Nurses lived Experiences, burdens and coping strategies during the COVID-19 pandemic

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Abstract

This is a qualitative interpretative phenomenological study which was designed to navigate through nurses’ lived experiences, burdens and both positive and negative coping strategies while working with COVID-19 patients. The sample included 20 nurses who had worked with COVID-19 patients for more than or equal to six months in the country’s variable health sectors. The interviews were conducted between 1,October,2021 and 15,April,2022. At that time, the third COVID wave had elapsed and we were peaking on a fourth pandemic wave, so included participants had lived through a minimum of two to three peaks. Six themes had emerged which were: nurses coping with COVID-19 crisis, professional relationship burden, personal burden, environmental burden, physical symptom burden and emotional burden of the crisis. Nurses lived experiences during the pandemic were deep and intense and moderately to highly affecting their ways of thinking, feeling and behaving. Certainly such experience had opened nurses eyes on countless number of challenges that could be faced during the times of adversity which requires special attention, care and preparation on many levels. The minimal preparatory levels are personal, departmental, organizational and strategic at the level of country’s proactive health planning.

Introduction

COVID-19 pandemic was a massive wave which had hit the health care systems all around the world. By (6 July 2022) the total number of diagnosed cases had reached cumulatively (547,901,157), cumulative deaths were (6,339,899) and the newly diagnosed cases in last 24hrs, were (467,144) ( World Health Organization [WHO].2022). The health care systems were steeply challenged and the man power behind the wheel were struggling simultaneously. Nurses, the daily runners, were working around the clock to meet the emerging and escalating health care demands for COVID-19 clients (Maideen et al. 2022). It had been a marathon under strict conditions such as fear from being infected or communicating the infection for the beloved ones, physical and emotional fatigue, sleeping problems, wearing personal protective equipment (PPE) for long hours with the associated heat, hypoxia and discomfort. That was a short list of a cascade of unpleasant burdens, emotions and intense nurses daily lived experiences during the early COVID-19 waves (Martin-Rodriguez et al.2022).

Background

Nurses lived experiences during pandemic times of recent history had been comprehensively investigated. The world had the Spanish Flu (1918–1920), Asian Flue (1957–1958), AIDS pandemic (1981 till now), H1N1 SWINE FLU pandemic (2009–2010), West African EBOLA epidemic (2014–2016), and The COVID-19 pandemic (2019-till today) ( Centers for disease control and prevention [ CDC].2022). Surveying nurses lived experiences during pandemics yields super attention because at the end of the day, it is them, the nurses who fight the battle against death and degraded quality of life. They are the war front liners, if they manage to survive through the times of adversity, then the whole war is inevitably won (Arnetz et al.2020).

Many researchers had described an aspect or more of nurses experiences during the COVID-19 crisis. Sun et al (2020) reported that nurses in China went through negative emotions in the early stage consisting of fatigue, discomfort and helplessness, then they managed the situation through life adjustment, team support and rational thinking. Ultimately growth happened under pressure with increased gratefulness and professional responsibility. Thus, positive emotions had blossomed under layers of negativity ice. There was a study done by Khatabeh et al (2021) which reported the lived experiences of physicians and nurses caring for COVID-19 patients in Jordan. It described their emotional reactions such as fear and anxiety, the preparation phase to deal with the crisis at personal and organizational levels, sources for support like peers and family, extreme work load and its impact on psychology, cognition and behavior, occupational challenges like stigma. Those interpretations reinforced the conclusion that the COVID-19 pandemic came with burdens.

From the reported burdens faced by health care providers in Ireland/United Kingdom were those by McGlinchey et al (2021). They stated that some nurses felt frustrated and helpless because they were unable to ease patient’s fear or discomfort along with that hesitation to engage the best way in the patient’s care because of the fear of getting the infection. It was evident that there was a high degree of confusion due to receiving ‘mixed messages’ particularly in the early stages, from both United Kingdom government and managerial level in regard to COVID-19 necessary protective protocols which created a deep sense of uncertainty and anxiety.

The study done by Zamanzadeh et al (2021) revealed duality in forms of care as nurses in Iran emphasized that they were distracted from care provision due to political issues initially, then due to the growing sense that the disease could intimidate nurses and nurses’ families health. Such intimiders had become worse because of lack of scientific information, a sense of ambiguity, increased workloads, changes in life style like nurses self- quarantine, social isolation and a perceived care pressure which was doubled by imperative need to wear the PPE on each encounter. Besides, there was a study by Grailey et al (2021) which profoundly described the effects of the COVID-19 pandemic ( first wave) on United Kingdom nurses such as the evidence of psychological distress, fear, feeling of isolation, indicators of nurses moral injury, mostly because they couldn’t provide pre-pandemic standard client care. On the other hand, there were changes in team dynamics; some were positive such as improved teamwork and cohesiveness, while others were relatively negative especially when talking about redeployed nurses who lacked the ‘ necessary knowledge and experience’ to manage the COVID-19 needs and workloads complexities. At the end of the first wave, the researchers had spotted proofs of nurses’ coping strategies effectively activated.

Sehularo et al (2021) conducted a narrative literature review summarizing the coping strategies used by nurses during the COVID-19 pandemic. Their findings identified the following coping strategies: use of COVID-19 protective measures, avoidance strategy, social support, faith based practices, psychological support and management support. While Puto et al (2022) compared the coping strategies used by nurses who worked with patients infected with COVID-19 during the pandemic with those used by nurses who managed regular cases. They concluded that nurses managing active cases...
were more stressed and used coping strategies focused on both: the problem (active coping, planning and seeking instrumental support) and the related emotions (seeking emotional support, turning to religion or denial), but nurses who managed non-COVID patients focused mainly on the problem.

Here in Jordan, nurses lived intense experiences during the quarantine and the lockdown. The cost of caring was high but not well rewarded as they hoped for. Being under tremendous continuum of multi-dimensional pressures had drawn ominous states of mind at certain points of the battle to protect self, beloved ones and the community while trying to save lives of COVID clients (Al-Amer, 2022). It had been a real day to day struggle of will, power, system, policy and belief. Hereby came the importance of purposefully commencing those 20 in-depth interviews to navigate through the real lived experiences of nurses who intensively managed COVID-19 clients, investigate the encountered burdens and understand the coping styles activated to keep nurses more resilient at the time of unexpected crisis and unprecedented adversity.

