

## Article

# “Everything Is Changing, but I Am Not Alone”: Nurses’ Perceptions of Social Support during COVID-19

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**Abstract:** COVID-19 has created numerous stressors for nurses, which have impacted their work, self-efficacy, and wellness. Social support helps manage stress and burnout. Through 24 semi-structured interviews, the current article explores the perspectives of nurses who worked with COVID-19 patients in the initial days of the pandemic in the United States. This study unpacks the types and sources of social support nurses sought during this time, especially as they faced significant burnout. Through thematic analysis, the current study found that these nurses interacted with the crisis situation to evaluate their social support needs and the plausibility of fulfilling these needs. They focused on the support that was available or at least perceived to be available and let go of certain needs that could not plausibly be addressed in that moment. Peer-to-peer support was critical during this process, and nurses avoided sharing concerns with their families as they enacted protective buffering. The findings also highlight the complex and dynamic nature of social support as nurses interact with their peers and evaluate the support they receive. Peers helped with haptic support like providing hugs to coworkers, and at times even became surrogates for coworkers’ family members as they participated in communal coping. Organizational support was critical for sharing information centrally with nurses and for organizational sustainability.

**Keywords:** social support; sustainability; COVID-19; health care workers



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## 1. Introduction

Since the onset of the COVID-19 pandemic, nurses have been confronted with added stressors [1,2] as they have adapted to changing protocols, changes in technology, and higher patient mortality rates, while remaining isolated from their own families due to the highly contagious nature of the disease [3]. Studies have shown that the stress level and psychological pressure have increased for nurses during the COVID-19 pandemic [1,4], which affects their self-efficacy and ultimately their work and wellness [5]. These added stressors and isolation from family members have made it difficult for the nurses to find a balance between work and family obligations [6]. These stressors have also caused added retention challenges for organizations, with more nurses leaving the organizations due to burnout and exhaustion with an impact on organizational sustainability [7,8].

Scholars have pointed out how social relationships may help individuals cope with these stressful moments. Specifically, researchers have identified social support as instrumental in aiding psychological health under stressful situations, especially when individuals have to isolate or socially distance [9–12]. Research on social support has investigated social support in multiple ways, such as examining types of social support (e.g., emotional, cognitive, material, or network) [11,13–15], sources of social support (i.e., family members, peers, and supervisors) [16–20], expectations and needs around social support [21], and awareness and availability of social support [22,23].

In this study, we look at the perspectives of nurses and their social support needs as they deal and cope with the crisis thrust upon them. It becomes important to explore

these needs for our frontline workers because crisis situations have consequences for their work and wellness. Scholars and organizational leaders can understand these emotional responses and strategically plan to provide support to our frontline workers, such as nurses, which could enhance organizational sustainability [24]. Therefore, the study is interested in understanding the different types of social support needs for nurses, who these nurses turn to for social support, and sources of support they may avoid during this time.

### 1.1. Social Support

Seminal works in social support have tried to develop typologies of the subject [11,13–15]. Cutrona and Suhr [13,14] categorized social support as: emotional support, esteem support, cognitive support, instrumental/tangible support, and network support. While these typologies have received significant attention, they have also been criticized for overlapping and not being exhaustive [25]. For instance, cognitive support that one receives through information from others can also provide emotional support or comfort during a crisis situation. Similarly, an individual deriving comfort from another individual's network by gaining access to their resources may even feel a sense of belonging, and thus they would be receiving emotional, esteem, network, and tangible support simultaneously. Therefore, it has been suggested that these categories should be used cautiously. Furthermore, some behaviors may not fit neatly into these prescribed categories.

Another important line of research on social support aims at identifying social support sources [19]. Social support may be offered by family members [17,18,26], but may also come from coworkers and organizational members such as peers [16,27] and supervisors [20,28]. This social support is extremely helpful in countering occupational stress and work-related problems, which likely leads to resilience [29,30] and long-term organizational sustainability [8]. For instance, in their survey study of nurses, Kim and colleagues [8] found it important for organizations to provide social support more strategically to their employees. They explained that medical organizations usually require employees to work closely with each other, where cooperative and positive attitudes become relevant and helpful. Therefore, organizations must construct teams carefully to offer social support through these team structures.

Researchers have also differentiated between expectations and needs around social support [21] and awareness and availability of social support [22,23]. Scholars have noted that social support is most helpful when it is perceived to be need-based [21]. For instance, when mitigating work–family conflict, where employees face conflicting demands between work and family life [31], organizations can support their employees by rearranging their schedules to encourage work–family balance [27]. Supervisors can provide for family-friendly policies to support the work and family needs of their employees [32]. However, these needs are not constant and they change over time, for which adjustments have to be made by organizations [21]. Additionally, social support may not always be available or accessible. These social support needs are thus altered or modified based on what is available and from whom.

During COVID-19, these social support needs and sources changed for nurses due to the uncertainty surrounding the disease and the separation from family members. Research suggests that during difficult and uncertain times, individuals may try to protect their loved ones by withholding their concerns [33]. This is known as protective buffering. Joseph and Afifi [34] found that protective buffering enacted by military wives to protect their husbands from family stressors may actually worsen the physical and mental health of the wives. Drawing on these studies, we believe that the enforced isolation from family members and the uncertainty around the pandemic would discourage nurses from sharing their concerns with family, maybe even push them to seek social support from peers and support communities [35]. Along the same line, Valaitis and colleagues [35] found that creating an online community of practice for nurses who worked with homeless or marginally housed people helped them get over their feelings of isolation. They received peer support through these communities, shared information, and felt valued while increasing their scientific

knowledge. These nurses developed a sense of community and validated their practice through their online participation with other nurses and thus felt supported.

