“This Isn’t Just Busy, This is Scary”: Stress, Social Support, and Coping Experiences of Frontline Nurses During the COVID-19 Pandemic

Erin S. Craw  
*Chapman University*

Tess M. Buckley  
*Chapman University*

Michelle Miller-Day  
*Chapman University, millerda@chapman.edu*

Follow this and additional works at: [https://digitalcommons.chapman.edu/comm_articles](https://digitalcommons.chapman.edu/comm_articles)

Part of the [Epidemiology Commons](https://digitalcommons.chapman.edu/comm_articles), [Health Services Research Commons](https://digitalcommons.chapman.edu/comm_articles), [Other Nursing Commons](https://digitalcommons.chapman.edu/comm_articles), [Other Psychiatry and Psychology Commons](https://digitalcommons.chapman.edu/comm_articles), and the [Public Health and Community Nursing Commons](https://digitalcommons.chapman.edu/comm_articles)

**Recommended Citation**


This Article is brought to you for free and open access by the School of Communication at Chapman University Digital Commons. It has been accepted for inclusion in Communication Faculty Articles and Research by an authorized administrator of Chapman University Digital Commons. For more information, please contact laughtin@chapman.edu.
“This Isn’t Just Busy, This is Scary”: Stress, Social Support, and Coping Experiences of Frontline Nurses During the COVID-19 Pandemic

Comments
This is an Accepted Manuscript version of the following article, accepted for publication in Health Communication, volume 38, issue 10, in 2023 at https://doi.org/10.1080/10410236.2022.2051270. It is deposited under the terms of the Creative Commons Attribution-NonCommercial License (http://creativecommons.org/licenses/by-nc/4.0/), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited.

This scholarship is part of the Chapman University COVID-19 Archives.

Creative Commons License

This work is licensed under a Creative Commons Attribution-Noncommercial 4.0 License

Copyright
Taylor & Francis
“This isn’t just busy, this is scary”: Stress, Social Support, and Coping Experiences of Frontline Nurses during the COVID-19 Pandemic

Erin S. Craw, Tess M. Buckley, and Michelle Miller-Day

Author Note

Erin S. Craw is a Ph.D. student in the School of Communication at Chapman University. Tess M. Buckley is a Ph.D. student in the School of Communication at Chapman University. Michelle Miller-Day is a Professor in the School of Communication at Chapman University.

Correspondence concerning this article should be addressed to Erin Craw, One University Drive, Orange, CA 92866. Email: craw@chapman.edu.
Abstract

Despite having previous experience and extensive trauma training, the COVID-19 pandemic presented unprecedented challenges for nurses working in hospital settings. During the pandemic, nurses struggle to care for patients and protect themselves from infection, while navigating ongoing organizational changes. Guided by prior literature on social support and coping, this study explores nurses' experiences of coping with stress while treating COVID-19 patients during the pandemic. In-depth semi-structured interviews were conducted with 14 active staff nurses working in hospitals and one licensed practical nurse (LPN) at a rehabilitation center who treated COVID-19 patients during the pandemic. An inductive thematic analysis was employed to analyze those data, and three overarching themes emerged: (1) nurses’ unique experiences in the [COVID-19] trenches, (2) nobody else understands, and (3) coping with stress together. Practically, this study is heuristic and generates an increased understanding of professional communication during times of healthcare crises, illuminating the need to enhance communication skills for both staff nurses and management. This study also extends our understanding of communal coping in the context of healthcare organizations.

Keywords: nurses, communal coping, interpersonal communication, COVID-19, stress
This isn’t just busy, this is scary”: Stress, Social Support, and Coping Experiences of Frontline Nurses during the COVID-19 Pandemic

By March 2021, one year after the novel Coronavirus (COVID-19) was deemed a pandemic by the World Health Organization (WHO; 2020a), over half a million American citizens died (Centers for Disease Control and Prevention [CDC], 2021b). Behind each of those deaths are numerous healthcare workers who sat with them, treated them, and cared for them. Despite being trained to respond to crises and manage high levels of stress (Godley, 2021), the COVID-19 pandemic presented unprecedented challenges for healthcare workers who face unique concerns about having adequate personal protection equipment, contracting the virus, and their families (Ehrlich et al., 2020). In 2020, more than 9,000 healthcare workers were diagnosed with COVID-19 (CDC, 2020), and nearly 3,000 died from the virus (McCarthy, 2021). As such, many healthcare workers are also treating and experiencing the death of their colleagues (Miotto et al., 2020).

In a 2020 survey of about 1,120 healthcare workers, over 90% of healthcare providers reported feeling stressed and exhausted (Mental Health America, 2020). Previous crises such as the September 11th terrorist attack (DiPierro et al., 2020) and Ebola outbreaks (Raven et al., 2018) have demonstrated that healthcare workers experience both short and long-term mental health effects following exceedingly stressful and traumatic events. Nurses are a particularly vulnerable group to workplace stress because they spend the most time working bedside with patients and are highly involved in the coordination of patient care with other members of the healthcare team (U.S. Department of Health and Human Services, 2010). Thus, they need social support, not only from those with whom they have personal relationships, but also support in the workplace (Lim et al., 2010). The current study looked specifically at frontline nurses, which
refers to those who directly treat and are exposed to COVID-19 patients (see CDC, 2021b). Frontline nurses have suffered from anxiety and depression (Zhang et al., 2020), leading to a decline of morale and decreased job satisfaction (Tolomiczenko et al., 2005). Therefore, information is needed on how best to support nurses during an unparalleled health crisis of a pandemic (Figueroa & Aguilera, 2020). For the purposes of our study, we were interested in the experiences of staff nurses, or those that provide direct patient care and act as the primary contact for patients and their families (Alvernia University, 2019).

