecting loved ones and not seeing their loved ones again, fear of death-anxiety-loneliness, fear-anxiety-worry towards the unknown, living with pain	P6: "Of course, they are also worried about their own life safety. We have a little thing about the doctors, they act from a distance, they are a little worried about their own safety." N6: "After I started working in the COVID ward, I thought I could not do it and I would catch it from the first patient I saw. That way I was very scared, paranoid. " P2: "I felt a bit lonely because you can't get help from anyone. So you know you can't bring your family or something. I got bad yesterday because the vapor medicine made my heart pound so badly, it was like my heart would pop out. At that moment I was very scared, very sad. They are also afraid. " N2: "They may feel lonely because they never go out in a room alone, they do not communicate, they cannot communicate with their families except on the phone, we cannot spare enough time for them. I think they might be ten times more anxious than I am because the patient profile is older and they usually have a fear of death. " P7: "I went to the other side… I arrived at noon yesterday, I was in torment (36 days intubated in intensive care)… Because there was vascular occlusion and I lived all of them together. If you told me, how did you live but I was tormented. I don't know which one was more difficult, because the two were together" N7: "So we having troubles in that overall … you are sweating it's extremely hot, I have had headaches and also visor masks, you are constantly breathing in your own oxygen and this causes headaches too, of course, this is also a source of stress." P1: "Maybe it's because COVID-19 is something unknown but we had prejudice against the disease, more fear than precaution. Health workers, nurses are the ones experiencing that." N1: "They are also in anxiety constantly, they are afraid. Especially they thought they were gonna die if they had COVID-19 at first."
	Experiences	Different opinions about feeling incomplete or inadequate due to not being able to fulfill the profession fully, nurses as a disadvantaged group, difficult symptoms, experiencing loss-mourning	P8: "…nurses here are usually good, they come here call me "uncle". You would think I am their actual uncle. They give my medicine, what else is there to do? They do everything they can." N8: "I used to train my patients frequently. Now, we are trying to keep the distance and cannot do the trainings. We treat them and leave. Yes, we cannot. This bothers me. We turned into robots."

(Continued)

Table 3 (continued)

Themes	Sub-theme	Codes	Quotations
Getting strong together	Getting stronger by communication-trust	Nurses' dedication and trust in the health system, Mutual empathy, patients feel valued	P7: "God knows they are too. They live in this torture, this fear. We can escape it outside but they cannot, they are indoors. We run away from the patients, I bring my mom, dad and leave them. On the other hand they take care of them, clean them. They experience harder things. … They take care of them as if they are their own parents." N7: "You put myself in their shoes and try to help them considering this." P1: "The nurses care for us perfectly, we feel their desire to help us. This gives us confidence. Nurses are really close and sincere, we can see their efforts." N1: "I worked the best way I could. …COVID ward is the same thing for me. I thought, if I were to catch COVID I would catch it here or outside, but I need to take care of that patient."
	Getting stronger by mutual learning	Sharing disease experiences and empowerment, positive effect of experience on anxiety and mutual learning	P9: "But I started to feel better starting from the second day I was admitted to the hospital. These anxieties got less and less." N9: "At first, fear then anxiety then I became COVID-19 diagnosed patient, then social isolation, sadness after all these negative situations I focused on myself and found myself and focused on other social and activities and art." P1: "Thank goodness COVID-19 did not put a psychological pressure on us as it was when it was first out. So we got through. The disease is more recognized, it is not an unknown enemy as in the early days, we are fighting the virus that we relatively know more about now, and there is a comfort this has given. " N1: "…now when we see cases moving forward and patients getting better and being discharged from the hospital, patients feel more relaxed too."
New horizons	Coping mechanisms	Positive coping mechanisms Spiritual coping mechanisms	P12:"I have friends with cancer that are getting treatments, we stayed for a month here and we are getting better already, but their treatment takes years sometimes, we are grateful for our situation." N12:"I was being extra careful about what I eat. I wasn't normally careful about my diet. In this process I tried to be healthier. I started jogging to protect myself. Because I had to keep myself strong mentally and physically. I tried to go to nature even if it's occasionally."
	Positive outlook	Understanding the value of health and life, Increased visibility of the nursing profession	P10:"Our way of living and learnings did not cause a negative feeling during this sickness. I am watching the world, man." N10:"What did I feel? It is really a stressful time, you understand the importance of breathing, the importance of health."