### *1.2. Health, Nursing Work, and Social Support*

Health communication and nursing scholars have discussed various physical and psychological stressors nurses face that are caused by numerous challenges, including exposure to communicable diseases and radiation, excess workload, exclusionary work practices, negative relationships such as workplace bullying, and power inequity [36–42]. All of these stressors have led to nursing shortages and pose challenges for nurse retention [43]. COVID-19 has exacerbated these demands on nurses and impacted them psychologically, which has increased these retention concerns [8]. As suggested by Grah [7], health care leadership should aid in development of sustainable organizational strategies to support the nursing profession and create a healthy work environment. One way to do that would be to offer social support. Social support is known to reduce anxiety, stress, and burnout in nurses [5,8,44].

Notably, scholars have examined social support in relation to the sources that provide such support to nurses [45], the types and functions of social support nurses seek [30,46], and the outcome of receiving social support [47]. Family support has been found to be critical for nurses as it can help enhance resilience [48]. Similarly, Wang and colleagues [45] found that for early-career nurses, friend support scored higher than family or coworker support.

Coworker or peer-to-peer support has been found to be especially significant because it helps improve nurse resilience during crisis situations [45]. Ellis and Miller [30] have argued that, when dealing with workplace stressors, organizational sources will be more likely to provide greater support to nurses than will support from their friends and families outside of work. Moreover, perceived social support from coworkers is known to improve job performance and decrease the level of reported job stress [49]. For instance, peers can help divert attention from a problematic situation by introducing humor, which is a form of emotional support [50–52]. Supervisor support has also been known to improve work engagement [53]. Grube and colleagues [54], for example, found that the probability of reporting unsafe practices in hospitals increased on par with the level of supervisory support nurses received.

New research in social support in health care organizations has also begun to look at implications of space and design, where supportive design systems can improve relational communication among patients and staff [55]. For instance, centralized units and physical proximity enhanced communication between individuals and teams and fostered a supportive, communicative climate [55]. These new studies have just started to explore the implications of physical spaces and designs, which we believe are especially important during COVID-19 due to social distancing challenges.

While scholars have widely studied social support, we believe that the findings of this article will expand the social support literature by exploring the particulars of the pandemic and how the pandemic has impacted nurses' need for social support, especially as the nurses face burnout, which is problematic for sustainability [7,8]. Nurses have encountered new challenges that may have altered their work roles, stress levels, and personal and professional relationship dynamics. The pandemic, especially the uncertainty around the disease, its high degree of contagiousness, the importance of space and distance, the dearth of resources such as personal protective equipment (PPE), and the mounting death toll, are likely influencing the type of support nurses need. The pandemic also likely has caused nurses to rely on some sources more than others based on their circumstances, particularly if they remain isolated from family members. Moreover, nurses would require unique types of social support in these uncertain and extraordinary times to help them function and to manage their well-being. Therefore, we ask the following research questions in the current study:

RQ1: What sources of support are available to nurses during the global health care crisis?

RQ1a: Why do nurses turn to these specific sources over other sources?

RQ2: What types of support do nurses receive during the global health care crisis?

## 2. Materials and Methods

We utilized qualitative semi-structured interviews [56] to collect data from 24 hospital nurses who worked on COVID-19 floors. The data collection began in May 2020, during the initial phase of COVID-19 in the United States. The principal investigator collected the data and did some preliminary coding. To refine the codes and check for reliability, another coder joined the principal investigator in the coding process. Once the initial coding was conducted, the coauthor joined the analysis process and helped consolidate the codes into themes with the principal investigator.

### 2.1. Participants and Recruitment

The principal investigator contacted health care professionals (five nurses and one nursing manager) from her personal and professional network and asked for their help to recruit for the study. These contacts helped the principal investigator connect with possible recruits. The investigator reached out to these prospective recruits via text messages. Once the recruits had agreed to participate, the principal investigator established a convenient date and time for each phone interview. Snowball sampling was used to recruit additional participants.

Most of these nurse participants who had moved to their COVID-19 floors were moved from medical/surgical units (10), intensive care (6), and pulmonary care (5) to COVID-19 floors. The rest of the nurses were floaters, which refers to nurses who move from one unit to another based on staffing needs. Most nurses were employed at facilities with at least 800 beds. Twenty nurses were female and four were male. In terms of geographical location, most nurses were from the East Coast ( $n = 18$ ), while 6 were from the Chicago area. With regard to age, the majority of participants fell in the range of 30–45 years of age. The average age was 38.62 ( $SD = 8.5$ ). The years of service for most participants was 5–10 years. No additional demographic data were collected.

### 2.2. Data Collection

We developed a semi-structured interview protocol for this study, which was broadly configured to understand how nurses' roles and identities had been modified by COVID-19. The questions and follow-ups relevant to this article asked: Has COVID-19 caused more anxiety or concerns than usual and why? What are the major concerns? Are there ways to counter these and how? What are some coping mechanisms you use? How is your organization helping you?

