The labor of talking to stay healthy and socially connected: Communication work during the COVID-19 pandemic

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ABSTRACT

One of the primary means through which people protect themselves and their loved ones from COVID-19 is by communicating with others, as they discuss preventive health behaviors and make decisions about safe social interaction. These conversations are sometimes quite challenging. Guided by the conceptual lens of communication work, this study was an investigation of how communication during the pandemic was experienced by people as work. Findings validated and extended the communication work construct. Communication during the pandemic is effortful because it is high stakes, relentless, and takes an emotional toll. Nonetheless, many people feel a sense of responsibility and obligation to have these conversations. Communication about COVID-19 is divisible labor that can be shared. People engage in strategic preparation and message design to accomplish multiple goals before, during, and after discussions about pandemic topics.

1. Introduction

Because health and illness are psychosocial as well as biomedical experiences, health stressors can easily become interpersonal communication and relationship stressors (Duggan, 2006). In the case of the COVID-19 pandemic, this has been uniquely true. As families, friends, coworkers, and neighbors have coped with upheaval throughout their lives, they have also been faced with unfamiliar and stressful tasks for managing conversations and relationships. The objective of the present study was to investigate and theoretically organize the interpersonal communication challenges that individuals report experiencing during the pandemic, using the theoretical lens of communication work (Donovan, 2019).

1.1. Communication challenges during the pandemic

Interpersonal communication is a complex and meaningful component of the COVID-19 pandemic. Relational partners are managing tremendous uncertainty, negotiating disruptions to their health and their lives, and establishing norms for preventive health behaviors through their conversations with others (e.g., Hernandez & Colaner, 2021; Knell, Robertson, Dooley, Burford, & Mendez, 2020). Measures to control the spread of the disease have created unfamiliar social environments marked by impediments to typical communication at best, and destructive conflict or estrangement at worst (Feeney & Fitzgerald, 2022; Mheidly, Fares, Zalzale, & Fares, 2020). Physical, or "social," distancing has contributed to diminished social support, especially in already vulnerable populations (Marziali et al., 2020), and been associated with marked increases in mental health difficulties such as depression and anxiety (Marroquín, Vine, & Morgan, 2020).

There is a particular urgency for understanding how communication both complicates, and is complicated by, the COVID-19 pandemic. First of all, it is through communication that people cope to manage the evolving scientific understanding of the virus and the associated public health recommendations (Houston, 2021). This communication takes the form of information seeking and sharing as people circulate updates–both factual and not–within their social networks, receive guidance from their health care providers, and offer each other emotional support (Afifi & Afifi, 2021; Donato et al., 2021). Furthermore, relational partners communicate with each other to navigate the social situations that have been borne from and hampered by pandemic circumstances. For example, to mitigate infection, professional teams make arrangements to adjust workflows to minimize face-to-face contact, and families face difficult decisions and conversations about potentially canceling

important gatherings. All of these types of conversations have implications for people's health beliefs and health behaviors, which have direct bearing on rates of transmission, immunization, and mortality.

Second, these communication processes have consequences for the quality and quantity of people's interpersonal relationships and social networks, which have already been severely strained by the events of the past few years. Throughout travel bans, lockdowns, remote work, virtual school and canceled worship services, people have experienced isolation in its many forms and suffered the mental health consequences (Brooks et al., 2020; Holmes et al., 2020). As the pandemic has extended from weeks to months to years, social connectedness and social capital have declined (Folk, Okabe-Miyamoto, Dunn, & Lyubomirsky, 2020; Yu et al., 2021). Relationships have suffered and loneliness has soared (Bu, Steptoe, & Fancourt, 2020; Naser et al., 2020). Thus, not only has the communication required to exchange information and make decisions during the pandemic become more difficult, but it may feel especially fraught when remaining interpersonal ties are both desperately needed and extremely vulnerable to further unraveling. It is perhaps no wonder that scholars have declared research on communication during the pandemic to be a key priority for developing interventions aimed at improving quality of life (e.g., Horesh & Brown, 2020).

In sum, it is clear that interpersonal communication during this already tumultuous and stressful era may be creating additional burdens on people. Communication is necessary to survive the pandemic, but sometimes communication itself is stressful. There is much to be learned about how people are experiencing the communication challenges of the pandemic–their lived experiences with why communication is difficult, what they do to manage that, and why. More theorizing is needed to understand how communicative challenges are intertwined with other aspects of the pandemic, which could lend insight to broader social processes central to health and illness and suggest avenues for improving communication. For these reasons, the present study was designed and guided by the concept of communication work.

1.2. Conceptual framework: communication work

This study was grounded in Donovan's (2012, 2019) conceptual framework of *communication work*. Communication work has been theorized in recent health communication literature as an extension of the theory of illness trajectories (Corbin & Strauss, 1988), a social scientific framework that explains various effortful tasks that people have to manage while coping with a chronic illness or other health stressor. According to the original theory, distinct lines of *work* must be carried out to adequately manage the responsibilities and shifting trajectories of chronic illness (Corbin & Strauss, 1988). Three lines of work were detailed as follows: illness-related work, which involves tasks specific to disease management such as tending to an ostomy bag, taking prescription medications, or performing physical therapy exercises; biographical work, which entails reformulating one's identity through individual and collective sensemaking (e.g., "Who am I now that I can no longer do my woodworking?"); and everyday life work, which includes paid employment and other day-to-day chores both in and outside of the household.