The aim of the current study was to better understand the experiences of stress, coping, and supportive communication that is occurring in the lives of frontline nurses during the COVID-19 pandemic. Specifically, we explored how staff nurses’ perceptions of supportive communication in interpersonal relationships within and outside the workplace influenced coping while working on the frontlines during the pandemic. Organizations such as the American Nurses’ Association (ANA; 2021b) and the CDC (2021a) include social support on their list of recommendations for how hospitals can care for healthcare workers during the pandemic. However, limited research has looked at how support is being communicated internally. A qualitative exploration of frontline nurses' (staff nurses and an LPN) views of communication and social support in interpersonal relationships during the pandemic will allow first-hand insight into the communicative behaviors that influence coping.

Background

Nursing During the COVID-19 Pandemic

As stated by the ANA, “When everyone else ran from the storm, nurses ran directly into the middle of it all.” (2021a, para 1). Since the COVID-19 pandemic began, nurses have suffered adverse mental health effects such as depression, anxiety, and excessive stress (Leng et al.,
2020). These mental health-related problems are linked to are a lack of sleep, fear of exposure, and high levels of ambiguity (Sampaio et al., 2020). Nurses utilize evidence-based practice to ensure safety and effective care for all patients. Given the volume of new information and a lack of substantive evidence or data about treating their COVID-19 patients, nurses are having to cope with uncertainty and think critically about how to best treat their patients without adequate data (Wierenga & Moore, 2020). As a result, nurses are experiencing hopelessness and emotional exhaustion (Goldstein, 2020). In addition, nurses are uncertain about their responsibilities as many no longer work in the same units or practice the type of nursing they were educated to perform (Godley, 2021). The displacement is critical to note because nurses strongly identify with their roles, specific unit, and even floors in which they have developed small, close-knit groups (Moreland et al., 2020). Also, typically after treating patients involved in a crisis (e.g., natural disaster), nurses go home to decompress and cope with work-related stress. Given the nature of the COVID-19 pandemic, nurses have limited opportunities to separate themselves from trauma while having to remain distanced from outside family and friends. As outlined by the Code of Ethics for Nurses (ANA, 2015), these professionals are faced with decisions regarding how to provide and maintain the highest-quality care while protecting themselves and their families during a pandemic.

Prior literature on communication in nursing contexts has focused heavily on the interactions between nurses and patients (e.g., Afriyie, 2020). For instance, researchers have examined patient satisfaction with nurses’ communication (Uitterhoeve et al., 2009; Ledlow et al., 2003). Studying communication between peers as well as nurses and external social networks is also essential to consider. During highly stressful situations, communication between peer nurses often changes, and a focus on collaboration may shift to more independent problem-
solving (Andre et al., 2016). Though, less is known about how communication has changed among nurses during the COVID-19 pandemic in terms of workplace interactions and peer support.

**Stress, Social Support and Coping**

Nurses working under threatening conditions such as a pandemic are more apt to feel psychological stress, especially for those who care for infected patients during these disease outbreaks (Wu et al., 2009). This can result in anxiety, depression, and even increased suicidality (Liu et al., 2012) and can ultimately negatively impact patient safety (Hall et al., 2016). The capacity to cope and manage stress, however, can serve as a protective factor for nurses experiencing extreme stress and emotional exhaustion.

A previous study on emergency department nurses demonstrated that a lack of social support may increase their risk of developing Post Traumatic Stress Disorder and other adverse mental health effects of trauma experiences (Laposa & Alden, 2003). In organizational contexts, stress caused by uncertainty can be reduced by supportive communication (Ray, 1987). Previous research found that nurses who report favorable views of interpersonal communication at work also feel more control over their job (Moreland et al., 2020).

*Social support* refers to interactions in which nonverbal or verbal messages are produced to assist someone in need (Burleson & MacGeorge, 2002). Social support is a transactional process that helps recipients feel greater control in challenging circumstances (Albrecht & Adelman, 1987) and enhance coping mechanisms (Curtona & Russell, 1987). Emotional social support involves listening, allowing an individual to vent, and communicating compassion (Cohen, 2004). Prior literature on social support in nursing demonstrates that emotional support is particularly significant in this population (Sodeify & Habipour, 2020). Notably, a 2020 survey
conducted by Mental Health America found that nurses specifically expressed a lack of emotional support during the pandemic (Mental Health America, 2020). Individuals who have shared experiences are likely to provide and receive more effective social support than those who do not (Albrecht & Adelman, 1987).

Social support can help prevent negative consequences of work-related stress among nurses and decreases feelings of isolation (Bennett et al., 2001). Specifically, social support enhances individuals’ ability to cope with stress. Prior research showed that the stress inherent to nursing might be alleviated by social support from co-workers (AbuAlRub, 2010). Nurses who feel supported by peers have previously reported more positive views of their work environment, better performance, and higher job satisfaction (Bennett et al., 2001). Therefore, nurses' perception of social support from their peers is an essential aspect of coping with the profession's intrinsic stressors.

Nurses may also receive social support from family members or friends outside of their job (Albrecht, 1983). Prior research demonstrated that support from family and friends is particularly important to nurses' well-being as they navigate shiftwork (Gifkins et al., 2017), or working outside of the typical working hours, including nights, weekends, and overtime (Antunes et al., 2010). Given the extremely stressful nature of the pandemic, the significance of social support from family and friends in addition to peers is likely even more critical at this time.