The average length of the interview was 52 min ( $SD = 16.2$ ), with interviews ranging from 35 min to 118 min. Most participants chose to be recorded ( $n = 20$ ) and their recordings were transcribed by an external transcribing company and checked by the principal investigator. For other participants who did not want to be recorded ( $n = 4$ ), the researcher relied on extensive note-taking. The researcher wrote memos following each interview, which were helpful for later analysis. The final transcript was 582 double spaced pages, excluding memos.

### 2.3. Data Analysis

The data were analyzed using thematic analysis, which helped explore themes that emerged from the raw data [57,58] with respect to social support—both sources and types of support were identified and coded.

Braun and Clarke's [57] six phases of thematic analysis were used to create a rigorous and well-documented analysis [58,59] (See Figure 1). In the first phase, the principal investigator became acquainted with the data and started to explore the codes around stressors nurses experienced and the social support needs they spoke about. In the second phase, the principal investigator and the coder developed preliminary codes by coding three

transcripts together through open, line-by-line coding. This helped develop the codebook with 21 preliminary codes regarding social support (see Appendix A for examples). At this point, some codes were further collapsed into themes or subthemes. For instance, nurses often spoke about missing the physical touch from family members and described it as “I miss hugging my kids” or “It has been a while since I have held my mother and I miss that” or “I wish I could just go inside the house and hold my husband.” These initial codes included: hugging, holding, physical touch, which were synthesized in this second phase as missing physical touch.

Phase 1	The principal investigator became acquainted with the data; started to explore the codes around stressors and social support needs. <i>Parties Involved: Principal Investigator</i>
Phase 2	The principal investigator and another coder developed preliminary codes; 21 codes were developed; some codes were collapsed into themes and subthemes. <i>Parties Involved: Principal Investigator and Coder</i>
Phase 3	The principal investigator and the coauthor further arranged a hierarchy of the themes; explored interrelationships among the codes and themes. Example: the relationship between missing physical touch and receiving hugs from peers stood out and was further examined. <i>Parties Involved: Principal Investigator and Coauthor</i>
Phase 4	The themes were further refined and it was ensured that nothing was missed. <i>Parties Involved: Principal Investigator and Coauthor</i>
Phase 5	Themes were revisited and finalized or renamed. Example: we named the theme “consistent updates,” which was made up of two codes. <i>Parties Involved: Principal Investigator and Coauthor</i>
Phase 6	Member checking of broad themes. <i>Parties Involved: Principal Investigator and Coauthor</i>

**Figure 1.** Data analytic process based on Braun and Clark’s phases.

In the third phase, the principal investigator and the coauthor tried to further arrange a hierarchy of the themes drawn from the codes. For instance, the codes regarding nurses needing hugs from peers were synthesized into haptic support. All interrelationships among the codes and themes were discussed. The relationship between missing physical touch and receiving hugs from peers stood out and was further examined. This excerpt helps exemplify the relationship:

*I felt lonely, I could not see them [family] but I missed my kids. I missed my four-year-old running to give me that hug, but I can’t risk it. When I went back the next day, my coworker was like “here, I am giving you a hug from [child’s name].” I hugged it out. These nurses are my lifeline.*

This exploration helped us draw connections between the codes, where nurses felt better after receiving support from their coworkers, especially because they could not risk going to their families. Furthermore, nurses understood the importance of providing this missing support to each other.

In phase 4, the themes were further refined and reviewed to ensure that nothing was missed. During this stage, we revisited our data to ensure all the excerpts and codes around social support had been included in our analysis. We did not find any missing codes and worked on refining the connections we had found. In phase 5, we revisited some themes

and finalized or renamed other themes. For instance, we named the theme “consistent updates,” which was made up of two codes, namely, “central updates” and “information sharing”. In the last phase, we shared the broad themes with available participants who had shown an interest in receiving study results ( $n = 4$ ) for member checking. During member checking, main themes were shared with the select participants who confirmed the validity of the findings.

### 3. Results

The findings are organized by research questions and the participants are designated by their participant numbers (e.g., P1 is participant 1). RQ1 and RQ1a asked what sources of support are available to nurses during the global health care crisis and why do nurses turn to these specific sources over other sources. We found that in general, nurses preferred peer-to-peer support and avoided getting support from their families. RQ2 asked what types of support do nurses receive during the global health care crisis. We found that nurses received different types of support from their peers, supervisors, and the organization that helped with sustainability during the first few months of the crisis.

In response to RQ1 and RQ1a, exploring the sources of social support available to nurses, we found that in the initial days of the COVID-19 crisis, most nurses understood that social support would be limited. They wanted clarity of information and advisory support, but they also knew that such support was not possible due to the uncertain and changing nature of the crisis. During this time, perceived peer-to-peer network social support was beneficial as it provided reassurances around facing this crisis together with other nurses and health care professionals. A few weeks after the initial days of the crisis, this form of peer-to-peer support became a prominent type of support for nurses. While nurses did not overtly reach out to other nurses to solicit this support, the nurses just assumed that they would be there for each other. Peer-to-peer support also became essential because nurses avoided soliciting support from their family members, since they believed that their family members could not fully comprehend their predicament due to a lack of shared experience. Additionally, nurses did not want to overburden their families with their difficult day-to-day experiences and enacted protective buffering. During this time, some nurses even counted on work relationships as a way to fulfill their familial support needs.