Donovan-Kicken et al.'s (2012) qualitative research on cancer survivorship revealed an additional line of work during illness: communication work. Communication work is an interpersonal health communication construct that developed from interpretive and ethnographic research on individuals managing a range of health-related circumstances, including but not limited to cancer; chronic pain; life-threatening allergies and dietary restrictions (e.g., Hintz & Scott, 2020; Iannarino, 2018; Rafferty & Beck, 2020). Communication work entails interpersonal and informational behaviors that are demanding and effortful; are undertaken out of a sense of duty or obligation; are divisible labor; involve preparation, planning, and message design; and have perceived desirable outcomes. Consistent with Corbin and Strauss' (1988) research, Donovan and colleagues maintained the terminology of *work* to emphasize that these activities are laborious. Furthermore, they

can be assigned or delegated; require resources such as time and energy; can be performed with greater or lesser success; and in other circumstances, depending on means, could even be outsourced to paid professionals (e.g., to a home health worker or a personal assistant).

The seminal research on communication work during cancer illustrated the communication that cancer survivors engaged in, and demonstrated that some of it was experienced as yet another difficult task on an already long to-do list during a trying time. For instance, survivors detailed the effort that they put into delivering bad news to loved ones about their cancer: gathering statistics, editing emails, and selecting just the right words so that they could be clear and reassuring (Donovan-Kicken, Tollison, & Goins, 2012). Since this initial study, a growing body of research has substantiated the premise that communication about health stressors requires work. For example, people will sometimes delegate the responsibility of keeping loved ones updated to a family spokesperson when they feel too burned out to handle the communication themselves (Iannarino, 2018). Cancer survivors exert effort to maintain a sense of personal control and promote preferred identities in workplace settings (Robinson, Kocum, Loughlin, Bryson, & Dimoff, 2015). Parents of children with food allergies, desperate to keep their children safe, describe over and over the seriousness of their children's allergies to people who are skeptical of them (Bute, Bowers, & Park, 2021). Members of online support communities collaborate to translate medical research findings to share with fellow community members (Walsh and Al Achkar, 2021).

The COVID-19 pandemic presents a socially significant and theoretically valuable context to study communication work. It is a massive health stressor that requires communication to manage, even when not all of the people communicating are actually ill with COVID-19. With that scientific warrant, the present investigation centered around this research question: *What are the features of communication work during the COVID-19 pandemic?*

2. Methods

2.1. Participants

Semi-structured interviews were conducted with 62 individuals who were asked to describe the conversations they had had with others during the pandemic, with a focus on what had made communication and health decisions more or less difficult. Participants ranged in age from 18 to 77 ($M = 33$, $SD = 15$). The sample included 39 individuals who identified as women and 23 who identified as men. Participants self-identified as White ($n = 24$; 39%), Hispanic ($n = 15$; 24%), Asian ($n = 9$; 14.5%), Other ($n = 7$; 11%), Black or African American ($n = 6$; 9.6%), and Lebanese ($n = 1$; 1.6%). The sample included college/current university students ($n = 26$), individuals with associate's degrees ($n = 4$), bachelor's degrees ($n = 18$), master's degrees ($n = 10$), and doctorates ($n = 4$).

2.2. Procedures

2.2.1. Data collection

Following approval from the research team's university IRB, recruitment occurred from October 2020 through May 2021 via network and snowball sampling. A team of undergraduate and graduate student researchers who were trained by the first author in qualitative social scientific methods for interpersonal health communication research advertised the study to their social networks. They invited individuals to take part in a research interview about communication and health decision making during the pandemic that would last 30–60 min and could take place via video or in person according to the participant's preference. People were eligible to be interviewed if they were at least 18 years old.

Purposive, non-probability sampling was employed to include participants from a range of ages, ethnic and racial groups, and geographic locations. We were mindful of the potential for network sampling to

render our sample too homogeneous in terms of age and race/ethnicity. Given the population health data at the time (e.g., Pennington et al., 2021), our purposive sampling was meant to include voices from populations who were particularly vulnerable to covid health risks/health inequities, mainly older individuals and people of color. All but three of our participants had health insurance. We did not keep records of where participants lived, although the majority of our participants were from the state of Texas, from regions that spanned more than 700 miles (1100 km) and included both rural and urban areas. Based on the transcripts, we can infer that we also had participants who lived in Alabama, Kansas, Tennessee, Wisconsin, and the East Coast of the U.S., plus Korea and the United Kingdom. Multiple respondents described conversations with family, friends, and coworkers who were geographically dispersed. Recruitment and interviews continued until theoretical saturation was reached (Morse, 2015).

A semi-structured interview protocol was created to explore the lived experiences of individuals during the COVID-19 pandemic, with specific emphasis on their communication and health decision making. The qualitative, interpretative approach taken in this research was selected because of its capacity to honor the individual experiences and sensemaking processes throughout the pandemic that were the focus of the study (e.g., Thompson & Parsloe, 2019; Tracy, 2013). The interview guide provided consistency in the data collection that was spread across multiple interviewers, but was designed and IRB approved to be flexible so that the conversations between researchers and participants could flow according to participants' construction and articulation of their ideas and experiences. This approach was consistent with the premise that research interviews about health communication are themselves rich instances of health communication (Donovan, Miller, & Goldsmith, 2014).

