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Editorial: The COVID-19 Pandemia

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Editorial

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Our experiences with the COVID-19 pandemia and its sequelae on all aspects of our social, cultural, and economic life have lasted more than a year. During the past year many countries around the globe have had to cope with the enormous challenges imposed by the pandemia on almost all aspects of life. Millions of deaths, severely injured patients, and disability due to long term consequences of the disease are the costs of the pandemia, not to forget the burden of the social and economic stress under which large social groups still have to suffer.

Obviously, hospitals and health care systems are a focal point of the crisis in times of pandemia. Due to their exposure in the care of infected patients, medical personnel are at a considerably higher risk of infection. This led in many countries to a situation in which the death rates of the medical staff exceeded significantly that of the general population. Now after more than a year and towards the end of the third wave in many countries, healthcare workers are suffering from fatigue and burn-out. The ongoing confrontation with a large number of patients dying or suffering severely and over a long period in intensive care results in feelings of desperateness and numbness. It is not only the result of work overload, but also the human misery that eats away at the nerves and souls of the medical staff.

If there is one aspect of the pandemia that could give rise to hope for a better world it would be the fact that the global nature of the disease has lead to a growing awareness that this disaster can only be controlled by means of global solidarity. Otherwise the risk of an ongoing spread of new mutations can hardly be eliminated. Since the virus does not care about borders, the danger of new outbreaks of the pandemia remains as long as there is mobility across continents and borders. Therefore, it seems clear that a successful strategy against the disease cannot be a national or isolated one, but must be a global strategy. In addition, the discourse on the experiences regarding the impact of the pandemia on people's health, the observations of medical treatments, and the organization of healthcare systems have all become topics of common interest around the world. The awareness of a common

global threat comparable to the climate change might help to realize the need for international cooperation. COVID-19 has become a common point of reference around the world both in politics and science, which is reflected in the enormously increasing number of publications in the international scientific literature.

The articles collected in the current volume of the Journal of Body, Mind, and Culture give an impression of the multiple facets of the COVID-19 pandemia and its sequelae. The aim of the present volume was to collect contributions from different countries and cultures reflecting the respective experiences and situations regarding the pandemia. Sollmann and Feihuan for example report on their observations of COVID-19 in China, where the pandemia started. In China, but also in many other countries of the world, the health care systems turned out to be insufficiently equipped to cope with the pandemia. The initial hit by the virus therefore was severe. Due to the immense efforts to develop vaccines and to improve the health care systems, the infections and death rates in many countries gradually decreased. The focus of attention therefore shifted towards the psychosocial sequelae of the pandemia and the disadvantages of the lock-down strategy. A panel of American psychologists delineated three reasons why the mental health consequences of the pandemia are so difficult to cope with (Gruber et al., 2020). First, the pandemia is long-term and widespread with an uncertain end. Second, COVID-19 is a multidimensional stressor, affecting individual, family, educational, occupational, and medical systems. And third, “the protections needed to safeguard against infection necessarily, but ironically, block access of protective factors that are known to reduce the effects of stress (e.g., enjoyable distractions, behavioral activation, social relationships) because they are difficult to employ while adhering to stay-at-home and social-distancing mandates” (Gruber et al., 2020). All these factors have contributed to the deleterious effects of the pandemia on mental health. As the paper on challenges in the clinical education environment illustrates, the stress due to COVID-19 not only affected nurses and medical staff, but also medical students. In a qualitative interview study, five main themes emerged as most important, which were problems in medical education, work conflicts, future professional challenges, and challenges related to institutional issues and issues of stigma.

However, we should be aware that although the problems caused by Corona are clearly in the foreground for many reasons, there are also other medical issues which deserve our attention. One of these is the psychosocial situation of caregivers of disabled persons. A paper by (please insert authors) reporting on a study performed in collaboration between Isfahan and Hamburg Universities shows a high prevalence of depression, anxiety, and somatic symptoms in the group of caregivers. The study indicates that this group requires more attention and support in order to cope with their psychosocial and practical demands.

Since internet-based interventions are gaining increasing importance in times of Corona, the Chinese experiences with a platform provided by Wuhan Mental Health Centre offering online crisis intervention is interesting. Even when the Corona pandemia was under control, the platform was still well received and used by the Wuhan population.

In sum, this edition of the Journal underlines the potential of an international perspective on issues of health and disease in psychosomatic medicine. What we might learn from the pandemia as a global threat is that our efforts to cope with the challenges need also to incorporate international learning from experiences in different cultures and improvement of collaboration.

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Exposed to Extreme Psychological Stress during the Corona Crisis; Qualitative Metasynthesis of Chinese Research on the Psychological Burden of Medical Treatment Personnel

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Empirical Study

Abstract

The Covid-19 virus crisis is related to virology, medicine, politics, economy, lockdown, the constitution, masks, the future, and short-time work. But what about the mental health of the medical practitioners on the frontline? Experiences and research in China provide not only an insight into the almost superhuman medical performance, but also the most extreme mental stress and strain of these same practitioners. Some of the key conclusions derived from these studies may be of interest to practitioners in other countries.

Keywords: Corona crisis; Mental stress; stress management; anxiety; Depression; China

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Introduction

The outbreak of the Covid-19 virus crisis began in December 2019 in Wuhan in the Chinese province of Hubei. Within a very short time, this epidemic has developed into a worldwide pandemic. The treatment and care personnel working in this field are exposed to extraordinarily high psychological stress. The experiences gained in China have been scientifically evaluated and published in renowned journals such as The Lancet, Journal of Health Psychology, or Psychotherapy and Psychosomatics.

According to the experts, these publications should help us better understand the unique situation on the front line and to learn from the experiences gained, wherever in the world one is confronted with the Covid-19 virus crisis. Here are some of the experiences gained in the Covid-19 virus hotspot, Wuhan, and other regions of China as well as recommendations derived from them:

What were the psychological challenges?

As if from nowhere, the medical practitioners were confronted with completely new dangerous circumstances. There was very little experience on which they could rely, such as from the SARS epidemic (2002/2003). There was uncertainty related to the medical requirements as to how to react to the infection in the first place. This uncertainty led to a deeply traumatic experience for frontline personnel. On the one hand, they were working almost around the clock. On the other hand, they were separated from family and friends, and placed in social quarantine, so to speak. Added to this was the stress caused by the infection of the treatment personnel and deaths among overworked doctors and nurses. Everything flooded in on the treatment staff, as if from nowhere; they were completely unprepared. They learned about the crisis in real time, made the best possible preparations for the circumstances directly, and immediately began treatment. There was no time to get used to the situation before going into social quarantine for many weeks, sometimes even months. Younger practitioners were particularly affected by the psychological stress (Liang, Chen, Zheng, & Liu, 2020). This has been confirmed by a psychological study in Germany, which reported that younger people especially suffered from the psychological effects of the crisis (I am referring here, among others, to the younger practitioners who are in social quarantine on the frontline) (Rudlin, 2020). Moreover, it is feared that these experiences will have long-term consequences for the practitioners (Kang et al., 2020).

There were 3 main reasons for this work overload, the teams worked on site without interruption, sometimes for 16-18 hours or even longer, over several weeks at a time. Most of them slept in the hospital and not at home. For example, in Wuhan/Hubei, there were about 42000 treatment personnel working with about 67801 clients/patients as of 18.2.2020. In addition, a very large number of people from the population were also providing support. Finally, according to various Chinese studies, the practitioners personally experienced this work overload and stress as traumatizing.

Quite quickly, towards the end of January 2020, guidelines for psychological crisis management were issued by official government agencies. These guidelines are mostly related to general psychological support in crisis groups. They also developed manuals for psychological crisis counselling, initiated research, and paid attention to practical, pragmatic professionalism, depending on the situation. These guidelines are related to the supporting of local practitioners and the population in general.

In China, this mental health support is faced by difficulties such as

- In 2015, there were about 27733 psychiatrists for a population of more than 1.4 billion people, only 57591 psychiatric nurses and about 5000 psychotherapists (Duan & Zhu, 2020). In 2020, evidently this number has increased. However, the increase in the number of experts until 2020 cannot hide the blatant shortage (In comparison, in Germany, more than 75,000 psychiatrists and psychotherapists work for a population of about 83 million) (DGPPN, 2019).
- Concepts of psychological crisis intervention were certainly already developed during the SARS crisis and the earthquake in Sichuan, but they have not yet been sufficiently incorporated into the further training of therapists and counselors, and thus, into their everyday practice. At that time there was neither the Internet nor social media.
- The structures of official coordination are not sufficiently developed or do not function according to concrete needs. There is no central organization/coordination/agreement and provision of necessary psychological crisis counselling by competent authorities and between the regions. In addition, there is a lack of qualified experts in many places for the local provision of competent and adequate psychological care (Duan & Zhu, 2020).
- Added to this is media coverage or staging of media reports, which in part stirred up fears and prejudices in general, especially against the Chinese in general and China as a state (Sollmann, 2020). One study has been devoted specifically to the potential impacts of misleading and biased media coverage on Chinese individuals' mental health (Wen, Aston, Liu, & Ying, 2020). This study considers the perceived racial discrimination stemming from coronavirus and the effects of such discrimination on individuals of Chinese heritage as a public health crisis (Wen et al., 2020).

In the course of my professional activities in China (currently only online), I observed the enormous commitment in this field in China as early as mid-January 2020. On 24.1.2020, I was asked, as well as other colleagues, to create a concept for psychological crisis consulting, which was then communicated via social media and official consulting institutions. Due to my work in China in the field of psychotherapy, I was from the very beginning prompted, differentiated, and informed by experts/colleagues working in relevant positions. Through my own online activities (lectures, supervision, etc.), I also gained insight into the daily working situation, and thus, I was faced with questions related to handling such a crisis, which had not yet been raised by my colleagues. This insight, on the one hand, confirmed what was reported in investigations, and on the other hand, gave me a more comprehensive understanding of the situation. This is important, for example, in order to be able to compare possible differences between on-site treatment at the frontline, general psychological crisis counseling, and online counseling; moreover, to find differences between what is officially reported and what is really done on the frontline.

In China, there are countless psychological counseling initiatives, online platforms, webinars, etc. For example, since the beginning of February, the Chinese Academy of Social Sciences has offered a special counseling service for foreign students. Since January, there has also been an active exchange of experiences, for example, between the German-Chinese Academy of Psychotherapy (DCAP) and their Chinese colleagues. Such cooperation has been kept quiet, and the resulting valuable experiences are therefore only available to a small circle of practitioners in Germany

"in secret". In China, health practitioners have had many valuable and corona-specific experiences since the beginning of the corona crisis. Sharing these experiences could be in the interest of the health care systems in other countries, since they provide scientific knowledge about the psychological and emotional burden on practitioners. It seems, however, that these are either communicated publicly to a very limited extent, at least in Germany, or are only available to the small circle of practitioners who have direct contact with practitioners in China.

The results of 72 online surveys in China on the psychological impact on practitioners were already available by 8.2.2020, and 29 books on Covid-19 virus had been published at that time 11 of which dealt specifically with its psychological effects (Liu et al., 2020).

What were the significant effects on health practitioners?

The results of some of these studies are summarized in the following points:

- In a survey on more than 1500 participants in Guangzhou Nanfang Hospital (the target group included practitioners) reported stress related symptoms, depression, anxiety, and insomnia in 73.4%, 50.7%, 44.7%, and 36.1% of participants, respectively (Lai et al., 2020).
    - A study in Beijing in early April on more than 700 participants reported that treatment personnel show the highest number of stress symptoms and fear of illness from the virus compared to non-treatment personnel (Cuifh, 2020). They also showed a higher prevalence of hyperarousal (hyperexcitability of the autonomic nervous system), trauma symptoms, and insomnia. In addition, they felt hopeless, powerless, and anxious about returning to their homes and their old life routines. What is astonishing, however, and this has been reported in various studies, is that it is precisely the treatment personnel on the ground, working on the frontline, who have made little or no use of psychological support. There is some speculation that these practitioners simply wanted to have peace and quiet rather than psychological support. Ultimately, however, as I have been told, this phenomenon has not yet been sufficiently clarified. One possible reason could be that many psychological experts in China are not sufficiently familiar with the distinction between (objective) stress and (emotional) strain, which is very important especially in stressful situations. At this point, objective stress is understood in terms of aspects such as above-average working hours, and risk of possible infection. Emotional strain is understood to mean the way in which each individual emotionally and psychologically processes what has a stressful effect on him or her. I guess that there could also be some specific cultural pattern of reaction, typical to Chinese people, which makes it difficult to ask for help, and personal and emotional support (Sollmann, 2018).
- Other studies have reported psychologically detrimental effects (especially among the population) on both divorce behavior and (self-) understanding with regard to love, intimacy, and relationship.
    - A study of the Beijing Union Medical Hospital in Beijing (PUMCH) confirms that more than 50% of nursing personnel showed great concern in response to negative information during the crisis (only 6.7% of doctors) (Cao et al., 2020). The same study points out that, as is the case in other studies, the researchers did not specifically refer to possible patterns of stress reactions or the danger of burnout.

- Great importance is ascribed to digital media and social media. For example, an artificial intelligence (AI) tool (Tree Holes Rescue) was used to evaluate social media messages in order to assess the possible risk of suicide. The tool was used via WeChat. The AI tool analyses messages and informs the sender of the messages in case of a threat (WeChat can be compared to WhatsApp) (Liu et al., 2020).
- Even if there was good acute treatment in the clinic, it was not possible to provide the absolutely necessary psychological care and follow-up treatment for the patients (including stress management). The practitioners were not trained for this. This put them under additional stress, as they were directly confronted, helpless or even powerless, with the psychological effects of the corona crisis in such cases. In addition, there was often a lack of structure and cooperation with the authorities to ensure reliable aftercare.
- At RenMin Hospital in Wuhan, four different functional groups for psychological crisis counselling were identified. Each of these groups needs a different approach. The groups are the psychological communication team (responsible for the internal organization of communication and communication to the outside world), the psychological-technical support team (responsible for the development and provision of specific methods, regulations, technology, and supervision), the psychological-medical team (medical-psychological staff consisting for example of psychiatrists and psychologists responsible for specific on-site psychological treatment), and the telephone hotline team (consisting of volunteers with specific training, e.g., telephone counseling) (Xiang et al., 2020).
- In almost all studies, the loss of a careful, (pro-)active preparation for a possible (epidemic) crisis in society is criticized. Such a preparation is increasingly demanded for the future.
- A merger of numerous Chinese hospitals is not only calling for psychological crisis counseling, but also for psychological screening carried out at short intervals in order to be able to recognize possible overload at work (stress, anxiety, depression, etc.) at an early stage or to take countermeasures.

Summary and outlook: What is the lesson learnt?

The results of the studies speak for themselves. They can serve the international exchange of experience (Kang et al., 2020). This exchange of experience has already taken place in Iran, for example, the study by Fardin (2020) emphasizes the need to learn from these psychological experiences for future similar crises. The experiences of health practitioners over the past months in the Covid-19 hotspot in China should be transferred (modified) to the circumstances of the local practitioners in Germany and other countries. The following considerations are necessary:

- Learning from the experiences of the Chinese health practitioners can lead to a substantial improvement of the psychological status of practitioners in Germany and/or other countries (improvement and strengthening of the psychological burden of the practitioners). Psychological disaster assistance and counseling has become an important part of the disaster relief system, playing a crucial role in restoring and maintaining emotional stability and security, and reducing trauma-related stress (Wang, Zhao, Feng, Liu, Yao, & Shi, 2020).

Psychological disaster assistance and counseling includes

- Improved training in psychological crisis consulting
- Coordination of structural offers: Integration of pre-operative and post-operative

care and acute treatment

- o Coordination of O&O offers (online and offline offers)
- o (Integration of) quantitative research and qualitative studies or differentiation of research items: Instead of focusing primarily on psychopathological items/concepts such as depression, anxiety, stress, etc., criteria for everyday experience should be integrated such as loneliness, homesickness, powerlessness, aggressive behavior, etc. On the one hand, this would make it easier to depict everyday experience. On the other hand, the results of the examination would not pathologies people or classify them in pathological categories.
- o Promotion of the development and integration of AI
- o Differentiation of the stress load by objective external stress factors and emotional and psychological strain. Thereby, one does justice in particular to the experience of individuals. This should also include the development of research designs that can also be differentiated according to individual stress profiles. These are typical patterns of experience and behavior that are "automatically" activated in the sense of individual survival patterns under stress in crises. The more such a subdivision and allocation of the results succeeds, the more purposeful stress management can be (Sollmann, 1999). A specific consideration of the situation under criteria of possible burnout is absolutely necessary (Cao et al., 2020).
- o It is important to conduct quantitative and qualitative research in this regard. Items, according to the study by Wang et al. (2020), which cannot be measured quantitatively, can be qualitatively touched and clarified, e.g., through supervision.
    - The specific psychological strain is given far too little consideration in the media coverage of the Covid-19 virus crisis (improvement of the social perception of practitioners).
- Finally, the international exchange of experience between China and Germany and/or other countries can be clearly and concretely improved by taking into account the experiences of practitioners in China and transferring them to the situation in Germany (improvement of the intergovernmental exchange).

Conflict of Interests

Authors have no conflict of interests.

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Medical Humanities Reveals the Neglected Aspects of the Covid 19 Pandemic

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Theoretical Study

Abstract

The Olympiad for Medical Sciences Students has been held in the field of medical humanities for several years in Iran. This year, with the outbreak of the corona pandemic, the question arose as to whether this student competition could be adapted to this new and complex situation. This article will explain the joint efforts of the scientific committee and biomedical students to address this challenge. The main question we had to answer was whether the medical humanities have anything to say in the face of the corona pandemic. The danger we felt was that as the corona pandemic crisis deepened, the biomedical narrative would fill the entire discourse, and this would ultimately lead to the ineffectiveness of corona interventions and policies. This paper shows how these questions were addressed through an action research that the scientific committee, as an interdisciplinary team, and several groups of medical students have worked on together. The result showed that criticism of classical medical humanities, return to the roots of interdisciplinarity, attention to the role of technology, and the crucial role of biopolitics are the neglected aspects of the Covid 19 pandemic.

Keywords: Covid 19 pandemic; Medical humanities; Olympiad for medical students; action research; Philosophy of medicine

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Introduction

The Olympiad for Medical Sciences Students has been held in the field of medical humanities for several years. This year, with the outbreak of the corona pandemic, the question arose as to whether this student competition could be adapted to this new and complex situation. This article will explain the joint efforts of the scientific committee and biomedical students to address this challenge.

The Olympiad for Medical Students has been designed to highlight the importance of reasoning and problem-solving in medicine that have been ignored in formal education in respect of education and assessment. This is because, in addition to the formal curriculum in medical schools, other educational interventions are required to develop meta-competencies relevant to healthcare. Since the contemporary formal educational settings mostly develop students' biomedical knowledge, but rarely consider their non-biomedical higher levels of thinking such as problem-solving and reasoning, one of these interventions could be planning a competition which is focused on thinking and problem-solving (Monajemi et al., 2012).

Medical humanities is an interdisciplinary field, which consists of various conceptions and models that have been formed over almost 5 decades. The movement sought to criticize the dehumanization of medicine and the reduction of the patient to a disease, and to humanize medicine once again. The pioneers in this field believed that the humanities (e.g., philosophy, history, literature, etc.), social sciences (e.g., sociology, anthropology, psychology, etc.), and arts could help solve this medical crisis. Various interpretations and models, such as integrative, concrete, supplementary, and complementary, have been proposed for the interaction between the humanities and medicine (Evans, 2007; Evans & Macnaughton, 2004; Greaves, 2018; Monajemi & Namazi, 2020a)

The main question we had to answer was whether the medical humanities have anything to say in the face of the corona pandemic. Does the medical humanities provide frameworks for understanding the corona crisis outside the biomedical paradigm? The danger we felt was that as the corona pandemic crisis deepened, the biomedical narrative would fill the entire discourse, and this would ultimately lead to the ineffectiveness of corona interventions and policies. This paper shows how these questions were addressed through an action research to provide a theoretical basis for how medical humanities approaches the Covid 19 pandemic and what are the neglected parts of this pandemic that medical humanities could reveal.