#### 3.1. Limited Social Support Expectation

As the crisis began, nurses felt uncertain about the situation due to unclear information about the virus, its contagiousness, and the changing protocols. Nurses highlighted their hesitation and concerns about seeking help and support from anyone. As this nurse posits:

*Initially, like in March, it was complete chaos. My family was afraid for me and I was afraid for them and we were all getting massive amounts of information, sometimes fake ones too from social media and even those who cared. [There] was no turning to them. (P6)*

The nurses discussed being emotionally impacted by the crisis. They were inundated with information, sometimes even misinformation or disinformation, which they received from many sources, including social media. This heightened their confusion and enhanced their need for informational support. As this nurse further elaborates:

*My colleagues, work friends, supervisors were all as lost. In terms of support, we wanted clarity and information, but rules were changing on an hour-by-hour basis and honestly, we were not expecting others to know any more than we did. There were no expectations regarding support. The only relief was we were in this together. (P6)*

Another nurse echoed these feelings and said, “We could at least share things with each other, but we all had limited information. We wanted information, but we also knew it would take time as new information became available” (P9). Nurses needed clarity and some advisory support to help them sift through relevant information, but they also understood that this form of informational support need was not pragmatic or plausible,

and thus they did not actively seek it from friends and colleagues. The only helpful support that seemed to work was received from nurses' peer networks, which was embedded in the perceptions of belonging to a group and facing these challenges together.

### 3.2. Peer-to-Peer Support Emphasis

We found that in time most nurses naturally bonded over crisis-related adversities as they collectively made sense of what was happening and focused on possible ways of coping. In some ways, these nurses were collectively aware of the "burnout" and emotions "running higher than usual" (P14), and over time, they actively started seeking support to cope with the turmoil so they could continue to function, which contributed to self- and organizational sustainability. One nurse pointed out, "I believe after that initial jolt of 'Hey this is really happening,' I think it was natural to start sharing with each other [peers] because we all saw this firsthand and we were just there for each other" (P11). As this excerpt suggests, after the initial weeks filled with uncertainty and confusion, nurses began to discuss their concerns with each other. This was an organic interaction that transpired without overt requests for support. It was just assumed that nurses would stand by each other and hear each other out. As another nurse noted:

*I count on my peers, we are all in this together, even though I know they might not have the information and the information is changing every minute, we have each other. We can turn to each other and talk about a bad day when we lose patients. They are right there with me and they don't have to say anything. Their presence is all that I need. (P3)*

This idea of perceived network support also provided nurses with emotional support. Nurses could turn to their coworkers for comfort on a bad day if they were feeling overwhelmed. The nurses did not expect actual support but found solace in the enactment and perceptions around being "present for each other" (P8). As another nurse elaborates, "Sometimes it is just about being there for someone. I don't have to say anything, but they know I and other nurses on the unit are there and that gives them confidence. We know we are not alone" (P4). Therefore, this network support was also critical for providing emotional comfort to reinforce the sense that nurses were not alone.

### 3.3. Avoiding Family Support

Although nurses spoke about their families being extremely supportive of their work, during the initial days of the pandemic, nurses believed that most family members could not relate to what they were feeling, as the family members were not able to observe their work environment directly. In addition, nurses did not want to further burden their families with more concerns and worries, since the situation was already stressful for everyone. Thus, by keeping certain information from their families, nurses enacted protective buffering to safeguard their loved ones.

#### 3.3.1. Unrelatable Experiences

Nurses found it difficult to relate their experiences to their families and did not expect their families to understand what they were actually going through. As this nurse comments, "My husband is very supportive, but the fact of the reality is that unless you're in those rooms, in that PPE day after day, seeing these people dying, you just don't get it" (P11). Nurses did not expect their family members to understand their predicaments because they were not there to observe it firsthand. "And that's the hardest part for us. Because even with my family and friends, trying to talk to them about something that they can't possibly understand [is hard]" (P15).

Nurses felt it was more tedious to share with and explain their work to family members and other friends compared to coworkers. As this nurse described:

*Some days I will try to explain it to my mom, but it is difficult and time consuming. She can never feel what I am seeing and it is not her fault. She tries, but I am expecting too much. I do count on my nurses more than ever before. (P12)*

Therefore, nurses tried to minimize conversations with family members and relied on their peers for support, especially when sharing their pent-up emotional reactions caused by work environment changes. Nurses believed that their peers understood them due to shared experiences and knowledge, which they could not expect from family members. As this nurse posits,

*The other nurses know, they understand. Our patients, we see them struggling, dying, and sometimes have a ray of hope when they recover. We feel the joy, but mostly sadness together. I don't expect my family to understand this (P13).*

### 3.3.2. Reducing Burden

Nurses also did not share their concerns and worries with loved ones because they did not want to scare them. Nurses developed protective buffering for their families by trying to control for work-to-family conflict and spillover of emotions. As this nurse states, *"We were constantly bringing our worry home, but I could not share it with my family because they would get worried"* (P4). Another nurse emphasized how they were already worrying their families just by their presence, which raised fears of bringing the virus home. Nurses shared these concerns with peers: *"They're [family members] already scared of us coming home. So, in that instance, we need to vent to each other and not come home and vent to our family members and bring more burden upon them"* (P7). This quote illustrates the awareness that nurses had to consider their need for social support against the consequences of burdening family members. In summary, nurses tried to avoid sharing their concerns at home and relied more on other nurses for support.