Because the focus of this project was on interpersonal health communication experiences and challenges during the COVID-19 era, participants were asked about conversations they had been having with others about the novel coronavirus pandemic and strategies for managing social interactions. For example, interviewers asked: "What are some challenging conversations about health and health decisions you've noticed that people are having during the pandemic?" "Why do you think they're difficult?" and "Is there anything that makes those conversations easier?" We strategically framed questions to be nonjudgmental and not leading, so that participants could share freely and so that we did not presume that all respondents had experienced communication work (Brinkmann & Kvale, 2015; Charmaz, 2014; Seidman, 2013). We treated participants' reflections on other people's experiences as instances of communication work as sensemaking that added to our explication: for example, when they made comments about how people were having ongoing conversations with their social networks to negotiate risk tolerance. We followed up with probes such as "Have you personally have had to do this (e.g., discuss certain topics repeatedly)?" Most participants pivoted immediately to their own communication without being prompted.

Interviews lasted an average of 40 min. All interviews were recorded and transcribed using a secure web-based AI transcription service, yielding 1003 single-spaced pages of data. The research team listened to the audio files while checking and cleaning the transcripts to ensure accuracy. Some minor typographical errors were detected and corrected. Personally-identifying details were deleted from the transcripts.

2.2.2. Data analysis

Over the course of several months, the entire research team met weekly to discuss emergent findings, test out nascent ideas, and resolve discrepant interpretations. Throughout the course of the study, we engaged in iterative processes of conducting interviews, reviewing interview files and transcripts, composing theoretical memos, discussing patterns in the data, and consulting the scholarly literature as ideas crystallized (Charmaz, 2014).

We made sense of and organized our data using Braun and Clarke's (2014) reflexive thematic analysis approach, which is designed to interpret data and structure them into a coherent story that yields conceptual meaning from participants' explorations of their personal experiences (Braun & Clarke, 2014). Reflexive thematic analysis emphasizes open and iterative coding "to develop an understanding of patterned meaning" (Braun, Clarke, Hayfield, & Terry, 2019, p. 848). This approach enables revision of researchers' understanding and distillation of key themes as new data are collected and integrated into emerging patterns, while new and previous interpretations are critically interrogated.

Braun et al. (2019) recommend a series of steps that were undertaken in the present study, including familiarizing ourselves with the transcripts, noticing initial features, generating codes, and chunking data into potential meaning patterns. During our ongoing research team meetings, all authors participated in the processes of constructing, revising, and defining themes that were suggested by respondents' descriptions of their experiences. To establish a valid fit between the purpose of the research, the conceptual framework of the study, and the data analytic methods, thematic analysis was guided by the sensitizing concept of communication work, while the authors remained open to other patterns if the data suggested theoretical departures from existing literature (Bowen, 2006; Charmaz, 2014).

2.2.3. Rigor, reflexivity, and positionality

In addition to grounding our study in the literature on communication work and following recommended procedures of reflexive thematic analysis, we further strove for excellence in qualitative inquiry by following criteria outlined by Tracy (2010), including credibility, transparency, ethics, and meaningful coherence.

Several steps were taken to critically examine our roles as researchers and consider how our worldviews and positions of influence may have influenced the study. The nine-person research team was relatively diverse in terms of race, ethnicity, and socioeconomic status. Interviews were conducted by multiple individuals using a standardized interview protocol to maintain consistency while minimizing the impact of any one researcher on the data collection and analysis. All members of the research team have been formally educated at the baccalaureate level in health communication; although one co-author is still completing undergraduate studies, the remaining team members have at least a bachelor's degree, including the lead author who has a PhD and two co-authors who are currently in doctoral programs. Eight of the researchers were raised in the United States. Not all of the authors speak English as their first or only language, but every author speaks English fluently and all interviews were conducted in English.

All of the authors share an ideological commitment to public health that may have introduced some bias into the network sampling, interviews, or data analysis, although training prior to the interviews emphasized the importance of conveying to all participants that there were no right or wrong answers and that we were striving to be inclusive of a diverse range of experiences and opinions. As we developed our interview guide and conducted practice interviews, we talked openly about the importance of working to build trust and rapport with participants. This included meeting with them when and where it was comfortable for them, expressing gratitude throughout the interview for their time and their perspectives, and stating that we valued their honesty. The topic of our research and the care that we took with our participants fit with Lincoln's (1995) criteria for quality in qualitative and interpretive research, specifically the criterion of sacredness, which emphasizes approaching the research enterprise with a profound respect for human dignity and appreciation for the human condition.

3. Results

Several themes emerged from the data that validated and amplified Donovan et al.'s explication of communication work: (1) Conversations about the pandemic are effortful because they are high stakes and

repetitive during an already difficult time; (2) There is a sense of responsibility and duty to engage in conversation about pandemic matters; (3) Communication about the coronavirus is labor that can be divided and shared; and (4) People engage in strategic preparation and message design to accomplish multiple goals when discussing pandemic topics. Each of these themes and their evidence-based subthemes provided specific insight into the communication work that people have been doing during the pandemic. They are elaborated in the following section, and within each theme are illustrations that deepen the explication of communication work in health contexts.