Methods

The present qualitative study was performed with an action research approach (Hatch, 2002; Insch, Moore, & Murphy, 1997; Denzin & Lincoln, 1994). This style of research is performed in a context where authorities focus on promoting their organizations' performance and is carried out in the form of participatory action research (PAR) (Hatch, 2002; Insch et al., 1997; Denzin & Lincoln, 1994). PAR is based on cooperation and mostly deals with the challenges of organizations; it simultaneously focuses on the problems and their solutions.

First, literature and databases were extensively reviewed, and then, analyzed through content analysis (Insch et al., 1997). In the next stage, the main issues were determined after holding several sessions (about 100 two-hour sessions) with experts (i.e., medical philosophers, medical ethicists, medical educators, clinicians, and philosophers of science and technology). The group discussed the various

dimensions of the corona pandemic from the perspective of the medical humanities and what has been overlooked in terms of the biomedical approach. An aspect that received special attention in the discussions was its significance for clinicians and medical students. The ultimate goal of these discussions for the scientific committee was to determine a range of issues that students could reflect on and find approaches to fram or recommended solutions for health problems. Finally, all the issues were summarized, categorized, and reviewed by the Scientific Committee and the following results were obtained.

Results

Results are presented in the 4 sections of criticize classical medical humanities, interdisciplinarity, the role of technology, and biopolitics.

Criticize classical medical humanities: Contemporary medical humanities has not been well prepared to engage with pandemics. Medical humanities has been traditionally focused on the doctor-patient relationship and has been aimed at humanizing this relationship. However, in the current pandemic, we need a type of approach to critically scrutinize and evaluate public health issues and the relationship between medical and health institutions. Therefore, the major challenge for us is to formulate and highlight parts of medical humanities that are more relevant to our approach. Thus, it initially seems that this action research is a sort of self-criticism (Monajemi & Namazi, 2020b). For this reason, the field of critical medical humanities that has been introduced in 2000 and continued with greater vigor since 2015 received greater attention and some of the relevant articles were added to the students' references. In other words, to deal with the corona crisis, what we need is not classical medical humanities, but a critical approach.

Interdisciplinarity: One of the most important issues to consider was interdisciplinary theory per se. The issue of combining disciplines and emerging disciplines in the field of medicine and health has created a historical and epistemological background for the humanities of health. The transition from mono-disciplines to multi-disciplines occurred because problems became complex and multifaceted, and single disciplines could not solve new problems. Several disciplines also encountered various problems over time. The problem of summarizing and conclusion, the problem of compatibility, and the problem of conflict between their epistemological and methodological foundations caused the disciplines to abandon some of their foundations and to merge with each other. For this reason, different fields of interdisciplinary studies were created. These interdisciplinary studies presented new educational and research considerations, which we will address in the next chapter. What matters here is that the emergence of interdisciplinary studies is the result of a fusion of a humanities discipline with the medical sciences. Medical education, medical ethics, medical sociology, medical aesthetics, medical history, medical hermeneutics, medical anthropology, and medical philosophy are some of these interdisciplinary studies. However they built great walls between themselves and other disciplines and instead of solving the problems of medicine, care, and health, they sought to solve their academic and bureaucratic problems.

Threads of medical humanities: Some of the most important threads in applying medical humanities in the corona pandemic are bureaucratization, technicalization, and over-ethicization of all concepts (Ethicalization). To overcome these problems, the humanities should address the following three issues.

a) Interaction: Interaction means that the interdisciplinary studies break down the

walls between disciplines and create dialogue between them to solve the problem. The pattern of interdisciplinary forums, each of which hosts other disciplines, is helpful in this regard.

b) Integration: As mentioned earlier, an integrated model is important in several ways in the humanities. Instead of simply giving ready-made answers to pre-prepared questions, a field called health humanities should be based on distinguished problmatics. For example, an integrated approach to an additive approach here means, instead of inviting a sociologist to comment on health problems, to seek the formation of a research field in health sociology that has distinct issues, methods, and answers. The second aspect of integration is to integrate interdisciplinary fields in the field of health and create new interdisciplinary or transdisciplinary fields.

c) Critical approach: The result of interaction and integration should be to critique each other in the field of health and to form a critical dialogue. For example, the critique of medical philosophy on medical ethics, critique of medical ethics on medical education, critique of medical literature research on medical sociology, and critique of medical ethics on medical anthropology is one of the goals of health humanities. Hence, health humanities as an interdisciplinary field seek to create an umbrella to focus the interdisciplinary field of health, to create new interdisciplinary fields, and to drive philosophy as a driving force, and critique the basic concepts of medicine and health.

The negligence of history of medicine in pandemics: The Covid 19 epidemic demonstrates the importance of interdisciplinary dialogue in the field of health humanities. In the meantime, the history of medicine, which used to be considered as a decorative and ultimately identity-creating/pride-creating thing among physicians and health professionals, has found a high honor and a pivotal role in the discussion of health humanities. Re-examining the Spanish flu pandemic and its effects on medicine and health has shown that the pandemic, despite its prevalence and lethality, has not received much attention in health history. It seems that the wound of the memory of epidemics is such that it is preferable to forget them. Medical historian, Mark Hoenigsbaum, points out that the Encyclopedia Britannica in 1924 "did not even mention this epidemic in the most adventurous years of the twentieth century" and that the first history books on the disease were published around 1968. Hoenigsbaum says no special memorial service was held even on the 100th anniversary of the epidemic. Only a few cemeteries held programs to honor the sacrifices of doctors and nurses. It seems that reflection on many questions in health humanities requires a rethinking of the role of medical history and its various conceptions. Covid-19 has been instrumental in reminding us of this (Honigsbaum, 2020).

Hospital as a treatment machine and medical knowledge production technology: The hospital, according to modern medical theory, classifies people according to their disease and places them spatially within different sections, in such a way that the separation is clear; this leads to patient individuality and disease visibility.

The hospital organizes patients in time by dividing the time, planning the operation, and analyzing the patients' behavior. In this way, the hospital, as a machine, organizes the spatial units in which patients are distributed in such a way that they are always under care. This, in turn, leads to order and economy in time. This condition leads to two important features in the hospital:

a) Patients in the hospital are controlled by the medical staff, authority. On other side, doctors are controlled by the rules and regulations of the

hospital, and the treatment and diagnosis devices.. That is, patients and the doctors in the hospital are both under the control of this treatment machine.

b) The hospital is the place where both the professor and the student observe the disease. It is like a laboratory in which new diseases are discovered and new treatment techniques are tested, and in the process, the medical teacher practically teaches the students to diagnose and treat patients. The hospital is a place for observation, experience, education, and treatment, and medical knowledge is the result of this process.

Political power and medicine: According to Foucault's analysis, quarantine in house arrest- the death of blacks in the fifteenth century - created a set of distinct individualities who were not allowed to mingle with each other. Nevertheless, the function of quarantine was not only to isolate individuals, but also to place them under house arrest with a general system of surveillance mechanisms that enable spatial observation and immediate identification. Everyone in the city was constantly watching the subject. In other words, the quarantine created a network of power in which all the inhabitants of the city were visible. Quarantine guards monitored each detainee at home and recorded their health and illness. The dead were separated from the living and their statistics were collected. Thus, the epidemic became an object of observation and one of the important results was the emergence of knowledge of statistics and information about the population.

In fact, what made the quarantine technique important was its ability to preserve public health as the plague, with its outbreak in the late Middle Ages, dealt a terrible blow to the European population and severely shook the continent's economy and politics. Although its importance had been shown with the outbreak of the Black Death in the late Middle Ages, it had not yet become a serious issue for the government. Centuries later, in the late eighteenth century, we see that "population does not simply mean a large group of human beings, but a living being whose biological processes and laws encompass and dominate them." The population has a birth and death rate, has an age curve and an age pyramid, has a disease prevalence rate, and has a state of health, and the population can decline or increase (Foucault, 2003, p. 190). In other words, it was in the eighteenth century that population became a topic of concern.

Hence, complete set of observation techniques led to new type knowledge such as statistics. This new knowledge was not just a byproduct, but a basis for better monitoring and care of the population. In other words, statistics became the main technical factor or one of the main technical factors of governing the population. "Statistics ... gradually discovered and showed that population has its own rules: the number of deaths, the number of diseases and the order of events. Statistics show that the population has special effects on accumulation ...: massive infectious diseases, the spread of indigenous diseases, the spiral of work and wealth" (Foucault, 2003, p. 256).

3 important goals of declining death rates, increasing life expectancy and longevity that are all linked to population. While quarantine was a technique used after the outbreak of epidemics to control and break the transmission chain of an epidemic Water, sanitation and hygiene interventions were the attempts to prevent epidemics. In the nineteenth century, quarantine provided the ideal medical-political plan for a good health institution in cities. According to Foucault, the plan "includes the political power of medicine; distribute people so that they are together.a) Separation them, b) Individualize them, c) View them one by one, d) Monitor their health status, d) Control whether they are alive or not. "Putting society in a segmented space that can be easily

seen and controlled by recording the details of events" (Foucault, 1997a, p. 146).

The strategy used in quarantine was based on "accurate analysis of the city and continuous recording of information" (Foucault, 1997a, p. 146). In fact, urban medicine in the eighteenth century, which was based on public health, was the continuation and development of the medical-political organization (plan) of quarantine in the late Middle Ages. The basic premise of the plan was "to study the concentration and accumulation of unemployed people who could cause disease in urban areas and to study the places where the endemic and epidemic phenomena multiplied and spread" (Ibid). In other words, "the public health program was introduced as a health regime for the population that required a certain number of authoritarian medical interventions and controls" (Foucault, 1997b, p. 282).

In the nineteenth century, the formation of the authoritarian medical institution was a limited model of the application of the universal view of medicine and health in society. At the same time, the idea of a nationwide prison was proposed by Jeremy Bentham. The two proposed mechanisms necessitated the establishment of a continuous, precise, and particle-like power. In this way, there was a transition from a general, concentrated, and slavish power to a continuous, particle, and individualizing power that, instead of macro and general controls, controlled each individual in himself, in his body and health, and in his social movements.

Running the Olympiad: Based on the results, both references for students' studies and the content of webinars were identified. We believe that the Olympiad is not just a competition, but is a platform to attract and educate interested students.

In the first stage, to familiarize universities with the Olympiad, each medical school participated in an online workshop. In this workshop, participants were familiarized with basic medical humanities concepts. The webinar also introduced students to resources they had to study to take the screening test. After conducting an initial screening test based on a knowledge assessment test with multiple choice questions (MCQ), a number of students were selected for the next round. Admitted students participated in the final exam in teams of 3 or 4 individuals. In the 6-month process, the teams were trained and asked to write critical analytical essays on a topic related to medical humanities and the corona pandemic. The teams were given 3 months to write papers. After the deadline, the articles were uploaded to a platform and reviewed by a scientific committee. The method of judging was similar to that of journal articles (peer-review), and issues such as innovation, analytical power, the use of medical humanities frameworks, the ability to formulate problems, the ability to apply theory to practical issues, and the academic style of writing were considered by the jury. In addition, concept map exams were taken from the students to assess their analytical abilities to read and understand texts.

Table 1. The process of holding and conducting the Olympiad in medical humanities

	Topics
1	Webinar on the basic concept of medical humanities
2	Knowledge exam (MCQ, KF)
3	Webinar on medical humanities, Covid 19, and philosophical writing
4	Concept mapping
5	Essay writing
6	Essay evaluation and feedback

MCQ: Multiple choice questions; KF: Key features

Table 2. Themes of critical reflective papers

Theme	%
Politics/Biopolitics and pandemic	35
Doctor-patient relationship	21
Existential/Phenomenological approach	16
Technology and pandemic	14
Culture and pandemic	14

Out of the 30 teams that submitted their papers to the jury, 10 teams made it to the finals, which included submitting an article to the jury. In the presentation phase, the rhetorical power and verbal expression of the group, the ability to analyze the questions of the jury, the ability for group work and discussion, and mastery of medical humanities knowldge were evaluated. The judges then provided feedback to the groups on the articles. Articles are to be presented in the form of a conference at the national level and be published in a book. In all these phases, health protocols have been strictly followed.

After the final modifications, the framework and structure was finalized in the form shown in table 1.

The 28 articles submitted to the jury were analyzed in terms of main themes as well as the thinkers and experts cited, a summary of which can be seen in tables 2 and 3. Among these, the issues of power and politics and their relation to the corona pandemic had received the most attention, and a thinker like Foucault had been cited more than others.

Conclusion: Lessons we learnt

This study showed that in a real health issues that are both challenging and have many unknown dimensions, the cooperation and participation of students and experts are very useful and insightful for both parties.

The scientific committee, which included medical philosophers, philosophers of science and technology, clinical physicians, and specialists in ethics and medical education, was a great example of what is called an interdisciplinary team. The scientific committee tried to analyze the issues based on their knowledge and professional approach and put them in the mine based on communication and dialogue with other members in order to reach a fusion of horizons. Of course, such an event was the result of the continuous and close dialogue and cooperation of the members of the scientific committee. Of course, it should be noted that such a mutual understanding cannot be reached through instrumental and bureaucratic approaches.

It should be noted that due to the background of students, which is mainly biomedical sciences, training them to work on medical humanities is a difficult task and requires special training. Since the number of people who can accurately transfer this material to students in medical universities in Iran is small, this has become one of the main challenges in this endeavor.

Table 3. Scholars cited in critical reflective essays

Scholars	Percentage*
Foucault	17%
Heidegger	14%
Žižek	10%
Agamben	3%
Rawls	3%
Nietzsche	3%
Merleau-Ponty	3%
Deleuze	3%

*The percentage is not cumulative.

The Olympiad seems to be a platform for building a network of scientists in the field of health and for expanding the discourse of medical humanities in medical universities. The experience of the Olympiad showed how it is possible to involve scholars and students in the national context by understanding and focusing on solving the problems of the field, which can be considered as a huge social capital.

Conflict of Interests

Authors have no conflict of interests.

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(Self-) Experience and (Self-) Support as a Body Psychotherapist in the Time of Corona: An Essay

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Thoretical Study

Abstract

The essay mirrors the process of self-experience of a German body-psychotherapist who came into contact with the corona crisis already in the beginning of January 2020. The author`s close virtual communication with colleagues in China by social media opened up a process of mutual experience and support on body oriented and psychological crisis counselling. This process challenged both: the Chinese colleagues and and the author in the way that one had to find a way, a relationship and a (self-) support to navigate without a compass, without a best practice just like living in a dense fog. The author decided to choose the literary form of an essay to invite interested readers to take part as if they were "part of the game". The author is convinced that this literary form is the adequate form to communicate such an experience in such a strange and scary time. The author is also convinced that this form is the adequate professional response in order not to create the impression of "we know what it is all about and we know what is to be done".

Keywords: Self-experience; Self-support; Corona

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Prolog

The beginning is indescribable. I am lost for words, in the truest sense of the word. Was it a tornado that swept over the world? Was it an undertow, a whirlpool that pulled the world into another global state? Was it a chaotic eruption that is both destruction and birth?

I lack the words to describe in more detail what was thought to be impossible. I lack the words, as my senses stagger in a state of blind alarm. I lack the words to describe life, and am paralyzed, lonely, and lost in the time of Corona.

It began unspectacularly. My colleague mentioned that her trip to Shanghai to visit her parents for the Chinese New Year could take a little longer. There was a new virus in Wuhan. Her university in Beijing had arranged for the holidays to be extended somehow. This worked out to be a state of overprotective precaution, so to speak, and realistic foresight. It came faster than expected and unlike any foreseeable possibilities. After all, she could not go back to Beijing until mid-July.

Within a few days, I observed my colleague's dismay, anxiety, and concern about how the virus had developed so intensively and explosively, especially in Wuhan. Remembering the SARS epidemic, I began to suspect the possible impact on China. At the same time, I felt an imperceptible whiff of fear, without this fear having already created an inner image in me of what could possibly be frightening. As I said, it was a diffuse fear.

Psychological crisis counseling in Wuhan

A good friend and colleague of mine works as a psychologist and psychotherapist in a clinic in Wuhan. Of course I was also worried about him. Unfortunately, my messages via WeChat and email remained unanswered, unlike usual. I wondered how he was doing and whether I was right to worry, especially about his health. But no answer, no sign of life, came. Finally, weeks later, I learned from him that he and his colleagues had put together a team of experts immediately after the outbreak of the virus to counteract the psychological distress of both practitioners and the population. The team worked around the clock, 24 hours, 7 days a week. My colleague had not been home with his family for 3 months; he was constantly on duty. I wondered how he could have coped with this extremely stressful situation. I wondered how he fared at the sight of the appalling human fate, the devastating conditions in Wuhan, Hubei Province. I also wondered how he had coped with the uncertainty of facing a virus that was so surprising, so explosive, and so disastrous. After all, it had mercilessly controlled the entire life of the province and the city of Wuhan. Not to mention the extreme medical challenge of facing a completely unknown new virus. In the end, more than 70 million people were in absolute lockdown.

The first phase: beginning support

As I have been travelling regularly in China on a professional basis for many years and feel a close connection to many colleagues, and naturally in view of the extreme strain on the colleagues on site, I offered my support. At that time, I did not know precisely what I could offer, and what would be useful and helpful. At the same time, I was uncertain how my Chinese colleagues would interpret my surprising offer of support. They had not explicitly asked for it. Contrary to my fears, I was met with a response that encouraged me to provide them with Western concepts of psychological crisis counselling, guidelines, concepts, and essentials, and my own

experiences with crisis counselling. Since I was not on site in China, I considered it my task to communicate this perspective through lectures, concepts, ppt-presentations, and concrete supervision talks. This resulted in a very lively, friendly, and professional exchange. Other colleagues from the German-Chinese Academy of Psychotherapy (DCAP) had similar experiences. But the correspondence did not stop at this kind of psychological support. There was a clear need for protective clothing as well as masks, which we tried to compensate for with small deliveries, even if only to a small extent. At times it seemed as if we would fail because of the Chinese bureaucracy. Sometimes our parcels would be at customs for weeks. Despite correctly filled out forms, it took far too long for the packages to be delivered.

A "scary virus cocktail"

By the end of January, it was clear to me that it was not just the virus itself that kept life in China on the move. I began to suspect that the people, life, and politics had been "infected" with a virus cocktail. A cocktail consisting of the corona virus, as well as fear/panic as an emotional virus and viral communication. I gradually began to sense that the impact of this virus cocktail would extend beyond the borders of China. Therefore, I published my impressions in an article "The scary virus cocktail". The article spread rapidly via social media. It was translated into English and Chinese. Even the Peking-Rundschau published the German version. Colleagues who were complete strangers to me helped with the translation. I was fascinated by the viral communication, which made it clear to me how impressive the collegial cooperation was. Even before the viral call triggered by my article was in full effect, I heard the committed collegial and viral echo. I experienced this like a spontaneously developed feeling of togetherness and was reminded of the psychoanalytical concept of the "community of brothers". This sense of community was characterized by joy, bonding, gratitude, fear, support, lively exchange, and insecurity, but also creative energy.