4 Discussion

As a result of analysis of the interaction and life experiences of patients diagnosed with COVID-19 and the nurses who care for them, four main themes come forward: life change, pandemic journey, getting strong together, new horizons.

4.1 Life Changes

During the pandemic, COVID-19 patients and nurses who care for them have gone through many social changes. Patients and the nurses, their families were stigmatized by society and socially isolated. Kaçkın et al. stated that nurses who care for COVID-19 patients experienced stigmatizing attitudes towards them from the society in Turkey [18]. On the studies conducted with COVID-19 patients, Moradi et al. detected that they felt rejected, they were afraid to be stigmatized and discriminated against [6–8]. This situation might have caused the patients and the nurses to choose social isolation and cut down their interaction with the outside world in order to prevent transmissions. Along with this, they might have been isolated due to forced restrictions and being labeled by society. Another finding of this study is the participants stating that they experienced socio-economic hardships due to patients, being in the hospital and nurses, working too hard to fulfill their in-family roles and feeling insufficient because of this. Studies conducted have shown that, the nurses who care for COVID-19 patients were affected negatively because of the pandemic [18], have experienced economic hardship for working in hard conditions and under pressure [33], and had feared toward the future [34]. In our study patients and nurses have stated that, apart from the negative life experiences, they interacted with each other more, they showed understanding and care for each other and challenging conditions like the pandemic had improved their relationships. The fact that there are plenty social support systems in Turkey might have caused this. In addition, the reason for the increased mutual understanding and interaction between dyad members is thought to be that nurses try to reduce the feelings such as loneliness, fear, and anxiety of patients under restraint, and patients have the thoughts of helping nurses who work devotedly in difficult conditions.

During the pandemic which is a long and challenging process, nurses stated that they had a hard time getting their physiological needs met due to the hardships caused by equipment and patients stated that they thought wearing masks all the time could be hard for nurses. Qualitative studies conducted with health workers during the pandemic emphasized the hardships of using protective equipment for long periods of time [10,33–35]. In the studies conducted, health workers stated that they had fear of getting infected, and wearing protective equipment was hard, painful, and tiring. In fact, the nurses stated that in protective equipment, they could not get their physiological needs met such as eating, drinking water, and going to the bathroom [12,13,16]. Dyads stated that they took more precautions and washed their hands often during the pandemic in order not to catch the infection. In a study conducted in Turkey, it was found that the nurses felt fear and anxiety, their obsessions increased and they showed depressive symptoms [18]. Sun et al. [10] emphasized that in order to create a supportive and secure workplace during a pandemic, appropriate human resources and personal protective equipment should be provided. Stating that even if patients diagnosed with COVID-19 are under restrictions, their communication with nurses has increased even more and that nurses are more interested in and trying to communicate with them by actively listening to them; on the other hand, nurses stated that they felt inadequate and incomplete due to their inability to communicate adequately with patients. Studies conducted stated that infected patients' quality and speed of communication decreases [6], in stressful situations like this, health workers find it hard to communicate and build good relationships with patients [16]. Halkomb et al. [35] detected that the nurses have experienced positive sides about communication during pandemics. It is thought that nurses have felt inadequate because they have not had sufficient and quality communication and could not have fulfilled their educator and counselor roles in order to reduce the risk of infection and transmission, as required by social distance and isolation rules. Patients, on the other

hand, may have thought otherwise because they received attention from nurses, which they did not receive from their relatives during this process.