3.1. Communication is demanding and effortful during an already difficult time

Several participants reported feeling added layers of complexity in their COVID-19-related conversations as their communication efforts were affected by challenges introduced by the social and health environment of the pandemic. Data showed that while the conversations necessitated by the pandemic were in themselves demanding and effortful, they acquired an additional sense of burden due to the state of the world outside of these interactions. Specifically, communication challenges during the pandemic have been exacerbated because the stakes feel high; people are often negotiating multiple, competing goals introduced by the pandemic; and the persistence of the pandemic results in repetitive, relentless conversations.

3.1.1. High stakes conversations

Participants reported a heightened sense of importance of conversations about COVID and felt pressure to communicate their ideas clearly and persuasively. For some, this stemmed from an awareness of the risks posed by the pandemic and a subsequent desire to keep loved ones safe. It felt crucial to effectively explain the need for behaviors such as mask-wearing and social distancing in order to protect people's health and safety. One participant noted the following about her experience talking to her child, who was a fourth grader (and thus would have been around nine or ten years old):

> There is more work going into communication because, for me, it's important that she understands why we're doing these things. And so yeah, a lot of the conversations … we have to put more work into, to make sure that we're communicating or that I'm communicating the right things to her.

This participant's account reveals that her worry for her child led her to put forth more effort than normal into these conversations. In addition to wanting to safeguard loved ones, others felt increased stress and a sense that the stakes were high because they feared damaging their relationships. Amid political divisions over mask-wearing, social distancing, and vaccines, new sources of conflict were introduced into many relationships. One participant mentioned people in their social circle "having conflicts with roommates over them having people over, or how many people they can have over." People felt their relationships could be at risk when talking about COVID-19 if their view of the pandemic differed from that of friends or family. Individuals reflected on poor outcomes of conversations where people were offended. A respondent described a family gathering on Thanksgiving when "one of the people just decided to get very angry about, you know, their side. And so they kind of drove everybody out of the room with all this stuff." Said another: "Because these topics are tied into politics, and people are very passionate, it can become very heated … it feels like conversations are a lot more raw and visceral." They also described putting more thought into interactions when talking about COVID-19 in order to prevent conflict in relationships, discussed next.

3.1.2. Multiple, competing goals

Having conversations about the pandemic was experienced as effortful because people were managing multiple, competing goals within single conversations. For example, people attempted to gain information about others' behaviors to gauge the risk involved in interacting with them, while simultaneously trying to avoid offending the other with those questions. The crux of the issue often was the moralizing undertones of pandemic-talk and the potential for clashing viewpoints. Asking, "Are you staying safe?" not only implies that the question needs to be asked, but also that the asker is entitled to know the answer and may render judgment on the response. As a result, this type of question became a potential landmine and people described how they put effort into seeking information while mitigating the risk of jeopardizing relationships, for example:

> I skirt around trying to get the answer. So I might, like, start way out and then gradually get into something … more specific to help me get the information … I ask those questions like, "So when was the last time you went to the grocery store? And what was that like?" And then, you know, asking something a little bit more specific each time. Because I don't want to come across as judgmental.

Throughout the pandemic, the challenge of trying to preserve relationships for the long-term while also protecting one's health and safety in the short-term further complicated many COVID-related conversations and introduced an additional burden in communication.

Others described the competing goals of communicating information about the pandemic and its health risks clearly without being alarmist, especially when communicating with children. It was imperative that children understood the need for so many changes, but no one wanted to scare children unnecessarily. One mother detailed this challenge:

> With a seven-year-old and a twelve-year-old, we have had to, you know, have discussions with the seven-year-old on what exactly it is, why aren't they going to school? Why can't they go places? and stuff like that. So just trying to get that across, to explain how serious the situation is without necessarily making it absolutely terrifying for children. It's probably the most difficult conversation we've had with our family.

Attempting to communicate the reality of the situation and the importance of adhering to safety guidelines without inducing panic was a balancing act that required substantial effort. If parents did not communicate well, their children's lives could be at risk (cf. Bute et al., 2021).

3.1.3. Repetitive and relentless

Another factor that contributed to COVID communication feeling like work was the repetitive nature of many conversations and the need to continue having them as the pandemic endured. Many people found themselves in the same types of conversations or asking the same questions over and over for months, and topic fatigue eventually set in: "'How are you feeling?' 'Are you feeling sick?' 'Did anybody get sick at your office?' 'How are the numbers?' Yeah, it's very exhausting."

Participants emphasized the amount of time and effort involved in communicating about COVID-19 and the emotional toll it was taking: "It's taxing, and draining, and stressful in so many ways." Sometimes, the weariness people experienced from these conversations was compounded because the repetition was constant and incessant. It felt as though there was no time to mentally and emotionally recover, and no end was in sight; talking about COVID-19 would continue to be necessary as long as the pandemic lasted. This sometimes meant that people lacked the energy to put forth their best. A participant spoke more in depth about this emotional facet of having repetitive conversations about the pandemic:

> I feel like once they're repeated over and over and over again, and it's the same outcome from the conversation, it feels like a burden, because it's not only emotionally draining, but it is affecting the

mental health of individuals to continuously focus on the negative, rather than the positive or even different parts of their lives.

