RESEARCH ARTICLE

"Getting caught unprepared": A phenomenological study of Indonesian nurses dealing with difficulties when caring for patients with coronavirus disease (COVID-19)

Sutantri Sutantri PhD[1] | Arcellia Farosyah Putri PhD[2] | Rini Ismiyati BSN, RN[3]

[1]School of Nursing, Faculty of Medicine and Health Sciences, Universitas Muhammadiyah Yogyakarta, Yogyakarta, Indonesia

[2]Indonesian Emergency and Disaster Nurses Association, Jakarta, Indonesia

[3]Health Promotion Unit, DR. Sardjito General Hospital, Yogyakarta, Indonesia

Correspondence
Sutantri Sutantri, School of Nursing, Faculty of Medicine and Health Sciences, Universitas Muhammadiyah Yogyakarta, Jln. Brawijaya, Tamantirto, Kasihan, Bantul, Yogyakarta, Indonesia.
Email: tantri@umy.ac.id or ns.tantri@gmail.com

Abstract

The emergence of coronavirus disease 2019 (COVID-19) has brought pressure and challenges to nurses worldwide. This study aims to understand the lived experiences of nurses in overcoming challenges when delivering care for patients with COVID-19 in Indonesia. The study employed a phenomenological research design. The researchers purposely selected nine nurses who provided care for patients with COVID-19 at an urban public hospital in Yogyakarta, Indonesia, between September and December 2020. The researchers conducted face-to-face interviews with participants. The interview data transcriptions were analyzed using Colaizzi's phenomenological analysis. The experiences of nurses in providing care for patients with COVID-19 can be summarized into three themes: (1) getting caught unprepared, (2) understanding and adapting to a new working situation, and (3) finding new meaning in the nursing profession. This study suggested that nurses overcame difficulties in caring for patients with COVID-19 by using multidimensional and culturally informed coping strategies. Hospital managers and policymakers need to consider culturally relevant coping strategies (i.e., religious-based coping strategies) when supporting healthcare providers during public health emergencies.

KEYWORDS
coping strategies, COVID-19, Indonesia, nurses, nursing care, qualitative research, pandemic

Key points
- Nurses play important roles in combating a pandemic and providing treatment for the infected patients. This situation puts nurses at high risk of infection and leads to significant stress and other physical and mental health problems.
- Indonesian nurses used multidimensional coping strategies, including personal, social, environmental, and religious, to overcome challenges when delivering care for patients with COVID-19.
- Hospital managers and policymakers are expected to tailor available support initiatives during public health emergencies, informed by and based upon the culture and values of targeted healthcare workers.

*The first author only has a single name, hence a double name

1 | INTRODUCTION

During public health emergencies such as Ebola, severe acute respiratory syndrome (SARS), Middle East respiratory syndrome (MERS), and coronavirus disease 2019 (COVID-19), adjustments are necessarily put into, and implemented in, healthcare services. Thus, the service can still provide expected care across different needs. These cases are examples in the healthcare services reminding us that changes are inevitable and resources, including healthcare professionals, should respond accordingly to the changing needs of patients and the demands of the emergencies. Rapid and unexpected changes during these times lead to stress, fear, anxiety, and other physical and mental health problems among healthcare professionals, including nurses (Lee et al., 2018; Ness et al., 2021). Those professionals were under tremendous stress associated with, or caused by, high risk, stigmatization, and/or staff shortages (Lee et al., 2018; Maunder et al., 2003).

Healthcare providers are a vital resource for every country. Their health and safety are of paramount importance, not only for the continuing safe care of patients but also in their efforts to contain outbreaks (Chang et al., 2020). Therefore, comprehensive support should become a top priority during an outbreak period and beyond, thus enabling healthcare providers to safely, comfortably, and effectively cope with sudden changes.

Several studies highlighted that multidimensional support at different levels, including personal, family, community, colleague, and institutional, were used to cope with psychological issues and other changes during public health emergencies, such as Ebola and COVID-19; as well as across different countries including Sierra Leone, the United States, the United Kingdom, Canada, and Australia (Demirci et al., 2021; Kelley et al., 2021; Nowell et al., 2021; Raven et al., 2018). Although similar multidimensional strategies were generally used across countries in dealing with public health emergencies, there were also several differences in the implementation, such as the levels of support that the nurses received from their institutions. These variations were understandable, considering differences in policy, capacity, and available resources in each country (Jo et al., 2021).

Nurses, as the largest population of the healthcare workforce, play important roles in combating a pandemic (currently COVID-19) and providing treatment for the infected patients. As frontline healthcare workers, nurses are in the closest contact with infected patients during hospitalization and spend a lot of time taking care of patients. This situation puts nurses at high risk of infection; an occupational situation that can, and often does, lead to significant stress and other physical and mental health problems (Kackin et al., 2020; Sun et al., 2020). Finding effective coping strategies is essential as, according to Sun et al. (2020), the strategy can turn the negative feelings experienced into positive emotions that lead the coping process of healthcare professionals, including nurses, toward creating a healthy physical and mental condition.