Patients and nurses stated that they are worn out physically, mentally, socially and economically due to the unknown nature of the disease and tough work conditions. Ardebili et al. [34] stated that death of too many patients has caused health professionals to feel disappointed and worn out physically and emotionally. Studies have emphasized that despite their scientific knowledge, over time, participants entered a phase of burnout or "pandemic fatigue" [5,18,34,36]. Factors such as working in pandemic wards for long periods, use of equipment, socio-economic concerns, insufficient social support, tired nurses out, and dealing with the infection alone tired the patients out. Studies indicate that inadequate workforce and equipment, colleagues being stressed [13,16,17,33], having a limited number of nurses while there are many care needs of patients [12], and being alert all the time caused health professionals to feel pandemic fatigue [34]. Along with this Eisazadeh et al. [6] indicated that infected people were always tired. In our study, patients and nurses stated that they were affected psychologically during the pandemic process and needed psychological support. Studies have found that nurses are negatively affected by the pandemic both psychologically and socially, and they need psychosocial support and resource management [16,18,37,38]. Galehdar et al. [12] have shown that nurses who witnessed the death of their patients would be affected psychologically. In addition, Liu et al. [16] emphasized that patients need psychological support before they need nursing care. For this reason, it is recommended to monitor the mental state of both patients and nurses and to apply and follow online early intervention methods such as professional psychological support and strengthened crisis support systems [16,17,39].

4.2 Pandemic Journey

Many nurses stated that they experienced intense fear and anxiety due to the uncertainty, lack of experience regarding the pandemic, unfamiliarity with the procedures, and they thought that it would transmit COVID-19 to patients, colleagues, and relatives. Studies support the findings of our research [16,17]. Almost all the dyads participating in the research have said that they were afraid to transmit the virus to their loved ones and they were afraid to never see them again. Studies detected that the patients [8] and the nurses [12,13,16,18,33,34,40,41] have experienced the fear of transmitting the virus to their friends and families. While these concerns are thought to be caused by the difficult and exhausting process for nurses and the observation of the difficult symptoms that patients had and losses they experienced, for the patients it is thought that these concerns may be caused by the people who had negative experiences and the negative experiences shared in the written and visual media.

The nurses participating in our study stated that the patient profile was mostly composed of elderly patients and that they may be experiencing loneliness and fear of death during this process. Patients who experience COVID-19 symptoms intensely stated that they were isolated and experienced feelings of loneliness due to fear of death and not being able to see their relatives. The studies have shown that, during the pandemic, patients [10] and nurses [15] have experienced loneliness. In the literature it is stated that, during the pandemic, patients and nurses have had the fear of death [6,33], dying alone, and falling apart from their loved ones [12,34]. The participant has experienced fear, anxiety, and death anxiety due to COVID-19's unknown nature. In the studies conducted, it was found that even though it was stated that healthcare workers adapted to the pandemic, their fears and anxieties continued [17,34]. Along with this, in our study, a patient who was intubated in the intensive care unit for 36 days stated that they were living in torment. Sun et al. [7] supported our finding by stating that patients diagnosed with COVID-19 experience fear, denial, and fear of death in the early stages of the disease.

The patients stated that they had stopped breathing, could not sleep due to coughing, could not perform daily life activities, and struggled with very difficult symptoms. Literature also supports the findings of our research [7]. Nurses stated that they did not leave the patients alone, supported them for possible symptoms,