Emotionally drained from the pandemic, some participants noted that their ability to communicate clearly was affected and conversations went poorly. The continuous flow of bad news and the communication throughout was hard on people; for example, a participant described the family group text that was a "repeating conversation" about the latest updates in their community:

> This is sad, but we're constantly having a conversation about hearing about friends and family who have got it or are passed away … I'm from West Texas. And the cases there are insane. They run out of beds … and we're like, "did you hear so and so got COVID? And then people will post stuff about like, "Oh, did y'all see this post on Instagram or Facebook that so and so about?" … It's a constant.

3.2. People feel a sense of duty and responsibility to engage in communication

Consistent with previous theorizing, a sense of duty and responsibility to carry out communication work emerged from our findings. People felt compelled to engage in conversations about the pandemic and share what they thought, especially when they encountered someone who was not adhering to COVID-19 safety guidelines. There were two main sources for the sense of duty people described: duty due to one's personal or professional identity; and duty stemming from a sense of moral obligation.

3.2.1. Duty because of personal or professional identity

For many, the obligation to engage in COVID conversations originated from valued personal or professional identities, for example: supervisors, coworkers, teachers, health professionals, and parents. These identities compelled people's communication behaviors, such as the case of a college student who stated:

> I do feel like I have to have a sense of responsibility to have these conversations with people, especially those around me. I feel like as a public health major, it's important for me to, to try to educate others why it is, it is important and for them to understand that this is not just for their own best interest. It is the best interest as a society as a whole.

This participant perceived her chosen study path and future career field as an anchor to her interactions with others and her role in the world, giving rise to a sense of duty to share knowledge with others for the sake of public health. There were others whose sense of duty to engage in conversations about the pandemic came from recognizing their own role in their professional setting, for example, a respondent who said, "I do feel a sense of responsibility … just for the sake of work and just to keep people just keep people safe. It'd be a lot better for everybody if nobody got sick." Additionally, many participants who were parents detailed the work of having conversations about COVID-19 with their children, and shared the sentiment that "as a parent, you just don't really have a choice" but to have serious and complicated conversations to protect children.

3.2.2. Duty because of moral obligation

Another source of duty we identified was an intrinsic sense of morality that was not dependent on any particular personal or social identity category; rather, for some, it was simply consistent with their values and "the right thing to do" to keep themselves and others healthy. Participants reflected that it was important to engage in these conversations despite the effort required. As one participant said,

> I feel like I have to have a conversation with anybody that I come into contact to let them know what I do … for their safety and for mine and

who I interact with … because I could potentially be exposing them and not knowing it, or they can potentially be exposing me.

It was clear that some people did not enjoy communicating in this way about the pandemic with others, yet this discomfort did not overcome the feeling that these conversations were necessary and important.

In addition to trading information about personal preferences and activities, some participants described a moral obligation to dispel misinformation and correct others' erroneous beliefs. One participant noted, "I mean, I do feel some sort of responsibility with things like that, just to make sure that people know what the truth is versus like what they see on Facebook, you know?" With so much conflicting information circulating, many people felt that it was the right thing to do to rectify misconceptions, both to protect individuals and to assist in broader efforts to slow the spread of the virus. Those conversations felt difficult but obligatory.

3.3. Pandemic communication can be shared, divisible labor

According to previous research, a key feature of communication work is that it is divisible labor. In the midst of the pandemic, many found themselves working with others in an attempt to manage pandemic communication. People took on certain communication tasks, approached hard conversations together, and coordinated to prepare a shared message.

In some instances, assigning one person to handle all communication regarding a topic helped facilitate updates and answer questions effectively. This tactic has been observed in previous research with cancer patients, where one individual becomes the spokesperson for the family, decreasing the communication burden on the patient and those closest to them (Rafferty & Beck, 2020). This same strategy seemed useful for families severely affected by COVID-19. One participant recalled the following:

> And I can think of one or two examples where they have kind of like, been the ones to share that information on behalf of somebody, like, letting everyone know, 'My mom's in the hospital now. She got diagnosed.' You know, and being the one to kind of give updates, you know, things like that, on their behalf.

By designating a single person to be the point of contact for updates regarding a person's health following a COVID-19 diagnosis, the work of communicating was less of a direct demand on the patient's family, leaving them able to focus on caring for their sick loved one.

People also shared the labor of communication during the pandemic by having a partner to support their point of view in a conversation. Having conversations about COVID-19 with people who had different opinions on mask-wearing, social distancing or quarantining, and vaccination was a source of stress for many. Due to this, people found it helpful to have someone like-minded with whom to approach pandemic conversations in which they expected opposition. One woman outlined how she and her sister were supporting each other through COVID-19 conversations with family members who did not want to take precautions during the pandemic:

> So definitely having those conversations we like, share that responsibility with each other, because we want to keep our parents safe … And if you have like, reinforcement hence like a sister who can like also like, you know, backup, what you're saying, then it also makes it a lot easier.

Having someone else to endorse one's viewpoint on hot-button topics provided tactical and emotional support to deal with tension, resistance, and criticism when talking to someone who had a different perspective on pandemic topics. Finding a partner also enabled many to prepare for conversations about COVID with someone else's input, splitting up the planning work with someone else. Another person described collaborating with a sibling:

Me and my sister kind of have a thing like, with communicating with family, where it's like, one kind of broaches the topic. And then the other one kind of is like, in there, and sometimes we're, like, we've talked about things beforehand [to prepare].