This background clearly indicates research support that frontline nurses are particularly vulnerable to workplace stress and in need of social support—both from others in the workplace and in their personal lives—to enhance their ability to cope with that stress. Yet, the literature is not clear about what kind of support this group of professionals is provided during the COVID-
19 pandemic if that support is desired and—importantly—perceived as effective. Hence, to guide this descriptive study and allow us to explore the perceptions and experiences of frontline nurses, we posed the following research question:

   RQ1: What experiences of workplace stress do nurses report when working in hospitals directly with COVID-19 patients during the pandemic?

   RQ2: In what ways, if any, has supportive communication in interpersonal relationships within and outside the workplace influenced nurses’ coping while working on the frontlines during the COVID-19 pandemic?

Methods

Participants

Participants were 15 active female nurses aged 26 to 62 (M = 36.93, SD = 12.91). Most nurses (n = 13) resided and worked on the east coast, and two on the west coast. All participants were from different hospitals in these geographical locations. At the time of data collection, about seven months into the officially declared pandemic, most nurses had been working as nurses for one to five years (n = 7), five nurses had 15 more years of experience, while two nurses had six to ten years of experience, and one nurse had 11 to 15 years of experience (see Table 1). With the exception of one LPN who worked at a rehabilitation center offering short and long-term care, all participants were staff RNs working in hospitals providing direct care to COVID-19 patients at the point of data collection. The nurses in our study worked in various units, yet all treated COVID-19 patients given the inundation of patients.

The inclusion criteria for this study were that individuals must be (1) 18 years or older; and (2) a nurse (e.g., RN, LPN, APRN) who were currently treating or had previously treated COVID-19 patients. Participants were recruited through purposeful network sampling. A
recruitment script was posted to the researchers’ personal social network accounts (i.e., LinkedIn, Facebook, Instagram), and interested nurses were asked to follow up via email to schedule their interview.

**Procedures**

To explore our research question, data were collected through in-depth semi-structured interviews with the participants. The research team consisted of three female health communication scholars trained in qualitative interviewing techniques. After receiving approval from the institutional review board, we first asked participants to complete a brief demographic survey and an online consent form via Qualtrics. Next, a flexible interview guide was used to prompt and guide discussion on topics related to the research questions. The semi-structured interview guide provided direction for the interview while allowing for a natural conversation about personal experiences. The interview guide addressed workplace stress, perceptions of support from peers, family, and friends during the pandemic (e.g., “What is your perception of the support you have received—or not received—from your family/friends during the pandemic?”), desired support during health pandemics, and coping strategies. All semi-structured interviews were conducted via Zoom, were audio and video recorded, and then transcribed verbatim. Interviews were conducted for an average of 49.64 minutes, resulting in 132 single-spaced pages of transcription. All participant names were removed and replaced with pseudonyms to ensure confidentiality.

**Analysis**

Two researchers individually read all transcripts and engaged in consensus coding, which involved active discussion about interpretations and addressing any discrepancies collaboratively (Richards & Hemphill, 2018). An inductive thematic analysis was conducted to identify, analyze,
and describe themes that emerged from our conversations with frontline nurses and addressed our guiding research question (Braun & Clarke, 2006). First, primary-cycle coding was employed initially to assign labels to codes that best describe the meaning of related words or phrases (Saldaña, 2015). Then, codes were further developed while considering prior literature and organized into categories through secondary-cycle coding (Saldaña, 2015). In identifying linkages between those categories and patterns in the data, we then developed overarching themes. A theme can be defined as an idea that recurs in or pervades the data and can be identified through recurrence, repetition, and/or intensity of an idea (Miller-Day, 2004).

The goal of this study was to gain insight into the lived experiences of our purposeful sample of beside nurses who were treating COVID-19 patients directly. To ensure data saturation was reached, responses were analyzed continuously throughout the data collection process, and interviews continued until no new information emerged (Guest et al., 2006). The sample size was consistent with prior qualitative research with nurses (e.g., Alicea-Planas et al., 2012), who are a difficult to reach population, especially during a pandemic. Each discussion with participants varied slightly, given the flexibility of the semi-structured interviews. Thus, we discuss overarching themes related to our research questions. To enhance the study's trustworthiness, the researchers practiced self-reflexivity and engaged in debriefings as a team after interviews (Lincoln & Guba, 1985). Beginning with initial data collection, the research team maintained an audit trail including memos outlining analytical decisions. In enhancing the credibility of our study, member reflections were conducted with six nurses in which we asked the nurses to indicate their agreement, provide reactions, and identify any discrepancies in our interpretations. All six nurses confirmed that the study findings aligned with their own personal experiences. In
addressing confirmability, we utilized excerpts from participants’ responses to support our
claims and illustrate findings (Lincoln & Guba, 1985).

Findings

The aim of the current study was to better understand the experiences of workplace
stress, coping, and supportive communication that is occurring in the lives of staff nurses and an
LPN during the COVID-19 pandemic. Three overarching themes emerged from our analysis,
including (1) nurses’ unique experiences in the [COVID-19] trenches, (2) nobody else
understands, and (3) coping with stress together. These emergent themes describe the
experiences of frontline nurses participating in this study and help us understand what might be
needed to help frontline nurses in future pandemics. Specifically, the themes explained below
illuminate the factors that influenced participants’ views of and experiences with supportive
communication. Moreover, these themes underline how those experiences affected the nurses’
ability to cope with pandemic-related stress.