### 3.4. Surrogating Family Roles

Most nurses discussed how peers became surrogates for family members for the time being. When family social support was missing for a variety of reasons, nurses assumed the roles of each other's family members to provide much-needed support. This was manifested in two ways: The first method involved nurses explicitly drawing a comparison between their coworker and a member of their family; the second consisted of nurses characterizing their coworkers metaphorically as family members for the family-specific actions they performed.

In this quote, the nurse compares her sister to another nurse:

*I haven't seen my sister in months and we are quite close. I miss my sister talk, but I have a coworker and she has really helped me out when I can't talk to her [sister]. We have laughed and cried together and believe me that has been a life saver. (P12)*

This quote explicates how the nurse draws an explicit comparison between her sister and her coworker. She talks about how she shares her emotions with her coworker, which is sustaining her through this ordeal. In this other instance, the nurse characterizes other nurses and coworkers metaphorically as family members. As this nurse notes, *"We joke how we have nurse wives and husbands"* (P5). Similarly, another nurse characterizes herself as a mother to the younger nurses and therefore needed to perform specific actions such as actively protecting her younger counterparts: *"So I have to scream at the younger nurses. I am responsible and I am their mom"* (P23). Nurses were balancing these familial-based roles with their formalized day-to-day obligations. Nurses thus sought familial support from their peers, who had to assume familial roles and provide support that they were unable to obtain from families while maintaining task-related interactions.

Our second main research question explored the types of support nurses received. Our data indicated that nurses received haptic support, emotional support, and job-related material support from their peers. Furthermore, their organizations also provided them spiritual/emotional support, informational support, and material support.

### 3.5. Peer-to-Peer Support

Nurses provided haptic support, job-related support, and offered reassurances to each other. Importantly, nurses relied on their workplace support communities, because nurses understood the shared experiences they were facing together.

#### 3.5.1. Haptic Support

Haptic support was the most common form of support nurses listed in the interviews. COVID-19 had caused nurses to physically distance themselves from loved ones. Nurses felt exhausted with all that was going on around them and they missed human touch, which forced nurses to rely on each other for physical support. This nurse states how it was important for her to receive hugs from peers: *“And I haven’t seen my mom. I miss her. And she’s by herself. The only people I ever hug are the nurses I work with at this point because we all figure, ‘Ah, we probably got it [the virus] already’”* (P18). Nurses were more comfortable hugging each other because they were all working in the same place and had an equal likelihood of contracting the virus. They avoided hugging family members because they were isolating and could not risk infecting them. They instead turned to their peers who understood the need for these hugs. Another nurse spoke about peer hugs being an inclusive form of support, *“A simple hug from a colleague may help the nurses meet their need to be a human,”* since the pandemic has required changing rules and norms about physical contact, so the nurses *“can’t hug anyone else”* (P8). The finding highlights the importance of tangible support during this time and also emphasizes the network support where nurses were comfortable hugging those they were working with, heightening their feelings of solidarity. In their perception, hugging each other was the only allowed physical contact they could enact, making it a rare but very important type of support.

#### 3.5.2. Reassurance and Checking In

Nurses looked to each other for reassurance that they were protected and doing the best they could under the circumstances. This nurse highlights the concern they have for each other: *“We look at each other and have that reassuring look. Like we are protected and we can do this, because we can”* (P7). Other nurses spoke about how they shared their positivity with nurse colleagues to help each other get through the day. Interactions also helped nurses check in and provide a combination of material and emotional support. As this nurse suggests:

*I myself am a positive person. I try and—every day, when I go into work, “We’re gonna have a great day today.” We try and keep each other on task throughout the day but also check in. “Are you doing okay? Can I help you with anything? Have you taken a lunch break yet? Do you need a water break? Do you need a mask break?” Because wearing those for 13 h is just ridiculous.* (P7)

In the above excerpt, the nurse discusses how periodic check-ins helped to understand the emotional and material needs of the nurses. These check-ins also suggested to the nurses that they were important and kept them going through their shifts. Therefore, nurses used their formal day-to-day interactions to also check in and provide social support to each other. As another nurse posited, *“As we are discussing patients, we now ask each other how we are doing, and if anyone needs a break or anything, they can [say so].”* This illustrates how nurses used formalized task-based interactions to support each other. Another nurse said, *“I really appreciated that my coworkers care about me as a person, they constantly checked in and I checked in with them”* (P9). Ultimately, the check-ins during formalized interactions enhanced nurses’ esteem.

#### 3.5.3. Job-Related Support

Nurses discussed helping each other and the organization by being flexible and shifting their work hours based on organizational and peer needs. This nurse explained, *“That meant that day shift people chose not to work day shift, chose to work evenings, chose to work weekends, just to help out the organization and their coworkers. And that was huge”* (P8). This

quote illustrates how tangible support related to the job could help nurses accommodate each other's changed hours.

### 3.6. Social Support from Organizations and Managers

Organizations also offered more formal institutional support, for which nurses expressed their appreciation. These resources helped nurses manage their emotions in a more effective way. Institutional support included spiritual support, consistent updates provided by organizations, and supporting familial needs. These resources were identified as being critical for organizational sustainability, *"where the organization could help us, but also help itself by providing for us and meeting our needs so that we could focus on important obligations"* (P12).