It is worth noting that what is considered as "powerful coping" is different among nurses. One international survey conducted in Japan, the Republic of Korea, the Republic of Turkey, and the United States reported that the issues of organizational support and involvement of nurses in policy development were found to be important resilience factors during the COVID-19 (Jo et al., 2021). Meanwhile, Kelley et al. (2021) highlighted that the most frequent coping strategy discussed by the participants in their study was "peer support through teamwork." It should be noted that most of the previous studies were carried out in developed countries, with little research being conducted in low-middle income countries such as Indonesia. Cultural and general values held by nurses may be different across countries. These circumstances can lead to different coping strategies being used by the nurses, especially at the individual level.

Therefore, this current study aims to understand the lived experiences of nurses in Indonesia when overcoming challenges while delivering care for patients with COVID-19. The manuscript was prepared primarily to highlight the journey made by Indonesian nurses in coping with difficulties and changes during COVID-19, from the beginning of that experience until they achieve their state of well-being. In order to provide broader insights into this challenging issue the discussion compares similarities and differences of coping strategies used by healthcare professionals during several public health emergencies at different levels of support across different countries.

2 | METHODS

2.1 | Design

This study employed a descriptive phenomenological approach based on Husserl's philosophical underpinning. Husserl's philosophy aims to arrive at an essential understanding of human experience by describing features common to all people who have the experience (Lopez & Willis, 2004). The concept of bracketing is inherent in the descriptive phenomenological approach, in which the researchers are required to hold in abeyance any preconceptions or personal knowledge regarding the phenomenon or phenomena under study (Dowling, 2007). By writing a reflexive journal, memo, and holding constant discussions (peer debriefing) with research team members throughout the data collection and analysis, the researchers tried to minimize their personal preconceptions and biases toward the issues under investigation.

2.2 | Sample/participants

The study was conducted in a large teaching hospital in Yogyakarta, Indonesia, from October 2020 to December 2020. The researchers selected nine nurses working directly as "frontliners" in the hospital and providing care for patients with COVID-19 to participate in this study. The participants were chosen by using a combination of purposive and convenience sampling methods. Nurses who worked in the COVID-19 ward and provided direct nursing care for confirmed patients with COVID-19 were eligible to participate in this study. We initially used purposive sampling to recruit our participants. However, after 2 months, we were able to interview only six frontline nurses; thus, we supplemented our recruitment using convenience sampling. The sample size was determined by data sufficiency, as indicated by the presence of redundant information.

2.3 | Data collection

The first and third authors conducted semistructured, in-depth interviews between October 1 and December 25, 2020. The third author, who worked in the hospital, communicated the purpose and significance of the study to the participants in advance and scheduled interview times at their convenience. After informed consent was obtained, face-to-face interviews were conducted in a private, quiet conference room in the hospital, thus ensuring privacy and confidentiality. During the entire interview, both the interviewer and the participant wore surgical face masks and sat apart, separated by a 1.5-meter gap. The duration of the audio-recorded interviews ranged between 30 and 65 minutes. We obtained the participants' demographic information at the beginning of each interview. The interview began with an open-ended question: "What is it like to be a frontline nurse taking care of hospitalized patients with COVID-19?" or "Could you please describe your experience of taking care of hospitalized patients with COVID-19?" Afterward, we used probing questions to encourage participants to elaborate on their experiences (see Table 1).

All the interviews and original transcripts were originally recorded in the Indonesian language. All quotations in this study were translated into English by the first author and back-translated into Indonesian by the second author to ensure there were no inadvertent changes in meaning.

2.4 | Ethical considerations

The Medical and Health Research Ethics Committee, Faculty of Medicine, Public Health and Nursing, Universitas Gadjah Mada – Dr. Sardjito General Hospital approved the study (No. KE/FK/0783/ EC/2020). Informed consent was sought from the participants who agreed to participate in the study after receiving written and verbal information. The participants were also assured that they could withdraw from the study at any time without any consequence.

2.5 | Data analysis

We followed seven data analysis steps outlined by Colaizzi (1978) to provide a clear structure for data analysis. The first step of the data analysis was familiarization with the data. Three researchers read and

TABLE 1 Sample of interview questions

What is it like to be a frontline nurse taking care of hospitalized patients with COVID-19?
What did you feel the first time you had to work at COVID-19 ward?
Could you tell me your biggest challenge while working at COVID-19 ward?
Tell us your daily experience in caring for patients with COVID-19
How did you overcome the challenges when delivering care for COVID-19 patients?

reread the transcripts several times to understand the meanings conveyed. Second, the researchers identified meaningful statements and analyzed them contextually. Following that, we formulated meanings from the significant statements and organized them into themes and subthemes. We also defined all emergent themes into an exhaustive description of the investigated phenomenon. After discussion with the research team, we categorized the themes and subthemes based on differences and similarities. In the next step, we described the fundamental structure of the phenomenon. We revised the themes and subthemes by omitting redundant descriptions from the overall structure. After reaching a consensus on the themes, we requested the participants to validate the findings by giving feedback via the WhatsApp platform (Colaizzi, 1978; Morrow et al., 2015). We used Atlas.ti to facilitate data analysis in this study. The Consolidated Criteria for Reporting Qualitative Research checklist was followed throughout this paper (Tong et al., 2007).