Nurses’ Unique Experiences in the [COVID-19] Trenches

There is a Disconnect Between Nurses and Management

Internal communication with management emerged as important to participants, and
messaging among nursing staff and management was almost exclusively framed as deficient.
Nurses emphasized how more communication with leadership would have helped them cope
with the high stress levels during the pandemic. Collectively, nurses highlighted the
distinctiveness of their experiences as frontline nurses. Although the nurses in our study did not
specify management roles, the constructed meaning between interviewees and the interviewer
suggested that “management” were those who were not directly providing care to COVID-19
patients during the pandemic. In doing so, participants described a disconnect between
themselves and management. The disconnect described in our discussion with participants was related to feeling a lack of presence from members of management, physically and emotionally. Lisa said, "It seemed like they [management] just wanted nothing to do with the patient side of it." Several nurses described their frustration with management’s general lack of understanding of what is needed when working in COVID-19 units and treating those with the virus. For instance, Brittney said, "Well, you [managers] don't really know what we are going through," and Mary noted, "...any concerns, the response [from managers] was ‘it is what it is,' and we just have to suck it up and do it." The participating nurses emphasized how communication from management during the pandemic was “more vague than usual” and often lacked empathy.

In describing how information was shared, Charlotte described the atmosphere of a weekly meeting at her workplace. She said:

This is our only source of information about anything that's going on in the hospital. And our manager walked in at seven o'clock in the morning and was like, what are you all doing? So, no good morning, not how is everybody? No, 'I am sorry you are all going through this.' It was, “what are you all doing? You're not six feet apart.” And no one even turned their head around to look at her because we're like, “are you kidding me?”

Despite being up close and personal with severely ill individuals for most of their working day and working closely side by side with their peers in intensive care settings, many nurses complained that management tended to be ignorant of what was going on “in the trenches.” Charlotte expressed frustration with a perceived lack of knowledge and empathy on the part of management, but also the lack of interest management showed in the nurses’ daily activities, activities that were discussed as highly necessary yet increasing fraught with risk.
Some nurses described how new protocols imposed during the pandemic were not always practically feasible, further demonstrating the disconnect between management and the frontline nurses. Heidi noted, "They [management] don't seem to communicate clearly, or they keep us out of the loop as far as making major changes." The nurses in this study explained how they would have preferred more explicit messaging from management about daily practices and changes in policy. It is important to note that most nurses articulated that they understood the limitations of management to keep things running while being short of time and staff and often attributed deficient communication practices to management’s stress in working with limited resources and managing many tasks. Olivia said, "During COVID, it was hard because my manager was in charge of the entire intensive care unit and in charge of us." In addition, Tatum said, "my manager is spread so thin." The heavy workload hindered clear and open messaging between nursing staff and management and caused psychological strain on nurses themselves.

**Psychological and Physiological Strain**

All participants in our study discussed how the pandemic negatively impacted their physiological and psychological well-being. Across the study participants a range of physiological symptoms of stress ten months into the pandemic, reporting decreased appetite, difficulty sleeping, fatigue, nervousness, and frequent crying. Workplace experiences during the pandemic led most participants to experience fear and panic. In comparing her current experiences to before the pandemic, Jennifer shared, “I know it was still hectic [before]. It was still really hard. We still lost people, we still had our sad days, but I never remember feeling the way I feel now. It’s worse somehow.” Another nurse, Emma, described the different experience in terms of heightened psychological strain. She said:
There was terror, panic, thinking how can I do this? How long is this going to last? Just terror, because you know everybody's masked up, and all you see is their eyes, and they are wide…it was overwhelming. Absolutely overwhelming.

When explaining how COVID-19 increased their stress, nurses referred to uncertainty and not having clear instruction from leadership. For instance, Lisa described:

We would call the hospital supervisor and be like, “we have a COVID patient down here, and we don't have any masks,” and she was like, “I don't know what to tell you.”

The nurses in our study spoke in detail about the high level of uncertainty and how each day involved a new assignment, with little guidance and a single goal of saving lives. Some nurses related their experiences to those of other military and first responders when talking about the psychological strain during the pandemic. Sarah said:

It was like being deployed to war. That is how I can explain it because you didn't know what you were facing. You didn't know what was going to happen. It was like every day was different. You were somewhere completely different than where you were supposed to be, completely out of your element.

Participants emphasized how a lack of consistency in terms of where and who they were working with was taxing. Additionally, the nurses in our study also discussed the strain caused by a limited access to necessary resources. Similar to Sarah, other participants described how having a lack of PPE was especially stressful by comparing that to a lack of equipment in firefighters. Lisa said, “We kept comparing ourselves to firefighters. You wouldn't send a firefighter into a burning house without equipment. But that's how we felt because we didn't have equipment.” Overall, participants emphasized how not feeling protected or properly equipped with PPE and the uncertainty surrounding the COVID-19 virus were substantial stressors.
The New Normal

Nurses talked about how as the pandemic progressed a “new normal in nursing” emerged. This new normal included responding to constant updates and ongoing change. Nurses reported that from the start of the pandemic they have been navigating constant updates to protocols and regulations. Olivia explained, "We never saw anything like this. Just the rules were always changing. You just don't even know what the rules were or what you were doing going into a shift." Nurses described how the “new normal” was a continuous lack of consistency in procedures and what they were expected to do every day. Kelly also said, "Honestly, I feel like it's so hard because I still feel that day-to-day of, I really don't know what's going to happen today." Additionally, Jennifer said, "We're going to get through the day. And it really was boiling down to just get through the day because it was brutal." Heidi added, "You sort of just go, and you just do what you have to do." Nurses started to expect a high level of uncertainty and remained focused on day-to-day survival because of the lack of consistency at work.