#### 3.6.1. Spiritual Support and Counseling

Nurses spoke about a handful of organizational initiatives geared toward providing spiritual support and counseling. While the nurses appreciated this gesture, they also spoke about how they had very little time to take advantage of this resource. Their organizations too got tied up with other patient requests and were not always able to provide the support to nurses as they had originally intended. As one nurse explained:

*Well, they [the organization] had talked about it for a while. We were supposed to have some type of support, like our spiritual—we have a big pastoral care department. They were supposed to, but they just got slammed with so much from patients. (P9)*

Therefore, while the organization tried providing resources, it was tied up with requests from patients, thus not being able to provide the spiritual services as it had originally intended. Similarly, nurses too did not have time to participate in these counseling sessions. According to another nurse, *"Our organization provided us [counseling] from day 1 and even though most of us don't have the time. We will need it"* (P16). In general, nurses spoke well of their organizations, especially because the organizations had provisioned these spaces for counseling, even though they did not feel they would have time to attend.

#### 3.6.2. Consistent Updates

Due to the initial uncertainty and the constant shifting of information, nurses appreciated the efforts made by their organization and management to share any available information and updates as the crisis unfolded. Nurses valued information and updates from higher-ups that was relevant to treating patients. Some nurses stated that their senior management had established a systemwide information dissemination method, which provided the latest updates on what nurses were supposed to do as well as additional information on treatment of infectious diseases. These updates were very useful and important for nurses. For instance, as one nurse explained:

*It comes systemwide. So, we have a—every day, COVID-19 updates, systemwide, from the hospital, as to what we're supposed to do. We speak with our intensivist because he's the one running the show. That and the infectious disease doctors, they have a wealth of information. So, we sit down. We talk all the time about what we should be doing, because now, we're masking in and out of the building. We cannot take our masks off at all. (P10)*

Many managers also utilized their daily huddles to convey important information regarding the changes and the virus. As one nurse reported:

*Our manager was very clear. Every day, we do have a morning huddle. And all the things changed a lot. She was at the forefront, making sure like, "Hey, guys we are a different floor. We have to protect ourselves. If they tell you something different, this is what we are doing." (P20)*

Therefore, the organization and the nursing managers implemented centralized information-sharing, which was useful for nurses by consistently providing updates. This

information sharing did not begin immediately but was implemented as the crisis progressed. Another nurse pointed out:

*It was total chaos in the first week or two, but then the organization decided to filter the information and provided more centrally approved information that went out to all of us [COVID-19 floor nurses]. We were on the same page and we knew what was required. (P22)*

Therefore, these centralized systems helped to curb uncertainty and increased nurses' confidence in their management.

### 3.6.3. Supporting Familial Needs

Nurses also described concrete support their organizations provided for them and their families. For example, organizations made arrangements to help nurses run errands and obtain food. Concrete support helped reduce work–family conflict, because nurses were able to feed their families even when they were at the hospital or quarantining themselves. For instance, one nurse explained, *“I was so lucky that my organization actually delivered food to my family when I was stuck at long shifts. I was less worried and truly thankful for their thoughtfulness” (P17)*. Nurses positively characterized their organizations' efforts to help them maintain the work–family balance during these difficult times, which helped with resilience and organizational sustainability.

## 4. Discussion

In this study, we explored the perspectives of nurses regarding their social support needs and the sources they sought support from during the COVID-19 crisis. The study findings provide theoretical and practical contributions.

Theoretically, these research findings add to our understanding of social support needs and sustainability during crisis for health care workers at the forefront of the COVID-19 crisis. The study results highlight how available social support may be used instead of the support that is currently unavailable, which demonstrates how social support needs are complex and dynamic. More importantly, while the research questions explored the sources and types of social support, the findings provide a more complex assessment of how nurses navigated these social support needs [60,61] and coping mechanisms [62].

Furthermore, due to social distancing mandates and other spatial restrictions, the findings shed light on the importance of haptic support. The discussion concludes with practical implications for organizations and management to support frontline workers by embedding coworker and peer support in their structures.

### 4.1. Theoretical Implications

First, the findings highlight the highly contextual nature of social support needs, which evolve and change in crisis situations [21], as needs shift based on what is available and realistic. Nurses interacted with the crisis to evaluate their needs and assess the plausibility of fulfilling them. This sometimes led nurses to refocus on what was available and possible and to let go of social support needs that were less accessible at that moment. For instance, nurses realistically evaluated the difficulty of receiving informational social support at the advent of the crisis because everyone they knew faced similar uncertainties. Nurses faced both individual and organizational uncertainties. They felt uncertain about sharing work-related experiences with their family members and were concerned about infecting them. These uncertainties emerged because there was little credible information on COVID-19. Organizationally, nurses had to adjust to consistently changing protocols. In order to get through the day, these nurses sought the available network support that was easier to find as compared to family support. Isolation from family members, fear of infecting them, and unnecessarily burdening the family acted as barriers for seeking support from family. Therefore, even though the social support demand for nurses was high, these barriers and lack of resources guided the nurses to seek support from their coworkers. Moreover, nurses integrated providing social support into their daily tasks and balanced between keeping

things professional and providing social support simultaneously. This highlights the very complex nature of social support, which goes beyond our research questions that focused on exploring the types and sources of social support. What we found in the current study highlights how social support is fluid and created dynamically through an interpretive lens. As individuals choose to interact in specific ways to fulfill different purposes, their support-related actions are assessed by the recipients. The recipients draw on shared meanings and the context at hand to evaluate the social support actions.