"China-Bashing" as a defense against one's own unconscious fear

In the meantime, the virus-related events in China had also attracted the attention of the German media (mid-February 2020), not only in Germany, but worldwide. At the beginning of February, the first, albeit few, corona infections were observed in Germany. Due to the experience with my Chinese colleagues, I feared an increased corona event in Germany, and increasingly, the spread of the virus to other countries. Initially dismayed, and then also angry, I was amazed at an aggressive reaction in Germany and in the West in general. In a heated public discussion, which was amplified by the media and by politics, the term "Chinese virus" was repeated and often resulted from the, one could almost say, arrogant distancing attitude towards China in which the attitude: "You are bad, I am good" was exaggerated. In many cases there was a “China bashing". As if only China was responsible for the creation and spread of the new virus. In German shops/restaurants, for example, there were signs advising Chinese visitors not to enter the premises. From an analytical point of view, this behavior pattern has the function of a projection. In such a crisis, it can be "normal" to experience such a projection as emotional protection for the in-group to which one belongs against the "evil outside world". And yet I was shocked by the arrogant discriminatory media and political habitus. I neither wanted to hear nor read any of this. I was convinced that it was all about coping with the pandemic.

I no longer understood the world. On the one hand, I remembered the reports of

my Chinese colleagues about the situation in China and the devastating effects of corona infections, some of which had paralyzed my entire life. With what hubris, I thought, people in the West presumed to know better and to be able to do better, and were sure that everything would be under control if the virus were to spread globally. Today, we know better. Today, politicians, the media, but also many people can no longer lull themselves into the illusory certainty that they will be spared by the global crisis. For I not only have the current figures, the dynamics of exponential development, but also the pattern of behavior in mind, despite numerous research results, findings, and experiences, to continue "poking through the fog" scientifically and politically, or "driving on sight".

The second phase: Self-positioning in the social polarization between "China-enemy" vs. "China-friend”

A little defiant, but also professionally and collegially convinced, I tried to communicate the experiences in China within the scope of my possibilities in my life and sphere of activity. It was precisely this time that shaped the second phase of my self-experience caused by Corona. While the first phase was characterized by consternation, astonishment, bewilderment, and friendly support from colleagues, I now experienced myself more one could almost say in a combative, convincing, and admonishing position. I shook my head in response to the polarizing attitude I noticed in the West during this time in particular; suddenly there were "friends of China" on the one hand, and "opponents of China" on the other, corona experts and corona deniers.

In the meantime, the virus had arrived in Germany. After a period of initial hesitation, as well as social and political self-encouragement that everything was somehow under control, social and economic life in Germany was significantly reduced in mid-March. I am deliberately not talking about a lockdown at this point, because it would represent something completely different. Compared to other European countries, there was more freedom in Germany, even though restaurants, shops, etc. had closed.

The third phase: Fear in the "eerie no-man's-land" between waking and sleeping

A third phase of self-experience began insidiously, so to speak, in the transition between my experiences of day and night, between being awake and the beginning of sleep. I thought that I was sufficiently informed about the corona process (as it was of course only possible to a very limited extent under such conditions). I trusted my good body feeling and was therefore able to keep occasional fears at bay. This, however, converted into the complete opposite when I felt like I was in an "emotional no-man's-land" in the evening, still a little awake and not yet really asleep. Who has not experienced this state? You sink into a sleeping hole for a little while, for a few seconds, only to wake up again. A thought emerges, a picture, a memory, which in my case mobilized unmistakably old fears. I caught myself in the over-flooding fear of having been infected with Corona. It was not primarily about what I thought, but about panic that hit me like lightning and I was no longer able to control in the aforementioned "emotional no-man's-land". In this "emotional no-man's-land", I sometimes felt, even if only for a fraction of a moment, a slight itch in my throat for example, or heard myself coughing. Nothing special really, After all, I know my body and the sound of my cough. And yet, as if shooting up out of nowhere, this panic hit

me. Not only did it make me doubt, it also triggered the feeling of an imperturbable truth. I had to be infected. What I felt must have been a symptom of Corona. Fortunately, I fell asleep at some point.

The next day, however, this diffuse panic clung to a subtle fear of death. I felt clear in my mind and fully oriented in my living space, and was thinking clearly. What would I do the last few days I might have before a feared hospital stay? What would it be like to tell my family? Would we all cry together? And would I possibly die alone without my loved ones in the intensive care unit? How would I be able to deal with their pain and mine? What would still have to be dealt with? What would I have to say goodbye to forever, head over heels? And what would so dear to me that I would desperately cling to it?

Of course, this emotional haunting also disappeared again, but I felt wounded in my heart without a wound.

Fear that connects

This third phase of self-experience made me vulnerable to the interplay of my own fear and panic, as well as being affected in my encounters with others. It was clear to me, and I experienced this in each of the therapy sessions or coaching sessions with clients. I was afraid. We were afraid. This silent connection changed my professional life imperceptibly. We talked about Corona and our experience. I was more active in shaping the relationship. I began to ask questions earlier and was less able to endure confidently calm pauses in the therapy process. This happened especially in the sessions conducted online. I felt like I was not allowed to be inactive. As if the client and I needed this kind of encounter and connection. Some people would abstractly describe this as a vital agent without being able to describe this agent in words. We experienced ourselves in an emotional "emergency community", connected with the unexpressed confidence that we would meet again a few days later. In retrospect, it now seems to me as if we had made each other emotionally immune to this uncanny cocktail of viruses.

Experiencing myself like this also aroused in me an almost unreal feeling of insecurity that I seemed unable to name and identify in detail. In such a case, psychology may speak of a diffuse fear, of a floating insecurity, which is characterized by its very own life. This life of its own had taken possession of me, so that my attention was not only tied up, but also in a subtle, hardly noticeable state of alarm. I know this feeling in the transition between being awake and asleep, between normal life and fever. There, however, I experience the insecurity in a limited, concrete, manageable way, etc. The fever also stops after a few days. In contrast, this feeling of insecurity, as I experienced it in the transition between waking and sleeping, seemed to me to be an "insecure insecurity". This insecurity, like an independent being, exists and has an unmistakable grip on me, but is never within reach, is never grasped. I felt unstable, falling into a bottomless pit, moved and fascinated at the same time by the power of this feeling. For a moment, I sensed that this kind of "insecure insecurity" was beginning to spread in my life like a companion, like a shadow, like "an uncanny spirit".

The limited lockdown

The limited lockdown in Germany since the middle of March was characterized by:

- The working structure and the concrete therapeutic/counseling practice had to be

reorganized, such as

- I was more active and increasingly related to current events.
- Instead of body psychotherapy in the conventional sense, we practiced psychotherapy.
- Body support has been replaced by verbal support.
- Physical expression was imagined.
- Paying attention to the body took place clearly by referring to the context.
- The gradual difference in body experience, expression, and relationship building was referred to much more than usual.

- Since mid-January, I worked increasingly online through supervision sessions, lectures, webinars, etc. This was accompanied by a significant change in my approach. A central question was: “How can I, as a body psychotherapist, continue to work with the body?” I experienced all this both as a very unsettling change and as a challenging inspiration. Without much hesitation, I experimented like a child at play. Again, I experienced myself as an actor, as someone who could influence despite Corona.
- Even though public and professional life was greatly reduced, and meetings with friends were no longer possible, we enjoyed the wonderful spring in the family setting (fortunately we have a very large house with a garden). It seemed as if we were living on a small island, protected from the possible adverse effects of the terrible virus.
- Without having guessed the details at that time, I noticed a subtle creeping change of roles between China and Germany. While the situation here began to get out of hand, the situation in China seemed to be slowly, but steadily consolidating, even improving. Finally, our Chinese colleagues offered to send us protective clothing and masks (at that time these medical utensils were a rare commodity in Germany).

The fourth phase: "Feeling of security in insecurity" or the effort of professional devotion

While I, together with my family, thought of myself as being in a private and secure bubble, I experienced two major challenges in relation to my work. On the one hand, I was no longer able to work in the familiar way, as one would expect from a body psychotherapist, while trying to observe the rules of hygiene (mask, distance, etc.). On the other hand, I began to balance between caution that could be influenced and "calculated risk" without concretely knowing of a sensed orientation in myself. Therefore, I continued to work with some clients and patients in my practice. Most coaching processes took place online via Skype and Zoom. With the presence of some clients in my practice, I was aware of the possible risk of infection. In contrast to life in social public spaces, I knew my clients and had an idea of their self-care. If I had the impression that a client could be cautious in a particularly difficult situation, the risk of a face-to-face relationship seemed to me to be "calculable", bearable. Of course we also talked about this. One could call this "feeling of security in insecurity" (I have not yet found a more appropriate word or term for this). Spontaneously and intuitively, but without being able to justify it, I distinguish it from tolerance of ambiguity. This is characterized by something like the "feeling of insecurity". This ability to keep tensions in balance, to be able to live with ambiguity, and to tolerate insecurity or uncertainty is an ability that can ultimately always be based on or relate

to "something safe". Now, in the time of Corona, an emotionally securing anchor was missing when navigating through this absolutely new territory.

In this respect, prudent care and careful planning helped me to find and maintain this balance. It remained a very fragile balance. The immanent rhythmic or eruptive movement and constant variation of this balance could never be grasped or deciphered.

I succeeded in achieving a balance that could perhaps be described as "as if it were safe". With the awareness of the occurrence of corona in the “here-and-now” of the event, I tried to stay aware of any new aspects that might arise. At the same time, I respectfully felt an invisible, but tangible companion, i.e., the hidden, but real "insecure insecurity" (I still do not have a better word for this), which gave me the necessary humility because I did not try to fight it or even deny it in a rationalizing way.

The fifth phase: it is what it is

In the meantime, I had decided on a certain procedure regarding the observance of hygiene rules and realized that I was able to follow this procedure well. At the same time, I also felt a certain humility and "professional devotion" towards the restrictions imposed by this procedure. I began to accept what I had decided, and what the hygiene rules dictated, which in turn led to a reduction in body-psychotherapeutic interventions. I regretted that I could no longer work directly with my body, and that touching was not possible at all. I was helped, to put it succinctly, by the conviction that things are just the way they are. The resulting acceptance of the present, of limitations, of reduction, etc. helped me to stay in balance, not to constantly question myself, or to get emotionally unbalanced. Though I hesitated, faltered, and quarreled, I was aware of the seriousness of the situation, of the crisis, and of the all-encompassing effects of the Corona crisis. In doing so, I met my secret companion, namely the "insecure insecurity" with (perhaps naïve) respect, without necessarily defending myself against this secret "uncanny companion". How could I have done that? He was there and I was there too. He whispered fear, worry, concern, and panic to me, whereupon I, keeping him in mind of course, did not deny his existence, but I did not want to let myself be mentally crushed in the process either. Instead, I tried to respect myself, namely to appreciate what was worth doing. Certainly, it sometimes hurt to look at myself in the mirror and to see a (further) third companion before my eyes. This rather narcissistically characterized companion seduces me again and again in my life with the tempting promise of feasibility, omnipotence, or grandiosity, like: if I do this or that, I can handle the corona crisis in the right way. But there is no right way. The awareness of this very companion served as an emotional warning as well as an inner corrective to stay alert to the danger of subtle idealization.

The roller coaster ride in a three-dimensional loop

Of course, everything remained open and unclear. Every day anew there were surprises. Every day we experienced the roller coaster ride in a three-dimensional loop. Feeling an increasing inner stability and sensing professional security, I felt powerful and proactive enough to continue working with patients and clients. Of course, it was (still today) about Corona. As I have not been able to work directly with the body since February, I use two approaches to include the body. One way is the imagination of embodiment, of encounter, of touch, etc. The other way is the anchoring of the experience, together with the client in the here and now in the therapy session by means of the expression of his/her body without doing any

specific body exercise.

This can be compared to a real experience, which, in my opinion, is of outstanding importance, especially in the current pandemic. This event has a direct, complex, and emphatic influence on the life of the client and me. The same applies to experiencing togetherness in the “here-and-now” in the therapy room. In my opinion, the two approaches mentioned above, i.e., to be able to work with the body in the transferred sense, represent useful and meaningful possibilities for intervention.

The sixth phase: Germany as a national self-experience group

In the meantime, Germany has, in my opinion, changed into a national self-experience group. The corona event has a grip on life, media coverage, economy, and politics, simply everything. In reporting, and also in the reaction to it, a culture of debate is opening up in which there is a competition between corona and fundamental rights. Either one accepts life with all its limitations as it presents itself, or one indulges in histrionic counter-arguments or even hedonistic self-assertion.

Some of the lessons I learnt (autumn 2020) are as follows:

- We are not dealing with the corona virus alone, but with a "scary virus cocktail".
- Tolerance of ambiguity is not comparable to what I call "insecure insecurity.
- In addition to professionalism, professional humility and dedication are required.
- In the experience of the "here-and-now" lies the chance to create your own design or even to make it effective (If you do not judge too early what might be right or wrong).
- Experiencing fear as a mutual fear strengthens what is called cohesion. This strengthens confidence in navigation in such difficult times.
- Confidence in self-positioning, even if in an unknown dynamic equilibrium, creates a sense of perspective. On the fact that something can be done or planned awakes the sense of a spirit to try anew supported by one's own involvement in the "community of brothers".

Epilog

Out of what was initially a chaotic nothing, the time of corona eventually led to a rediscovery of "sensed knowing". After the initial wordlessness and paralysis, staring at what was called corona, words became words, experienced words, words that were shared with others, words that changed to become connecting words, words that were born out of sensual experience, and companions in navigating through the corona event.

These words balanced knowledge and non-knowledge, the feeling of security and insecure conditions, and directly experienced life and virtual communication. These words are always carried by fear, hope, pain, desperation, and a togetherness which, to my surprise, like a precious carrier of hope, united the past, present, and future into a meaningful living and professional space.

This awakened a new kind of self-confidence in me. This occurred across borders. This can increasingly be expressed in new words, which enable me to no longer, as if paralyzed, build up a protective distance from the corona event.

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Investigating and Designing an Online Psychosocial Support Platform for Caregivers

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Qualitative Study

Abstract

Background: Healthcare professionals are prone to many psychosocial issues including job burnout, depression, and anxiety, which can affect the healthcare systems and societies. This has been intensified by the outbreak of the Covid-19 pandemic. Many of the caregivers' problems are due to insufficient psychosocial competence and lack of suitable training for basic skills such as self-awareness, rapport, empathy, compassion, reasoning, decision-making, etc. The main purpose of this study was to design a psychosocial service package for caregivers to help them throughout their lives.

Methods: Data gathering was performed by conducting 2 focus groups, searching for studies to identify urgent and important healthcare needs, and finding the best way to address their necessities through a proactive and sustainable method.

Results: The online "healers' healing" platform is designed with 3 general objectives. The first objective was to present practical and effective materials to support caregivers in order to improve their psychosocial competence. The second objective was to monitor

the member's progress and measure the effectiveness of the program. Moreover, to make the members more active in training and their own health promotion, this platform leads and supports self-help groups for caregivers as the third purpose of this project. Furthermore, healers can be active in content development and community education in order to experience a more productive interaction within the communities of caregivers.

Keywords: Caregivers; Burnout; Compassion Fatigue; Empathy; Psychosocial Support System; Online Learning

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Introduction

Since the beginning of the Covid-19 pandemic, all human beings have had new experiences that have caused many fears and disappointments and affected their lives in all aspects. Therapists and health care providers have shouldered so many mental and physical burdens as they were supposed to serve the patients, and there was no effort from the national health services to support them, especially in developing countries.

Many meta-analyses show that health care providers may face psychosocial difficulties such as anxiety, distress, fear, burnout, and compassion fatigue (Busch, Moretti, Purgato, Barbui, Wu, & Rimondini, 2020; Cavanagh et al., 2020; Zhang, Zhang, Han, Li, & Wang, 2018) Another meta-analysis examined and validated previous data during the Covid-19 pandemic period (Busch, Moretti, Mazzi, Wu, & Rimondini, 2021).

Health professionals are highly vulnerable to burnout syndrome, namely emotional exhaustion, alienation, and low job performance/satisfaction, in hospital work (Zanatta & de Lucca, 2015). Maslach, et al (1996) described burnout as a psychological syndrome that includes physical depletion, feelings of helplessness, negative self-concept, and negative attitudes towards work, life, etc.; it is an internal reaction to external stressors, combining emotional exhaustion, depersonalization, and a sense of reduced personal accomplishment.

Cospormac (2020) showed that burnout is a behavioral and occupational syndrome that affects healthcare professionals and medical students. The widespread manifestation of burnout is a significant risk for the medical system, and affects the efficiency and quality of medical services (Coșpormac, 2020).

In the study by Gazelle, Liebschutz, and Riess (2015), physicians were twice as likely to suffer from burnout and work–life dissatisfaction. Numerous studies have shown that 25%–60% of physicians have reported burnout (Brecka, Vnukova, Raboch, & Ptacek, 2018; Brindley, Olusanya, Wong, Crowe, & Hawryluck, 2019; Gazelle et al., 2015; Shanafelt, 2009; Shanafelt et al., 2014).

The risk factors of burnout can be divided into the 2 categories of work setting factors and individual factors (Shanafelt et al., 2016; Shanafelt et al., 2015; West, Dyrbye, & Shanafelt, 2018).

Some studies show that organizations that allow physicians to control workplace issues and are "physician-friendly" and "family-friendly" are able to employ physicians with lower reported stress and higher career satisfaction (Williams et al., 2002).

We recognize burnout as a late-career phenomenon, while recent studies suggest that younger physicians are nearly twice as likely to experience stress and that the onset may be as early as residency training (Shanafelt, Sloan, & Habermann, 2003).

Gender is not a predictor of burnout, but after adjusting for age and other factors, some studies have realized female physicians to have 20%–60% increased odds of fatigue (Dyrbye et al., 2017; Shanafelt et al., 2016; West et al., 2018). Women experience more burnout because of the intense influence of emotional exhaustion. There is higher exhaustion levels among women due to work-home conflicts (Houkes, Winants, Twellaar, & Verdonk, 2011; Langballe, Innstrand, Aasland, & Falkum, 2011).

Neurotic personality types are more prone to burnout, while conscientious, extroverted, and agreeable individuals are less likely to present symptoms of burnout (Moss, Good, Gozal, Kleinpell, & Sessler, 2016; Naidoo, Tomita, & Paruk, 2020).

Empathy and burnout are related yet distinct. There is evidence of a negative association between burnout and empathy (Wilkinson, Whittington, Perry, & Eames, 2017). Enhancing healthcare professionals' ability for empathy through systematic

training programs may have significant effects on burnout syndrome. Studies suggest that the relationship between empathy and burnout is complex, and a capability to self-regulate emotions during empathic engagement may diminish the risk of burnout (Petros Galanis, 2019)

In a meta-analysis, a significant negative relationship was reported between burnout in caregivers and quality and safety of care (Salyers et al., 2017).

A reduction burnout program suggests that caregivers' skills like coping strategies, mindfulness-based stress reduction, self-compassion, and fostering compassion are effective in reducing caregivers' burnout (Adinda & Bintari, 2020; Gerber & Anaki, 2020; Hofmeyer, Taylor, & Kennedy, 2020; Shin & Song, 2019).

Decision fatigue is another characteristic affecting health providers' ability (Carminati, 2020). Some studies have shown that decision fatigue in caregivers affects their decision-making ability, and since it has been increased during the present pandemic, healthcare providers require education on ethical dilemmas (Masiero, Mazzocco, Harnois, Cropley, & Pravettoni, 2020; Persson, Barrafrem, Meunier, & Tingh, 2019). Hu et al. (2020) suggested that increasing shared decision-making can help decrease job burnout during the pandemic.