The Study Context

The Hashemite Kingdom of Jordan is an Arab and Middle east country with a population of (10,303,137) based on projections of the latest United Nations data (Jordan Population, 2022). Jordan literacy rate for 2018 was 98.23% (Macrotrends, 2022), and a world bank classification of income level as an upper-middle-income country (World bank, 2022). The Health care system in Jordan is covered by 5 major umbrellas: governmental, semi-governmental, military services, private sector, UNRWA and other nongovernmental refugee health services (Nazer et al, 2017). Jordan is achieving success because of the focus it has placed on the development of quality healthcare as 9.3% of the general budget is spent on health. During the COVID-19 outbreak all hospitals in Jordan implemented anti-infection programs, in an attempt to mitigate the losses and break the contagiousness cycle (Private Hospitals Association Jordan, 2022).

Methods

Design

A qualitative interpretative phenomenological methodology was applied as it seemed to be one of the most useful research approaches in exploring nurses lived experiences, burdens and coping styles during the COVID-19 emerging context. It had offered the chance to “use nurses word of mouth” rather than to offer them scales and prepared set of optional answers that may or may not touch, approximate or capture the essence of the true meaning of their experiences (Tuffour, 2017).

Study Participants And Sampling Strategy

Purposeful sampling method was carried out, guided by pre-specified inclusion criteria. The first criterion was to include nurses who hold field work not administrative roles. The second criterion was to choose nurses who had worked at least six months with active COVID-19 cases on a regular basis especially during the first two pandemic waves in Jordan which had peaked on (18, November, 2020 and 17, March, 2021) respectively (Ministry of Health, 2021). It worth mentioning that the third pandemic wave had approximately peaked in Jordan on 21, November, 2021 (Arabic CNN, 2022) and the fourth wave had peaked on 18, February, 2022 (AlmamlakaTV, 2022).

The picked clinical sittings composed from a major academic hospital, major semi-governmental hospital, large private hospital, central governmental hospital and nurses from COVID-19 field hospitals. The principles of data saturation were rigorously employed where the data were considered sufficient, indicated by in-depth redundant data on interview number 18, though two more interviews were conducted to confirm saturation (Saunders, 2018).

Data Collection

Data were collected between 1, October, 2021 and 15, April, 2022. The research team headed towards the selected clinical settings and held prescheduled meetings with nursing managers and supervisors to facilitate data collection processes. Then, the research idea was explained to nominated nurses, consent forms were read and interview guide was delivered as a printed version. All inquiries were answered especially those related to anonymity, privacy and confidentiality before heading to a private spot to sign the consent and perform the interview. The interview time ranged from 45 minutes to 75 minutes.

Participants refused to use audiotape device for recording because of the sensitivity of the discussed topic and a vague sense that a legal implication could pursue; in respect to that two research assistants participated in each interview, one of them led the questions while the other handled the immediate verbatim transcription in the interview manual which was designed with appropriate spaces to contain the provided answers. The paper-based research manual was based on a highly relevant literature review and revised by three specialists in the field. It was specially prepared to give deep-enough comprehensive insights into the studied phenomenon (Busetto et al, 2020).

Data Analysis And Rigor

Thematic content analysis was carried out by three researchers who executed regular weekly sessions to analyze the research manuals one by one. Open coding was initially done to identify words with similar meanings (Lorelli et al, 2017). Focus coding was conducted to group codes that sounded similar, a
process which ended up with formulation of the preliminary themes. Constant comparative method of data analysis was adopted to make sure that all data are checked, coded, categorized and compared thoroughly (Cypress, 2017). Disagreements on themes and subthemes were discussed constantly and reached consensus. Ultimately, a revision process was run twice to ensure credibility and trustworthiness of analytical decisions. Those decisions were enhanced through reflexivity process that included writing reflective journals, memos and appropriate referral to supportive literature (Forero et al, 2018). In addition, other researchers were invited to cross-check the themes to reduce subjective bias and confirm the findings, conclusions and recommendations (Johnson et al, 2020).

Findings

Table 1 shows the socio-demographic characteristics of the participant nurses who were assigned numbers to ensure anonymity and non-traceability. The ranks, work places and units are not reported to further minimize the chance of identifiability. The sample included a total of 20 nurses, 10 staff nurses with Baccalaureate level, 3 nurses with diploma level, 1 PhD holder, 6 nurses with master degree. The average age of participants was 34.15, the youngest participant was 24, while the oldest was 48 years old. The average nursing experience was 10.9 years with a minimum reported experience of 1 year and a maximum experience of 25 years. 9 nurses were married, 2 divorced and 6 single. Male nurses were 9 and females were 11.

### Table 1: Demographic characteristics of the participants

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<th>Code</th>
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<th>status</th>
<th>experience</th>
<th>Education</th>
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</tbody>
</table>

m: male, F: Female *withdrawn ** he was a clinical instructor outside Jordan
Six themes had emerged which were: nurses coping with COVID-19 crisis, professional relationship burden, personal burden, environmental burden, physical symptom burden and emotional burden of the crisis. As shown in Table 2 along with the relevant subthemes.

### Theme 1: Nurses Coping With Covid-19 Crisis

During the COVID-19 pandemic, it was understandable that nurses were fighting under stressful conditions. A successful use of effective coping strategies can help nurses manage stress resiliently and pass through critical moments with intact morals and less traumatized souls, minds and bodies. There were two subthemes here.

#### Subtheme 1: Positive Coping Strategies

There were three main reported positive coping strategies. First, many nurses described talking to significant others (social support) such as a mother, a grandmother, a wife, a friend, a colleague or a relative as a major technique to help ease turbulent emotions and stressful thoughts. C4 said: “talking with family and friends helped me during the crisis”. Second, after along tiring day, physical rest and sleeping helped. C2 said: “having rest at home after a full day of pressured work helped me through the crisis”.

Third, many participants turned to “faith based beliefs and practices” which helped them float during tough intolerable times especially for believers who think that a higher power has dominance over their lives, things are predestined and death is a final destination for every living creature; it can't be avoided no matter what, so it may be a wiser decision to accept death or God's will rather than to repel against or turn faith. C6 said: “Reading from the holy Quran, belief in the certainty of death and the belief in God’s control over everything in our life helped me through the crisis”. While C23 reported: “nothing deserves, there is no escape from death even with the availability of supplies and highest price medicines. I reached a conclusion that age is predetermined even with the artificial lung! Spiritual beliefs are so important and they helped me so much during the crisis, I am so astonished from people who don't believe in death and after life, my psychological distress made me unable to argue with them. Money doesn't mean anything and it doesn't take you away from death.”

#### Subtheme 2: Negative Coping Strategies

At the times of adversity and hardship, some nurses turned to less resilient coping strategies that could help them escape reality and avoid thinking or overthinking. Substance use is one mechanism of negative coping. The interviewed nurses reported over drinking coffee, increased smoking, turning to use electronic cigars because they could be used easily anywhere, taking panadol/Panda or non-steroidal anti-inflammatory drugs (NSAIDs) as Brufen for stress induced headaches, smoking shisha, Panadol night alone or combined with serdalod to ease falling into sleep, power drinks to keep awake, deanxit to reduce anxiety.