and provided the needed health services. Many patients and nurses stated that they have experienced or observed mourning, some patients had to stay in the hospital even when they lost their spouses, their families. During the pandemic journey, nurses indicated that due to the nature of the disease they could not communicate with the patients enough, they could not spare their time and they had anxiety about providing the needed medical care thus felt professionally inadequate. Unlike nurses, patients stated that although nurses are a disadvantaged group and constantly struggle at the forefront, they made them feel very special and valuable, that nurses had sufficient professional skill and provided the highest quality health care services. Jia et al. [42] stated that nurses feel inadequate in terms of knowledge and skills in caring for patients diagnosed with COVID-19. Galehdar et al. [12] stated that the nurses do not have enough skills in managing patients and feel inadequate, in their study. In addition, nurses reported that although COVID-19 patients felt helpless and disappointed, their love and interest in caring for nurses increased, and they were proud to be nurses. Nurses may have sometimes felt insufficient in their roles of educators, counselors, and caregivers, due to reasons such as isolation, social distance, and the risk of transmission, while providing professional health service in the normal process. On the other hand, it is thought that different opinions have emerged on this issue as the patients better understand the place and importance of the nursing profession, which has become more visible with the media and hospital experiences.

4.3 Getting Stronger, Together

The patients indicated that the nurses provided them with top level service with care, that they were well educated and they have done the best they could, due to this they trust the health system. Most of the patients think that when they are admitted in the hospital, the most important supportive factor is the care of health workers and they trust them [7]. Galehdar et al. [12] showed that the nurse is the first person to get in contact with the patients and despite the fear and anxiety of transmission, they welcome the patient with gratitude. In this difficult process, patients stated that the health services and nursing approaches provided made them feel valuable. While patients could not even care for their parents, they stated that nurses provide holistic care to their families despite difficult conditions. About this matter, the nurses said that they put themselves in their shoes and help them considering that. Between patients and nurses, mutual empathy has increased and communication and trust between them got strengthen. Studies mention that health workers empathized with the patients and felt happy about their recovery [17,33]. It is thought that mutual empathy and understanding have increased among the dyad members who spend this process together but alone, so while nurses serve with devotion, patients also feel valuable and trust nurses.

Patients and nurses stated that their anxiety decreased as the disease became more recognizable and the experiences of themselves and those around them decreased, and their coping skills with mutual learning improved and strengthened. He et al. [15] detected that when the nurses get accustomed to COVID-19, their fears about the virus decrease. Schroeder et al. [14] indicated that the nurses had anxiety at the beginning but once they talked to their supervisors, their anxieties declined. Sun et al. [7] reported that patients diagnosed with COVID-19 experienced anger and anxiety in the early stages, but as they accepted the disease and as their experience increased, they showed comfort and calmness. Our research is in line with the literature.

4.4 New Horizons

In our study, some patients and nurses improved their positive coping skills by spending time in nature, taking walks and stating that they should stay strong, while others developed spiritual coping skills by being grateful for not experiencing more difficult diseases such as cancer. Sun et al. [43] stated in their study that they deal with distracting patients with COVID-19, setting new achievable goals every day, communicating with healthcare personnel, seeking professional counseling, and their religious beliefs. In this process,

healthcare professionals were encouraged to practice breathing exercises, listen to music [10], obey restrictions and social distance rules, work with religious obligations such as conscience and sacrifice [34], compassion satisfaction, belief in healing patients, social support. used problem-oriented [33], individual [16] coping strategies, such as, spirituality, and orientation to religion. In a study conducted in Turkey, nurses used sport and music to cope with the negative effects of the pandemic [18]. In this context, interventions must be on an individual level. Depending on the individual's personality, psychological resilience, current sources of support, motivation, and experiences from past crises; it will provide diversity in the coping abilities of individuals now and, therefore, in the interventions they will need.

In this process, nurses and patients found a positive outlook by realizing how important it is to breath and to be healthy and they stated that the process had been a unique experience for them. In a study, they defined the fight against a pandemic as a phenomenon that supports positive experiences and growth, according to nurses [10]. In a study conducted in Iran, it was found that healthcare workers gained experience over time, normalized, adapted to the pandemic and grew over time [34]. Studies indicated that nurses experienced positive sides about sharing information and communication [35] and an unforgettable learning process [13,15,16]. While some patients and nurses state that pandemic has been a disadvantaged and challenging process, others state that nurses who was not treated humanely before, now at least their existence is accepted and their professional visibility has increased. According to the study by Galehtar et al. [12] nurses evaluated the COVID-19 crisis as an opportunity for the development of the nursing profession and stated that people gained a positive view of the nursing profession. In the emergence of different views on this issue; this is thought to be the reason why nurses did not improve their bio-psycho-socio-economic rights.