Decision-making that includes true telling can cause an ethical dilemma (Zhang & Min, 2020). Healthcare professionals face many ethical dilemmas in their workplace (Monrouxe & Rees, 2017). Ethical dilemmas faced by caregivers are growing during the Covid-19 pandemic (Menon & Padhy, 2020) and can affect their mental health. Some abilities like critical thinking can help caregivers' through such dilemmas (Zhang & Min, 2020). Skills like coping with emotions, critical thinking, empathy, and self-awareness define psychosocial competency, which plays a vital role in caregivers' self-efficiency (Singh, Singh, & Poonam, 2016).

The importance of identifying risk groups among nurses employed in psychiatric institutions in order to preserve and improve mental health, as well as improving the quality of the provided health services has been reported (Miloševic, Dimoski, Miljanovic, Stojanovic, Terzic-Markovic, & Jovanovic, 2020). Physician fatigue has destructive impacts on patient care, well-being, and the health care system. This may be the cause of decreased work productivity, low job satisfaction, poor quality of patient care, medical errors, healthcare system failure, early retirement, depression, fatigue, and increased level of stress (Moss et al., 2016; West et al., 2018).

A systematic review and meta-analysis on general practitioners worldwide showed that approximately half of them had the intention to leave their current position (Shen et al., 2020). Higher professional title, lower income level, lower job satisfaction, and lower morale were the factors related to turnover intention (Shen et al., 2020). Mahmoud, Elhosany, and Helal (2020) reported a significant correlation between psychological well-being and work motivation amongst nurses in governmental hospitals.

Caregivers may experience mental problems due to the Covid-19 pandemic. Mental health services ranked first among the most urgently needed measures (Fitzpatrick, Carson, & Weisz, 2020). Long-term caregivers experienced more psychosomatic symptoms than short-term caregivers, and both (long-term and short-term) reported mental disorders during the pandemic (Park, 2021). Individual mental health of caregivers may have unknown impacts on the child-parent relationship (Russell, Hutchison, Tambling, Tomkunas, & Horton, 2020). Negative emotions were dominant in frontline nurses at the beginning of the pandemic, but positive emotions appeared gradually through the development of self-coping styles and psychological growth (Sun et al., 2020).

Accordingly, psychosomatic symptoms, mental disorders, occupational fatigue, and job burnout were prevalent within caregivers, especially with the occurrence and spreading of the Covid-19 pandemic. Thus, there is an urgent need to maintain caregivers' mental health, which can affect the health conditions of the community. The outbreak of the pandemic drew our attention to the essential needs of the health care community. These needs already existed and are part of the nature of health care. Lack of knowledge of and inattention to these needs have created problems for the health care community. Therefore, we decided to design and offer a psychosocial support system to meet the existing needs.

Methods

The present practical action research was conducted with the aim to help caregivers cope with the pandemic situation, a practical action research in which researchers and practitioners came together to identify potential problems, their underlying causes, and possible intervention projects.. This kind of action research is expected in the field of human service development (Burton, 2000; McKernan, 1996).

The first step in this action research was to gather information about the research problem. By searching the available literature on caregivers' mental needs and individual and occupational factors before and after the pandemic, we encountered many shortcomings regarding health care providers.

The second step was to hold focus groups. In this step, we organized expert panels to answer the following two questions in order to find a deeper understanding and identify the needs of health care providers:

1. What are the exact needs of healthcare providers?
2. How can we develop and implement a sustainable service package to address caregivers' needs?

Therefore, we performed 2 focus groups. The participants were selected using purposive sampling method and based on relevant job experiences related to the subject of the study.

The first one was held on the 27 October 2020 and the result was a list of healthcare providers' needs. The second focus group was conducted on 03 December 2020 with the subject of designing online service packages for psychosocial support for caregivers. In these 2 sessions, 11 experts participated (9 men and 2 women), including psychiatrists, psychologists, psychotherapists, general practitioners, nurses, and informatics specialists.

In order to analyze the content of the focus groups, all the interviews were first audiotaped, and then, transcribed. The questions were open-ended questions focused on general subject matters to prevent bias. The coding step was performed separately by 2 researchers, and it was reviewed and approved by a member of the focus group.

We used information obtained from the expert panels and research literature to design an online service package called "Healers' Healing".

Results

Healthcare providers' needs based on the first focus group (27 October 2020): Providers' needs based on the first focus group (27 October 2020) is shown in table 1.

Result of the second focus group (03 December 2020) with the subject of designing online service packages for psychosocial support for caregivers:

Result of the second focus group (03 December 2020) with the subject of designing online service packages for psychosocial support for caregivers is shown in table 2.

Therefore, in designing an appropriate response to address these growing needs in the medical staff, a proactive, evolutionary, and sustainable approach should be adopted.

Table 1. Results of the first focus group (27 Oct. 2020)

Problem Title	Problem Types
Workload	A sudden increase in workload due to the pandemic Increased incidence of disease in the treatment staff due to the pandemic Inadequate cooperation of governmental and non-governmental institutions in observing the protocols Lack of facilities and economic sanctions Insufficient incomes of therapists and lack of welfare facilities to reduce the burden of life Physical stress due to the use of COVID-19 safety equipment Mental and temporal pressure to learn and adapt to new tasks
Work uniformity (mainly after the pandemic)	Many patients with similar complaints Mechanical work processes Repetition of disabilities and uncertainties
The pressure of adapting to the multiplicity of roles	The various therapeutic, educational, research, or managerial roles that many nurses, physicians, and paramedics have The difference between the pace of work and the energy it takes to prepare for each role Incomplete work due to insufficient presence in each of the roles Feeling lower control over tasks
Sudden growth of digitalization (In recent years, especially after the pandemic)	Communication inefficiency due to Internet technical problems Confusion between personal and professional communication Work processes that lead to being a "Simple Clerk" and away from patients Training and lowering the quality of some work The pressure of learning new technologies
Inability, ambiguity and uncertainty in the management of the disease (Always, especially in the post-Corona period)	Doubts about the effectiveness of treatment protocols Ambiguity in the effectiveness of prevention methods Ambiguity in diagnostic protocols Inability to fully immunize oneself against disease Inability to fully immunize the family against disease Intra-organizational and inter-organizational inconsistencies Insufficient training in clinical reasoning Inadequate training in clinical decision-making The economic situation of the patient that causes some difficulties in decision-making
Emotional Dysregulation	Excessive contact with diseases and fear of infection Inability to maintain a certain distance from Covid-19 reveals a greater crisis Lack of empathy training and emotional regulation and resilience Lack of structured and regular psychosocial support programs for therapists Excessive exposure to difficult decisions and the resulting hesitation and feeling of guilt Dealing with multiple deaths (especially in the post-Corona era) and affecting from surprising from not having the opportunity for emotional cognitive processing Dealing with the death of colleagues (especially in the post-Corona era) and fear of imminent death due to excessive exposure to corona virus Putting their family at risk because of their job and the resulting feeling of guilt (especially in the post-Corona period) Rejection by others and even loved ones because of the possibility of contamination and the resulting feeling of anger, rejection, and heartbreak Poor help-seeking behavior of therapists due to job considerations and stabilization in the role of the therapist Confusion between the two roles of hero and disease carrier Anger about patients considered as careless Feeling guilty about their anger with their patients

Table 2. Results of the second focus group (03 December 2020).

Discussion title	Solutions
Review of the results of The first consensus meeting and additional recommendation	Being personal and professional involved in crisis, being involved in crisis by person? Or being involved in crisis.
	Uncertainty
	Contradiction between knowledge and practice
	Missing work cycles
	Social isolation
	Physical barriers to communication
	Preferring bad option to worse options
The objectives of the healers' healing program	Finding a way to reduce healers' distress
	Thinking about alternative strategies
	A social support team to integrate users into digital platforms
	Improving empathy, compassion, and relational skills
	Accelerating the project to provide services as soon as possible to those who need support
	Focusing on mental health, especially the prevention of major depressive disorder and suicide
	Improving decision-making and reasoning skills and prioritizing communication capabilities over medical techniques
	Social supporting of healthcare professionals by their peers (We can talk about our professional experiences)
	Structuring and organizing for supporting care teams
	Long-term planning for other possible future crises
	Spreading technological support and teaching caregivers to use digital instruments
	Providing more options for receiving psychosocial services
	Using online services instead of limited local ones and benefiting from more and more capable professionals
	Clarifying the identity of the employee and the client and determining the exact goals and needs of the client for better planning
	Improving self-care skills
The main strategies for meet the objectives	Providing easy points to establish in daily work
	Using videos
	Producing platforms for the best communication, such as forums
	Implementation of complete control and supervision
	Avoiding the presentation of too much information in order to make the platform as simple as possible
	Thinking about realistic strategies instead of Idealistic ones
	Using short and precise methods of education
	Taking advantage of shared decision-making
	Improving accessibility and providing easy ways to reach the exact answer
	Presenting a complete package including all tactics together in one platform to avoid confusion and guide the user as well as possible
	Discussing more practical strategies instead of exclusively theoretical ones
	Not forgetting physical activities to improve the morale of users
	Application of new strategies such as games, applications, and so on, instead of traditional ones
	Using step-by-step strategies and not offering everything at once
	Thinking about dynamic strategies instead of static ones
	Discussing interactive strategies instead of dissociated ones
Online service packages	Videos
	Podcasts
	Forums
	Webinars
	Main topics: how they can help themselves; personal and professional areas; how to maintain balance between themselves, their family, and their job; communication and decision-making skills
	Different packages with different topics and aims
	A searchable helpful resource collection to increase user's information

In addition to the apparent needs mentioned, the specific "time constraints" of this group should be taken into consideration and, at the same time, a platform for exploiting the potential of these individuals to care for and change their approach from "reactive" to "proactive" should be provided in the response process.

The expertise and abilities of this group to care for other people can be used effectively in response to their own needs and the needs of other health care providers.

According to the focus group results, the healers' healing program is designed in 3 subsets of general objectives. The first part is presenting practical and effective material. The platform content is presented in the form of lectures, webinars, infographics, practical exercises, and infomotions. Members can also produce content using the facilities of the system. The second part is intended to measure the progress and effectiveness of the program. Therefore, in different sections, quizzes and psychometric tests appropriate to the content will be conducted online to monitor the members' progress. The third part is the possibility of group activities in the form of relative groups freeform groups called self-help groups to increase the effectiveness of the content.

The principle investigators of the project suggested a service package based on the focus groups and gathered expert opinions, and finalized healers' healing platform with the following structural components.

Healers' Healing program: Healers' Healing website was designed with the aim of educating caregivers all over the world and improving their psychosocial skills. Healthcare providers can use the educational content, interact with each other, and share experiences in their personal life and work settings.

We considered gamification strategies for designing this service package. Gamification is an approach that can make people more engaged in and responsible for their health-related decisions (Pereira, Duarte, Rebelo, & Noriega, 2014). E-learning websites that use gamification as an engagement strategy are deemed as the most effective websites by experts (Rebelo & Isaias, 2020). Moreover, applying gamification to websites can also enhance communication efficiency (Hsieh & Yang, 2020).

For the gamification of the program, we used principles of knowledge transfer strategies, and we were inspired by the Jungian evolutionary journey. We are trying to design a lively and intimate space for the caregivers with fewer technical and scientific terms. To be realistic, we can only steal a portion of their leisure and web surfing time.

According to the focus groups' findings, the content of the program is defined in 7 major parts called "seven arts" and each art includes subdivisions as listed below:

Art of presence

-Fields of awareness: proprioception, attention, perception, thinking, emotion, relation, intention

-Presence experience: in personal life, in practice

-Optimizing body, mind, and relationship economy

-Mindfulness-based training

Art of rapport

- Care and attachment
- Emotion regulation
- Sympathy, empathy, compassion
- Relationship
- Communication
- Synchronization

Art of thinking

- Recognizing biases, errors, and heuristics

- Clinical Reasoning
- Critical thinking
- Creativity
- Decision-making

Art of moral work

- Moral sensitivity
- Moral reasoning
- Moral principles
- Narrative ethics
- Ethics of care

Art of meaning work

- Chance, teleology, and teleonomy
- Consciousness evolution
- Pragmatics of meaning
- Values and meaning
- The absurd, the meaningful, and liberty
- Meaning of work
- Meaning of care
- Singularity of meaning of life

Art of spirituality

- Spirituality and religion
- The Pre-personal, the personal, and the transpersonal spiritualties
- Ego and higher selves
- Intentionality and prayer
- Spiritual care

Art of balance

- Self-family-organization balance
- Non-dual energy investment
- Intra-inter-transpersonal integrity
- Coherent narrative
- Synergism

The program should also be attractive so that the audience can relate and experience it as an enjoyable journey that helps them feel better about their job and themselves. They should not feel like they are in an educational program and perceive it as an overload of work time.

The content of this project will be released in the form of articles, podcasts, and videos. This project is available for healthcare staff, and the only requirement for joining the program is that each member be proved as a member of the health care society by uploading their educational certificate.

The 3 main parts of the website include individual journey, group journey, and wall.

All members have the same journey in healers' healing. They should pass 7 steps called "seven arts", and after each step, they receive a badge of their level on this journey. The badge can be found in the profile section.

Each member can follow the program individually or by joining a group called "self-help group". Group activities include reviewing the content of the "seven steps", sharing experience according to the journey, content production according to their needs and project mission, and holding project promotion programs.

Each group will have its own page on the website, and they have to upload the reports of their meetings after each appointment.

Table 3. Individual scoring terms

Individual scoring terms: Individual score = 4A +5B +5C +4D +5E +4F +5G +3H +5I	
A	Member's Satisfaction
B	Presence in self-help group meetings
C	Passed steps
D	Number of specialized courses passed
E	Group scores
F	Running self-help group meetings
G	Scientific articles related to Healer's health
H	Wall posts
I	Change in health status

In order to motivate companionship and the implementation of gamification strategies, and provide a new and lasting experience for each member, they will be evaluated within some activities as shown in table 3. By receiving scores on each parameter, they will be graded in the levels and receive certificates. They can also benefit from webinars and other educational courses.

Individual journey will be measured by the parameters listed below:

There are 4 levels for individual scores including traveler, wayfarer, facilitator, and leader.

In addition to each member's score, being placed in a level during each individual journey includes the condition that members of each level supervise the members of previous levels.

Moreover, in group journey, we have parameters for each of the group activities. Group scoring parameters include the following: Group scoring parameters includes terms in table 4.

There are 4 levels for group scores including silver, gold, platinum, and diamond.

There will be some webinars and certificates for each group level.

Another part of this online platform is called the "Healers' Healing wall", which is an opportunity for each member to share their lived experience while going through the journey. It helps other members see the results of the program in daily life and motivates them to join and become a more active traveler on the seven arts journey.

Each wall post could also be a source for further research on caregivers' needs and the impact of the healers' healing program on each member.

In many countries like Iran, there are only a small number of eligible consultants who can lead Balint and supervision groups, so we perform team work on gathering data from more or less similar platforms and adopt a compatible and integrative program mainly on self-help group dynamism, and systemic and mindfulness-based approaches. The program is basically a virtual program, but the self-help group can be held in person. We intend to compile a workbook for this caregivers' self-help program.

The platform also leads the users to more professional webinars, in person workshops, Balint groups, supervisions, and retreat courses.

Table 4. Group scoring terms

Group scoring terms: Group score = X + 5A + 5B + 3C + 4d + 5E + 5F	
X	The years of the group work experience
A	Members' satisfaction
B	Order of meetings
C	Intergroup activities
D	Group wall posts
E	Average change in members' health
F	Holding promotional programs

Conflict of Interests

Authors have no conflict of interests.

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Challenges in the Clinical Education Environment during the COVID-19 Outbreak: The Experiences of Medical Students

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Qualitative Study

Abstract

Background: The aim of the present study was to determine the challenges of medical students in the clinical education environment during the outbreak of Covid-19 to understand their experiences.

Methods: This qualitative study was performed based on the hermeneutic phenomenological approach and Van Manen's analytical method from 10th of August to 12th of September 2020 in different departments of Qazvin University of Medical Sciences, Iran. In this phenomenological study, using the purposive sampling method, the participants were selected from among medical students. The data were collected through semi-structured interviews with 12 medical students. All the interviews were recorded and transcribed, and then, the codes, categories, and themes were extracted using Van Manen's analytical method.

Results: The 5 main themes of the present study were 'inefficient clinical education', 'dealing with real work conflicts', 'the future professional challenges', 'the challenges related to organizational policy', and 'the challenges related to the sense of stigma among the medical staff'. The most important challenges consisted of 'moving away from the educational goals due to reduced attendance at the clinical setting', 'the cancellation of some clinical courses', 'the creation of stress in the students by professors', 'fear of getting sick and transmitting the disease to family members', 'fatigue and heavy sweating due to caring for a large number of patients while wearing isolation gowns', 'the prolongation of the students' studies and delay in starting their thesis'.

Conclusion: The results of this study provided a deeper insight into the perceptions, feelings, and experiences of medical students during the coronavirus pandemic.

Keywords: Education; Medical students; COVID-19

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Introduction

Medical personnel have always been exposed to contagious diseases. The likelihood that Covid-19 can be transmitted even by asymptomatic individuals multiplies the risk of infection (Taghrir, Borazjani, & Shiraly, 2020; Biscayart, Angeleri, Lloveras, Chaves, Schlagenhauf, & Rodriguez-Morales, 2020; Bai et al., 2020). Presently, all attention is on the Covid-19 pandemic. Medical students are directly or indirectly in contact with this disease (Ikhlaq, Bint-E-Riaz, Bashir, & Ijaz, 2020). Thus, they are considered a high-risk occupational group (O'Byrne, Gavin, & McNicholas, 2020). These students are the best and most reliable sources for the examination of clinical education problems because they are directly involved in this process.

The risk of this disease being transmitted to health care professionals is very high in this pandemic (Han & Yang, 2020). Stirling and Harmston have noted that the risk of disease transmission could be a serious threat to the students and that they should be aware of this risk. The direct connection between the students and hospitals and universities can act as a disease transmission channel between pathogenic factors and large and susceptible populations (Stirling & Harmston, 2015).

Previous studies have suggested that the challenges of the clinical environment could lead to anxiety and stress (Meyer, Nel, & Downing, 2016). As a result, they may reduce students' critical thinking and affect their learning (Khan, Begum, Rehman, & Khan, 2020). The prevalence of Covid-19 can cause significant psychological stress in students, which may have adverse effects on their learning and mental health (Al-Rabiaah et al., 2020). During the pandemic, the students in the clinical environment have often suffer from stress and learning disturbances, which can have negative impacts on their academic achievement (Lovric, Farcic, Mikšic, & Vcev, 2020).

In a study by Gallagher and Schleyer, students were asked about the challenges they experienced in the clinical environment during the Covid-19 outbreak. They replied that by approaching the fourth year and the internship period, being away from the clinical environment were very problematic for them. Moreover, they felt that they were not useful enough and it was very difficult for them, conscientiously and morally, not to be able to help (Gallagher & Schleyer, 2020). One of the challenges that medical students are faced with, especially those who have taken the residency test, is their absence from the clinical environment (Menon, Klein, Kollars, & Kleinhenz, 2020; Theoret & Ming, 2020). Liu et al. (2020) showed that the challenges of working in the Covid-19 ward for the treatment team providing patient care included working in an overall new environment, burnout due to heavy workload, lack of equipment, fear of getting infected and contaminating others, and feeling unable to handle the patients' needs and to overcome the challenges in these stressful situations (Liu et al., 2020).

This pandemic provided an opportunity for the students who voluntarily helped in this crisis to explore the risks and costs. It is important that any decisions the students make (whether to enter the clinical setting or choose a purely theoretical path) be fully supported without being judged (Swift et al., 2020).

Negligence in identifying the problems and challenges that students face in the clinical education environment hinders effective learning and progress. Jamshidi, Molazem, Sharif, Torabizadeh, and Najafi (2016) found that the inefficient presence of students in the clinical education setting increases the rate of dropout. Some students have abandoned the medical profession because of such challenges in the clinical setting (Jamshidi et al., 2016).