C2 said: “I used to drink 400 ml coffee before the COVID-19 and smoked 15 cigarettes. After the crisis I started to drink 800 ml coffee daily and smoked a packet and half. I started taking deanxit to ease my anxiety level. Then I quit regular smoking and turned to electronic cigarettes; I started to smoke everywhere at home, at work and in the car”. Besides, C25 reported: “after COVID-19 I had trouble in falling asleep, I can't sleep except if I take two tablets..."
of Panadol night and serdalod 3mg, 2 tablets”. He added: “I watched TV movies for 9 continuous hours to escape reality”. The last quote describes another negative coping and reality escape mechanism which is “TV addiction”.

**Theme 2: Professional Relationship Burden:**

Four subthemes emerged which were nurse-nurse relationship, nurse-patient’s family turbulent relationship, nurse-patient relationship and nurse-manager relationship.

**Subtheme 1: Nurse-nurse Relationship**

It was evident that nurses were like soldiers on the fire frontlines; they were back to back. It was almost unanimous that the relationship between nurses was supportive during the first pandemic waves. It was almost instinctual for them to simply understand that at the end of the day we only had each other. C2 said: “my relationship with my senior colleague was good during the crisis ...colleagues supported each other by lending a hand”. C20 said: “The colleagues were supportive; the in charge nurse wore the PPE and entered the patients’ rooms with us”.

**Subtheme 2: Nurse-patient’s Family Turbulent Relationship**

Nurse-patient’s family situation was a dichotomous relationship which was most approximate to the word “weird”. Some nurses felt relieved and less stressed because there were no visitors to bother them with redundant inquiries, multiple complains and extra tasks to perform. On the contrary, the other aspect was expressive for the need of the family to be there, at the bed side, and to participate in the care as well as in the direct supervision of their sick family member. Many nurses attributed that to a desire to minimize portion of the care burden, to be lent a hand during providing patient’s self-care, to have someone attending all the time to monitor the patient, report deviations from normal and escort patient to the bathroom, feed, return oxygen devices and call for help in case of need or emergency. C3 reported: “the absence of patients’ families “visitors” helped me focus during the COVID crisis and time was more available... with the quarantine my worries faded and the load became less because I only communicated with the clients not with 100 clients’ families”. While C20 said : “I won’t forget a patient who was on CPAP. She frequently removed the oxygen mask, I was not able to be available for her 24 hours a day...sometimes patients were about to die, but you don't know, they could die in the bath room ...it takes time to prepare ourselves and wear the PPE to be able to offer help, the family was not there! So the patient could aspirate and there is no one to tap his back or call for help.”

**Subtheme 3: Nurse-patient Relationship**

Nurses are usually overloaded and the time for communication with clients is kept to a minimum. Because of the COVID-19 special nature, isolation of infected clients which mitigates their social interaction chances, special end of life emotional needs, and a kind of nurses emotional involvement with patients challenging experiences; some nurses shifted their formal communication paradigms and took a more active role. For example C3 said: “Before COVID, I didn't socially communicate with the clients or their families; I preferred to stay formal. I didn't want to be affected emotionally by them. During COVID crisis, things became different. I started to communicate with the isolated COVID clients more than other patients, but I was anxious from staying too long in the room due to the fear of infection transmission”.

**Subtheme 4: Nurse-manager Relationship**

Relationship of nurses with their managers and direct supervisors during the pandemic was variable in nature. It fluctuated between positive, negative and neutral. C1 said : ” My manager was neutral. He didn't support me. He didn't thank me. We didn't see the managers. We didn't take raises on the salary. They didn't cover the lack of staff”. On the other hand, C23 said : ” my manager had a very negative role. There is no empathy, no encouragement, nor appreciation! Those who did mistakes were exposed in public and that was totally wrong! He refused to let me leave early one day and I committed a medication error”. Finally, C4 said: ” My supervisor was cooperative and understood the psychological and physical burdens of the COVID times. He arranged the schedule well. Verbal recognition was given constantly. The break time was good. He used good manners in dealing with the staff nurses but financial reward was lacking”.

**Theme 3: Personal Burden Of The Crisis**

Nurses revealed two challenges at the personal level during the pandemic which were the social distancing effect on family dynamics and cost of social status.

**Subtheme 1: Social Distancing Effect On Family Dynamics**

Social distancing measures were imposed to decrease contagiousness of the disease but caused suffering in more than one way to nurses and their families. Some nurses were relying on their families to care for their children or as a resort for time out and social life but due to the lock down and geographical distance, they were unable to reach such destinations and a relative state of loneliness and a sense of isolation resulted.
Besides, mourning for the beloved ones took a totally different mode where you couldn't hug your diseased or say goodbye to him nor funeral houses were allowed to let neighbors and friends play consolation role. Finally, nurses were reluctant to hug and kiss their children or socially interact with their fathers, mothers and beloved ones, some nurses even forbade themselves voluntarily from seeing their parents for extended durations. C8 said: "They were nasty days.. It was difficult for me to manage my life.. My family and my husband's family were so distant." Whereas C21 said: "My grandmother passed away in the COVID time, when it was forbidden to see and say goodbye to those who die due to the unfamiliarity with the contagiousness of the disease. I can't talk right now about my feelings towards her. And he fell in tears." C20 reported: "At the beginning, I wanted to hug my daughters but I couldn't, I was afraid. I cried more than once because I was the care provider for them; my husband works outside the country."

**Subtheme 2: Cost of social status (marital status of the nurse, caring for children and elderly)**

During COVID-19 difficult times nurses with family responsibilities and family members to care for were the most challenged. For example, some nurses were married with children, some children were so young and require more attention. Other nurses were divorced with children and they faced the single mothering high demands aligned with the lock down responsibilities of buying the groceries, emotional nourishing, caring and remote teaching. Some single nurses who lived with their parents were pushed negatively and stigmatized in a certain way by their families because they deal with COVID patients and simultaneously carry the risk of disease transmission. Notably, younger male and female nurses especially singles were experiencing higher stress levels during the pandemic and they were managing their days with extreme difficulty.

C10 who is a new mother of a 70 days baby and a boy who is one year old said: "I married female nurses were in severe struggle during the pandemic and before that as well. They can't handle things in equilibrium inside and outside home! I can't perform less than expected at work so the defect was at home, with my husband, my children and caring for the cleanliness of the home. I communicated less with my husband and he complained because of that. I didn't show affection to my eldest son due to lack of time." While C12 said: "I am a divorced mum. I had to provide all my children's needs during the pandemic. I had the challenge of keeping my family and children safe and away from the COVID risk. I had to teach my children after doing two rounds shifts because the learning during the lock down was totally online. The father was totally absent!"