Given the influx of patients, nurses were also required to take care of more patients than previously allowed. Hannah said:

... there are supposed to be five nurses with six patients each, with perhaps someone assigned seven. During [the period] when everybody was getting sick, two people would come to work. So, imagine you're getting like 15 patients, and each of them has COVID. In addition to changes in protocols, nurses experienced changes in their responsibilities and the tasks they had to do. Lisa recalled:

Nurses who do not have experience with older adults or critical care patients were kind of thrown into an ICU and these nurses were like, I take care of five-year-olds. I don't know
how to take care of an adult. And [management] are like, well, you have an RN license, so you can pretty much do anything.

Jennifer, an emergency room nurse also noted, “We're used to a whole other life. A whole other situation when it comes to that stuff, we don't take care of patients once they are stable, we make them stable, we do this, and then they go.” Given the need for nurses to take on new tasks and float to different floors to help with the flood of COVID-19 patients, the pandemic required even more nurse-to-nurse collaboration than ever before. To prevent "making it up as we went along," some participants argued that protocols needed to already be in place ahead of time for pandemic care, and they seemed frustrated with this lack of planning and forethought.

**Nobody Else Understands**

**Challenges Relating to Others**

Previous research on nurses found that social support from family and friends was positively related to their ability to cope with stress (AbuAlRub, 2010; Albrecht, 1983). However, the nurses participating in our study explained that during a pandemic it is challenging to relate to family and friends outside of the nursing context. Participants articulated that it is difficult for “friends and others to understand” the breadth or depth of their experiences. This impeded the effectiveness of social support efforts from friends and family. Across the participant pool, most reported refraining from seeking support or even talking about their experiences with non-nurses. Tatum said, "So really, to my friends outside of work, [my interactions] were very superficial." Notably, the CDC (2021a) and the WHO (2020b) recommend that individuals remain closely connected to social networks during the pandemic, but for nurses in this study, the pandemic made it more challenging to communicate with people outside of work. In referring to her interactions with family during the pandemic, Olivia noted, “I
just don’t think that they would get it. I always just told them about the numbers, not what I saw, because they just don’t understand it. They don’t understand terms or what things mean.”

The nurses in our study explained how it was challenging to articulate their experiences because of the unique and stressful challenges they were facing. In describing an interaction with her boyfriend after work, another nurse admitted:

You know, he doesn't get it either. He is like, ‘yeah, I know it's busy’, but I'm like, no, you don't. I don't think you understand when I say busy. It's been busy. I've had busy jobs. This isn't busy. This is scary.

In addition to feeling scared, nurses described how they were often questioned by family and friends throughout the pandemic, and sometimes felt judged for working directly with COVID-19 patients.

**Getting Questioned and Feeling Judged**

Nurses explained that during the COVID-19 pandemic, they often had difficulty talking about their experiences with non-nurses because they felt as though others would likely not understand. Further, nurses noted how they constantly received questions from family and friends who knew that they worked in healthcare, using them as sources of information rather than providing support. For example, Charlotte said, “We were like CNN for them. It was tough to give the information because you could just say like, yeah, it's bad.” Similarly, Heidi described, “Every time you spoke. ‘Oh, you're a nurse. Oh my God, where do you work, you know, how bad is it? Is it really that bad?’ I'm like, yes, it is. It's really bad.”

Additionally, nurses described encounters in which others were insensitive to what nurses were experiencing. Some participants mentioned how individuals would question if COVID-19 was real and if there really were sick people dying. For instance, Tatum disclosed:
I guess you can feel judged and then they're also friends that would say that COVID wasn't real, not directly to me but on social media. And that was hard when you're working with it, seeing it, busting your butt putting yourself at risk, putting your family at risk, and seeing people die, seeing people very sick that those comments felt like a slap in the face because it's like, wow, if only you really knew.

Generally, the nurses in the current study described feeling frustrated by non-nurses’ continuous questioning, misinformation, and lack of sensitivity. Given that others did not understand, participants explained how coping during the pandemic was a relational process among peer nurses who had shared experiences.

**Coping with Stress Together**

**Communal Coping**

Participants emphasized that despite previously working in specific units (e.g., surgery, med telemetry), nurses assisted with COVID-19 patients, and some experienced the shift of their entire unit to a COVID-specific wing. As such, the nurses in the study described the pandemic as a shared problem that they were facing together. Heidi said, “We were all in it together, and there was no other way to survive besides, relying on each other, honestly.” Other nurses also mentioned feeling closely connected to peers during COVID, as they were coping with the same stressful experiences. Susan explained:

> Between nurses there was a closeness of people. I know that you understand the way I feel, and I understand the way you feel because we're living in the same sphere of stress.

While some nurses described an initial tension between peers related to the requirement to float and those associated fears, most nurses engaged in communal coping from the beginning of the pandemic. Specifically, nurses recalled creating a system for determining who went into
patients' rooms, removing PPE, providing needed equipment, and developing a schedule to ensure floating was fair. Given that this was a common and recurring issue, one participant explained that nurses and “not management” created a system to ensure these floats were fair. Several participants discussed how communication with other nurses going through the same stressful experiences was beneficial to their own personal coping with stress and adapting to adversity. Emma shared, "The [other nurses] were supportive and always encouraging, and you know, we can do this. We got this. We're going to get through the day..." Similarly, Kelly stated:

It almost felt like this is our patient because when I'm in the hot zone, I will answer your alarms or suction your patient or whatever, and when you're in the hot zone, I know you'll do the same for me.