Qualitative studies provide an opportunity for the in-depth exploration of mental experiences, taking into account the broader factors of the subject matter. In addition,

qualitative studies on other infectious diseases have recommended that clinical trials be conducted and health policies be formulated (Robinson et al., 2020). Educated and efficient manpower is the most important asset of any nation and training efficient people is the goal of any educational system, especially the higher education system. Moreover, the economic, social, political, and cultural developments of any society depend on its specialized human resources. Given the importance of this issue and the fact that we need to be aware of the various challenges of and concerns about Covid-19, all efforts should be made to explore the students' perceptions and experiences in this regard. Since no study has yet been conducted on the experiences of medical students in relation to Covid-19 in Iran, the current research team conducted a qualitative study with a phenomenological approach in order to obtain a deep understanding of the experiences of these students regarding the challenges of the clinical education environment.

Methods

This phenomenological study was conducted to gain an in-depth understanding of medical students' experiences of the challenges of the clinical education environment during the outbreak of Covid-19.

The participants of this study were a number of medical students who were doing internships in different departments of Qazvin University of Medical Sciences, Iran. In total, 12 medical students (volunteers) were selected using purposive sampling method.

The study inclusion criteria were studying in one of the fields of medical sciences and the ability of hearing and speech, and the exclusion criteria included incomplete answers to interview questions and unwillingness to participate in the study. Sampling was continued until data saturation was reached.

The data were collected using semi-structured interviews and non-structured observations until data saturation. The interviews were conducted from the 10th of August to the 12th of September 2020. In order to reach a deep understanding of the experiences of these students about Covid-19 and the challenges of the clinical education environment, the participants were initially asked to express their challenges in the clinical education environment. The sample questions were as follows:

Have your clinical education and learning rates changed significantly during this period?

Are there any new issues in your clinical learning?

Has your desire for internship changed?

What did you experience in your current internship that you had not experienced before Covid-19? Has your opinion about your profession and field of study changed compared to before?

Do you feel useful as a medical staff member these days?

What is your general sense?

The average duration of the interviews (in 1 to 2 sessions) was 30 to 50 minutes. All the interviews were performed by the fifth author (MSh) and analyzed by all the authors. From this point on, the transcribed data were the raw source for the deeper understanding of these students' experiences with respect to the challenges of the clinical education environment in this study.

Non-structured observations were also used during the semi-structured interviews to record the participants' behavior and establish non-verbal communication, facial expression, and eye contact.

The data were analyzed based on van Manen's phenomenological method. Van

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Mann introduces 6 methodological themes that play a practical role in performing hermeneutic phenomenology. The 6 steps suggested by researchers (van Manen) to researchers are as follows:

1). Explore the experience under study as lived.3. Reflect on the intrinsic themes that reveal the characteristics of the phenomenon.

4. Describe the phenomenon using the art of writing.

5. Establish and maintain a strong and conscious communication with the phenomenon.

6. Create coherence with respect to components and the whole.

In the coding process, each interview was initially read several times and this question was asked: “which statements are necessary to a deep understanding of the experiences of the students regarding the challenges of the clinical education environment”. Then, the statements were identified and underlined and their meanings and interpretations were written down. Finally, the thematic sentences were merged and categorized so that the major themes and minor categories were obtained. After initial coding, 130 codes were extracted. Similar items were omitted and the codes were reduced to 113, as a result, 15 categories and 5 themes were discovered. The accuracy of the qualitative findings was confirmed by assessing their validity, verifiability, reliability, and transferability (Burns & Grove, 2005).

The interview files and extracted codes were reviewed by external observers and their opinions were taken into consideration (Menon et al., 2020).

Ethical Considerations: The ethical code of the study was obtained from the Deputy of Research and Technology at Qazvin University of Medical Sciences (IR.QUMS.REC.1399.125) and informed written consents were obtained from the research participants.

Results

In the present study, 12 participants (6 women and 6 men) ranging in age from 21 to 35 years (24.83 ± 1.23 years) and undertaking various internships at medical training centers were interviewed in an in-depth and semi-structured manner (Table 1).

Initially, 130 codes were extracted and after reduction, deletion, and merging, 113 original codes remained. Finally, by analyzing the information, 5 themes (including inefficient clinical training, dealing with real work conflicts, future professional challenges, organizational policy challenges, and challenges related to the sense of stigma among the medical staff), 15 categories, and 66 sub-categories were extracted. One of the most important challenges for the students in clinical education at the time of the coronavirus outbreak was inefficient clinical education (Table 2).

Table 1. The demographic characteristics of the participants

Participant	Age	Sex	Marital status	Semester	The clinical wards
1	29	Female	Married	Second	Surgery resident
2	32	Female	Single	Second	Anesthesia resident
3	30	Female	Married	Second	Internal resident
4	35	Female	Married	Third	Infectious resident
5	34	Male	Single	Fourth	Anesthesiology student
6	30	Male	Single	Fourth	Emergency Medical Science student
7	22	Male	Single	Third	Operating room student
8	32	Male	Married	Fourth	Internal resident
9	21	Male	Married	Fourth	Nursing student
10	22	Male	Married	Fourth	Nursing student
11	26	Female	Married	Fourth	Emergency Medical Science student
12	25	Female	Married	Third	Intern

Table 2. The clinical challenges in the education environment during the outbreak of Covid-19

Themes	Categories	Sub-categories
Inefficient clinical education	Instructor-related challenges	Reluctance of experienced professors to attend clinical training environments
		Creation of stress in the students by the professors
		Prevention of students’ attendance in the coronavirus wards by some professors
		Lack of psychological support for the students in the clinical environment
		Insufficient ability of some professors in the clinical setting
		Lack of a suitable scientific background regarding Covid-19
	Challenges related to educational planning	Cancellation of some clinical courses
		Reduced duration of some clinical courses
		The gap between virtual and clinical types of learning
		The low speed of the virtual education system
		Not learning practical skills through virtual education
		Lack of clinical scenarios in a virtual format
		Inadequate number of students in different wards
		Presence of students from various clinical disciplines and congestion in the clinical environment
		Disregard for the students’ opinions in clinical planning
	Challenges related to the quality of education	Reduction of the number of clinical procedures
		Moving away from educational goals due to the students’ reduced time of presence in the clinical environment
		Lack of access to scientific information
		Lack of learning without the presence of professors
	Student-related challenges	Fear of becoming disabled due to illness while dealing with infected patients
		Fear of transmitting the disease to family members
		Fear of being a carrier and dealing with patients
	Challenges of clinical evaluation	Professors’ excessive valuing of theoretical knowledge
		Lack of clarity of the final evaluation process for the student
		Lack of evaluation based on the lesson plan
	Challenges related to lack of independence in clinical wards	Lack of planning for the independence of students
		Lack of mentorship in the clinical setting
Resolution of real work conflicts	Inconsistency-related challenges	Inconsistencies between the existing infrastructure for clinical education and the intended objectives
		Lack of coordination between the educational goals and the expectations of the students in the clinical environment
		Inconsistencies between lesson plans and clinical activities
		Inconsistencies between the goals that the professors and the clinical staff set for the students
	Administrative barriers to the acquisition of clinical skills	Lack of valuing education and the dignity of the students and professors
		Students’ lack of exposure to various cases and diseases
Professional challenges in the future	Concerns about not obtaining the desired professional qualifications during their studies	Students’ inability to manage the patients due to insufficient education
		Students’ not having the opportunity to deal with patients during their internship
		Students’ attendance in the clinical wards without having the necessary knowledge and skills
		Limited access to the clinical skills learning center
		Lack of training for working with devices and equipment in the clinical setting
	Concerns about not obtaining their desired jobs	Failure to obtain the expected income
		Concerns about the lack of job opportunities
		Prolongation of the students’ studies and delay in starting their thesis
Challenges related to organizational policies	Challenges related to the clinical environment	Working in a completely new and different clinical environment
		Lack of capacity of the clinical environment for the presence of students
		Lack of enough space for the students to rest
		Presence of a large number of students in the pavilion
		Fatigue and heavy sweating due to caring for a large number of patients while wearing isolation gowns

Table 2. The clinical challenges in the education environment during the outbreak of Covid-19 (continue)

Themes	Categories	Sub-categories
	Challenges related to hospital staff	Some hospital staff members' not having accepted the presence of students
		Some clinical staff members' inappropriate treatment of the students
		Lack of communication between the hospital staff and faculty members
Challenges related to organizational policies	Managerial challenges	Multiplicity of national programs and policies
		Cumbersome bureaucracies
		Pressures from educational groups
		Lack of financial resources
		Lack of human resources
		Lack of transparency regarding the roles and duties of managers
		Disproportionate authority and responsibilities of the managers
		Lack of transparency in the rules and processes of the organization
		Failure to comply with the requirements of teamwork
Challenges related to the sense of stigma among the medical staff	Individual challenges	Feelings of isolation and depression
	Sociocultural challenges	Feeling frustrated due to failure to treat patients
		Attaching the stigma of 'carrier' to the medical team
		People being fearful of the medical staff and distancing themselves from them
		People's inappropriate treatment of the medical staff

1- Inefficient clinical education: The first extracted theme of this study included the categories of 'professor-related challenges', 'challenges related to educational planning', 'challenges related to the quality of education', 'student-related challenges', 'challenges of clinical evaluation', and 'challenges related to the students' lack of independence in the clinical environment'.

In this regard, a participant stated: "the professor does not allow us to attend the coronavirus ward because she is afraid of contaminating herself and the students" (Participant 1).

"We had less clinical activity than the other groups because some of our clinical courses were canceled or cut short", said one student (Participant 2).

"Most of our professors pay attention to the students' theoretical knowledge, which reduces our motivation to learn clinical activities", said one participant (Participant 9).

Another student stated: "some professors do not leave us alone for a moment in the clinical setting, which makes us dependent on them and prevents us from learning independently" (Participant 10).

2- Dealing with real work conflicts: The second theme of the qualitative data was dealing with real work conflicts and included 2 categories and 7 sub-categories. The categories of this theme included 'inconsistency-related challenges' and 'administrative barriers to the acquisition of clinical skills'. In this regard, one participant said: "there is a huge difference between our theoretical training and our clinical activity in the clinical environment, which confuses use" (Participant 4).

Another participant asserted that "most of the objectives of our clinical course plans are not performable in the clinical setting" (Participant 3).

Another student said: "some members of the clinical staff do not respect the students and their education" (Participant 4).

3- The future professional challenges: The third theme included the categories of the students' 'concerns about not acquiring the desired professional qualifications during their studies' and their 'concerns about not obtaining their desired jobs'.

In this regard, a participant announced, "I am worried that at the time of my graduation, I might not have the necessary abilities to manage patients because I was not taught the various treatment procedures" (Participant 6).

Another participant reported that "most students are concerned that they will not have a job and enough income after graduation; therefore, they do not have the motivation to engage in clinical activities" (Participant 6).

4- The challenges related to organizational policy: The fourth theme was 'organizational policy' that included the categories of 'challenges related to the clinical environment', 'challenges related to hospital staff', and 'managerial challenges'.

In this regard, a participant noted that "due to the lack of human resources, we are used as medical personnel in fields that are irrelevant to our educational goals. In addition, no welfare facilities have been provided for us" (Participant 7).

Another participant stated: "our numbers in the pavilion are high, which makes us tired and reluctant to engage in clinical activities" (Participant 8).

5- The challenges related to the sense of stigma among the medical staff: The fifth theme included the categories of 'individual challenges' and 'sociocultural challenges'. From the students' point of view, people being fearful of the medical staff and distancing themselves from them caused them to feel isolated and depressed.

In this regard, one participant stated: "when I got into a taxi and the others realized that I was a medical staff member, they asked me to get out of the taxi" (Participant 3). Another participant stated: "when the treatment methods are not effective and the patient is lost, I feel frustrated and defeated" (Participant 4).

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Discussion

The present study was conducted with the aim to understand the students' experiences regarding the challenges in the clinical education environment during the outbreak of Covid-19. The 'educational planning challenges' was one of the categories of the theme of inefficient clinical education. In this regard, the students stated that there was a large gap between what they had learned in theory through e-learning and their clinical training. In their study, Elahi, Alhani, and Ahmadi (2014) pointed out that one of the problems of nursing education was the large gap between theoretical education and clinical practice. Scully asserted that most clinical educators have an important role in teaching both theoretical and clinical principles (Scully, 2011). Therefore, the ability to combine academic knowledge with nursing clinical practice in order to apply theory in clinical practice is one of the key issues in ensuring the competence of nursing educators (Parsh, 2010). In the studies by Theoret and Ming (2020) and Menon et al. (2020), it has been mentioned that one of the medical students' challenges was their absence from the clinical environment, especially for those who had taken the residency test.

In their study, Baraz, Memarian, and Vanaki (2015) aimed to determine the challenges of students in clinical settings and stated that the most important challenges for students were the learning environment and the adequate competence of the instructors. Identifying the challenges of clinical education in order to eliminate or modify them is useful in creating more learning opportunities, improving the achievement of educational goals, promoting the students' skills to meet complex care needs, using theories in a clinical setting, and improving the quality of health care (Baraz et al., 2015).

One of the most important challenges mentioned by the students in the category of 'professor-related challenges' was the 'creation of stress in the students by the professors'. In this regard, Al-Rabiaah et al. (2020) reported in their study that 77% of the students in the Covid-19 crisis had severe stress and there was a significant relationship between their stress levels and general health.

Joolaee, Jafarian Amiri, Farahani, and Varaei also acknowledged that the students' challenges in the clinical setting included the lack of skill and preparation for the clinical setting and dealing with real patients, which could affect the learning process.

The results showed that, in the category of the 'quality of clinical education', the most important challenges were the 'reduction of the number of clinical procedures' and 'moving away from educational goals' due to the reduced number of days in the clinical environment.

The results showed that in the category of 'student-related challenges', the most important challenges mentioned were 'fear of being disabled due to illness through contact with infectious patients', 'fear of infecting the family', 'fear of being a carrier', and 'exposure to patients'. In their study, Lovric *et al*. (2020) found that most students feared infection and were concerned about the health of their family. They regularly took protective measures, were afraid of the clinical environment, and often reported difficulty in concentrating and learning (Lovric et al., 2020). Liu *et al.* (2020) showed that the challenges of working in the Covid-19 ward were burnout, fear of getting infected, and fear of infecting others. In another study, researchers found that the reasons for some students' unwillingness to work in the coronavirus ward included their concerns about not having adequate physical support, the possibility of infecting their relatives, and belonging to a family or having a family (Collado-

Boira, Ruiz-Palomino, Salas-Media, Folch-Ayora, Muriach, & Balino, 2020). Elrggal et al. (2018) and Al-Hazmi, Gosadi, Somily, Alsubaie, and Bin (2018) also mentioned that the fears of unemployment due to Covid-19, being infected, and contaminating their family members were the most important challenges for the students in the clinical environment. The results of these studies are rather logical because they indicate the students' level of awareness of the pathogenicity and high risk of coronavirus transmission in the clinical environment. In the study by Stirling and Harmston (2015), it was demonstrated that this risk can be a serious threat to the students and the direct relationship between the students and hospitals and universities can act as a channel in transmitting the disease to large and susceptible populations.

One of the categories of the theme of 'inefficient clinical education' was the 'challenges of clinical evaluation', which is one of the important topics in clinical education. Parsh (2010) suggested that the clinical educators' ability for effective evaluation is one of their important characteristics.

The results showed that the second main theme was 'dealing with real work conflicts' with the category of 'inconsistencies and administrative barriers to the acquisition of clinical skills'. The students considered the most important challenges of this theme to be the 'inconsistencies between the existing infrastructure for clinical education and the intended objectives', the 'inconsistencies between educational goals and expectations of the clinical staff from the students', the 'inconsistencies between the curriculum and clinical activities', 'lack of valuing education and the dignity of the students, professors, and instructors', and the 'students' lack of exposure to various cases and diseases'. Jamshidi *et al.* (2016) studied the challenges of students in the clinical education environment in Shiraz, Iran. They concluded that the most important challenges for the students in facing the clinical education environment included insufficient and dysfunctional communication skills, discrimination among the students, insufficient preparation, insufficient knowledge, and incorrect practical skills, which affected the students' learning in the clinical environment (Jamshidi et al., 2016).

The results demonstrated that the third main theme was 'professional challenges in the future', the most important categories of which included 'concerns about not obtaining the desired professional qualifications during their studies', 'concerns about not obtaining their desired jobs', 'inability to manage patients due to insufficient education', 'the students' lack of exposure to patients during their internship', 'their lack of training for working with the devices and equipment available in the clinical wards', and 'their concerns about the lack of job opportunities'. Furthermore, Elrggal et al. (2018) and Al-Hazmi et al. (2018) showed that the fear of Covid-19 and not having a job were the most important challenges for the students in the clinical environment.

The results showed that the fourth main theme was the 'challenges related to organizational policy', the most important categories of which were the 'challenges related to the clinical environment', the 'challenges related to the hospital staff', and 'managerial challenges'. Liu et al.(2020) explained that wearing personal protective equipment and an isolation gown for a long time was stressful, especially for nurses who had to be in the isolation wards during all shifts (Liu et al., 2020). Magerman (2016) noted the existence of educational facilities as a necessity for clinical education and considered it as one of the important responsibilities of clinical managers. Magerman (2016)also noted that the clinical environment should be well-equipped so

that health care providers can receive the necessary training.

This study is one of the first studies conducted on this phenomenon among medical students during the Covid-19 period in Iran. Students had many experiences of missed care and were eager to share their experiences. One of the limitations of the current study was that due to the new pandemic, limited research has been performed on the subject. Hence, the results of the current study cannot be compared with those of other papers. Another limitation of the current research was the small number of participants. Therefore, it is recommended that future studies be performed with a larger number of participants.

Conclusion

The results of this study provided a deeper insight into the perceptions, feelings, and experiences of medical students during the coronavirus pandemic. The information obtained helped us to identify the needs, problems, and challenges of the students in the clinical environment during this pandemic and improved their academic performance. Therefore, to create effective support mechanisms for the students, it is important to have a comprehensive understanding of their perceptions, feelings, and experiences in crisis.

Conflict of Interests

Authors have no conflict of interests.

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Psychosomatic Symptoms, Depression, and Anxiety among Parents and Caregivers of People With Disability

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Quantitative Study

Abstract

Background: Caring for people with disabilities creates stressful conditions and may lead to mental health problems in parents and caregivers. The aim of this study was to investigate somatic symptoms, depression, and anxiety in parents and caregivers of individuals with disability in Isfahan, Iran. This study was conducted as a joint study by Isfahan University of Medical Sciences and the University of Hamburg with financial support from DAAD.

Methods: This cross-sectional study was performed on 454 parents/caregivers of people with disabilities in Isfahan in 2019. Randomized sampling was performed and participants were selected according to the inclusion criteria. The Patient Health Questionnaire-9 (PHQ-9) (Depression), PHQ-7 (Anxiety), and PHQ-15 (Somatic) were used for data collection. Questionnaires were distributed among the participants and completed with the coordination and cooperation of the government and NGOs related to people with disability. Data were analyzed using descriptive statistics (mean and standard deviation) and analysis of variance (ANOVA) in SPSS software.

Results: The results showed that 28.4% of parents/caregivers of people with disabilities did not have any depressive symptoms and the remaining 70% experienced mild to severe levels of depressive symptoms. Regarding the level of anxiety, 30.2% showed no symptoms of anxiety and 69.8% showed mild to severe levels of anxiety symptoms. In terms of somatic symptoms, 17.8% reported no somatic symptoms and 82.2% reported mild to severe levels of somatic symptoms. Parents/caregivers differed significantly in terms of depression, anxiety, and somatic symptoms according to the type of disability.