**Theme 4: Environmental Burden Of The Crisis**

This theme is composed of seven subthemes which are: ambiguity, PPE strain and isolation precautions, Low morale of some nurses, Lack of financial reward and nurses feeling of injustice and dissatisfaction, unpreparedness to deal with COVID-19 crisis (a dual challenge made of the rapid and unexpected deterioration of COVID patients combined with high mortality rates, and a fake sense of readiness to manage the escalating COVID rhythms), workload and care demands, and lack of supplies, equipment and experience.

**Subtheme 1: Ambiguity**

Nurses revealed that ambiguity of the virus behavior created a state of ambivalence in the treatment and pharmacological management approaches of the disease. The protocols were frequently changing and conclusive evidences were critically lacking.

C9 reported: "It was a totally new experience! Everyone is learning. Every time we are trying a new COVID management protocol. The doctors try it then stop it. I felt that whatever we do with the COVID patients who are on CPAP BIPAP or ventilators; their condition will never improve. I felt so disappointed and I thought that this virus is manufactured! Every client is affected in a different way. No case scenario is similar to the other. At the beginning, things were so confusing!"

**Subtheme 2: PPE Strain And Isolation Precautions**

It was unanimously stated by interviewed nurses that wearing the PPE to provide care for the COVID patients was a real torture especially when worn for long times and when the nurses involved in the care were smokers. They added that it was lengthy to wear the PPE, annoying to be in it, and they couldn't see well.

C20 said: "Wearing the PPE was a burden. It takes time to wear the PPE. Sometimes the patient suffocates, dies, arrests, collapses, falls in the bathroom and we can't timely help him because we need to wear the PPE first. There was no family member to help or to call for help!". Whereas C2 said: "I am a smoker and I drink coffee; the PPE made that difficult. After 2 hours in the PPE, continuing to provide nursing care becomes almost impossible". C3 added: "I was psychologically upset from wearing the PPE and the eye goggles. It was annoying to me and I couldn't properly see in front of me. I reduced the time I spend with the client and the number of times I enter the client's room due to the PPE and fear of getting the infection".

**Subtheme 3: Low Morale Of Some Nurses**

Some participants reported that a few nurses specially those who were redeployed from other hospitals to the COVID-19 care centers, had low morals, weren't professional and didn't meet the minimum standards of nursing care during their duty days. For example, C23 said: "Some nurses had no conscience! They took temperature once per shift. They worked two hours and rested for the rest of the time, especially redeployed nurses; they were not cooperative. Some patients may have died of negligence; due to aspiration, for instance".
Subtheme 4: Lack Of Financial Reward And Nurses Feeling Of Injustice And Dissatisfaction

All interviewed nurses almost felt certain injustice during the COVID-19 duty days because they were not sufficiently financially rewarded, or didn't take extra paid vacations, and work burden was doubled when senior nurses were infected or when help nurses were replacing the sick.

C3 said: "There were a lot of injustices secondary to COVID. Nurses who reside far away and said I couldn't come to work, were excused. Nurses incentives decreased because the financial returns were less and the number of patients was less too." C21 added: "We felt severe injustice as a medical care team. We didn't take our right as the other managerial employees, who took two paid week vacation...there was a shortage in nurses in the first two peaks because they got COVID. Once four seniors were infected and the floor was left with junior majority who lacked any nursing experience!"

Subtheme 5: Unpreparedness To Deal With Covid-19 Crisis (A Dual Challenge)

Unpreparedness to deal with the emerging COVID-19 was a dual challenge which included: the rapid and unexpected deterioration of COVID patients combined with high mortality rate, and a sense of fake readiness to manage the escalating COVID rhythms.

A-the Rapid And Unexpected Deterioration Of Covid Patients Combined With High Mortality Rate:

Nurses expressed that they weren't used to rapid deterioration and sudden collapse scenarios especially for younger populations or for people who were previously healthy. Besides, high mortality rate of patients secondary to COVID-19 complications such as pneumonia, respiratory failure and renal failure was one aspect that nurses were not, by any means, prepared to deal with, endure or accept.

C22 said: "During the second peak there were a lot of mortality in hospital and in the family". C5 reported: "The experience was shocking! I am so used to the ICU work but the rapid change in the condition of a stable patient who was ready to be transferred to the floor, then all of sudden his lungs collapse and fail! It was something difficult to absorb. COVID nature is not foreseeable. Deterioration and death can ensue within minutes or even seconds!"

Whereas C20 commented: "...a patient who was 36 years old and he had a chest tube. He was calling us repeatedly. We thought that he was nagging and a bad tempered client...we got shocked! He was fighting death and those calls were his last ones in life. We found him dead in his room minutes later. We were sorry for him. We weren't used to that rapid rhythm of deterioration and sudden death especially for young people!"

B-fake Sense Of Readiness To Manage The Escalating Covid Rhythms

Despite the national efforts to combat the virus and the huge budgets which the ministry of health had located for prevention, vaccination and treatment of COVID-19, there were shortages, gaps, weaknesses and lack of proper training specially on the new imported machines. It worth telling that a percentage of relocated nurses to COVID care units hadn't any ICU experience and didn't know how to manage ventilators. It seemed that the nursing bodies were managing at the microcirculation level, rather than on the higher managerial or strategic levels.

C21 said: "My direct supervisor helped as much as he can; but the management was pretending that the situation is stable! And when the things went wrong, they told us to manage the situation alone. They didn't increase the staff number. There were new devices which were left in the storehouse and weren't used because we didn't know how to operate them!"

Subtheme 6: Workload And Care Demands

Work load was significant during the first two peaks but may became less later on secondary to certain action measures such as decrease number of admissions, closing outpatient clinics, over-phone consultations, renewal of medicines by delivery, and providing volunteer nursing and medical services at home level.

C10 said: "Number of patients was huge. More than 50 patients and only assigned nurses will take care of them. They needed a lot of care." C25 commented: "Number of work hours was exhausting during the pandemic". C21 explained: "The elderly clients had higher physical needs. They were weak and lost their muscle tone. They weren't able to stand. They needed help in their basic needs. They had bad nutritional status and they refused to eat. We asked the doctors to insert nasogastric tubes for them..." C3 highlighted: "People are talking and complementing our work as we were the white army. But on the ground, we were the only ones who were tortured. For us, the work load was increasing in the time when the rest of people took paid vacations." Finally, C22 said: "The hospital stopped allowing escorts and this doubled the load on nurses. The management forced us to stay intensively with the patient in his room, and this thing was severely annoying due to the PPE and the increased infection risk."

Subtheme 7: Lack Of Supplies, Equipment And Experience

It was reported that there were sometimes lack of supplies, protective equipment, oxygen, BiPAP/CPAP, some medications as well as a clear defect in the infrastructure that supports a unit to receive COVID-19 patients.