Nurses also explained how the shared experience of treating COVID-19 patients made them feel as if they were coping together. Lisa said, "It was a time where all the nurses, we really felt like we came together." These accounts demonstrate that, unlike social support in which a stressor is perceived as one's own problem, nurses viewed the pandemic as a shared problem that they cope with together, aligning with communal coping (Lyons et al., 1998). The nurses in our study collectively appraised the COVID-19 pandemic as a shared issue, requiring support and collaboration from all nurses, regardless of their primary specialty or prior experiences. In explaining how nurses came together to cope with COVID-19-related stress, participants described how cohesiveness allowed them to move forward in the workplace.

**Focusing on Getting Through**

Multiple nurses compared their current experiences almost ten months after the beginning of the pandemic to the first few months of the pandemic, highlighting how they are now focusing on long-term endurance despite experiencing astronomical levels of stress and uncertainty.
Participants explained how, given the nature of their job, they had no choice but to cope with stress to adequately perform nursing duties. For instance, Jennifer said, "We just have to make it through. I mean, we just have to make it through." Likewise, Olivia explained, "During COVID, we really just didn't know how to treat [patients]. And now we are just more comfortable and confident compared to months ago." Seven months into the pandemic most of the nurses in the study believed that they are now equipped to handle future challenges because they believe that they have been through the worst. Susan noted:

Not much fazes me anymore. We just need to get through the shift. The shift is going to end, every shift ends. I think it's just, that's just kind of now, looking back, I can always say, well, it used to be worse.

Nurses emphasized how the pandemic was especially challenging but made them prepared for their jobs moving forward. Moreover, given that these nurses felt that they have been through the worst, they are able to focus on the future.

**Forward Thinking**

Nurses identified ways in which better communication could have made a positive difference in their ability to cope with stress during the pandemic. At a foundational level, nurses discussed simply wanting to engage in emotion-focused coping through feeling heard and understood by management and administration. For example, Emily suggested, "I just would say better communication and just listening to us and helping us." Yet, many other nurses talked about problem-solving-focused coping and the need for leadership to have a greater presence and a prepared plan for the workplace during a pandemic. Thus, in addition to listening, the participants discussed how management offering to assist with tasks or be physically present on the floor would have been beneficial. Lisa noted, “…if the manager was willing to, come out of
her office, even during the day and take an assignment. That would have helped so significantly.” Participants highlighted how having managers a physical presence or demonstrating a willingness to help nurses hands-on would be helpful moving forward.

In addition to increasing communication, improving listening, and boosting involvement of management, nurses suggested that it would have been useful for leaders to actually pay attention to the support needs of nursing staff. Several nurses suggested that management implement consistent check-ins with nursing staff. Clarifying this recommendation, Emma explained, “[Check-ins] are not about giving us ‘it is what it is.’ We already know it is what it is. But we want something more from you. Ask if there is anything you can do [to support us].”

Overall, the nurses in our study discussed how their perspective shifted to focusing on getting through the challenges of the pandemic and their experiences presented opportunities for necessary internal change moving forward.

**Discussion**

This study explored frontline nurses’ unique lived experiences off workplace stress, social support, and coping during the COVID-19 pandemic. The contribution of our study lies in the findings that these frontline nurses experienced heightened and unique stress during the pandemic that affected supportive communication from family, friends, and non-bedside management, and illuminated the significance of coping as a relational process. Based on our conversations with nurses, we learned that various aspects of their unique reality during the pandemic influenced supportive communication and coping. The nurses in our study perceived a disconnect between management who were not directly treating patients and the practice of nursing, including the support needs of the nurses. Participants reported that communication
strategies embraced during the pandemic by management exacerbated their stress and that in the workplace, they generally did not feel supported.

Role strain experienced by frontline nurses has been reported elsewhere (for example, Lim et al., 2010) but is further exemplified in this study in the context of a pandemic. The nurses in this study reported additional role strain due to the absence of management, vagueness in messaging initiated from management, and novel protocols that did not make sense to those who were actually "working in the trenches." Other research has found that increased visibility and an overall presence of leadership can help mitigate the adverse mental health effects of stress on health care workers (Heath et al., 2020) and that nurses desire increased interaction with their managers (Bennett et al., 2001). Most nurses in the current study argued that if they are going to have to accept constant updates and changing policies and procedures, increased interaction with managers is necessary. This finding relates to previous research that highlighted how high levels of ambiguity increased nurses’ stress levels during the pandemic (Sampaio et al., 2020). Not just any interaction was desired by these nurses, however. The nurses in our study articulated a desire to have satisfying and respectful interactions with managers who also tried to stay informed of what was going on in their units and worked alongside nursing staff to implement policy change. This became particularly clear when nurses discussed the practice of floating nursing staff into units where they had no experience or training. Instead of management addressing this change, it was the nursing staff who had to work together to handle resistance from other nurses not comfortable with new care assignments. Working together to implement and "work out the kinks" of new policies was one way nurses supported one another. As demonstrated by prior research, social support is a transactional communicative process that allows individuals to feel greater sense of control in difficult situations (Albrecht & Adelman,
and improves their ability to cope (Curtona & Russell, 1987). Our study illuminated how support between nurses was not transactional, instead they took a collaborative approach to coping together.