2.6 | Rigor

This study's rigor was enhanced by following the Lincoln and Guba (1985) criteria for the establishment of rigor in qualitative research. To establish credibility, the researchers implemented strategies such as bracketing, as well as prolonged engagement with each participant and the data. Nine nurses with valuable experience caring for patients with COVID-19 were recruited to achieve a thick and rich data set for confirmability. The first and second authors, who were qualitative research specialists with PhD credentials, ensured the descriptions and coding were accurate. In addition, we established confirmability by member-checking. We described all research details in terms of transferability, from sampling to data analysis. Atlas.ti was used to store and manage the data, in order to facilitate the audit trail and enhance dependability.

3 | RESULTS

Nine nurses participated in this study, and none withdrew prior to completion. The sample consisted of seven females and two males across the age range of 18–58 years. Seven out of nine participants were married, and eight of the participants were Muslims. All of the participants have been deployed in COVID-19 ward since the first wave of COVID-19 in the beginning of 2020. A detailed description of the participants is offered in Table 2. Three themes identified in the analysis that captured the essence of participants' lived experiences can be seen in Table 3.

3.1 | Getting caught unprepared

This theme illustrated participants' anxiety and fear during the first few weeks of deployment in the COVID-19 ward. The participants described their feelings of working (a) with an unusual disease,

TABLE 2 Participants' characteristics

No	Age	Sex	Level of education in nursing	Working experience, years	Practice area	Marital status	COVID-19 ward start date
1	58	M	Diploma	37	Medical-surgical	Married	Jan-20
2	36	F	Diploma	15	Infectious disease	Married	Jan-20
3	44	F	Diploma	22	Medical-surgical	Married	Mar-20
4	27	F	Diploma	7	Medical-surgical	Single	Apr-20
5	35	F	Diploma	13	Pediatric	Married	Mar-20
6	36	F	Diploma	9	Infectious disease	Married	Mar-20
7	31	M	Diploma	9	Medical-surgical	Married	Mar-20
8	35	F	Bachelor	5	Intensive care	Married	Oct-20
9	28	F	Bachelor	3	Intensive care	Single	Oct-20

TABLE 3 Themes and subthemes

Themes	Subthemes
Getting caught unprepared	1. Experiencing anxiety and fear 2. Being challenged by exhaustion from protective gears and workload 3. Being treated like a virus
Understanding and adapting to a new working environment	1. Feeling protected while wearing personal protective equipment 2. "Hoping for God's protection" 3. Receiving multiple social supports
Finding new meaning in the nursing profession	1. Joining the fight: "If not me, then who else?" 2. Feeling proud to be the frontline fighters 3. Feeling a strong sense of solidarity among colleagues

(b) within a distinct environment, (c) with unfamiliar equipment, and (d) with a fear of getting infected and infecting others. Hence, three subthemes that fell under this major theme were (1) experiencing anxiety and fear, (2) being challenged by exhaustion from protective gears and workload, and (3) being treated like a virus.

3.1.1 | Experiencing anxiety and fear

All the participants explained that they experienced the feeling of uncertainty and fear the first time they encountered patients with COVID-19. These feelings were triggered by several factors, including (a) limited information regarding the disease, (b) pathogenicity, (c) treatment, (d) fear of getting infected and infecting others, and (e) concern about being subjected to discrimination. Most of the participants had no prior experience working in an infectious disease ward; thus, entering the isolation ward was initially viewed as uncomfortable and stressful. One nurse stated:

> Deep down in my heart, I am scared. I am afraid because I have to live far away from my children. I am also afraid of being discriminated against by people. In

the beginning, people looked at health workers as something negative and something to avoid. That is what I am worried about. (P5)

3.1.2 | Being challenged by exhaustion from protective gears and workload

Under this subtheme, the participants described their challenges to do clinical work while wearing Level 3 personal protective equipment (PPE). In terms of nursing intervention, the participants described no significant difference between an isolation and regular ward. However, the biggest difference was in the use of PPE, which required nurses to wear airtight protective gear. Based on the participants' experiences, providing nursing care while wearing protective gear was challenging. This situation made the nurses feel guilty, as they could not provide optimal care. One participant stated:

> We are in the isolation ward; we cannot be as free as we were used to in a regular ward. When we are in an isolation ward, we have to use a hazmat suit. It is indeed difficult to carry out nursing interventions, for example, when we want to set up an IV line or perform a patient assessment. Sometimes we have to use more energy and put much more effort into doing it. (P7)

The participant expressed that working with PPE for long hours caused major physical discomfort and fatigue. In addition, wearing PPE also restricted the wearer's mobility, made them sweat, dizzy, and feel suffocated. Because the air conditioning system in the COVID-19 wards was turned off to minimize the circulation of contaminated air, this situation caused additional discomfort for nurses. The participants also had restrictions on eating, drinking, going to the bathroom, and praying while wearing PPE. One participant described she had to adjust her prayer time while wearing PPE:

> As a Muslim, I had an obligation to pray five times a day (morning, noon, afternoon, evening 2x). So, if I had

an afternoon shift, I would miss some prayer time (Ashar, Magrib, and Isya'). So, usually, before wearing my hazmat suit, I take ablution first, and then I pray while wearing hazmat. (P7)

Furthermore, performing a simple nursing intervention was a struggle for the nurses because of their PPE, as explained by one participant:

I remember when I had a night shift, I had to set up an IV line for this child. That child was fussy, so we needed to hold the patient. Once we were done, I had no energy and felt so dizzy. I sat on the floor shaking, and I was sweating all over my body because I wore so many layers. (P5)

3.1.3 | Being treated like a virus

Data analysis showed that the nurses experienced social stigma both from the people in the community and healthcare workers involved in a non-COVID ward. The participants stated that they felt alienated from society since working in COVID-19 wards. Therefore, many of them refrained from any social gatherings, because of potentially being the source of viral transmission. They chose to distance themselves from their closest family members (i.e., parents, children, spouse) by using separate rooms at home. Sometimes, they chose not to tell people, other than their family members, that they worked in COVID-19 wards. One nurse explained:

...there are one or two stigmas. Yes, they (healthcare workers of the non-COVID ward) know we are from the isolation ward, and then it is like they tried to avoid us. Yes, some friends told us that they were being treated badly. (P2).

One nurse recalled that one of her colleagues could not go home after work because people in her neighborhood blocked the road. At the beginning of the pandemic, people were afraid of healthcare workers, owing to their close contact with patients with COVID-19. This situation happened as there were many misconceptions and a great deal of misinformation regarding COVID-19. The general public believed that the healthcare workers could be agents of transmission of the virus, as expressed by one participant:

People were scared since we worked in a field related to COVID; for example, when I came home, I had a feeling that my neighbors and people in the community were afraid of me. So, I decided to stay at home. (P5)

3.2 | Understanding and adapting to a new working environment

This theme described how the nurses started to adapt with their new working situation. Overall, the nurses needed from between 1 week

to 2 months to adapt to their new working environment. In their adaptation process, nurses were traveling on a voyage of uncertainties. They started the duty with a mix of negative emotions (fear, anxiety, stress) because of the limited information available about the disease and an initial lack of PPE. However, the negative feelings gradually eroded after a while, and they began to adjust to their new working conditions. They felt protected using the level-3 PPE and considered themselves safer than the other healthcare personnel in the non-covid ward. Therefore, in this theme, the researchers identified three subthemes: (1) feeling protected while wearing PPE, (2) hoping for God's protection, and (3) receiving multiple social support.

3.2.1 | Feeling protected while wearing *PPE*

Data analysis showed that most nurses felt safer working in COVID-19 wards than those in regular wards. Although in the beginning they were worried and scared, after working in the COVID-19 ward for a while, they started to enjoy it. They believed that if they wore the PPE properly, they would not get infected by the virus. This belief is also supported by the result of their COVID-19 tests, all of which were negative. Hence, the use of protective clothing gave assurance to the participants that they were safe and protected:

We already got PPE support and even level 3, so we feel safe. Those who work in the non-isolation ward sometimes have patients who came with a different health issue but, in the end, they tested positive for COVID, and their PPE is not level 3. That is more worrying! (P4)

Furthermore, the fact that none of the nurses working in the COVID-19 wards got infected by COVID-19 also became a source of comfort for the nurses.

Alhamdulillah (meaning: praise and gratitude to Allah), no one from the isolation room is ever exposed to COVID. That is what makes me feel safe, Insha'Allah (meaning: Allah willing). (P7)

3.2.2 | "Hoping for God's protection"

To cope with their situation, the participants used multiple strategies, including religious-based coping. Participants explained that praying to God has become the most important method to reduce their emotional distress caused by working in a high-risk ward. They felt that by praying, they would get help from God and God would protect them. In this sense, participants' faith in God became a source of comfort helping them to cope with adversity and uncertainty and prevent feelings of desperation, as described by one of the participants:

Well, just keep praying in every action; our prayer will always come along with us. (P2)

Praying has become one of the vital sources of comfort for the nurses, as described by this participant:

Since the beginning of my deployment, I have always prayed. I started doing everything by reciting Bismillah [meaning: in the name of Allah (we ask for help)]. (P4)

3.2.3 | Receiving multiple social supports

All the participants expressed their gratitude for the support given by colleagues, friends, families, the hospital, and even the government. The nurses appreciated their hospital's responses, which addressed their basic needs. Because their placement was in the COVID-19 ward, the hospital provided abundant support, including free vitamins, free meals, adequate PPE, temporary accommodation, regular health checkups, and examinations, as well as financial incentives. The participants also valued the importance of family and friends as their source of support. For the married participants, their spouses and children were identified as their biggest supporters. Participants who were single received the greatest support from their parents and friends:

The hospital provides accommodation and provides us with standardized PPE. It is already one of the best supports. They also provide us with periodic checkups. Some friends also send me food to show their support, indirectly raising my morale. It shows that many friends care for me. (P7)

Participants not only valued material support but also mental and spiritual supports from their families and friends:

Yes, Alhamdulillah [meaning: praise and gratitude to Allah], I live in a nice environment, so they understand that I work as a nurse, and I work in a COVID isolation room. When I have to take care of my first COVID patient, the mosque congregation prays for my friends and me. (P8)

3.3 | Finding new meaning in the nursing profession

Fear and anxiety that the nurses experienced during the first few weeks of their placement subsided once they adapted to their new working environment. The nurses felt proud of their profession and appreciated their respect, cooperation, and gratitude, as stated by one participant:

Well, yes, yes, yes, we are here; we feel like the patients need us. However, if we are on the regular ward, they see us just like "oh just nurses," but when we are in the COVID isolation room, we are for 24 hours taking care of them, we feed them, clean them, and bath them, so maybe the patients will realize that the role of nurses in these services is needed. (P7).

Furthermore, three subthemes were identified: (1) joining the fight, (2) feeling proud to be the frontline fighters, and (3) feeling a strong sense of solidarity among colleagues.

3.3.1 | Joining the fight: "If not me, then who else?"

During the interviews, participants described their deployment in COVID-19 wards. Out of nine participants, one participant volunteered, and the rest of them were asked by the hospital management to care for patients with COVID-19. As the virus rapidly spread worldwide, the hospital opened the isolation ward for patients with COVID-19 and assigned the healthcare personnel in early March 2020. Although at the first time, the participants were worried, they were willing to take the assignment because they were aware of their oath as nurses to work at the front line helping patients, as explained by a participant:

We chose to do it because there was no one else going to do the same. We all are nurses, and we took an oath to serve, Bismillah. [meaning: in the name of Allah (we ask for help)]. (P6)

Beyond professional commitment, helping others is one of the central principles of Islam and it is emphasized on numerous hadith and Qur'anic verses that are used as a basis of Islamic law. Muslims believed that there is a clear reward for a person who aids another, both in this world and in the afterlife. Therefore, for the nurses in this study, helping others is not only a form of professional commitment as a nurse but also a religious duty.

3.3.2 | Feeling proud to be the frontline fighters

Despite the exhaustion and fatigue caused by working long hours and putting themselves at risk of infection, the nurses described that they felt proud to be chosen for this important mission. They felt proud knowing that they had helped the patients and played their part in helping tackle the virus. Seeing the patients recover was one of the factors that kept them motivated. One participant said,

I feel proud when the patient could go home safely and was fully recovered, as we know that they came to the hospital initially with bad conditions [...] Being grateful, being proud of myself because I have been a part of taking care of those patients... that is an achievement for me. That is something valuable··· (P2)

3.3.3 | Feeling a strong sense of solidarity among colleagues

Participants reported that they experienced a greater sense of solidarity and collaboration that they had never felt before with other healthcare personnel. The nurses valued the shared experiences with colleagues who were "in the same boat." This feeling kept them motivated to take care of patients with COVID-19 in the front-line.

> Because I have a lot of friends, I did not feel alone...
> although in the beginning, we did not know each other,
> as time went by, we got to know each other, and they
> have become my family. (P5)

4 | DISCUSSION

The findings of this study highlighted how a small sample of Indonesian nurses coped with changes when delivering care for patients with COVID-19. This study reported that nurses were getting caught professionally unprepared when the COVID-19 struck Indonesia. Such a circumstance led to psychological impacts on the nurses such as anxiety, fear and exhaustion. These impacts also became the main themes in other studies conducted across countries that explored healthcare professionals' experiences in caring for patients during public health emergencies such as SARS, MERS, and COVID-19 (Kheirandish et al., 2020; Lee & Lee, 2020; McGlinchey et al., 2021). During public health emergencies, sudden or unpredicted changes often lead to a higher risk of experiencing psychological disorders among healthcare professionals. The condition may become more severe than that resulting from planned changes.

Moreover, the nurses delivering care for patients with COVID-19 in this current study experienced an initial level of social stigma, both from members in their working environment and their communities. As a result, this negativity based on fear and ignorance worsened their psychological well-being. The result is in line with the findings of other studies conducted in Indonesia by Manik et al. (2021) and Yufika et al. (2021). Global studies have supported this finding, such as in Nigeria (Kwaghe et al., 2021) and Italy (Ramaci et al., 2020). Moreover, a similar case of stigma among healthcare professionals also occurred during SARS (Demirci et al., 2021; Verma et al., 2004). According to Sulistiadi et al. (2020), such stigma frequently occurs whenever people are dealing with a new disease (e.g., COVID-19) as they do not clearly understand its transmission and management, or how to avoid it.