For example, C6 said: "I had told the hospital director about the disadvantages of the COVID department. I told him about the absence of a proper ventilation system. Having one bathroom. No place for nurses to eat. No sink. No negative pressure. And no proper staffing because the nurses were
afraid.” While C22 said: “Most of the clients were on CPAP and ventilators. Not all the nurses had adequate experience how to deal with those equipment. We were originally a CCU team! Suddenly we became ICU team. The ventilation system was ineffective and there was no negative pressure”. C12 reported: “There were a lot of patients whom the oxygen and medications as well as escorts were not available. They needed a lot of help.” At the end, C20 commented: “It was a COVID floor not an ICU; so I can’t be with the patient for 24 hours. The hospital provided CPAP only for those whose oxygen saturation level is less than 80%. And ventilators only for those whose saturation level is less than 70%. If the PPE was insufficient we didn’t work with clients!”

**Theme 5: Physical Symptom Burden Of The Crisis**

Majority of nurses suffered from one type or more of physical symptoms secondary to their work during the pandemic such as headaches, lack of sleep, nightmares, pain in the knees, joints, muscles, bones, legs and back, lack of concentration and a loss of appetite.

C21 mentioned: “My concentration had dropped significantly during the pandemic due to high stress. Nursing work during the crisis had brought muscle and bone pain and headaches...we were officially running on pain killers!” C13 said: “Till the moment (2, January, 2022) there has been no continuous sleep. I have nightmares. I see the patients strangulating me especially those patients who were arrested and resuscitated! The maximum sleeping time was three hours”. C10 added: “I didn't take care of my self during the pandemic, so I didn't take my vitamins. I had experienced knee, back, joint and bone pains beside headaches.”

**Theme 6: Emotional Burden Of The Crisis**

**Subtheme 1: anxiety and fear**

Anxiety and fear were significantly dominant in the analogue with the interviewed nurses. Fear for themselves, their families, patients, other people, risk of infection, complications, death, stigmatization among many others.

C4 said: “I was afraid that I could infect my family or anybody. I live alone in Amman. I didn't see my Mum for five months. I never went back to Ajlune during the peaks.” While C3 said: “I was afraid that anything bad could happen to me at any time because I had seen a lot of young people who were medically free, and gone to ICU. I had seen others who developed lung fibrosis and went home on oxygen therapy!” Besides, C12 commented: “people died from COVID. I was always afraid even after me and my family got the infection! I used to shower immediately and wash my clothes. I didn't blend with people to avoid contaminating them.” C9 added: “I was so afraid from the situation. I was afraid for myself and my family. My brother was afraid from me despite me taking all the necessary precautions. He left home for two days! At first I resented this. I felt Forsaken!” Finally, C13 explained: “I was lonely and afraid for my family. There was a constant feeling of dereliction because all of patients died. In March, April and May, no body reverted post CPR. The patients died suffocated or chocking.”

**Subtheme 2: Sympathy**

Some nurses exceeded the safe borders of empathy to the dangerous edges of sympathy with their COVID-19 patients. They went through tough suffering induced experiences of wide range of intolerable feelings.

C5 reported: “... a 36 years lady who was on cortisone though she died very quickly. I was so sad for her husband and children. I imagined myself in their place and that feeling was tough.” Where C4 illustrated: “the suffering and the moaning of the dying clients accompanied me home!” C13 said: “Nothing could express the shock that I was in. Suddenly, the face of the client turns to a face of a beloved one. I was afraid that today I am working with this client but tomorrow, I could work with my mother! That feeling was unbearable.”

**Subtheme 3: Compassion Fatigue And Depression**

Many nurses reported deep feelings of shock and a kind of intense psychological trauma due to the rapid unexpected losses and clients’ suffering that was happening directly in front of their eyes, day to day and every day. Nurses who were managing COVID-19 patients were experiencing high risk of depression and compassion fatigue.

C21 said: “A lot of clients were on mechanical ventilators. Numerous codes and deaths. All contributed to my depression and compassion fatigue.” Where C13 added: “At the beginning of the crisis we thought that everything was okay...we had misestimated the whole situation, so we were emotionally shocked. If you close your eyes for seconds a client could die! It was so difficult to separate life from work.”

**Subtheme 4: Sadness**

The feelings of sadness were frequently reported because of patients stories. For example, C4 said: “I felt severe sadness for the mother who had lost two sons in a car accident. Then, she lost her remaining son who had asthma and was 23 years old with COVID”. And C22 told us that: “There was a
prisoner whose hands were cuffed to the bed and a cup was watching him. His lungs were collapsing. He was in terror. I can't forget his eyes. I was severely touched. I told the cup to un-cuff him and told the client not to worry anymore! Then, he passed away!"

**Subtheme 5: Burn Out**

Some nurses went so far in their stress levels until they reached a level that they were threatening almost every day that they will quit and look for another job. They were totally burnt out.

C25 said: “I planned to quit. Leave work. I could work as a driver instead!” And C23 said: “I was so depressed to an extent that I was ready to quit nursing!”

**Subtheme 6: Nervousness And Anger (Loss Of Temper)**

Nervousness, anger and loss of temper was characteristic of the mood status of some nurses both at work and at home because of the high unprecedented stress they faced during the pandemic.

C13 said: “I was always wondering whether the PPE could 100% protect me from infection. I didn’t allow my family members to enter my room, and they understood that. I became so nervous, ill-tempered and so hasty in decision making. It was easier for me those times to misinterpret any person’s talk and be angry with him! I didn’t want to talk most of the time!”

**Subtheme 7: Hopelessness And Helplessness**

Nurses felt so desperate when it came to the ultimate outcomes of COVID-19. Negative feelings of losing hope and being unable to offer help to postpone or hinder death were overwhelming and prevalent.

C25 said: “I felt detached from reality during the COVID-19 CPRs. I felt so helpless when the patient dies. I felt so lost” (Facials were full with emotions mixed with terrible silence). While C22 illustrated:” Burial and shrouding of COVID-19 clients was a complete horror. Their pictures are not leaving my mind. The moments of death, and the horror in their eyes because their families were not around! You knew as a nurse that the patient is totally heading towards his grave but you couldn’t tell; and the patient himself didn’t know that he is dying!” C23 elaborated: “I felt so helpless during COVID times. Even with expensive drugs available like ECMO and IV immunoglobulin. All seemed so irrelevant and useless. Thousands are spent but no difference is brought! Depression is escalating with don’t resuscitate cases (DNR). It was a mixture of losing hope!”

Finally C5 closed:”Sometimes a thought keeps crossing your mind that this client is definitely going to die. I don’t give him life and I was unable to win him extra time as well. In such context, it was so difficult to deal with the clients.”