Conclusion: The findings of the present study show that the rate of symptoms of depression, anxiety, and somatic symptoms in parents/caregivers of people with disabilities is higher than that in the general population. In addition, different types of disability can have different effects on the mental health of parents/caregivers.

Keywords: Depression; Anxiety; Somatic symptoms; Parent/Caregivers; Disability

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Introduction

Taking care of persons with disabilities is performed by parents and caregivers and it involves different, exclusive, and hard responsibilities such as punctual medication supervision, taking care of their physical, emotional, and financial needs, and helping them go to the rehabilitation center. They are burdened and suffer from stress; hence, they require help to cope with it. If the coping strategies they use to ease the burden are unhealthy and immature, they may directly affect their functions (Chadda, 2014).

Many studies have pointed out that mothers of children with developmental disabilities like intellectual disabilities (IDs), developmental delay, and physical and sensory handicap have shown noticeable signs of psychological distress. Mothers show more psychological distress or depressive symptoms (Chadda, 2014; Olsson & Hwang, 2008; Feldman, Mcdonald, Serbin, Stack, Secco, & Yu, 2007). Parents and caregivers of individuals with disabilities are at increased risk of a high level of stress and that may be the cause of the high rate of depression among them (Chi & Hinshaw, 2002; Olsson & Hwang, 2001). Previous researches have shown that psychiatric disorders are more common among caregivers of individuals with ID compared with the general population (Cooper, Smiley, Morrison, & Allan, 2007; Kobayashi, Inagaki, & Kaga, 2012). The caregiver's burden can be noticed in the procedure of illness and their hopes have been replaced by disappointment, this burden has appeared in a complete range of symptoms (Chadda, 2014).

It has been reported that mental disability causes different kinds of distress in family members, particularly in parents and mostly in mothers who suffer from psychological, physical, financial, and social distress due to the constant contact with the disabled child (Schwartz & Tsumi, 2003; Weiss, Sullivan, & Diamond, 2003; Pelchat, Lefebvre, & Perreault, 2003). However, fathers are not severely affected by the situation and show far less symptoms of psychological distress than mothers of normal children; less impact is observed on their psychological health because they are less involved (Romans-Clarkson et al., 1986; Moes, Koegel, Schreibman, and Loos, 1992; Cuskelly, Pulman, & Hayes, 1998; Hastings, 2003). Some psychiatric morbidity (depression, anxiety, and high level of distress) has been approved to be common among mothers of mentally disabled children. Overall, 35-53% of mothers of children with disabilities show symptoms of depression. There is evidence that depression and anxiety are more common in caregivers and parents of children with disability (Schwartz & Tsumi, 2003; Weiss et al., 2003). The main question here is whether the somatic symptoms in these caregivers and parents are more than that in the general population. The aim of this study was to determine the frequency of psychosomatic symptoms, depression, and anxiety among parents and caregivers of people with disability.

Methods

This cross-sectional study was extracted from a comprehensive study in Isfahan University of Medical Sciences (Psychosomatic Research Center), Iran, and the University of Hamburg, Germany. This project was implemented within a 3-year (2017-2019) interval in the format of a memorandum between the 2 universities with funding from DAAD. The study participants included 953 individuals (499 people with disabilities and 454 of their family members and caregivers) selected through random sampling method. To determine the psychosomatic symptoms and mental health status in their families, 454 participants were selected according to the list of clients in educational and rehabilitation centers and other related centers of Isfahan, Iran, in 2019. The questionnaires were

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completed either by going to the participants' homes, inviting them to centers related to people with disability, or inviting them to the meeting room.

Inclusion and Exclusion criteria: The inclusion criteria for the families of people with disabilities included 24 to 65 years of age, literacy, absence of serious psychiatric and neurological diseases, and lack of any disability. The exclusion criteria included unwillingness to continue participation and failure to respond to at least 20% of the items in each questionnaire.

Measuring tools

1) Demographic and disability information questionnaire

2) Patient Health Questionnaire-15: The Patient Health Questionnaire-15 (PHQ-15) was developed by Spitzer (2002). Its items include the somatization disorder/somatic symptoms of the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV). The participants were asked to rate the severity of 15 symptoms as 0 ("not bothered at all"), 1 ("a little bothered"), or 2 ("bothered a lot") for the preceding 4 weeks. Thus, the total PHQ-15 score ranges from 0 to 30 and scores of ≥ 5, ≥ 10, and ≥ 15 represent mild, moderate, and severe somatization/somatic symptoms, respectively. The validity and reliability of the PHQ-15 are high in clinical and vocational health care settings. The Cronbach's alpha of the original English version of the PHQ has been reported as 0.79-0.89 in different studies (Kroenke, Spitzer, Williams, 2002; Kroenke, Spitzer, Williams, & Lowe, 2010). In this research, the Cronbach's alpha of the PHQ-15 was 0.78.

3) Patient Health Questionnaire-9: The PHQ-9 assesses the frequency and severity of depression symptoms using 9 items scored on a 4-point Likert scale ranging from 0 (not at all) to 3 (nearly every day) (Kroenke & Spitzer, 2002). The total score of the PHQ-9 is the sum of the scores of all items and ranges from 0 to 27. The total score can be classified at a cut-off point of 10 to discriminate between minimal/mild and moderate/severe depression (Kroenke et al., 2010; Kroenke, Strine, Spitzer, Williams, Berry, & Mokdad, 2009). However, a systematic review showed that a cut-off point of 8 might increase sensitivity to depression (Manea, Gilbody, & McMillan, 2012).

4) Patient Health Questionnaire-7: The PHQ-7 measures the frequency and severity of symptoms of anxiety, specifically generalized anxiety disorder (Spitzer, Kroenke, Williams, & Lowe, 2006). It consists of 7 items that are scored on a 4-point Likert scale ranging from 0 (not at all) to 3 (nearly every day). The total score of the PHQ-7 can be classified at a cut-off point of 10 or 8 to optimize the test's sensitivity and specificity for identifying other anxiety disorders (Plummer, Manea, Trepel, & McMillan, 2016). The validity of the PHQ-7 and PHQ-9 was confirmed through a correlation of -0.32 to -0.76 with the 36-Item Short Form Health Survey (SF-36) and 0.76 with the Posttraumatic Stress Disorder Checklist (PCL-5) (Teymoori et al., 2020).

Data analysis method: Descriptive data such as the status of somatic complaints, depression, and anxiety of people with disabilities and their families were analyzed and displayed using descriptive statistical methods such as mean and standard deviation and frequency distribution. Moreover, analysis of variance (ANOVA) was used to compare the mental health and somatic symptoms of people with disabilities and their families according to the type of disability and SPSS software (version 23, IBM Corp., Armonk, NY, USA) was used for the statistical analyses.

This study with the scientific code 298062 has been approved by Isfahan University of Medical Sciences and has received the ethics code IR.MUI.MED.REC.1398.214 from the ethics committee. Figure 1 show consort flowchart.

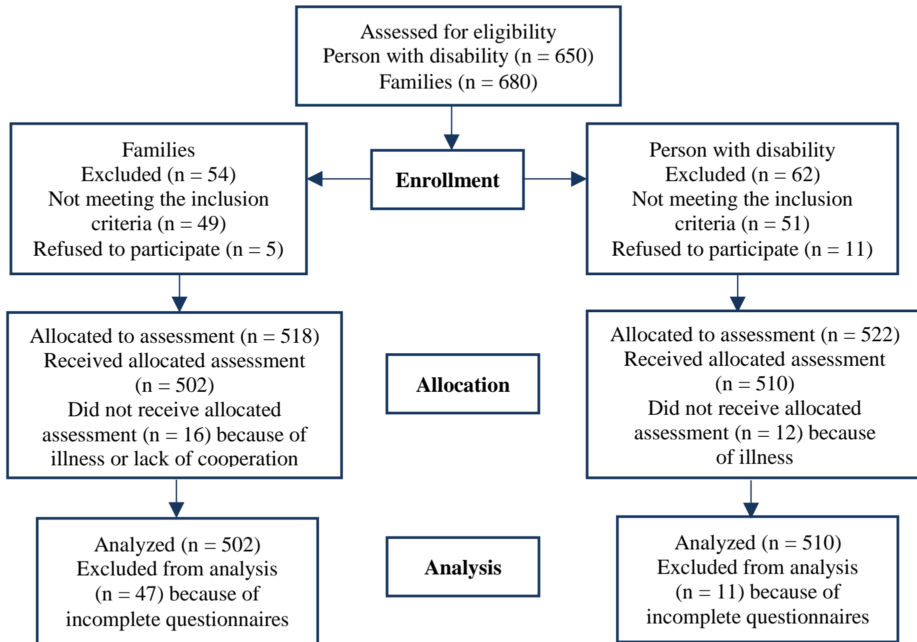

Figure 1. The Consort Flowchart of assessment of persons with disability and their families

Results

From among 454 parents/caregivers of people with disabilities, 449 completed the questionnaires. The mean age of the participants was 46.4 ± 10.4 years, 52% of them were women, and 86.3% were married. The other demographic characteristics of the studied subjects are presented in table 1.

Table 1. Demographic characteristics of the study population (n = 449)

Demographic Characteristics	Value
Age (Mean ± SD)	46.4 ± 10.4
Sex (Female) [n (%)]	268 (59)
Marital Status [n (%)]	
Married	391 (86.3)
Single	40 (8.8)
Divorce/etc.	7 (1.5)
Education [n (%)]	
Illiterate	10 (2.3)
Under diploma	224 (50.6)
Diploma	126 (28.5)
Upon diploma and BA	80 (18.1)
MA and more	2(0.5)
Type of disability [n (%)]	
Blind	94 (20.7)
Deaf	27 (5.9)
Sensorimotor	36 (7.9)
Mental	102 (22.5)
Missing	195 (43)
Psychological Symptoms (Mean ± SD)	
Depression	8.38 ± 4.10
Anxiety	8.15 ± 4.38
Somatic Symptoms	10.36 ± 4.9

Table 2. Mental health of parents and caregivers of people with disability

Status	None	Mild	Moderate	Moderately Severe	Severe	Missing
Depression	129 (28.4)	156 (34.4)	150 (33)	12 (2.6)	3 (0.7)	4 (0.9)
Anxiety	137 (30.2)	160 (35.2)	136 (30)	-	14 (3.1)	7 (1.5)
Somatic symptom	81 (17.8)	139 (30.6)	155 (34.1)	-	76 (16.7)	3 (0.7)

Data are presented as n (%).

Mental Health Status of Parents/Caregivers of People with Disability: According to the PHQ-15 cut-off point, 16.7% and 34.1% of the participants had severe and moderate somatic symptoms, respectively. Based on the cut-off point of the PHQ-7, 3.1% and 30% of participants showed severe and moderate anxiety symptoms, respectively. According to the PHQ-9 cut-off point, 0.07%, 2.6%, and 33% of subjects, respectively, showed severe, moderately severe, and moderate depression symptoms (table 2).

Depression, Anxiety, and Somatic Complaints in Parents/Caregivers in Terms of the Type of Disability: According to the results of data analysis presented in table 3, the severity of depression, anxiety, and somatic symptoms of parents/caregivers varies in terms of the type of disability ($P < 0.05$). Post hoc tests were used to determine significant differences between groups in terms of the type of disability of children and the results are presented in table 4.

Parents/caregivers of people with blindness differed significantly from those of people with spinal cord injury (SCI) in terms of depression and anxiety ($P < 0.001$). Moreover, a significant difference was observed between parents/caregivers of people with sensory-motor disability and blindness in terms of the severity of anxiety and somatic symptoms ($P < 0.001$). In addition, a significant difference was observed between parents/caregivers of people with SCI and parents/caregivers of deaf individuals in terms of severity of anxiety ($P < 0.005$).

As seen in figure 2, the mean score of depression in parents/caregivers of deaf children is higher than other groups. In contrast, the mean scores of somatic symptoms of parents/caregivers of people with sensory-motor disability are higher than other groups.

Discussion

The present study findings showed that, based on the cut-off points of PHQ versions, the level of depression, anxiety, and somatic symptoms in parents/caregivers is higher than the general population of Iran (Ebrahimi, Seyed mirramazani, & Hosseini, 2020). According to the results presented in table 2, about 70% of the participants had mild to severe depression and anxiety, and up to 80% of these people suffered from mild to severe somatic symptoms, and the prevalence of these severe symptoms is higher than those in the general population (Sadock, Sadock, & Ruiz, 2017).

Table 3. Analysis of variance of means of depression, anxiety, and somatic symptoms in parents and caregivers based on type of disability of family members

Status	Blind	Deaf	SCI	Sensorimotor	Mental	F	P
Depression	6.60 ± 2.83	6.98 ± 4.07	8.40 ± 4.92	7.60 ± 5.01	8.36 ± 5.21	4.17	0.002
Anxiety	7.63 ± 3.39	7.42 ± 4.99	8.39 ± 4.59	8.98 ± 5.97	8.22 ± 4.96	2.63	0.03
Somatic symptoms	7.79 ± 3.17	7.37 ± 4.74	8.75 ± 5.3	10.71 ± 5.66	9.42 ± 5.37	12.53	0.001

SCI: Spinal cord injury

Data are presented as mean ± standard deviation (SD)

Table 4. Tukey's honestly significant difference test results for group differences

Groups	Depression	Anxiety	Somatic symptoms
Blind			
Deaf	0.37	-0.37	0.41
Spinal cord injury	-1.79*	-1.79*	-0.95
Sensorimotor disability	-1.00	-1.00*	-2.91*
Mental disability	-1.76*	-1.76*	1.63
Deaf			
Spinal Cord Injury	-1.41	-1.41*	1.37
Sensorimotor injury	-0.62	-0.62	3.33*
Mental disability	-1.38	-1.38	2.05
Spinal Cord Injury			
Sensorimotor injury	0.79	0.79	-1.96*
Mental disability	0.03	0.03	1.28

*$P < 0.001$

These findings indicating the high levels of depression, anxiety, and somatic symptoms in parents/caregivers of people with disability support the findings of Resch, Elliott, and Benz (2012), which showed that these individuals suffer from higher levels of anxiety, depression, and somatic symptoms. Our results are consistent with the findings of previous studies indicating that parents of children with developmental disabilities have more mental stress, poorer psychological status, and greater somatic problems than parents with normal children (Fritz, 2020). Although the prevalence of psychological problems in caregivers and parents of people with disabilities was higher than the general population, the extent of these problems varied according to disability, which is discussed below.

Mental Health of Parents/Caregivers in terms of Disability Type: The severity of depression in parents/caregivers of people with mental disability and SCI was significantly higher than other groups of participants. These findings are consistent with the results of the study by Kayili (2018) that showed significant differences in depression levels of parents of children with different types of disability. According to our findings, it seems that persons with mental disability and decrease function in all life areas are regarded as a kind of social stigma for the family, this leads to feelings of hopelessness, despair, shame, and social avoidance. Although the parents/caregivers of blind children face many problems, their child can have occupational, educational, social abilities, and even access to higher levels of education such as the doctorate degree.

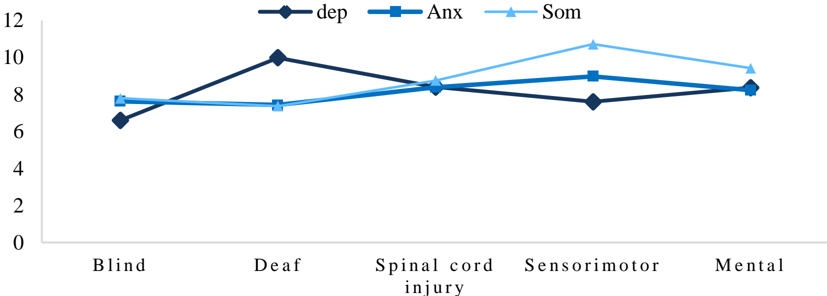

Figure 2. Comparison of means of depression, anxiety, and somatic symptoms in parents/caregivers based on type of disability of the family member

Furthermore, our findings revealed that parents/caregivers of persons with SCI suffer from a higher severity of depression than other groups. This result is consistent with the findings of Simpson, Anderson, Jones, Genders, and Gopinath (2020). Based on our finding, SCI seems to be a stressful event that occurs for an individual and his/her family and suddenly transforms a healthy and efficient person into a person with disability in all areas of life; hence, depression emerges as an inevitable psychological reaction.

Our findings also revealed higher anxiety in parents/caregivers of individuals with sensory-motor and mental disability, and SCI, and these findings support the findings of Lynch and Cahalan (2017). It seems that these parents/caregivers experience more insecurity and uncertainty due to their conditions. The findings also showed that the severity of somatic symptoms in parents/caregivers of individuals with sensory-motor disability is higher than other groups. It can be inferred from the findings of this study that the somatic complaints and health concern of parents/caregivers are related to type of disability. According to the study by Krishnan, Sood, and Chadda (2013), the family members of an individual with a major problem with sensory-motor symptoms focus on the physical condition of their family member, and this results in an increase in somatic complaints in these caregivers.

Conclusion

In general, parents/caregivers of persons with disability suffer from depression, anxiety, and somatic symptoms more than the general population in Iran. Moreover, families of individuals with sensory motor and mental disability, and SCI are more at risk of psychological problems than other groups.

Suggestions: Based on the findings, it is suggested that mental health screening of parents/caregivers be performed through questionnaires and clinical interview, and the people who are at risk of psychiatric disorders be referred for treatment and the necessary preventive measures be performed for others.

Limitations: The most important limitation of this research was that only self-assessment questionnaires were used to determine mental health, so it is suggested that clinical interview be used for a definitive diagnosis in future studies.

Conflict of Interests

Authors have no conflict of interests.

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Virtual Art Therapy at Home to Support Cancer Patients in the Covid-19 Pandemic: A Practice Report

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Report

Abstract

This practical report shows a possibility of psychosocial support for cancer patients in an online format by means of "Art Therapy at Home" and is intended to stimulate discussion about how patients can be supported virtually during the pandemic. The project "Art Therapy at Home" illustrates how profitable virtual art therapy can be for patients despite social distancing and what different possibilities exist. At the same time, the limits and disadvantages, such as the limited interpersonal interaction while using the digital medium, become visible and demonstrate that personal contact cannot be fully replaced.

Keywords: Virtual art therapy; Cancer; COVID-19 pandemic

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Introduction

Creative therapy forms such as art therapy are an integral part of psychosocial support and counseling for cancer patients as they offer a meaningful alternative or supplement to other medical and psychotherapeutic treatment methods (Kraus, 2002).

Art therapy allows a more holistic approach and enables cancer patients to express different emotions such as powerlessness, fear, and hope by using various creative media. As recent study showed that art therapy interventions effectively help improve patients' emotional well-being and reduce anxiety and pain levels (Elimimian et al., 2020). Depression and somatic symptoms can also be reduced through the creative medium [Czamanski-Cohen, Wiley, Sela, Caspi, & Weihs, 2019]. Thus, art-therapeutic support can make a positive contribution to improving the quality of life (QOL) and disease management of cancer patients and helps them develop new coping strategies (Petersen, 2002). Art therapy generally aims to support cancer patients in accepting the disease [Czamanski-Cohen et al., 2019], discovering and strengthening their own resources, dealing with and accepting a changed body image, and developing new individual perspectives (Menzen 2021). Art therapy can also make a particularly positive contribution to palliative care in terms of emotional well-being, meaning, and comprehensibility [Meghani et al., 2018]. Based on a resource-oriented approach, art therapy focuses primarily on the patient's strengths and creative powers.