The coping strategies used by the participants in this study (Figure 1) to deal with challenges during COVID-19 align with the concept of spiritual coping by Fisher (2011). Four domains became evident: (1) personal, (2) social, (3) environmental, and (4) religious, all of which contribute to overcoming the affected individual's psychological issues and obtain well-being. Personal coping in this study was reflected by the participants' self-awareness regarding their duty as
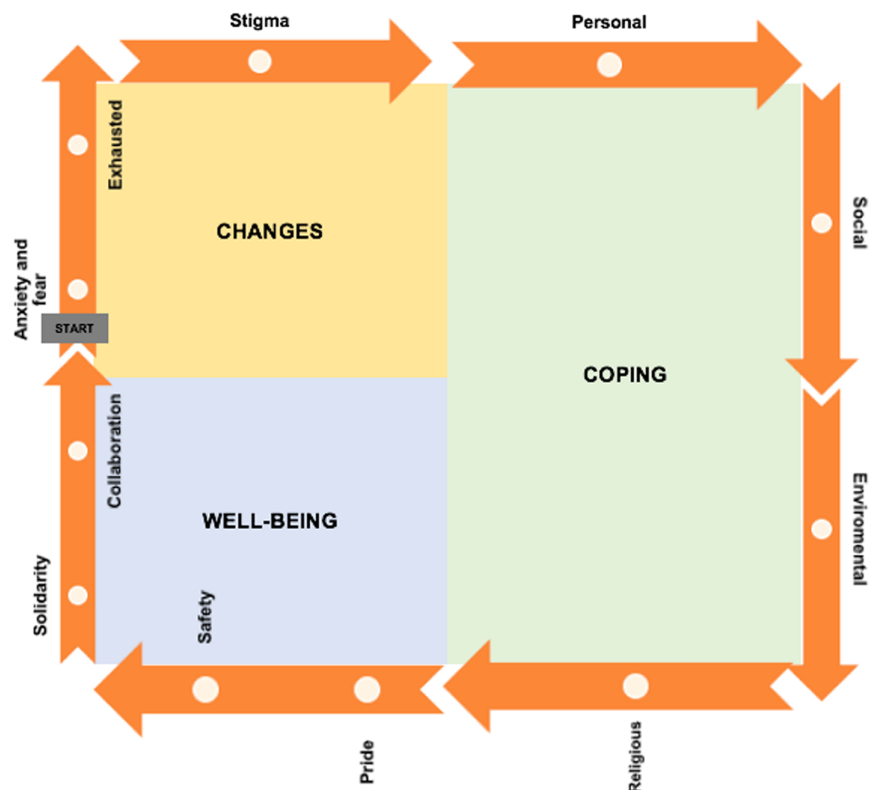

FIGURE 1 Cycle process of coping with changes

nurses, which gave them the strength to carry on caring for patients who had contracted COVID-19. Meanwhile, social coping was identified in this study through the support that nurses received from their colleagues, family, and friends. Such support nurtures in-depth interpersonal relations, which help strengthen nurses' coping performance. "Environmental coping" refers to physical support given by related parties, which in this study was demonstrated by the government and hospital. The practical needs of the nine nurses were met by the provision of such items as vitamins, nutritional supplies, adequate PPE, temporary accommodation, regular health checkups, as well as a financial incentives. Healthcare professionals, public health workers, and local governments massively educated the community through social media about COVID-19 to minimize social stigma among healthcare workers. Lastly, religious coping in this study was carried out through prayers.

Similar to this research, other studies carried out (Demirci et al., 2021; Kelley et al., 2021; Nowell et al., 2021) reported that nurses in Canada, Australia, the United Kingdom, and the United States also used personal, social, and environmental coping strategies when dealing with COVID-19. They received support from family members, colleagues, and hospital managers. For instance, parents, spouses, and children regularly talked to them and encouraged them via WeChat (Huang et al., 2021). Adequate staffing, education, PPE, and clear guidelines were examples of support that healthcare workers received from hospital managers during COVID-19 (Nowell et al., 2021), SARS (Lee et al., 2005), and MERS (Khalid et al., 2016).

Our study highlighted that inner reinforcement of Indonesian nurses, including professional commitment as a nurse to help others and religious coping, is considered a powerful personal strategy to cope with the professional difficulties the nine participants encountered during COVID-19. At the beginning of the pandemic, when there was not enough PPE or other external support, the two inner coping strategies became the most powerful forces that kept them going. When they experienced isolation due to stigma from the community and chose to distance themselves from their family because they were afraid of transmitting the virus, the two inner strengths became their favored options. Religious coping Islamic phrases such as *Alhamdulillah* (meaning: praise and gratitude to Allah), *Insha'Allah* (meaning: Allah willing), and *Bismillah* (meaning: in the name of Allah, we ask for help) were frequently used by the participants; their responses highlighting a strong religious coping strategy among the eight Muslim participants. They firmly believed the ultimate power goes beyond human efforts by saying such phrases. Such belief provides the leading protection insurance and gives the nurses positive energy that other humans, community, and institutions cannot give. Besides they also believed that helping others as the nurse's professional commitment is a good deed that leads to "a good" being returned in the future. This focus highlights a critical point that was less discussed in previous studies. Two studies mentioned the use of religious coping at a personal level among healthcare professionals but only limited information was provided in the two publications (Kelley et al., 2021; Raven et al., 2018). Other studies reported that at the personal level healthcare workers used strategies such as doing exercises, listening to music, writing, and relaxing (Sun et al., 2020; Huang et al., 2021).