**Subtheme 8: Empathy**

On the positive emotional scheme empathy with patients and their stories and conditions was reported by nurses who provided care to COVID-19 patients. Empathy reflected the very sensitive, humanistic and professional aspect of nurses personality.

C4 said: “The patients who were on BiPAP were frequently asking for water even a little. It was difficult for them to drink because of the device. But, I used to wet their lips. The deaths and the clients yawning, all reflected on me when I went home. The son wanted desperately to see his father or his mother. Those events had pushed me to think what would happen if I were in their very same situation?”

C21 added: “We started to care more for our clients physically and psychologically. We joked and laughed with them. We called the families whose relatives were intubated to see them. I remember the first pregnant female client who was 28 years old. We had tried everything with her. She had been given all the medications including Actemra. There was an argument whether to deliver her or not. The mother wanted the baby to see life but the family preferred the mother over the baby. Eventually a caesarian section was done. Her saturation level was 82–84% and she was put on BiPAP, then she improved and was put on simple face mask. We were so happy with the improvement. She was mobilized but unfortunately she developed fever and pulmonary embolism a couple of days after and given a thrombolytic intravenous. But nothing worked out. She passed away. Everyone empathized at every single moment with her and we were all touched by her departure.”

**Discussion**

Jordan had passed through tough times during the COVID-19 pandemic especially during the first three waves. Also, health care providers especially nurses went through difficult moments through which they were, to a certain point, testing their stamina, patience, tolerance, adaptability and even their faith.

Nurses used both negative and positive coping strategies to manage their stress and emotional suffering. On the positive coping side Jordanian nurses utilized social support by talking to significant others, sleep and rest, faith based beliefs such as God’s control of everything in our lives, inevitability of
death, and certainty of predestiny, and belief based practices like praying, reading from the Holy Quran, asking for forgiveness, and saying prayers. When we go to Sehularo, L et al (2021) we could find the social support and the faith based beliefs and practices combined with psychological support, management support and use of COVID protective measures. On the negative coping side some Jordanian nurses turned to less resilient coping strategies such as increasing their coffee and cigarettes consumption mainly, and less frequently they took analgesics to ease their headaches and physical pain and some pills to facilitate falling into sleep (Jarrad, R et al, 2018). Meanwhile Suhalaro's review revealed avoidance strategy being mentioned frequently by nurses globally to manage their caring associated stress. To compare against we took another study from Poland and Belarus where they had reported active positive coping strategies which were used frequently such as active coping and planning, while the least used strategies were avoidance techniques such as behavioral disengagement and substance use (Kowalczuk, K et al.2022).

The second section of this in-depth qualitative study covered the burdens that had been encountered by nurses during the crisis. On behalf of professional relationship burden, nurses described their back to back supportive relationship which was facilitative to their caring role. Such supportive collegial relationship was emphasized in literature (Bergman, L et al, 2021). On the contrary, nurse and patient's family relationship was ambiguous, troublesome, complicated and ambivalent before and during the crisis. It seemed that eliminating the visitations and/or limiting them had created a bipolar outcome. Thus, some nurses felt relieved and less stressed because there were no body to bother them while others felt severely stressed because there were no body in the patient's room to watch out continuously for him, help in the care and ask for help in cases of suffocation, desaturation, falling down or collapse. In-deed scarce literature discussed this very specific aspect during the pandemic. But we found that Guttormson J et al (2022) documented nurses complaining from the lack of family presence in the ICU. On the positive side, there was a study by Keen A et al (2022) which discussed the viewpoint of nurses about the importance of their role as a liaison as implemented during the pandemic, and this was found to minimize the nurses moral distress level and enhance family connections.

The third aspect of the professional relationship burden showed a shift in paradigm of some nurses to take a more active role in communicating with COVID clients and perform the roles of talking, listening and psychological support in spite of the standing fear of being infected. Shin S and Yoo H (2022) emphasized that South Korean nurses proactively provided care for COVID-19 clients, and accepted their roles in protecting lives and implementing effective communication strategies even in deviated health situations. They perceived the pandemic as an opportunity rather than a threat because it offered them the unique chance to contemplate the real meaning of nursing.

The fourth dimension of the relationship burden focused on the nurse-manager relationship which was viewed differently by participating nurses. Some nurses believed that it was supportive, others said it was definitely unsupportive, and the rest viewed it as neutral. Roe E et al (2022) documented a differing (polarized) perception of leadership and that communication with management varied with levels of leadership. They mentioned that communication with leaders was frequent but confusing, first level leadership was supportive but other leadership levels were absolutely non-appreciative.

Theme three discussed two major personal burdens of the pandemic which included the social distancing effect on family dynamics and cost of social status. First, social distancing helped in cutting the risks of infection (VoPham,T et al,2020) but gave birth to negative social consequences such as isolation, loneliness, lack of social interaction, difficulty in finding day/night care for children, and a distorted way in saying goodbye for the dying beloved ones. Häussl A et al (2021) matched our findings and reported an increase of nurses use of the new media may be as a compensatory mechanism for face to face interaction. Second, the cost of social status during the pandemic such stigmatization by family members, increase life demands especially for nurses who had children, lived with or cared for elderly, divorced with children, single mothers, and younger single nurses (less than 26 years); were all reinforced by various studies such as that one done by Galletta M et al (2021).

Whereas theme four proved that COVID-19 pandemic came with multi-arm environmental burden which was articulated from: ambiguity, PPE strain and isolation precautions, Low morale of some nurses, Lack of financial reward which created a sense of injustice and dissatisfaction among nurses, unpreparedness to deal with COVID19 crisis which was a dual challenge composed of the rapid and unexpected deterioration of COVID patients combined with high mortality rates, and a fake sense of readiness to manage the escalating COVID rhythms, workload and care demands, and finally a lack of supplies, equipment and experience.

Ambiguity in COVID-19 frequently changing policies, protocols, managements, and guidelines was confusing; that didn't help nurses do their job and increased their stress levels when thinking of their safety and patients ultimate clinical outcomes. Durodié B (2020) among many other researchers confirmed that perceiving ambiguity in health information; that is, uncertainty elicited from believing information that lacks credibility, reliability, or adequacy, is typically associated with pessimistic appraisals (e.g., high perceived disease risk) and behavioral avoidance. This was reflected on ground by nurses decreasing their entries to patients' rooms, minimizing therapeutic interaction time, limiting the medication frequencies to twice daily, and a dramatic feeling of discomfort and doubt that none of COVID trial managements would really help or cure, especially in the lack of critical and conclusive scientific evidences (Simonovic, N & Taber, M, 2022).