5 Conclusions

It was seen that COVID-19 patients and nurses who cared for them went through some life changes and saw this process as a journey. Additionally, both sides stated that they empowered each other in the process. Patients and nurses understood each other better with communication-trust and mutual learning, had positive experiences with the development of new meaning and values during the care process. In these challenging pandemic conditions, intervention programs must be planned in order to strengthen communication, interaction and life experiences between the patients and the nurses. Experiences on the pandemic journey will affect nursing profession to gain a professional identity. Our findings have shown that the COVID-19 pandemic offers an opportunity for greater awareness of the depth of the nursing profession and its true value.

6 Implications for Practice

There is no study in the literature that deals with the interaction and life experiences of inpatients and nurses who care for them in COVID-19 services regarding the COVID-19 process. Therefore, this study presents original findings that will guide nursing practices by conveying the COVID-19 process firsthand. The current study findings show that this process significantly affects the quality of life of patients diagnosed with COVID-19, and that these effects may be permanent. Perhaps it will not be easy for individuals who have gone through a great trauma to get over it. However, the findings of our study showed us that the nurses are tired and still want to do their best. It should not be forgotten that the nursing workforce, health and care systems will not always remain at the same good level. Our study has been revealed by considering not only this process but also the long-term effects of COVID-19. Therefore, this study, which deals with the interaction and life experiences of both patients with a diagnosis of COVID-19 and the nurses who care for them, will shed light on patients, families, communities, organizations, health policies and systems. Patients diagnosed with COVID-19 and nurses who care for them need to be supported psychosocially. In this process that has existed for a long time, nurses should be empowered for better nursing process and care. Preventive mental health interventions

(mental health screenings, mental health strengthening programs, awareness trainings, etc.) should be carried out against the possible psychological needs of nurses caring for COVID-19 patients. In addition, clinical rotations, detection of mental illnesses, receiving opinions and suggestions, developing policies to reduce administrative pressures, providing administrative support and making improvements in personnel rights are recommended. In order for patients to cope with possible psychological problems that may arise from the process of diagnosis, treatment and post-treatment of COVID-19, individuals and their communication skills should be strengthened and trained in problem solving techniques. The use of e-learning and video platforms in the education process of patients should be ensured by governments and media organizations, and their accessibility should be increased through public service announcements. In addition, patients should be supported to access accurate information about COVID-19 from the right sources. Media organs, non-governmental organizations and nurse associations should act in cooperation to prevent the society from stigmatizing patients with COVID-19 and the nurses who care for them. It should not be forgotten that a health system without a nursing workforce is unthinkable.

7 Limitations

The study has several limitations. First of all, the study was limited to patients diagnosed with COVID-19 and the nurses who cared for them. Secondly, the interviews were done virtually. This situation might have caused stress for participants and affected the way they expressed their emotions. Finally, since the interviews were done virtually *via* mobile phones or computers of patients and nurses due to pandemic conditions and infection risk, there could be the potential for the distraction of interviewees by environmental disturbances, internet outages and technological issues related to mobile phones or computers.

Acknowledgement: This study was orally presentated from the International Congress Reflections of Pandemic on Mental Health and Psychosocial Care on 24–25 June 2021 and won an achievement award. We are grateful to all the nurses and patients on the COVID-19 ward for their useful contributions to this study.

Funding Statement: The authors received no specific funding for this study.

Conflicts of Interest: The authors declare that they have no conflicts of interest to report regarding the present study.

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