Social support literature suggests that individuals seek support from family and friends to cope with stress (Goldsmith, 2004). However, most of the participants in this study eschewed disclosing and seeking support from friends and family. Instead, they described a more relational communal coping approach involving shared appraisal and action (Lyons et al., 1998) with their nursing peers in the workplace. In this study, nurses discussed how they appraised and viewed the pandemic as a shared problem and how they worked together to treat patients. Our findings align with the notion that coping with stress is a social process (Afifi et al., 2006). In realizing that family and friends outside of work were unable to relate, nurses felt validated in coping collectively with other nurses who shared their same experiences. In addition to being faced with severe stress and high uncertainty levels, nurses also described feeling unsupported by managers and minimally supported non-nurse family and friends. The absence of options for support or inadequacy of external support may also contribute to enhanced perceived closeness because of experiencing a shared stressor (Afifi et al., 2020), in this case, treating COVID-19 patients.

In response to the COVID-19 pandemic, resilience has been at the forefront of research on healthcare workers’ experiences during the pandemic (e.g., Heath et al., 2020). This study demonstrates the complexity of studying resilience and supports the notion that resilience may not be a simple outcome but rather a process (Manyena, 2006). While nurses were able to adapt in some ways, they described a focus on “getting through” instead of positively adapting or thriving in response to adversity. While resilience might be an outcome, the process of building resiliency is likely more intricate and requiring more long-term support, as exemplified by our
study. Although nurses might initially focus on merely surviving a shift, as they cope with stress together, they will find ways to adapt and flourish despite difficulty. The nurses in this study described how communal coping and focusing on performing their job allowed them to persevere, adapting to the stressors of the pandemic. Resilience has been conceptualized in a variety of ways, including the ability to positively adapt (Luthar, 2003), thrive or flourish, and “bounce forward” (Houston, 2018, p. 176). Researchers often look at resilience as an outcome of effective social support in populations exposed to high levels of stress such as military (e.g., Pietrzak et al., 2010) and first responders (e.g., Kshtriya et al., 2020). Resilience is also a predicted outcome of effective communal coping (Afifi et al., 2020).

**Theoretical Implications**

This study aligns with communal coping literature and highlights how a shared experience or stressor can relate to feeling as though others outside the experience cannot understand. According to the Theoretical Model of Communal Coping, communal coping is typically more likely to occur in close relationships (Afifi et al., 2020). However, the model also suggests that communal coping may occur in less established relationships (Afifi et al., 2020; Lyons et al., 1998). Although peer relationships were not necessarily close before the pandemic, most of the nurses in this study described the value of communal coping, that is sharing a unique stressor with others who truly understand, can relate, and offer support. Therefore, this study extends communal coping literature in demonstrating the feasibility of communal coping in the workplace.

Some of the most useful recommendations offered by Shen et al. (2020) who explored the psychological stress of frontline nurses during the pandemic include providing space and opportunities for “communication about stressors and fears, establish a social care and support
group to find and resolve worries accordingly, and set up a professional team to provide remote mental health training and guidance, individualized psychotherapy, or appropriate medical intervention to nurses (p. 2). We concur and wish to emphasize the importance of spending time fostering trusting close relationships among peers at work. In anticipation of the pandemic's lasting adverse mental health effects, researchers and health organizations have described the immediate need to develop resilience programs and interventions to support nurses (see Duquesne University, 2020). The current study demonstrates that resiliency programs aimed at helping nurses cope individually may not be enough in a crisis. Resiliency training programs should include building communication competency and provide strategies for remaining connected across ranks and departments. Our study emphasized how essential it is to consistently improve communication and foster relationships between nurses who work on the same floor, on different floors, and between nurses and their managers.

**Practical Implications**

The practical implications of this study are grounded in nurses' suggestions, providing first-hand insight into the potential for improving support for these professionals moving forward. First, liaison positions may allow for higher levels of shared understanding between the realities of nurses working bedside and managers who might spend little or no time with patients. Nurse managers are typically viewed as responsible for cultivating a comfortable and healthy environment, which is often an unrealistic expectation of administration (Baker et al., 2012). Based on our findings, nurse managers should encourage nurses to socialize and collaborate to build trust and enhance communication. As outlined in prior research, nurse managers are usually provided limited managerial training and are expected to attend to various administrative duties that impede their ability to be more present (Apker, 2002). For managers to actively
engage in regular communication with nurses, assistance with administrative tasks that take time away from face-to-face interaction with their nurses is needed (McCallin & Frankson, 2010).

These implications reinforce recommendations by Shen et al. (2020) for healthcare organizations. The suggestions for improvement by Shen et al. are based on a population of 85 frontline nurses who worked bedside in intensive care units at the beginning of the pandemic. As a result of feeling heightened stress, a myriad of guidelines for improvement were developed, which is also relative to our sample of frontline nurses working bedside throughout the pandemic. However, the accounts shared by the participants in our study call into question the feasibility of some of the proposed solutions, unless there is sufficient planning in place prior to any future pandemics. For example, they acknowledge that there will be a "lack of work experience in infectious diseases" among many in the nursing staff during a pandemic. The nurses in that study recommended that healthcare organizations assign appropriate patients to nurses with the actual education and nursing ability to address their needs. The findings from this study suggest that annual infectious disease training for all staff nurses, regardless of their specialty, might benefit hospitals and help them plan for future pandemics. Shen et al. provide some useful recommendations including the suggestion that nurse managers establish a communication mechanism with their staff within days of a pandemic outbreak. The nurses in our study described a lack of openness among nurses of various ranks. Thus, we recommend an open system where staff nurses are informed of new working procedures as soon as possible with the presence of management to facilitate implementation.