On the other hand, PPE and isolation precautions created a burden on nurses in many terms. Jose S et al (2021) supported our findings and stated the most common adverse health effects of PPE included headache, extreme sweating, and difficulty in breathing, fogging of the goggles; nasal bridge scarring, and indentation and pain on the back of the ears as adverse skin reactions after wearing N95 masks. Besides, Coen B et al (2022) said that the combination of exacerbated workload and the impermeable nature of the worn PPE increased the heat strain. The National Healthcare Communication Program (2022) stated that when clinicians wear the PPE, they appear intimidating to the patients, mask non-verbal communication and make hearing difficult. Our findings focused more on the difficulty and time required to wear the PPE, decreasing the number of patient rooms' entries due to the need to wear the PPE, suffering of smoker nurses which was minimized by the collaboration of their colleagues, and a system of two hours in/two hours out.
Besides, some nurses reported that if the PPE was insufficient they wouldn't enter the room, and there was a negative effect of wearing the PPE on salvaging clients in life threatening conditions or risk of falling down because of the time required to wear the equipment. Discomfort, inability to see properly and inability to provide care after two hours in the PPE were also reported.

When moving to low morale of some nurses which was exposed during the crisis; mostly in the form of low quality and low quantity of provided care. It can be said that some participants reported such criticisms especially from redeployed nurses who came from other hospitals and were assigned to COVID-19 care centers. This finding was supported by many research articles; for example, Drake K (2021) rationalized low team morale during pandemics by saying that “stress, distraction and fear can bring low morale”. She suggested that stress decreases morale by causing fatigue that lowers productivity, and it can lead to division replacing unity and criticism over caring. Disappointment could be tackled by more days off; but if not feasible, ways should be found to let staff members be away from the environment during their shift. For example, let staff take their 15-minute breaks and lunch breaks out doors or equip units with small zen room.

Then, lack of financial reward among other factors such as being in duty while others were paid while they were at home and that kind of inequity in risk and exposure to patients with COVID-19 when compared to resident doctors or specialists who kept their exposure to a minimum may be because they were afraid for their lives. We quote from Guttormson J et al (2022): “physicians were unwilling to go into the patient's rooms. That staff created a sense of injustice and dissatisfaction among nurses. Our participants frankly expressed their willingness to be rewarded financially not only to be thanked or appreciated. Specht, K et al (2021) reported that nurses took responsibility and were ready to help and contribute to whatever necessary during the pandemic but they expressed the importance of financial reward because they were leading a risky job with extra time and effort and felt a type of injustice.

Profoundly, unpreparedness to deal with COVID-19 crisis imposed a dual challenge: the rapid and unexpected deterioration of COVID-19 patients which was combined with high mortality rates, and a fake sense of readiness to manage the escalating COVID rhythms. On that behalf, a panel was created by WHO concluded that the world was unprepared for the COVID-19 pandemic, and remains vulnerable to the next major health crisis. They reported that political focus to prepare for more waves is flagging, and at the current pace, transformative change will take years to complete. They stated: “each death is a personal loss, and has reverberating health, social and economic impacts on families, communities, and countries... These losses were preventable but not prevented”. Finally, the panel’s extensive investigation had revealed failures and gaps in governments’ national and international responses, which sadly, failed to protect the public. The report declared that the world’s COVID-19 response remains “insufficient” and “inequitable” (Mitropoulos, A, 2022).

In Jordan, the National Center for Security and Crises Management (NCSM); teams of experts in epidemiological surveillance; public, private and military health sectors as well as the respectful Royal Family with their diplomatic relationships had tried their maximum, all the time, to keep up with the complicated and ascending rhythms of the COVID-19 pandemic (Higher Health Council, 2020), but this can’t cancel the fact that there were, at least sometimes; shortages, ambiguities, fears, gaps, weaknesses, and un-readiness on many levels such as knowledge, experience, equipment, supplies, infrastructure and staffing.

Although Jordan was among the first countries to implement highly strict preventive and control measures, the Jordanian preparedness and response strategy can benefit from the ongoing global experiences and scenarios regarding the COVID-19 pandemic (Al-Tammemi A,2020). However, during and after the battle of COVID-19, countries, including Jordan, must take more serious steps to strengthen their healthcare system capacity in order to be well-prepared for such crises in the future (Lawton, G,2020). Such steps must contain having a sufficient reservoir of medical devices and personal protective equipment as well as a backup of highly trained healthcare staff for critical units, generous emergency response fund, high and consistent individual compliance with the preventive measures, collaborative efforts in providing critical decisions during crisis times, adopting and implementing very precise technical WHO guidelines in emergency health situations, maintaining high levels of awareness within the Jordanian society, strengthening and operational translation of the government-society partnerships, having a well-formulated national preparedness and response strategy with effective leadership, as well as implementing internationally standardized guidelines in crises management (WHO,2020).

The final two subthemes in the environmental burden section were workload and care demands, and a lack of supplies, equipment and experience. In this regard, our respondents reported a fluctuated workload between high to acceptable levels which differed significantly between variable units, floors, health settings, pandemic waves and redeployment to other work places. Nevertheless, those nurses who reported high workloads and severe fatigue assured that they didn't neglect their patients and that they gave them full care, on the expense of their self-care, own comfort, family and home duties. Besides, nurses who cared for critically ill COVID-19 patients, elderly, weak, people with dementia, those on ventilators and oxygen delivery systems complained of the high, around the clock, care demands even in the very basic needs; which was exhausting physically and emotionally. Challenges extended to involve a lack of supplies such as PPEs (sometimes), some medications, etc; equipment such as BiPAPs, CPAPs, ventilators, and sometimes being unable to operate some imported technologies like intravenous pumps, along with the juniors lacking any experience, reallocated nurses lacking ICU experience and not knowing how to manage clients on ventilators, and everybody not quite sure about the accurate COVID-19 effective case management and sound protection precautions.

Those findings were supported well in literature. For instance, Bruyneel A (2021) confirmed that there was a significant increase of nursing workload during the COVID-pandemic. Given the impact of the high workload on both the risk of burnout of ICU nurses and on the quality of care; he emphasized a need to reassess ICU nursing staff requirements to adequately manage new waves of COVID-19 and recommended further research to explore possibilities for deployment of non-ICU nurses on the ICU. Furthermore, Hoogendoorn, M et al (2021) results showed both a significant higher number of patients per nurse and a significant higher Nursing Activities Score per Intensive Care nurse (76.5 versus 50.0, $p<0.001$) in the COVID-19 period compared to the non-COVID period. The Nursing Activities Score was significantly higher in COVID-19 patients compared to both the pneumonia patients and the
non-COVID patients, mainly due to more intense hygienic procedures, mobilization and positioning, support and care for relatives and respiratory care. Besides, PPE shortages were many times reported around the globe and in the USA especially during the first two waves and tracked by health care organizations (Cohen, J & Rodgers, Y, 2020).