Nurses' positive feelings were also reflected in the greater sense of solidarity and collaboration with other healthcare professionals. The findings are similar to another study conducted by (Liu & Liehr, 2009) who reported that professional identity and pride were boosted among nurses caring for SARS patients. A study by Sun et al. (2020) suggested that positive emotions, such as confidence, calmness, and happiness among nurses caring for patients with COVID-19, gradually appeared when they had found an effective coping strategy to handle their new challenges.

5 | LIMITATIONS

There are certain limitations to this study that should be considered when interpreting the results. Due to the nature of qualitative research, the sample size in this study is considered to be small and collected from only a single hospital in Yogyakarta, Indonesia. This decision was made to avoid potential cross-infection. Therefore, this study's findings might not reflect a greater population of Indonesian nurses' perspectives. Second, this study only focused on exploring nurses' experiences, and the majority of nurses (8/9) were Muslim. The researchers believed that including views from other healthcare professionals and from other religious beliefs would provide a broader and more in-depth insight into the psychological experience of caregivers of patients with COVID-19.

6 | CONCLUSION

This study explained how Indonesian nurses used multidimensional coping strategies, including personal, social, environmental, and religious, to overcome challenges when delivering care for patients with COVID-19 and how those same nurses eventually managed to achieve a sense of well-being. The researchers identified the repetitive pattern of multidimensional coping strategies employed in different countries across different cases of public health emergencies, such as COVID-19, SARS, and MERS. However, what are considered as powerful coping strategies might be different for each individual, at a personal level. Therefore, related parties are expected to tailor available support initiatives during public health emergencies, informed by and based upon the culture and values of targeted healthcare workers, both individually and collectively.

CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

AUTHOR CONTRIBUTIONS

Study design: Sutantri Sutantri, Arcellia Farosyah Putri. Data collection: Sutantri Sutantri, Rini Ismiyati. Data analysis: Sutantri Sutantri, Rini Ismiyati, Arcel Farosyah Putri. Manuscript writing and revisions for important intellectual content: Sutantri Sutantri, Arcel Farosyah Putri.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author, SS, upon reasonable request.

ORCID

Sutantri Sutantri https://orcid.org/0000-0002-2848-9616
Arcellia Farosyah Putri https://orcid.org/0000-0003-0189-1418

REFERENCES

Chang, D., Xu, H., Rebaza, A., Sharma, L., & Cruz, C. S. D. (2020). Protecting health-care workers from subclinical coronavirus infection. *The Lancet Respiratory Medicine*, *8*(3), e13.

Colaizzi, P. (1978). Psychological research as the phenomenologist views it. In R. Valle & M. King (Eds.), *Existential-phenomenological alternatives for psychology* (pp. 48–71). Oxford University Press.

Demirci, A. D., Oruc, M., & Kabukcuoglu, K. (2021). 'It was difficult, but our struggle to touch lives gave us strength': The experience of nurses working on COVID-19 wards. *Journal of Clinical Nursing*, *30*(5–6), 732–741.

Dowling, M. (2007). From Husserl to van Manen. A review of different phenomenological approaches. *International Journal of Nursing Studies*, *44*(1), 131–142.

Fisher, J. (2011). The four domains model: connecting spirituality, health and well-being. *Religions*, *2*(1), 17–28.

Huang, F., Lin, M., Sun, W., Zhang, L., Lu, H., & Chen, W.-T. (2021). Resilience of frontline nurses during the COVID pandemic in China: A qualitative study. *Nursing & Health Sciences*, *23*(3), 639-645.

Jo, S., Kurt, S., Bennett, J. A., Mayer, K., Pituch, K. A., Simpson, V., Skibiski, J., Takagi, E., Karaaslan, M. M., & Ozluk, B. (2021). Nurses' resilience in the face of coronavirus (COVID-19): An international view. *Nursing & Health Sciences*, *23*(3), 646–657.

Kackin, O., Ciydem, E., Aci, O. S., & Kutlu, F. Y. (2020). Experiences and psychosocial problems of nurses caring for patients diagnosed with COVID-19 in Turkey: A qualitative study. *International Journal of Social Psychiatry*, *67*, 0020764020942788. https://doi.org/10.1177/0020764020942788

Kelley, M. M., Zadvinskis, I. M., Miller, P. S., Monturo, C., Norful, A. A., O'Mathúna, D., Roberts, H., Smith, J., Tucker, S., & Zellefrow, C. (2021). United States nurses' experiences during the COVID-19 pandemic: A grounded theory. *Journal of Clinical Nursing*, *00*, 1–14.

Khalid, I., Khalid, T. J., Qabajah, M. R., Barnard, A. G., & Qushmaq, I. A. (2016). Healthcare workers emotions, perceived stressors and coping strategies during a MERS-CoV outbreak. *Clinical Medicine & Research*, *14*(1), 7–14.

Kheirandish, E., Rahnama, M., Abdollahimohammad, A., Noorisanchooli, H., & Hashemi, Z. (2020). COVID-19 nurses' experiences of caring: A qualitative study. *Medical Studies/Studia Medyczne*, *36*(4), 239–245. https://doi.org/10.5114/ms.2020.102317

Kwaghe, A. V., Kwaghe, V. G., Habib, Z. G., Kwaghe, G. V., Ilesanmi, O. S., Ekele, B., Umeokonkwo, C. D., & Balogun, M. S. (2021). Stigmatization and Psychological Impact of COVID-19 Pandemic on Frontline Healthcare Workers in Nigeria: A Qualitative Study.