Being able to share the task of preparing for difficult COVID conversations went a long way in helping people organize their thoughts and navigate the challenges of these conversations. Many also shared the work of preparing a persuasive message to modify people's behavior as public health guidelines were introduced. One participant recounted how a group of his coworkers coordinated to devise a messaging strategy aimed at customers who did not comply with masking and distancing requests–"We do discuss it amongst each other what we could possibly do or say to people to make them follow the rules"– but noted that ultimately, "We can't get [customers] to listen."

3.4. Communication work involves strategy: preparation, planning, message design

Whether done individually or collaboratively, strategizing before, during, and after conversations was an important component of communication work in our data. People described choosing their words, timing, and approach carefully in order to minimize offense and negative emotional reactions. Strategizing looked like employing active message design and making time for pre-conversational preparation and planning.

3.4.1. Active message design

Active message design was often used during conversations to help people deliver messages or make inquiries about the pandemic when they perceived these to be sensitive topics. Many wanted to sidestep the possibility of provoking a negative reaction from others. Consequently, they softened their language to make suggestions rather than direct requests, or they implied opinions rather than state them outright. They told us they felt a need to be careful, for example, "I have to like, really carefully plan out and be very strategic with the words that I'm using … because I don't want it to be received in a different way that would offend that individual." One participant described efforts to frame messages so that they would be heard as caring or casual and not accusatory or judgmental:

I might reframe it. Instead of saying, like, 'Have you been going out a lot?' Instead of saying, 'Have you been going out and doing things a lot?' I think I've reframed it to be like, 'Are you taking care of yourself? And mostly staying like, are you mostly staying in your home most of the time or anything like that?' I do it more like that.

Likewise, participants mentioned using linguistic devices such as disclaimers or hedges to preserve the autonomy of the other person and not bombard them with questions or demands:

So like, you kind of try to overcompensate by like, putting in a lot of qualifiers just being like, 'I just want to make sure' […] I think kind of mentioning it in passing, or like bringing it up in casual conversation, rather than it being like a, 'Hey, I want to talk to you about this.' But just like slipping in little things into conversation. Like, when you get home, just be like, 'Oh, do you want to wash your hands? Because we've been out.' Stuff like that. Or, like, 'Here's some Clorox wipes if you want to, like wipe off your phone or keys or anything.' So not like pressuring them? But more like sharing stuff.

Active message design was a common strategy for those whose communication goals during the pandemic included avoiding being rude or hurtful to others. While many individuals identified being deliberate about word choice as a large part of strategizing, many were also "careful with what kind of tone [they] use[d]" and "how [they] approach the conversation." Active message design helped people remain tactful and sensitive during their conversations, protecting their relationships through points of tension and doing their best to make it clear "that it's

not a personal thing." Overall, active message design proved integral to people's COVID-19 communication as they navigated the intertwined social and health contexts of the pandemic.

3.4.2. Involves preparation and planning

Another strategy some used to strategize for pandemic conversations was spending time before the conversations preparing and engaging in pre-conversational planning (Wilson, 2002). This pre-conversational investment granted people the opportunity to step into an interaction more confidently and better able to achieve their communication goals. People used this time to ask for a third-party opinion, craft a script ahead of time, gather relevant information, or prepare for possible negative outcomes.

In a time of uncertainty and unprecedented terrain, some found themselves questioning what was the best course of action and what they should believe. News cycles were ever changing with updated information and, as the pandemic progressed, the distinction between fact and opinion became unclear. As a result, many sought advice before engaging in conversations about the pandemic. One college student shared, "I think the way I prep myself for those conversations, is to be quite frank, like, I ask my parents … I always run my decisions or my opinions or my conversations by them, because I trust them." She relied on her parents to either endorse or question her perspective before she engaged in difficult COVID conversations. This ensured that when the time came, she could more confidently share and defend her position.

A common theme among respondents was developing scripts for conversations. For example, some participants created scripts of questions for future interactions. As information about exposure, symptom onset timelines, and asymptomatic cases became more widely available, people were better able to ascertain the risk of exposure and to prepare, they outlined their questions preemptively. One individual described her planning:

Maybe I have an internal script that I am getting ready just to be like, it's something that I prepared for, you know, like, 'How are you feeling? Are you feeling bad? Are you feeling sick? Or you know, how's everybody doing? What were the numbers at your office this week?' Or something like, you know, anything like that … like a checklist.

This person spent time before interactions listing questions that would be important to ask, making sure she would gather all the information she needed to make an assessment about COVID risk. By rehearsing this, the participant reduced the likelihood that she would forget to ask an important question. On a similar note, some participants were prepared with scripts for times when they were asked about their own health behaviors, for instance: "People know that I take all the precautions, but I think I am prepared to have those things in order, should somebody try to argue with me … I do have my script ready for that." For this participant, the desire to effectively defend his point of view and his decisions compelled him to prepare beforehand and arm himself with data and a script.

Another iteration of planning and preparation for pandemic conversations was fact-checking and information-gathering, which involved the labor of keeping up with frequent updates about scientific developments and health recommendations. For some people, this preparation task was crucial to their interactions. One individual stated:

Yeah, I feel like I want to be at least generally up to date on things, so if I'm talking about like, you know, I'm talking to family about our plans for December, I want to be sure to I can talk knowledgeably about you know, where we are nationally, but also then like, specifically to [where we live] and what rules are in place, things like that.