Theme five conveyed nurses suffering from physical symptoms secondary to their work during the pandemic such as headaches, lack of sleep, nightmares, pain in the knees, joints, muscles, bones, legs and back, lack of concentration and a loss of appetite. Similar findings were reported by Barello S et al (2020) where 45% of their sample experienced with high frequency at least one physical symptom in the previous 4 weeks. In particular, increased irritability, change in food habits, difficulty falling asleep and muscle tension were very frequently experienced by the majority of the respondents. Guttormson J et al (2022) surveyed 498 nurses who reported physical and emotional symptoms including exhaustion, anxiety, sleeplessness, and moral distress.

The final discussed theme was the nurses emotional burden of COVID-19 crisis. The most reported emotions were anxiety, fear, sympathy, compassion fatigue, depression, sadness, burn out, nervousness and anger (loss of temper), hopelessness and helplessness and empathy. Many studies around the globe had emphasized similar emotional outcomes of the pandemic. For example, Kishi H et al (2022) analyzed 895 questionnaires of nurses’ Accumulated Fatigue and Japanese Burnout Scale and found significant relationship between engaging in COVID-19 care and psychosocial/physical burden particularly in the form of distress, emotional fatigue, emotional exhaustion and burn out risks. Whereas Molina-Mula J et al (2022) survey of 892 Spanish nurses confirmed the presence of emotional fatigue (OR 1.9, p < 0.001), anxiety, moderate post-traumatic stress evident in general nurses, and severe post-traumatic stress evident in ICU nurses. Besides, Pisanu E et al (2022) ascertained psychological distress among nurses during the first COVID-19 outbreak in Italy. Female and younger respondents, experienced more frequently negative emotional states such as irritability, anxiety, loneliness, and insecurity. However, positive feelings like solidarity, were also reported.

On behalf of our study participants, anxiety and fear were provoked mainly by the risk of getting or transmitting the infection to family, other people and to the beloved ones, fear of death, fear of unknown, and sometimes due to lack of experience especially younger nurses. While the provokers of sadness were the patients tragic situations and stories, and their families loss especially when young people die leaving their mothers or children behind. The triggers of anger and loss of temper were basically work burden related; especially with COVID-19 protocols, stress, grief, moral distress and infection precautions. While, helplessness and hopelessness were stemmed in the fact that nurses were seeing people dying along with the associated high rates of failed cardiac and pulmonary resuscitations despite of all the high price medications, the advanced managements and the efforts to preserve lives and improve clinical outcomes.

Compassion fatigue, depression and burn out are interrelated emotional phenomena (Jarrad R, et al, 2020). Majority of our respondents reported those negative feelings which were attributed mainly to the high unprecedented mortality rates, bad clinical outcomes, being occupied with and hyper-vigilant to excessive patients’ suffering and families emotional reactions. In brief, nurses were emotionally shocked by reality and couldn’t, at least at the beginning, separate work from life. Nurses emotional responses with patients’ stories fluctuated between empathy and sympathy (Aliabadi P et al, 2021). When coping with a large-scale emergency like COVID-19, people often report a wide range of psychological experiences, including out-of-control emotional reactions, as demonstrated by recent studies on the psychological impact of COVID-19 on populations worldwide (Graffigna et al., 2020; Li et al., 2020; Lima et al., 2020). This “emotional surge” sadly has the likelihood to exhaust the medical system for as long as the public health crisis lasts.

**Strengths And Limitations**

This study included different rank of nurses of variable demographic and social characteristics which made the sample more heterogeneous. The picked clinical settings and units was a wide range as well; the thing that made some participants’ experiences more deep, rich, intense than the other participants, in spite of them ending recalling similar stories with consistent impacts. It could be said that, at the interview time our participants were at the beginning of the emotional recovery state, but the memories were fresh and touching as some of them fall in tears, tried to hold tears, their facial expressions exposed them, their body language was showing the moved inner state of mind, and there were severe moments of meaningful silence during the interviews.

**Conclusions**

This study could be viewed as an in-depth filming of the nurses’ experiences during the COVID times in Jordan which was so close to other nurses’ experiences around the world; that gives us the impression that nurses experiences unite in hardship. Need for care to be given for the care givers must be emphasized constantly at this point of recent history. Nurses can’t keep giving endlessly without being looked after, listened to, nourished and properly and continuously supported and rewarded. Policymakers and nursing administrators are recommended to actively ensure nurses stay resilient during pandemic challenging times. Moreover, increasing awareness about compassion fatigue, depression, empathy, sympathy, substance use, spiritual power, resilience and effective coping strategies with life and work stressors should be introduced and enhanced during preparatory nursing profession education. Further qualitative research may shed more light on the psychological distress “after effects” on nurses life and work viewpoints and decision making approaches. Another research focus could be lent to an in-depth investigation for nurses substance use, coping, resilience and spiritual space when implied in crisis situations. Finally, nurse-patient’s family relationship in stability as well as in crisis situations requires to be analyzed and understood more profoundly.

**Relevance For Clinical Practice**
Nurses’ physical, mental, emotional and spiritual health and coping strategies during the COVID-19 pandemic affected their way of comprehending and dealing with their self-care, family dynamics, patient's care, communication styles, work environment and professional future expectations, potentials and prospective. Nurses must be supported psychologically by reinforcing positive coping strategies, offering ventilation systems, open dialogues, support groups and professional mental health help at regular basis, not only in crisis times. Standardized operational and clinical guidelines should be grounded to facilitate nurses’ preparedness for the recurrence of COVID-19 waves and any future pandemics.

Declarations

Ethics approval and consent to participate

Ethics approval was obtained from the ethical and scientific committee in the school of nursing, in the University of Jordan. Then, a second approval was collected from the Deanship of scientific and academic research, in the University of Jordan. Afterwards, the University of Jordan institutional ethics review board’s approval was granted. Finally, ethics approvals were obtained from the Ministry of Health in Jordan as well as from the ethical review boards of the included hospitals. Consent forms were explained, handled and signed prior to data collection, with the rights to refuse and to withdraw at any point, being emphasized to participants along with no harm principle, highlighted (World Medical Association Declaration of Helsinki, 2013).

Consent for publication

This section doesn’t apply.

Availability of data and materials

Data supportive for the findings of this study are available upon request from the corresponding author. The data are not publicly available due to confidentiality and ethical restrictions.

Competing interest

The are no competing interests to declare.

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Authors’ contributions

We as authors declare that we meet the authorship criteria according to the latest guidelines of the International Committee of Medical Journal Editors. Our contribution to the paper building was almost equally significant and we are in agreement with the manuscript in its submitted version. RJ wrote the main manuscript. KD and MN reviewed the manuscript and contributed significantly in the data collection and analysis processes.

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