Limitations and Future Directions

Our findings should be considered with the following limitations. First, our sample consisted solely of female nurses, which may have affected our results. Male nurses may have
had diverse experiences communicating and coping with stress during the pandemic. Other demographic information, including ethnicity, would have been advantageous to collect in further exploring nurses' unique experiences. Moreover, data collection was cross-sectional, limiting the breadth of our understanding of the resilience-building process within the context of nursing during the pandemic. Future research should continue to explore and compare nurses' communicative behaviors, especially those in management positions to further understand the disconnect between those roles. Researchers should also look at how nurses' perceptions of support from management influence communal coping. The experiences reflected in this study are those of some staff nurses working in hospitals and one LPN. Further research is needed to understand stress and coping experiences across other roles in the nursing profession. Lastly, to gain a deeper understanding of the process of resilience building in nurses over time, scholars should also conduct longitudinal research in this area to collect data at multiple points throughout the remainder of the pandemic and after the crisis.

Conclusion

The current study sought to better understand the experiences of stress, coping, and supportive communication occurring in the lives of hospital nurses during the COVID-19 pandemic. The inquiry revealed that nurses are experiencing an array of stressors leading to physiological and psychological outcomes. Many stressors included a “new normal” of ineffective communication in the workplace, frequently changing practices and policies, and the need rely on communal coping strategies to move forward. Communal coping rather than social support from friends and family enhanced these frontline nurses’ ability to persevere despite continuous uncertainty, high levels of personal risk, ongoing change, and emotional strain.
References


https://doi.org/10.1016/j.comppsych.2011.02.003


https://doi.org/10.1177/0265407598155001


https://doi.org/10.1111/j.0361-3666.2006.00331.x


### Table 1.

**Participant Demographics**

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Occupation</th>
<th>Position</th>
<th>Treating COVID Patients (Y/N)</th>
<th>Length of time as Nurse</th>
<th>Length of time at current employer</th>
<th>Current United States residence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Olivia</td>
<td>27</td>
<td>RN</td>
<td>Progressive Care</td>
<td>Y</td>
<td>1 - 5 years</td>
<td>1 - 5 years</td>
<td>Northeast</td>
</tr>
<tr>
<td>Emily</td>
<td>35</td>
<td>LPN</td>
<td>Dementia/Long-Term Care</td>
<td>Y</td>
<td>11 – 15 years</td>
<td>11 – 15 years</td>
<td>Northeast</td>
</tr>
<tr>
<td>Sophia</td>
<td>26</td>
<td>RN</td>
<td>Mother-Baby</td>
<td>Y</td>
<td>1 - 5 years</td>
<td>1 - 5 years</td>
<td>Northeast</td>
</tr>
<tr>
<td>Tatum</td>
<td>27</td>
<td>RN</td>
<td>ICU</td>
<td>Y</td>
<td>1 - 5 years</td>
<td>1 - 5 years</td>
<td>West</td>
</tr>
<tr>
<td>Brittney</td>
<td>26</td>
<td>RN</td>
<td>Med telemetry</td>
<td>Y</td>
<td>1 - 5 years</td>
<td>1 - 5 years</td>
<td>Northeast</td>
</tr>
<tr>
<td>Lisa</td>
<td>27</td>
<td>RN</td>
<td>Labor &amp; Delivery</td>
<td>Y</td>
<td>1 - 5 years</td>
<td>1 - 5 years</td>
<td>Northeast</td>
</tr>
<tr>
<td>Sarah</td>
<td>37</td>
<td>RN</td>
<td>Surgical ICU</td>
<td>Y</td>
<td>More than 15 years</td>
<td>6 -10 years</td>
<td>Northeast</td>
</tr>
<tr>
<td>Charlotte</td>
<td>31</td>
<td>RN</td>
<td>Medical ICU Pediatric ICU turned to adult COVID ICU Medical surgical turned COVID floor</td>
<td>Y</td>
<td>More than 15 years</td>
<td>More than 15 years</td>
<td>Northeast</td>
</tr>
<tr>
<td>Emma</td>
<td>54</td>
<td>RN</td>
<td>Pedicatrt ICU turned to adult COVID ICU Medical surgical turned COVID floor</td>
<td>Y</td>
<td>More than 15 years</td>
<td>More than 15 years</td>
<td>Northeast</td>
</tr>
<tr>
<td>Hannah</td>
<td>45</td>
<td>RN</td>
<td>Medical ICU</td>
<td>Y</td>
<td>1 - 5 years</td>
<td>1 - 5 years</td>
<td>Northeast</td>
</tr>
<tr>
<td>Karen</td>
<td>41</td>
<td>RN</td>
<td>ICU</td>
<td>Y</td>
<td>More than 15 years</td>
<td>More than 15 years</td>
<td>Northeast</td>
</tr>
<tr>
<td>Heidi</td>
<td>62</td>
<td>RN</td>
<td>Surgery</td>
<td>Y</td>
<td>More than 15 years</td>
<td>More than 15 years</td>
<td>Northeast</td>
</tr>
<tr>
<td>Kelly</td>
<td>28</td>
<td>RN</td>
<td>Cardiac ICU turned to COVID ICU Emergency room Medical ICU turned to COVID floor</td>
<td>Y</td>
<td>6 -10 years</td>
<td>1 - 5 years</td>
<td>West</td>
</tr>
<tr>
<td>Jennifer</td>
<td>27</td>
<td>RN</td>
<td>Emergency room Medical ICU turned to COVID floor</td>
<td>Y</td>
<td>1 - 5 years</td>
<td>1 - 5 years</td>
<td>Northeast</td>
</tr>
<tr>
<td>Susan</td>
<td>61</td>
<td>RN</td>
<td>Medical ICU turned to COVID floor</td>
<td>Y</td>
<td>More than 15 years</td>
<td>More than 15 years</td>
<td>Northeast</td>
</tr>
</tbody>
</table>