This participant spent time looking up the latest on COVID-19 so he could be a competent contributor to conversations about the pandemic, especially when decision-making was involved. Preparation and planning was also pertinent for those who expected negative outcomes in

their conversations about the pandemic. While many spent substantial amounts of energy attempting not to offend others, there were those who saw causing offense as an inevitability. In that case, preparation was devoted to managing or remediating damage done as opposed to preventing it: "Just knowing that some people are going to take it personal, I have to prepare, whenever I'm having those conversations. To let them know, like, it's nothing personal."

In sum, strategizing was pivotal for many, as this technique made challenging, complicated conversations more manageable. It increased the likelihood that communication would be successful, especially when people found themselves juggling multiple, sometimes conflicting goals.

4. Discussion

This study offers a theoretically-grounded analysis of how interpersonal communication during the COVID-19 pandemic is far more than just a straightforward exchange of information. It is about balancing competing demands, enacting cherished identities, protecting personal and public health, and maintaining important relationships. Engaging in these behaviors often takes effort, and can be demanding and draining during a period of time that has already been wearying and tedious, if not outright dangerous, for billions of people. Having conversations about the pandemic is a necessary preventive health behavior–however, communication is dynamic and can be unpredictable, complicated, and fraught. This, in turn, can imperil relational ties that are more vital than ever as people cope with the isolation, loneliness, and mental health challenges that are considered by many to be the next looming health crisis (U.S. Department of Health & Human Services, 2021).

4.1. Theoretical contributions

The results of the present investigation yield three key theoretical contributions. First, they provide additional empirical validation of the construct of communication work, which had been examined in other health and illness contexts but not the novel coronavirus pandemic. The fundamental features of communication work were observed anew in this study: communication work is effortful, because the stakes are high and it is yet another demand during an already difficult time; there is a sense of responsibility and duty to communicate well; communication is divisible, shared labor; and communication work entails strategic preparation and message design. Studying communication about health and illness with a communication work lens is useful because it provides a theoretical means of organizing features of the communication, the relational partners, and the context to understand what makes communication difficult and why people might even decide to discontinue the communication if the costs outweigh the benefits of the labor (Hintz & Scott, 2020). One participant, a young adult, mentioned not wanting to ask older relatives about the pandemic because they expected that it would be "inflammatory" and they were unsure about how to gauge others' opinions without devolving into unpleasant discussions about politics. These findings corroborate other recent scholarship grounded in the communication work construct, such as Bute et al.'s (2020) observation that communication work in the context of life-threatening food allergies is complicated by the need to manage multiple goals, such as asking for information or accommodations without seeming unfair or impolite. The current study provides further evidence that the communication work framework coheres with existing communication literature including scholarship on pre-conversational plans (e.g., Wilson, 2002) and difficult conversations about health (Donovan, 2015).

It is likewise worth commenting on how these findings depart from previous research on communication work, notably with respect to communication in health care professions. Some respondents in the current study were health care professionals who reported feeling a sense of duty to perform communication work in multiple settings, not just at work, because of their professional identity. This finding has not been explicated in previous empirical scholarship on communication work, which has focused primarily on personal relationships, although it is mentioned as relevant to the overall theorizing in Donovan (2019). Previous publications on communication work, on the other hand, have considered the work that patients do to communicate with their health care professionals, including patients advocating for better care when their health/illness experiences are met with skepticism (e.g., Hintz & Scott, 2020). That theme was not prominent in our data; we did not see evidence that participants were expending effort in convincing their health care professionals that COVID was a legitimate concern.

The second theoretical contribution of this project is that it extends the relevance of the communication work construct beyond the bounds of previous literature, which focused on people who are actively coping with the diagnosis of a serious health condition. Communication work was not limited to those who had COVID-19 diagnoses or those who knew someone who did. Instead, during the present pandemic circumstances, communication work was carried out by people of all health statuses, and was designed to mitigate risk and prevent infection for the people doing the work, for their loved ones, and for the greater good.

Third, this project suggested some additional nuance in explicating the features of communication work. Participants in this project emphasized that conversations about the pandemic were not just challenging, but highly consequential. They noted concerns that they had about maintaining their relational ties with people and working to avoid hurting or offending people when talking about COVID-19, in part because the social isolation and existential threat of the novel coronavirus gave relationships a heightened significance. People talked about how communication felt like work because of the repetitive nature of these conversations: they said that COVID-19 was a constant topic of talk, they were incessantly bombarded with new information that influenced subsequent conversations, and they felt as though they were on a continual loop of asking and being asked the same questions over and over. Finally, individuals also described the emotional toll of conversations about the pandemic, as well as the preparation and aftermath of them. These are important findings as experts consider the mental health consequences of the pandemic. There is ample room for expanding this research, for instance, learning more about how communication work during the pandemic intersects with other lines of work from the original theory of illness trajectories. This could include retrospective interview or turning points techniques to elicit how difficult conversations were precipitated by and contingent upon everyday life work, which changed dramatically when many people were suddenly caring for children at home while trying to do their paid work, as well as biographical work, such as dealing with canceled rites of passage.