Our findings suggest that social support is dynamic, which is closely aligned to Goldsmith's work [60,61]. Goldsmith's work is based on the normative model of social support, which is an important interpersonal communication theory that can be applied to this organizational context. Goldsmith's [60,61] model focuses on the effectiveness of support rather than the quantity or the presence of social support. For support interactions to be effective, interactants address multiple and often conflicting purposes. These purposes are often centered on tasks, identities, and relationships [61]. People may have to give up on some purposes to accomplish other contradicting purposes, especially when there are varied contextual meanings.

Drawing on Goldsmith's [60,61] core assumptions from the normative models of social support, the findings reveal how nurses sacrificed attaining support from their families because they wanted to keep the family members safe. Soliciting family support would also put them in a difficult situation of burdening their families. Instead, nurses enacted protective buffering [34] and relied on communal coping with other nurses. Support was based on nurses' shared experiences as they continued to face the COVID-19 crisis together. Communal coping is "constructed jointly among people who are coping with similar stressful life circumstances" ([62], p. 378). The stressors nurses faced forced them to collectively take ownership of the situation, because most of these nurses were isolated from their families or were providing protective buffering for family members [34]. Nurses adopted a communal orientation [62], which helped develop a shared understanding among nurses regarding how they could support and help each other cope together. Nurses also utilized formalized spaces, such as their interactions during regular chores, as another way to provide social support to each other through check-ins. Nurses understood the challenges they faced as a profession and found it important to provide peer-to-peer support, while continuing to behave in a professional manner.

Additionally, the study findings add to the communal coping literature [62,63] by identifying how a crisis context can impact the willingness of individuals to co-own responsibilities through communal coping. Individuals understand that their common experiences and barriers can position them to finding solutions together. The data here suggest that when there is a widespread problem like a health care crisis, the impacted groups with established group identities may adopt a more communal outlook to finding solutions. This is because the members of the group face the crisis together through an ongoing coping process. They understand the barriers they face and provide different types of social support that work for nurses. The perceptions of support availability and communal coping help form more positive appraisals of social support. In this study, in the initial moments of the crisis, nurses did not have to actively seek social support, but they relied on the perceptions regarding togetherness and shared experiences to cope with the crisis.

Second, we identified an important form of social support need that emerged during the crisis, namely haptic support. As Cutrona and Suhr [13,14] mention, physical affection, which includes hugs, kisses, and hand-holding, are important forms of emotional support. We found that the human touch or haptic support, which was missing for nurses, became relevant during this time. Many nurses provided and received haptic support from each other because they were not getting it elsewhere, and they were more comfortable accepting support from those they worked with directly. The intentions the nurses listed did not necessarily delineate a demand to fulfill emotional needs, but instead were focused on managing physical needs, which may or may not have resulted in emotional support. The atypical nature of the COVID-19 crisis also made space and distance important variables

that impacted human needs. We know in general that space and design have major implications for social support [55]. Nurses in the current study also felt isolated from their family members, felt distant, and needed the sensation of touch, which is an important nonverbal behavior that helped them cope.

Third, our investigation pointed out that, unlike under normal circumstances, when nurses relied on their families for support [48] during the COVID-19 crisis, they wanted to shield their families through protective buffering [34]. This subsequently forced them to turn to their coworkers and the professional community for support [35]. The crisis situation made it acceptable at that time to fill in for missing family-based support. This particular idea expands our understanding of seeking social support, where individuals may intentionally or even unintentionally look for family support from their peers.

Last, our findings bring to light the important role that organizations play in managing employees' emotions during a crisis. As nurses faced the COVID-19 crisis and all its side effects of burnout, exhaustion, and stress, our findings suggest that organizational sustainability and resilience are possible if the organizations can embed social support in their structures [8]. Consequently, organizations should strategically make provisions for social support in the day-to-day functioning of the organization. For instance, nurses were more at ease when the organization was providing for their families. Moreover, organizations would be well served to note the value of coworker support and enhance that.

#### *4.2. Practical Implications*

An important implication for management is that supervisor support is critical for helping nurses cope with the by-products of working in crisis situations. This practical implication is also supported by past studies that outline how work engagement for nurses improves with supervisor support [53]. Developing family-friendly policies to support both work and family fronts is critical during crisis. Organizations can institutionalize such support by providing tangible necessities to the families and creating centralized systems to provide up-to-date information.

Furthermore, peer-to-peer support was found to be important for nurses during the early stages of COVID-19. Past studies also suggest that coworker or peer-to-peer support significantly helps improve nurse resilience during times of crisis, thereby enhancing sustainability [45]. Organizations must spend resources and enhance these platforms that aid in peer-to-peer communication. Creating healing or support circles has been found to help nurses as it makes available a place where they can talk about difficult times [64]. These circles were also formed during the COVID-19 pandemic and were geared toward listening to the challenges the nurses faced. These circles provided a space where nurses could develop recommendations around maintaining a healthy and sustainable workforce. Therefore, organizations will have to think creatively about expanding these interactive spaces.