Lee, N., & Lee, H.-J. (2020). South Korean Nurses' experiences with patient care at a COVID-19-designated hospital: Growth after the frontline Battle against an infectious disease pandemic. *International Journal of Environmental Research and Public Health*, *17*(23), 9015. https://doi.org/10.3390/ijerph17239015

Lee, S. H., Juang, Y. Y., Su, Y. J., Lee, H. L., Lin, Y. H., & Chao, C. C. (2005). Facing SARS: Psychological impacts on SARS team nurses and psychiatric services in a Taiwan general hospital. *General Hospital Psychiatry*, *27*(5), 352–358.

Lee, S. M., Kang, W. S., Cho, A.-R., Kim, T., & Park, J. K. (2018). Psychological impact of the 2015 MERS outbreak on hospital workers and quarantined hemodialysis patients. *Comprehensive Psychiatry*, *87*, 123–127.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. SAGE Publications.

Liu, H., & Liehr, P. (2009). Instructive messages from Chinese nurses' stories of caring for SARS patients. *Journal of Clinical Nursing*, *18*(20), 2880–2887.

Lopez, K. A., & Willis, D. G. (2004). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qualitative Health Research*, *14*(5), 726–735.

Manik, M. J., Natalia, S., & Theresia, T. (2021). Social stigma towards nurses taking care of patients with COVID-19 in Indonesia: A mixed-methods study. *Belitung Nursing Journal*, *7*(2), 98–106.

Maunder, R., Hunter, J., Vincent, L., Bennett, J., Peladeau, N., Leszcz, M., Sadavoy, J., Verhaeghe, L. M., Steinberg, R., & Mazzulli, T. (2003). The immediate psychological and occupational impact of the 2003 SARS outbreak in a teaching hospital. *CMAJ*, *168*(10), 1245–1251.

McGlinchey, E., Hitch, C., Butter, S., McCaughey, L., Berry, E., & Armour, C. (2021). Understanding the lived experiences of healthcare professionals during the COVID-19 pandemic: An interpretative phenomenological analysis. *European Journal of Psychotraumatology*, *12*(1), 1904700. https://doi.org/10.1080/20008198.2021.1904700

Morrow, R., Rodriguez, A., & King, N. (2015). Colaizzi's descriptive phenomenological method. *The Psychologist*, *28*(8), 643–644.

Ness, M. M., Saylor, J., Di Fusco, L. A., & Evans, K. (2021). Healthcare providers' challenges during the coronavirus disease (COVID-19) pandemic: A qualitative approach. *Nursing & Health Sciences.*, *23*, 389–397.

Nowell, L., Dhingra, S., Andrews, K., & Jackson, J. (2021). A grounded theory of clinical nurses' process of coping during COVID-19. *Journal of Clinical Nursing*, *00*, 1–12.

Ramaci, T., Barattucci, M., Ledda, C., & Rapisarda, V. (2020). Social stigma during COVID-19 and its impact on HCWs outcomes. *Sustainability*, *12*(9), 3834.

Raven, J., Wurie, H., & Witter, S. (2018). Health workers' experiences of coping with the Ebola epidemic in Sierra Leone's health system: A qualitative study. *BMC Health Services Research*, *18*(1), 1–9.

Sulistiadi, W., Slamet, S. R., & Harmani, N. (2020). Handling of public stigma on COVID-19 in Indonesian society. *Kesmas: Jurnal Kesehatan Masyarakat Nasional (National Public Health Journal); Special Issue*, *1*, 2020.

Sun, N., Wei, L., Shi, S., Jiao, D., Song, R., Ma, L., Wang, H., Wang, C., Wang, Z., You, Y., Liu, S., & Wang, H. (2020). A qualitative study on the psychological experience of caregivers of COVID-19 patients. *American Journal of Infection Control*, *S0196-6553*(0120), 30201–30207.

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19*(6), 349–357.

Verma, S., Mythily, S., Chan, Y., Deslypere, J., Teo, E., & Chong, S. (2004). Post-SARS psychological morbidity and stigma among

general practitioners and traditional Chinese medicine practitioners in Singapore. *Annals of the Academy of Medicine, Singapore, 33*(6), 743–748.

Yufika, A., Pratama, R., Anwar, S., Winardi, W., Librianty, N., Prashanti, N. A. P., Sari, T. N. W., Utomo, P. S., Dwiamelia, T., Natha, P. P. C., Salwiyadi, S., Asrizal, F. W., Ikram, I., Wulandari, I., Haryanto, S., Fenobilire, N., Wagner, A. L., Jamil, K. F., Mudatsir, M., & Harapan, H. (2021). Stigma associated with COVID-19 among health Care Workers in Indonesia. *Disaster Medicine and Public Health Preparedness*, 1–5. https://doi.org/10.1017/dmp.2021.93