4.2. Practical implications

On that note, it is worth considering some practical implications of the present study and its theorizing. Pinpointing theoretically-driven and evidence-based features of communication work provides a starting point for disseminating guidance for when people are struggling to communicate effectively with others, and potentially developing tools that can make the communication less taxing. For instance, given what our participants said about internal scripts, it may be useful to provide scripts that could assist people in better navigating challenging conversations. Scripts could be guided by the features outlined in this study that make conversations about COVID-19 difficult, and supported by the findings that having scripts at the ready is useful even though creating them is itself work. If people felt better equipped to navigate these conversations, ideally the discussions would become less taxing and more successful in terms of reaching shared understandings and preserving relationships.

The literature on imagined interactions (IIs; Honeycutt, 2008; Honeycutt & Ford, 2001) is relevant here. It offers evidence that scripts can help with clarity, accuracy, and efficiency of talk, as well as minimize conflict. IIs are an important form of social cognition in which people imagine themselves in past or future conversation with others, a mindful means of visualizing what will occur and how to overcome potential

barriers to competent communication (Honeycutt & Ford, 2001). According to II Theory, cognitive scripts, planning, message rehearsal, and revisions to anticipated interpersonal exchanges all can help people feel less apprehension about upcoming encounters. Creating IIs may entail some initial communication work that could reduce the subsequent work of the conversations that were planned and rehearsed. Working through IIs via internal dialogue or out loud can facilitate more positive feelings toward relational partners, less tension, and greater self-understanding (Honeycutt, 2008). There is some evidence that more visual IIs are more pleasant and positive compared to those that are more verbal in nature (Honeycutt & Ford, 2001; Zagacki, Edwards, & Honeycutt, 1992). It is an open empirical question whether imagined interactions that include strong nonverbal symbols such as face masks or band aids from vaccine injection sites would trigger more distressing emotions and therefore perhaps more communication work, either as inputs or throughputs.

Scripts and mnemonics are popular tools in health care communication because they can provide guides and shortcuts for effective, appropriate, consistent information exchange (Clancy, 2019). Other tools might be able to take on the feel of the checklists that participants described, where they keep track of the topics that they want to discuss and also are given an opportunity to reflect on how to prioritize competing goals or how to divide the labor of communication work. In addition, public health campaigns might activate people's sense of moral obligation and duty to engage in conversations around COVID-19, not unlike interventions that raise awareness and increase self-efficacy at communicating about other difficult subjects, such as sexual health history (e.g., Quinn-Nilas, Milhausen, Breuer, Bailey, Pavlou, DiClemente, & Wingwood, 2016).

4.3. Limitations

Although this study offered several insights about communication and social behavior during the pandemic, several limitations must be noted. We strove for diversity in terms of some participant characteristics, but did not capture an exhaustive or generalizable corpus of data. All of our participants had at least some university education, and 22% had advanced degrees. It is possible that the relatively high levels of formal education in the sample may have resulted in similar perceptions of COVID-19 risk or similarly high levels of health literacy, the latter of which is correlated with education. We asked participants about whether they had health insurance as a rough gauge of their economic security and access to health care, but we did not collect detailed data on socioeconomic status. Those types of attributes may all have yielded more homogenous perspectives on communication work during the pandemic than might be surfaced when talking to individuals with a high school education, for example, or who are experiencing financial insecurity.

We did not record participants' geographic regions as part of the demographic intake and thus cannot speak to systematic variation in communication work, which may have been influenced by how different states and local health departments were enacting public health policies and disseminating messaging. When geographic locations or variations came up during interviews, they mainly pertained to how conversations were sometimes complicated when talking to family or friends who lived in different parts of the U.S. or world. If they were living with different pandemic policies/restrictions, they were not always arriving at those conversations from a completely common set of experiences regarding "life during the pandemic." Future research on how individual communication work is contextualized by broader ecosystems of health information and protocols would be extremely worthwhile. Furthermore, it would be interesting to extend this research to examine how communication work is affected when people receive COVID-19 information and directives from institutions, such as universities. There are compelling opportunities here to connect research on interpersonal health communication efforts with higher education and organizational communication scholarship.

Finally, the design of this study was intended to surface people's detailed descriptions of their own lived experiences and to privilege their subjective recollections and beliefs without attempting to provide objective evidence that their reports were accurate or unbiased. Likewise, respondents' accounts of burden and causality are understood to be true to them, and although this type of inquiry is not designed to confirm or refute their perspectives, it will be useful for future research to examine antecedents and outcomes of communication work more systematically. The purpose of this study was not to quantify the extent to which, for example, communication work was associated with psychological distress or fatigue, although subsequent investigation of such correlations would be worthwhile. Finally, this study did not critically interrogate systems of power or privilege that may create expectations for communication work, distribute the work unevenly, or make the communication work systematically harder or easier for certain groups of people. Scholarship on communication work would be enriched by considering such matters.

5. Conclusions

When people communicate with others about COVID-19, sometimes they are doing more than just having straightforward conversations. They are engaging in communicative processes that are labor-intensive and draining; that can be shared with others; and that are undertaken because of people's beliefs about their roles and duties. People sometimes put a great deal of thought, time, preparation, and planning into conversations about the pandemic, because they are striving to accomplish the multiple goals of being clear and sometimes persuasive, while not alienating relational partners at a time when social connections feel particularly critical yet fragile. This study sheds light on what communication work during the COVID-19 context looks and feels like, and provides some opportunities to guide people through more successful conversations about important health topics.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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