#### *4.3. Limitations and Directions for Future Research*

Future studies can benefit from a holistic understanding of social support needs and the impact on sources by examining the perspectives of the family members, who are also coping with the current situation. Additional studies can also be conducted to help understand how social support needs have changed over the course of this pandemic for nurses. Future studies can also explore types of social support nurses received during this time that might not have been perceived as helpful. This would help us explore and theorize unhelpful forms of social support during crisis. Furthermore, a major limitation of the current study was that it did not collect additional demographic data such as race and ethnicity. This crisis has shed light on the pervasive health disparities that exist in certain racial groups in the United States during COVID-19, which also impacts health care workers [65]. More data can be collected with race- and ethnicity-based demographics to unearth the disparities and lived experiences of our nurses, who are already negatively

impacted by the pandemic and the disproportionate burden of psychological and physical labor and burnout [66].

## 5. Conclusions

The findings suggest that during the COVID-19 pandemic, nurses turned to their peers for social support and avoided further burdening their family members. In the initial days of this crisis, nurses did not openly seek social support, especially because they knew that everyone was facing the same uncertainties. However, they found strength in handling this crisis together with other nurses. Nurses also offered each other haptic support like hugs and assumed the roles of family members to fill the void left by the missing family support. In general, organizational support was critical for sharing information centrally with nurses, which reduced uncertainty as everyone was on the same page. Furthermore, management offering support to nurses to help balance work–family challenges was important. To conclude, the findings suggest that social support needs changed as the crisis evolved and nurses evaluated these needs realistically, often refocusing on using readily available support. This establishes the dynamic nature of social support.

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## Appendix A

**Table A1.** Codes Examples.

Code	Definition	Example
Limited Support Expectation	In the initial days of COVID-19, nurses understood that everyone faced similar uncertainties and thus it did not make sense to expect social support from others.	In terms of support, we wanted clarity and information, but rules were changing on an hour-by-hour basis and honestly, we were not expecting others to know any more than we did.
Peer Emphasis	Nurses felt more comfortable sharing their experiences with peers.	After that initial jolt of “Hey this is really happening,” I think it was natural to start sharing with each other [peers] because we all saw this firsthand and we were just there for each other.
Avoiding Family	Nurses tried avoiding family when sharing day-to-day struggles because they did not want to worry their families.	But I could not share it with my family because they would get worried.
Difficult Relating Experiences	Nurses found it difficult to relate their experiences to their families.	My husband is very supportive, but the reality is that unless you’re in those rooms, in that PPE day after day, seeing these people dying, you just don’t get it.

Table A1. Cont.

Code	Definition	Example
Difficult Explaining Experiences	Nurses found it difficult to explain their experiences to their families.	And that's the hardest part for us. Because even with my family and friends, trying to talk to them about something that they can't possibly understand is hard.
Reducing Family Concerns	Nurses felt that their families were already afraid of them and scared for them, thus they did not vent to family members in order to reduce the burden on the family through protective buffering.	They're [family members] already scared of us coming home. So, in that instance, we need to vent to each other and not come home and vent to our family members and put more of a burden upon them.
Surrogates	Nurses helped each other out by becoming surrogates for family members of their peers.	We joke about how we have nurse wives and husbands.
Missing Physical Touch	Nurses felt isolated from their families and missed the physical care and touch.	I miss hugging my kids. I really want to, but I can't.
Touch/Hugs	Nurses provided tactile support of touch to help fulfill the physical need that was missing.	The only people I ever hug are the nurses I work with at this point because we all figure, "Ah, we probably got it already."
Reassurance	Nurses provided reassurances to each other that they were doing everything to stay protected.	We look at each other and have that reassuring look. Like we are protected and we can do this, because we can.
Checking In	Nurses checked in with each other throughout the day.	We try to keep each other on task throughout the day but also check in, "Are you doing okay?"
Material Help	Nurses provided each other with additional material help for familial and work support.	Like this other nurse on my unit, she is a senior nurse, she shared her sister's number for childcare and this woman comes and watches my kids and has been isolating herself for a while.
Job Support	Nurses also provided direct job support to each other and helped each other out.	That meant that day shift people chose not to work day shift, chose to work evenings, chose to work weekends, just to help the organization and their coworkers. And that was huge.
Motivational Messaging	Another important form of network support where one person or a group of people would write out motivational messages and then other nurses would add to them.	And then, I left the sticky note with a pen nearby, and other people started adding to it.
Spiritual	Organizations sought ways to provide more spiritual support to nurses.	Well, they [the organization] had talked about it for a while. We were supposed to have some type of support, like our spiritual—we have a big pastoral care department.
Counseling	Organizations afforded counseling to nurses, but nurses could not always find the time to attend these sessions.	Our organization provided us [counseling] from day 1 and even though most of us don't have the time. We will need it.
Information Sharing	Management constantly shared information with their nurses, sometimes through central systems, other times through huddles and meetings.	Our managers were on top of things. They would collect all the recent information and share that during the huddles. Some hospitals have also created central hubs for this.

Table A1. Cont.

Code	Definition	Example
Central Updates	Central system of providing updates by the organization was considered to be a helpful form of informational support.	It comes systemwide. So, we have a—every day, COVID-19 updates, systemwide, from the hospital, as to what we’re supposed to do.
Support for Family	Organizations also provided support for nurses’ family members, which was deemed very important.	They would drop off food for the families. They would run and grab something if the nurses couldn’t. People were bringing in something just to help each other out.

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