Experiencing and handling various materials is an essential characteristic of art therapy. Materials like clay, soapstone, gouache colors, pastel chalks, and natural materials provide different levels of experience and can be used in a targeted manner. These materials appeal to each person in their own distinctive way and may trigger reactions, which then may allow him/her to get in touch with him/herself on a different level (Leutkart, 2010). The focus of art therapy is not the production of a formally aesthetic picture, but rather the process of individual creation and design. This process allows the designer to be completely with him or herself, to be guided by the materials and his/her own creations, and to express his/her state of mind through the movements of hands.

Another essential aspect of art therapy is the observation of one's own picture during the process of creation as well as at its completion. Tracing the individual design process and becoming aware of its content can offer numerous possible solutions for coping with the challenges of a cancer patient's everyday life and illness. Through the process of creating, patients can experience a stronger feeling of self-efficacy and they can discover and strengthen their own abilities and resources. This is furthermore supported by viewing and discussing one's own creations and designs in the group. The mutual exchange in a group allows the discovery of similarities, experiencing of compassion, and expansion of the individual's own perception through the perspectives and points of view of others (Leutkart, 2010).

Methods

The art-therapeutic support of cancer patients at the psychosocial cancer counseling center of the University Medical Center Freiburg is scheduled once a week for 2 hours. However, with the beginning of the Covid-19 pandemic in April 2019 regular meetings with the high-risk group of cancer patients were no longer possible in the original setting at the Medical Center. Thus, the following method describes an alternative virtual art therapy conducted from home. The primary goal of this 'art

therapy at home' version is to continue bringing the participant group together, despite the necessary spatial distance. Although held in an unfamiliar virtual setting, these online art-therapeutic sessions are intended to provide a space for mutual exchange and feeling of belonging as well as continued individual support of the cancer patients in the best possible way.

A total of 15 sessions were held in the virtual setting between April and August 2020. The group consisted of 5 participants, 2 of whom joined the group as new members during the online sessions. In order to provide the participants with a reliable time structure, the virtual art therapy session were held in the same time slot as before, i.e., on Mondays from 10 to 12am. The virtual meetings were conducted via an online platform. The technical requirements were clarified with each participant beforehand and, if necessary, individual support was provided for which simple descriptions and explanatory videos were provided to help lower the individual inhibition threshold.

Each participant received a package with all the necessary materials, such as gouache paints, oil crayons, watercolors, brushes, and papers of different sizes, before the first online art therapy session as it cannot be assumed that the participants have art supplies at home. The package furthermore included an *artistic impulse,* a personal postcard, and a *painting diary.* The package had an attractive design to further inspire and encourage the participants to start getting creative. Every week, the participants received a new *artistic impulse* and a short description of the task a few days before the next session by mail. The artistic impulses and the corresponding tasks mainly focused on strengthening the patients' resources, self-esteem, and hope. In addition to the weekly artistic impulses, a *painting diary* was made available to every participant. This painting diary could be used individually, even outside scheduled art therapy sessions, as a creative space and a mean to consciously take time for oneself. Moreover, the painting diary could ultimately provide a review on pictures of a virtual and socially distanced time.

A further component of 'virtual art therapy at home' was a *group booklet*. Usually, non-virtual art therapy sessions are characterized by the experience of joint creation, such as creating paintings as a group together. This process of joint creation is meant to be adopted in the group booklet. For this, the group booklet needed to be sent by mail from participant to participant, whereby each person could fill the empty pages individually. It was not about painting a complete picture, but rather about adding one's own creative ideas and as such opening the picture to further artistic possibilities. By actively designing together and passing on a continuously evolving painting, the participants could experience a sense of solidarity and belonging.

Every art therapy session started with a meeting in the virtual room, a quick feedback by the participants on their general mood, and a short explanation of the artistic task ahead. Then, the participants left the virtual space and each one could get creative by him/herself alone. After approximately 75 minutes, all the participants returned to the virtual space in which a viewing of the individual paintings as well as another feedback took place. In addition, the created paintings could be photographed and sent to each participant by e-mail in order to allow for a better viewing of the paintings. Finally, additional *one-on-one conversations* between patient and therapist could be arranged via phone.

Results

With the changed format to a 'virtual art therapy at home', the continued support of cancer patients was made possible even during lockdown and in spite of the

measures associated with the Covid-19 pandemic. Generally, all the participants accepted this new form of art therapy openly and gratefully. According to the participants' feedback, the continuation of regular art therapy sessions, even in this limited virtual mode, was perceived to be incredibly supportive and beneficial. It was regarded as very helpful and encouraging to have a fixed appointment every Monday, as before, which allowed the participants to be creative and take time for themselves. Having the opportunity to be in contact with each other was considered particularly positive. Since all the participants, who are a high-risk group, had to significantly reduce their actual personal encounters during the Covid-19 pandemic.

The *artistic impulses* given by the therapist were reported to be appropriate, strengthening, and inspiring. Moreover, the participants reported that they continued to contemplate the topics and developed creative ideas associated with the provided *artistic impulses* after the scheduled art therapy sessions. Furthermore, receiving these weekly *artistic impulses* through another medium (by mail) was met with great joy and appreciation by the participants.

The *group booklet* was generally considered to be the highlight of the participants' week. According to them, the *group booklet* was a way to stay in contact with each other on a different level, which allowed them to feel considerably more interconnected during a challenging time. This became particularly clear at the first "real", non-virtual meeting in September 2020, when the participants enthusiastically presented their *group booklets* and paintings. The participants emphasized how eagerly they always awaited the return of the *group booklet* in order to discover new additions to their paintings.

The *painting diary*, however, was used quite differently by each participant, by some it was used as a notebook during the creative process, and by others it was only used occasionally.

But the biggest challenge for the participants consisted in handling the necessary technology for the virtual art therapy sessions. Non-functioning microphones or cameras, poor internet connections, or being kicked out repeatedly from virtual meetings caused great frustration. Moreover, the virtual sessions made communicating successfully within the group more difficult. Thus, gestures and resonance in the virtual space were perceived differently and several misunderstandings occurred, which were reported as unsatisfactory and stressful by the participants.

A growing discontent and reduced willingness to accept technological difficulties was observed in the final virtual art therapy sessions. Communication, discussions, and mutual exchange, as they otherwise occur during the creative process in art therapy sessions, were felt to be much more difficult to realize. Furthermore, it was especially challenging for the new participants to share their private rooms via the camera, to get to know the other participants, and to successfully integrate into an already existing art therapy group.

Discussion

The primary goal of the 'virtual art therapy at home' was to provide continued psychosocial art-therapeutic support for cancer patients even during the Covid-19 pandemic. The focus was to strengthen the participants' own resources and encourage a self-sustaining creative process. Being a high-risk group, cancer patients were particularly affected by contact restrictions and the resulting physical isolation from others.

According to the participants' feedback, this new mode of 'virtual art therapy at home' facilitated and supported their contact with each other by providing a common space and creative task. Over a course of 5 months, this virtual mode of art therapy showed that it could contribute significantly to supporting and improving QOL for cancer patients by helping them develop new coping strategies. The willingness of the participants to get involved in a virtual art therapeutic setting was increased considerably by providing them with an appealing package, which contained various art supplies and weekly *artistic impulses* and tasks. Moreover, giving clear and concise instructions about the technological handling of Zoom proved to be quite important.

However, the necessary technology repeatedly reached its limits and caused much frustration among the participants. In some cases, despite intensive support by the therapist, it proved to be very difficult to access the technology. Thus, it was crucial to communicate and work via different media, such as letters via mail, e-mails, and the *group booklet*, in addition to the virtual Zoom meetings. This approach allowed us to reach and support the participants on different levels.

Including and integrating new participants into an already existing art therapy group proved to be particularly difficult in this merely virtual setting. For one thing, it was a considerable challenge and even obstacle to get to know each other virtually without having ever met in person before. Another point was that working creatively proved to be a great challenge for the new participants, who had never been in an art therapy group and had little experience of creative working methods before. It was quite difficult for them to get involved in the creative process and paint a picture all by themselves at home. Thus, the importance of art therapy sessions taking place in an inviting and comfortable room equipped with inspiring art supplies, which help encourage the participants' confidence and joy to get creative, became apparent. Moreover, the common creative experience and being able to observe others creating helps to develop one's own creative ideas. The virtual setting also prevented the art therapist from accompanying and supporting the participants individually with suggestions and ideas regarding materials, and limited their mutual exchange. New participants, who had no or little access to art therapy before, in the beginning often focused on creating formally aesthetic paintings. Therefore, they needed to be directly supported and encouraged by the therapist in order to be able to explore and get to know their own creative abilities as well as the diversity of the material. This could then allow them to process and express their inner thoughts creatively.

In order to be able to follow the individual creative processes and to provide a feeling of joint creation, it might be an option to stay virtually connected throughout the individual creative part of a session. However, it must be considered that sharing private rooms via camera can be quite a challenge and too great an intrusion into the participants' privacy. A sensitive handling of this matter by the therapist is therefore strongly advised. Thus, the therapist should be able to provide the participants with alternative strategies, e.g., which part of their private rooms they are willing to share with the group or whether there is a camera angle which does not reveal the background of their rooms.

The feedback by the participants revealed how much the *group booklet* contributed to creating a group experience and the feeling of togetherness. The *group booklet* was not limited to a merely virtual experience, but rater offered tangible and evolving paintings and the creative ideas of everyone involved. Moreover, the group booklet allowed the participants to get in touch with each other about their individual thoughts and ideas outside the scheduled art therapy sessions. By expanding and supplementing the

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paintings of other group members, the participants experienced empathy and gained new perspectives on their own individual and creative perceptions.

The study here described is a practice report with the aim to stimulate discussion on how to support patients online in the pandemic. It did not integrate an evaluation or psychometric questionnaires to tests changes in defined outcome parameters. The results describe the experience of a single group with a single therapist. This approach definitely has limitations regarding scientific criteria such as objectivity, reliability and internal and external validity. Still, it can be a valuable approach to stimulating discussion on how to establish online support and on how to evaluate approaches like this.

Conclusion

In our view, this new mode of 'virtual art therapy at home' contributed significantly to supporting cancer patients in their process of coping with the illness, in dealing with the restrictive situation due to the Covid-19 pandemic, and in strengthening their own individual resources. However, the importance of genuine face-to-face mutual exchange and communication in a suitable art-therapeutic environment as well as direct therapeutic support must not be overlooked. On the one hand, the virtual setting offered the possibility of coming together as a group despite social distancing measures.

On the other hand, new communication difficulties arose due to the limitations of a virtual setting, which would probably not have occurred otherwise. Misunderstandings in perception and lack of direct physical resonance contributed to growing miscommunications and discontent. Genuinely resonating with fellow human beings and experiencing empathy and oneself in interaction with a group is only partially possible in a virtual setting. Nonetheless, the 'virtual art therapy at home' sessions showed that personal resources and abilities could be fostered and expanded through targeted creative impulses and individual support by the therapist.

Conflict of Interests

Authors have no conflict of interests.

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Embodied Reflections of Body-Oriented Clinical Psychology Students during Covid-19

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Report

Abstract

The world has encountered a pandemic named Covid-19 that has affected people's lives in numerous dimensions. During this ongoing dramatic and stratified period, we have been shattered globally in various layers. As 12 students of the first Body-Oriented Clinical Psychology master's program at Maltepe University in Turkey, we experienced uncertainty caused by the pandemic accompanied with online Body-Oriented Psychotherapy classes. Our experiences in Turkey, mostly Istanbul between mid-March and June, 2020 can be an example of reacting with uncertainty to the unexpected Covid-19 pandemic and may highlight the role of the body coping. In this article, we intended to reflect our pandemic experiences of significant changes in our lives. We examined our perception of the *new normal* as 'Body-Oriented Clinical Psychology students' in our reflections with distinct and common experiences. In addition, we covered the experiences of body awareness, embodiment, emotions, and interpersonal relationships while coping with the coronavirus. Our reflections revealed that the uncertainty of online education and other circumstances during this time caused anxiety and anger, while body-oriented courses helped us feel regulated and attuned. Sharing our experiences and evaluating the effects of our education on these experiences of lock-downs were important in gaining a better understanding of the circumstances in order to determine helpful solutions.

Keywords: Body-oriented psychotherapy; Covid-19; Coping; Uncertainty

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Introduction

A rapidly changing and developing era seems to be facilitating significant progression in anticipating and controlling events in advance, but it is impossible to obtain absolute knowledge and utter foresight and to perceive the universe holistically (Yýldýz, 2017). The differences of the individual perceptions of uncertainty depend not only on events, but also on interpersonal relationships. Therefore, experiencing uncertainty in the transition from face-to-face learning to online learning during the pandemic will be reflected in this article by Body-Oriented Clinical Psychology students.

Considering the current situation, the uncertain course of events related to the Covid-19 pandemic has led people to become unable to foresee that which will happen (Aykut & Soner Aykut, 2020). Even though every individual has her/his unique way of dealing with uncertainty and unpredictability, some ambiguity themes could be seen as collective. Individuals and society might experience intense anxiety and trauma since problems like unknown treatment techniques, lack of consensus about general properties of the virus, number of infected people around the world, infection pace of the virus, the fear of ourselves or our loved ones getting infected, lost lives, fear of death, radical changes in life, and the influence on economy and alterations in social relations are present (Aykut & Soner Aykut, 2020; del Valle, Andrésa, Urquijoa, Yerro-Avincettoa, López-Moralesa, & Canet-Juric, 2020).

Anxiety is a common emotion with reactions similar to that of fear. Fear causes the fight or flight response in reaction to a currently identifiable threat (i.e., assault). It is a basic, appropriate, and protective emotion (Sahin, 2017). Moreover, anxiety is related to an unidentifiable or non-existent potential threat (Asmundson, Taylor, Bovell, & Collimore, 2006). Even with the knowledge of the distinction between fear and anxiety, classifying the current emotion toward the pandemic is not simple. Various researches have stated that uncertainty is a stressor with psychological and physical outcomes and a predisposition to anxiety (Sarýcam, 2014; Yýldýz, 2017; Berenbaum, Bredemeier, & Thompson, 2008; Kasapoglu, 2020).

Considering that there are many uncertainties in our daily lives, perceiving ambiguous situations as threats inevitably leads to negative emotions (Behar, DiMarco, Hekler, Mohlman, & Staples, 2009). These negative emotions might evolve into traumatic experiences that might bring about an anxiety response. According to Bessel van der Kolk (2000), people experience a mix of numbness, withdrawal, confusion, shock, and silent terror when faced with a life threatening situation.

Pandemic

The rapidly spreading coronavirus is threatening the world and influencing global economy and countries, and has brought about diverse precautions and practices. These practices are mainly enforced by local/government level administrations and include regulations intended to create social distancing, such as flight limitations, quarantine, and martial law. A suppression approach has been adopted to slow down the pandemic by keeping masses at home and diminishing mobility to the extent possible (Telli & Altun, 2020). These conditions match various dimensions of the definition of trauma.

As Bessel van der Kolk (2020) mentioned in one of his talks, trauma is being unable to sustain usual activities, and feeling helpless and unable to change the situation. The Covid-19 pandemic experiences match this definition precisely. When

coronavirus was introduced to our lives, individuals experienced unexpected radical changes in their daily habits and suffered significant losses, such as loss of freedom, separation from loved ones, increased domestic violence cases, job loss and the related poverty, increased drug abuse, and stigmatization and discrimination (Aykut & Soner Aykut, 2020). Such radical changes and losses cause distress through triggering a response in our nervous systems. The Polyvagal theory essentially emphasizes that the central nervous system has multiple defense strategies. The brain regions that are related to high level functions like thinking and reasoning stop responding and regions that are related to primal "fight-flight-freeze" response are activated when faced with a threat especially to our physical unity (Hanscom et al, 2020). The present pandemic visibly threatens our physical unity and that of our loved ones.

A situation like a pandemic which leads to isolation and social distancing could be seen as a trigger for itself. Isolation is described as an undesirable situation that might trigger negative feelings such as fear and anger (del Valle et al., 2020). Due to these negative feelings, individuals might experience lockdowns and social distancing as a trauma. As Porges (2020) has asserted, bodies of individuals often hold on to fear after a traumatic event. Both pandemic diseases and their related precautions influence the well-being of embodied minds. A visible uncertainty has emerged as a result of the destruction of boundaries and expectations in current conditions (van der Kolk, 2020). Individuals might be able to tolerate uncertainty when they interpret it as an exciting adventure, whereas uncertainty that is interpreted as an obstacle or threat is harder to tolerate, such as in Covid-19 lockdowns. A significant amount of the population suffers from anxiety and depressive symptoms due to Covid-19 lockdowns, which can be explained as intolerance to uncertainty regardless of age (Askin, Bozkurt, & Zeybek, 2020). Pandemic related uncertainty can present itself as an overwhelming stress due to the unpredictability of the future and inability to control events.

As the level of distress caused by uncertainty during the coronavirus pandemic and lockdowns vary depending on prior level of vulnerability, not all coping strategies provide equal benefits (Rettie & Daniels, 2021). Every individual has their own unique way of coping with the situation depending on their internal factors like compassion and vulnerability. In this article, these coping strategies will be discussed on the basis of body and interpersonal relationships.

It should be noted that past and daily life experiences (trauma, anxiety, etc.) are shaping our bodies, emotions, cognitions, and lives. Although trauma has emotional and cognitive effects, it is essentially a physiological process (Levine, 2016). In anxiety, a high level of energy is visible in the body, in addition to a great deal of neural tension sensations such as nausea, heart palpitations, inhibited breathing, and tension on the chest (Röhricht, Gerken, Stupiggia, & Valstar, 2013). Röhricht et al. (2013) stated that, in order to cope with these stances, regulating the nervous system, breathing, grounding practices, and body awareness can be used as strategies to facilitate the formation of a steady stance on earth when feeling anxious. Therefore, these bodily strategies help individuals stay in the "here and now" and feel embodied.

As it is known, humans are social beings and live as a whole with their environment. The new social life adapted to social isolation is incompatible with the human nature, and thus, causes profound mental impairments (Aykut & Soner Aykut, 2020). There might be some steps that can be used during this period to help individuals to feel positive in order to protect their mental health and provide them

with psychosocial support. Workout videos and health applications that encourage and provide physical activity through the internet, mobile technological devices, and television are other ways of maintaining physical functionality and mental health during these critical times (Arslan & Rcan, 2020). Consequently, people tend to discover and develop various protective factors for stress caused by the uncertainty brought about by the pandemic.

The aim of this article is to reflect the Covid-19 experiences and coping strategies of body-oriented clinical psychology students through a body-oriented reflection on body perception, body awareness, embodiment, emotion regulation, and interpersonal relationships. These concepts reflect our own experiences during the transition period to the "new normal" accompanied by online Body-Oriented Psychotherapy courses from the beginning of the pandemic.

All 12 of us students are women from Turkey with an age range of 24-32 years (*Mean* = 26.8). In addition, 10 of us live with our families, while 2 of us live with friends. Contributors tried to isolate themselves to the extent possible. All of us have completed our psychology undergraduate degrees and the first term of body-oriented clinical psychology program.

Body Perception

The effect of anxiety on body perception could be seen as a common concept within the contributors. As mentioned, social isolation is found to be increasing anxieties related to health, financial issues, and loneliness (Thunström, Newbold, Finnoff, Ashworth, & Shogren, 2020; Reger, Stanley, & Joiner, 2020). Therefore, when Covid-19 was introduced, uncertainty emerged in many areas of daily life. For example, Xiao et al. (2020) found that individuals, who are in high-risk groups, might be potentially infected, or have contacted infected people, experience negative psychological effects even though they were physically healthy and not infected (as cited in Askin et al., 2020). This shows that the perception of one's own body might be affected by anxiety related factors. For instance, Allen and Walter (2016) noted that factors such as body (dis)satisfaction, social physique anxiety, and body image disturbances reflect on one's perception of one's own body

They stated: "...perceptions of the physical self that can be damaging to psychological well-being. For example, high levels of body dissatisfaction, low levels of body esteem, higher dysmorphic facial beliefs, and low levels of body appreciation are generally considered to reflect a more negative body image." (Allen & Walter, 2016). In the same manner, one contributor's Covid-19 experience shows how overwhelming emotions might reflect on body (dis)satisfaction and affect one's body perception:

"*I felt anxious throughout this process and it affected my body perception negatively. I had a body perception that felt familiar and similar to that of my previous anxiety attacks. I was feeling a lot of pressure on my body. This feeling of repression led me to close in and allow my body to be still. My body became immobile and my vestibular system was affected. I became more careless, lazy, and anxious, and my body posture changed. As my anxiety increased, I started to look at my body more negatively. I found myself thinking that I was ugly because of the acne sores on my face*". (Author A)

The emotions that stood out in this process caused changes in our body perception. Anxiety caused by uncertainty was one of the most common emotions. According to Röchricht and Priebe (1996), body perception is negatively correlated with anxiety levels (as cited in Röhricht et al., 2013). This correlation has also been observed in our experiences.

Before Covid-19, there were many stressors in our daily lives. For example, as Allen and Walter (2016) cited: "Sociocultural factors, such as exposure to media images depicting a thin ideal, have been found to contribute to negative perceptions of one's body (Grabe et al., 2008; Groesz et al., 2002)." Therefore, it might be hard to be aware of the way we perceive ourselves because of concurrent overwhelming environmental factors. Thus, we might be in need of something such as body movements or focus on our own body, as one of the contributors mentioned:

"*My belly has gotten bigger and my legs have gotten thicker. I feel heavier and bulkier. It does not seem strange that this has happened while constantly staying at home … When we return to normal life, I will try to get rid of this dissatisfaction by losing the weight. I am aware that my perception about my body originates from society's ideal female figure. The feeling of my new weight results in an incredible tension, especially in my abdomen. Putting my hand on my belly in meditation relaxes me, makes me feel more regulated, and makes me more aware of my bodily sensations, but I have not felt motivated enough to do it for a longer time. Interactions at online Body-Oriented Psychotherapy classes motivated me to do it.*" (Author B)

Moreover, 'the perception of our own body is unique because it occurs from the inside, via touch and proprioception, and from the outside, via vision', as Allen and Walter (2016) stated. Because body perception is unique, not all of the contributors had a negatively affected body perception. The environmental factors that we underwent during the quarantine also affected perception. Another contributor who was able to move and exercise in her body more freely expressed her reflection more positively:

"*I try to work extremely hard in physical fitness activities to ensure that I maintain my fitness. Therefore, I am physically active and always engage in sport activities. As a result, I believe I have my ideal body, which has helped me to develop a positive perception towards it. Thus, when Covid-19 started, I felt the benefits of physical activities in maintaining mental health and body fitness.*" (Author C)

In addition, Sheets-Johnstone (2005) stated: "Perceptions of one's own body are, in other words, the *sine qua non* of both conceptual understandings of, and emotional attitudes toward, one's body. If one did not perceive one's body, one would have no grounds for building or having such conceptual understandings or emotional attitudes." (Prester & Knockaert, 2005). The effect of overwhelming emotions on our body perceptions can be so unbearable that people might engage in avoidant behavior. In this regard, a contributor stated:

I have always felt dissatisfied with my body, but it was different this time. I remember that my sensations were shut down at the beginning of Covid-19. I do not remember feeling or thinking anything. There was no action physically or mentally. It was like, I was in a state that had stopped and I was protected from the outside world by borders. When the Body-Oriented Clinical Psychology classes started, I started to realize how much weight I had gained and it was hurting for the first time. It was not the first time I had gained weight, but it was the first time I had felt shame and dissatisfaction to such a degree. (Author D)

With the examination of the body perception experiences of contributors, we can say that the effect of overwhelming emotions, body (dis)satisfaction, environmental factors, and embodied activities is visible on body perception during the quarantine period. Emotions have really affected the body perception of the contributors, whether positively or negatively. Thus, we can say that emotions may alter the perception, but the key point here is to notice and accept sensations by raising awareness and embodiment.

Body Awareness and Embodiment

Cebolla et al. (2016) described body awareness as a modulating factor of embodiment, which may alter the perception of our body. Therefore, the primary influence of body awareness and embodiment was another common concept between the contributors. This concept can be explained as high body awareness provides higher life quality, lower pain, and depressive symptoms (Erden, Altuğ, & Cavlak, 2013). Body awareness is beyond proprioception or having control over the body. Body awareness can be defined as "the perception of bodily states, processes and actions that is presumed to originate from sensory proprioceptive and interoceptive afferents and that an individual has the capacity to be aware of." (Mehling, Gopisetty, Daubenmier, Price, Hecht, & Stewart, 2009). Thus, it provides us with some valuable information for the well-being of a person. Without the information from body awareness, individuals might get disembodied, for example, as Totton (2003) noted, body awareness can be defined as a basic step to feeling embodied.

The pandemic process was a new and unpredictable experience; it diminished our awareness of our body and feelings at the beginning of the process. Because of constantly being alert to the dangers caused by environmental factors, we might move away our awareness and avoid our needs in order to cope with the overwhelming situation.

"*I started living with my family during the quarantine. Feelings of being stuck, intense anger, and anxiety occasionally created conflicts at home. I was unaware of the effects of this tension and its reflections on my body. During a mirroring exercise, I focused on my body and noticed the tension in my chest and shoulders, but somehow I could not feel embodied. It was necessary to find out what caused the tension in my body, which meant to face the event. I did not want to do this when I was in the same environment with my family, and so, did not complete that exercise.*" (Author E)

"*I have always had some semi-autistic features in my vestibular functions and body awareness, until I learned how to give attention to and feel at home in my body. Feeling grounded is not that easy for a person who barely touches the floor, but somehow I managed -or even forced myself- to do it. Shifting from a hypo-embodied state to a nearly hyper-embodied one changes not only your perception of your body state, but also the way you experience your emotions. I understood for the first time in my life what anxiety really is. Numbness in my arms and legs, irregular breathing, and constant discomfort without a concrete reason accompanied me for a while during the quarantine until I found a way to release the tension through mindfulness techniques.*" (Author F)

As stated in these reflections, gaining body awareness has not always been an easy process. Moreover, these experiences have clearly demonstrated the effect of body awareness on embodiment. According to Röhricht et al. (2013), "body awareness techniques are utilized with a view to emphasize the importance of embodied activity for one's state of mind." Embodied exercises enabled us to experience the process in a calmer and more realistic way by becoming aware of the bodily reflections of the mind.

Moreover, the continuation of body-oriented classes during this period enabled us to gain body awareness. This kind of awareness has led us to develop more potential for self-regulation as a result of strengthening the neuronal connections between the limbic system and the prefrontal cortex. In addition to doing this, it allowed us to use it as a resource to improve our functionality in everyday life and deal with problems. The following statement of a contributor refers to how obtaining body awareness through body exercises helped them to accept the process.

"I felt my emotions so intensely at the beginning, but right now I can regulate myself. The milestone of this regulation is of course the continuation of body-oriented courses. The online courses opened up a space for me to experience my body, which helped me to feel embodied. In addition, experiencing my body during the quarantine periods made me feel more connected with my soul. The body-oriented practices gave me the opportunity to explore my bodily resources and strengthen my awareness. The feeling of self-care and self-love helped me to feel more embodied and to make a distinction between my feelings and my senses from the beginning of the pandemic situation until now. I became aware that I am not composed of feelings, but rather temporarily affected by them." (Author G)

When we feel embodied, it is easier to come to the here and now, which creates a baseline for living in the moment. Totton (2003) explained that embodiment refers to the state of being united with bodymind, which is often used to name the state of experiencing this unity. According to our experiences, a person has to find their resources to have an enduring embodiment because the resource will provide the power to strengthen the bodymind connection. Increasing our bodily and mental awareness will help us to become easily grounded and it will lead to a better embodiment experience. The benefits of repeating body awareness exercises and accepting this experience throughout the process are clearly stated in the reflection of another contributor:

"Once you can observe what is going on with you, you start feeling able to make choices; so, I used some Hakomi exercises to activate my body to feel emotionally regulated. There were some times in which I closed my eyes and asked myself where in the body do I need a touch? I hugged my body and said: 'I am here.' This exercise helped me to feel embodied and emotionally regulated. Through the body-oriented techniques, we, as clinical psychologist candidates, have learned that without being embodied, one cannot fully understand others. When I need to regulate myself, I first start by being embodied because of this. Doing this made me feel less anxious throughout the day." (Author H)

In light of the above reflections, it can be clearly seen that we had diverging body awareness experiences via body awareness exercises during quarantine. In this period, we have experienced different emotions and bodily sensations. Body-oriented practices helped us to gain insight about our body awareness and to accept the overwhelming circumstances.

Emotion Regulation

Emotions are the most primitive experience of one's body. Although recognizing emotions could be considered as the most basic and natural need of human beings, we are mostly confined to the mind level due to our cultural norms. We tend to suppress and ignore emotions rather than just normalize them. In her reflection, one of the contributors pointed to the search for emotional regulation while dealing with her overwhelming emotions.

"Everything was overwhelming for me and I tried to escape from all my feelings by watching something or spending time on social media, but it did not work for long. Even though I really forced myself to do something, I could not concentrate on anything because I felt so anxious. I also felt lost, life was going on and I could not do anything like others, who I saw on social media, to improve myself. All these things made me more and more anxious". (Author I)

Our thoughts and feelings are shaping our body. Experiences, especially when they are overwhelming, change our nervous system and the body tries to find a solution to regulate itself (Levine & Frederick, 1997). What we define as emotion

actually arises through chemical changes as a result of mental processes linked to our nervous system. Thus, we can actually define our emotions as the defense systems in our body. If we are disconnected from our emotions, when we encounter an emotion, we usually see the effects of that emotion at the mind level and try to analyze its effects in our life. However, every emotion has a purpose, so the most important question to be asked is what does the emotion want us to know, and from what does it protect us? Being aware of these emotions and being able to stay with them enables the person to establish a better connection with their emotions, and accordingly, to express them in a healthy way. One of the contributors explained, in her reflection, how embodied exercise and self-acceptance helped when she had difficulty in recognizing and regulating these overwhelming emotions.

"*During the lockdown period, I always tried to calm myself down because I felt so intense. When I started to meditate to get calm, I had a hard time focusing. I felt like I was in my study room, because I could not get out of my mind. I have always planned something when trying to focus on my body and my feelings. Then, with the body-oriented psychotherapy courses I started to feel my body more through learning, experiencing, and touching, and concentrating on my breath, my heartbeat, and my senses. I noticed that I became more relaxed day by day. Being in the body makes me feel safer; when I was in my body, I also felt the here and now. After managing that, meditation became my routine and I started to try not to judge myself for not doing something I had planned.*" (Author J)

In many statements, body-oriented classes were considered as the biggest support for gaining insight. It is seen in our reflections that we, first, became aware of how to feel, and then, how to define those emotions and senses. At the beginning of the pandemic, we often had trouble recognizing our emotions because of the exhausting encounter with unpleasant emotions. Like many people, we did not know what reaction we should have in this new and unconventional situation. As we began to recognize and accept our emotions we discovered how to regulate them in our own unique way.

"*As a Body-Oriented Clinical Psychology student, when I became embodied, I was able to realize my unhealthy behaviors quickly and transform them into experiences which brought balance. In other words, at first I was disconnected from my emotions and body, and I felt almost numb. Then, as we went through our classes, I became aware of my emotions and tried to regulate them. In this period, I learnt that in order to cope with overwhelming emotions, the first thing is to accept them. I discovered some relaxation strategies that helped me accept the situation*"(Author K)

Movement was one of our primary sources for regulating our overwhelming emotions, which we could not define at first. We can say that this pandemic is a traumatic event and people who live traumatic experiences feel stuck in their body and need to release tension in order to heal the trauma (Totton, 2003). If we are not able to release the energy, we remain stuck in our nervous system and lose our resilience. Creating a safe place in the body to let the energy flow is necessary, because the energy comes from the body. Movements and exercises presented in the body-oriented clinical psychology classes helped us to eliminate the feeling of being stuck and to regulate our emotions.

"*Dancing, by myself or with my friend via camera, made me feel more energetic and gave me hope for life. Three or four times a week I practiced yoga. I started yoga before the quarantine so I knew the poses, functions, and breathing exercises required for practicing it. Sometimes, I confronted my unpleasant feelings and fears after yoga. I asked myself regularly: "What is happening in my body?" "How is my breath/my body at this moment?" I found*

many answers, but actually I did not want to look into those sensitive parts of myself intentionally. After starting the Body-Oriented Clinical Psychology master program, I became more aware of my body." (Author B)

Our emotions, mind, and body are acting as a whole, and in our work with the body, we actually increase the balance between them and our capacity of resilience. Our reflections showed that body movement/exercise have positive effects on regulating the nervous system and help us calmly accept the overwhelming outcome of difficult situations.

Interpersonal Relationships

Our daily routine was changed with the pandemic lifestyle. People started to stay at home and could not see their friends, co-workers, or even (elder) family members. The term "new normal" was introduced in order to define the new balance of our lives and relationships. The new normal has restricted our relationships with our environment. As embodied human beings, we are programmed to form relationships from the earlier stages of life (Totton, 2015). To fulfill this need, we sought different ways to build relationships.

Most people started to interact with others through smartphones and video meetings. As mentioned by Aristovnik, Keržic, Ravšelj, Tomaževic, and Umek (2020), in order to protect psychological well-being, survival mechanisms lead people to find alternative ways to communicate and relate during social isolation, such as online communication with family and friends or using social networks. As many people do, we started to communicate online with the people around us in order to cope with this process easier; we had the urge to sustain our relationships and social needs.

"*Sharing joyful experiences such as watching movies with a friend through video call or celebrating birthdays and having a family dinner on Zoom were helpful in fulfilling my social needs and it created the feeling of being surrounded.*" (Author E)

During the quarantine period, people had to quit the types of interactions they were used to and find a new channel of communication in order not to lose their social relations. The social psychology perspective emphasizes the importance of being socially active and in contact with others. The two significant aspects of contact, the sense of community and social support, are found to have a stress, anxiety, and depression buffering effect and enhance welfare (Obst & Stafurik, 2010). Sustaining our relationships with people throughout the process also affected our well-being positively. Being in similar conditions with these people also made it easier for us to attune to each other.

"*I usually contacted my friends online. Being in contact, even if online, felt significant for the connection and attunement. The most important thing that I have learned from this pandemic period about relationships is that attunement with other people is significant for a trustworthy and enduring relationship, but the main point is to feel the attunement in ourselves in order to make other people feel attuned to you.*" (Author K)

Feeling surrounded is an important aspect of this pandemic situation. It might help to create and to collect positive experiences. The feeling of being a part of one or more groups plays an important role in the construction of a person's social identity (Antonini, Schiavio, & Biasutti, 2020). Eisenberger (2012) defines the disruption of social identity as one of the most painful and emotionally unpleasant feelings a person can experience because it involves the risk of damaging one's ability to relate to other individuals. Therefore, we continued to stay in touch with people in order to protect this identity. One of the contributors expressed the effect of being united and

feeling accepted by others in the following words:

"Being with others during the pandemic situation gave me confidence because I knew that I was not alone. As social creatures we live in the eyes of others, so we need others to feel alive. Acceptance and seeing reaction are our needs, we need to feel accepted in a group. In a body psychotherapeutic group, as in any other small group, the members tend to listen to each other, but first we need to find out how we can understand each other." (Author A)

As social beings, we all needed to socialize and create connections with others to feel attached. Because of the pandemic, these social needs were restricted regardless of our wishes. According to Holt-Lunstad (2017), "lack of social relationships during isolation, influences psychological and emotional wellbeing negatively" (as cited by Askin et al., 2020). After getting out of the pandemic shock, people found a way to maintain their relationships for being regulated. Moreover, this regulation could be seen as helpful for gaining tolerance regarding the uncertainty of social isolation.

Discussion

This article has analyzed our embodied reflections during the pandemic in terms of body perception, body awareness, emotional regulation, and interpersonal relation. As previously mentioned, the authors of this article encountered the pandemic when their education proceeded as body-oriented master program students. The study group (13 students and professors who have traveled around the world) had previously met each other in person, and thus, were able to create a healthy and close relationship with each other. This may affect the authors' statements and reflections. The contributors' first contact with body work had not been during the pandemic; all contributors had experienced embodied exercises in "normal" classroom settings. Yet, all statements are reflecting embodied experiences during the pandemic, which were made in an online setting. Consequently, this article is written by authors who are new to the field of body work, but had the chance to experience it in physical close settings. It should also be mentioned that all experiential body exercises were performed under the supervision of body psychotherapists, which might also lead to a therapeutic intervention. Even though our statements are compiled under the key concepts of body perception, body awareness, emotional regulation, and interpersonal relation, they are experienced individually and vary in different reflections.

The theme body perception, which is defined as the perception of one's own body of both conceptual understanding and emotional attitudes by Sheets-Johnstone (2005), was repeated often in statements. The effect of overwhelming emotions, body (dis)satisfaction, environmental factors, and embodied activities are visible on the body perceptions of authors. Body awareness leads to the development of more potential for self-regulation as a result of strengthening the neural connections between the limbic system and the prefrontal cortex. The statements of authors were based on concepts like overwhelming emotions, environmental factors, embodied movement/exercise, and self-acceptance. The main idea remains with the outcome that bodily and mental awareness leads to a grounded state and shifts the body to an embodiment experience. The knowledge that emotions, mind, and body are acting as a whole led to a common statement that there was an increase in the balance between them and our capacity for resilience. Regular body work shows effectiveness in controlling the nervous system and on individuals' ability to deal with difficult situations without being overwhelmed by the intensity of emotions. Concepts like overwhelming emotions, embodied movement/exercise, and self-acceptance were repeatedly stated in embodied reflections under the term emotion regulation.

Relationships were also considered as a regulation tool. Daily life and communication had gained a new dimension called a new normal. Yet, reflections under interpersonal relations in general were made under the subjects social needs, acceptance, and sharing. This brand new lifestyle caused many changes such as different forms of communication. We benefited from communicating with people including family, friends, and professors, and maintaining relationships with them. This helped us to understand the situation and support ourselves. These connections through a screen helped to regulate and create tolerance for the pandemic.

During these experiences, some of us experienced focusing on the body and becoming embodied as easy and relaxing, while others found them difficult. Trying and not feeling successful in focusing on the body can emerge as a source of distress. Even though we had worked with the body before, we had never experienced it under the pressure of unexpected pandemic uncertainty. While experiencing various states in becoming embodied, all the body related exercises were applied and constantly supervised by experienced instructors. The presence of an instructor was essential and supportive for those who showed intense and anxious expressions. It is suggested that such training programs be guided by qualified instructors in order to ensure their ethically appropriate progression. While evaluating this article, the circumstances mentioned above should be considered.

Contributors knew each other very well before shifting to the online context and were regularly meeting. Sharing our experiences and evaluating the effects of our education on these experiences of lock-downs were important in gaining a better understanding of the circumstances in order to determine helpful solutions. Consequently, the setting of online body-oriented classes might have a group therapy effect. Further research might investigate the effects of body-oriented work on newly formed groups or individual practice. Moreover, all contributors had previously had the chance to meet and experience body related work in face to face settings. Future research can investigate the effects of body-oriented work on people who have never experienced body-oriented work before.

Conflict of Interests

Authors have no conflict of interests.

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