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Discursive, Communal, and Individual Coping Strategies: How U.S. Adults Co-constructed Coping During Preliminary COVID-19 Stressors

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ABSTRACT

This interpretive research study explores U.S. adults' lived experiences during the beginning months of the COVID-19 global pandemic. Participants (*N*= 44), recruited from a convenience sample of U.S. adults, engaged in in-depth semi-structured interviews or focus groups. Through an iterative analysis of participants' experiences and the theoretical model of communal coping (TMCC), the authors identified three convergent stressors (i.e., *isolation, uncertainty, conflict*) and several coping strategies related to participants' stressor appraisal (i.e., individual or joint) and action orientation (i.e., individual or joint). Based on these findings, this study offers the novel theoretical concept of *Discursive coping* and proposes a model for how this perspective might be integrated with current theorizing about individual and communal coping. Implications for communal coping and discursive theory are discussed as well as practical recommendations for public health messaging.

The experience of stress is fundamental to the human experience. In essence, coping is a response to a stressor. Past research indicates that how individuals cope with stress is linked with health outcomes like increased mental and physical wellbeing (W. A. Afifi et al., 2012; Aldwin & Park, 2004). While a vast literature has documented individual coping responses due to a variety of environmental stressors (e.g., Folkman, 1982; Lazarus, 1993; Vorell & Carmack, 2015), research on communal coping is more nascent (e.g., W. A. Afifi et al., 2012; T. D. Afifi et al., 2018, 2020; Pederson & Faw, 2019). Communal coping requires that multiple people "assume mutual responsibility for a stressor and act on it together in a proactive manner" (T. D. Afifi et al., 2006, p. 381; see also T. D. Afifi et al., 2020), indicating a joint stressor appraisal and joint action orientation. This theoretical orientation toward coping is no small point, as it acknowledges the (co)constructed, relational aspects of responding to and healing from stressors.

Past research has documented communal coping during collective experiences of environmental stress related to bodily harm, such as natural disasters (W. A. Afifi et al., 2012; Richardson & Maninger, 2016) and wars (T. D. Afifi et al., 2018; Nuwayhid et al., 2011). Likewise, the current COVID-19 global pandemic presents a context in which communal coping may be easily observed. The World Health Organization (WHO) recommended that because COVID-19 is a contagious, deadly, airborne virus, individuals should take action to reduce exposure, such as maintaining physical distance from others and wearing a mask in public places (World Health Organization [WHO], 2019). Within this context, individual and collective actions affect communal health. As such, individual actions – such as wearing a mask to reduce the collective stressor of COVID-19 contagion – could be considered a form of communal coping depending on the appraisal-action orientation (see T. D. Afifi et al., 2020) of the individual. In the context of the current pandemic, communal coping may be particularly important for developing public health campaigns aimed at reducing collective stress. Indeed, in response to the AIDS epidemic, Brashers et al. (2002) linked communal coping strategies to increased self-efficacy and W. A. Afifi et al. (2012) found that communal coping serves as a buffer against the negative mental health effects of environmental stressors.

Even though scholars agree that communal coping is a co-constructed process that occurs through discursive interaction, communal coping strategies have not been explicitly studied through a d/Discourse lens. Here, lowercase "d" discourse indicates the everyday talk of interactants (Alvesson & Kärreman, 2000), whereas uppercase "D" discourse indicates ways of talking that reveal broad ideologies and assumptions about social reality. Past research on communal coping demonstrates how people's everyday talk (i.e., discourse) orients them to appraise the stressor as either an individual or collective responsibility for action (T. D. Afifi et al., 2020; Lyons et al., 1998). However, this work leaves room to explore how larger Discourses influence stressor appraisal and subsequent health behavior. We argue that by focusing on d/Discourse, we may surface important theoretical insights on the role of culture, as well as practical considerations, for public health messaging.

Past health communication research indicates that culturally-bound Discourses influence individuals' perceptions of public health campaigns, behaviors, and outcomes (e.g., Elraz, 2018; Khan, 2014). For example, Elraz (2018) detailed how "pejorative" cultural discourses about mental illness

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stigmatized individuals living with mental illness with consequences for their positive identity construction and health behaviors. Attending to how d/Discourse functions within individual and communal coping could yield critical and timely insights to alter problematic assumptions about health risk and behaviors. Given the ubiquity of stressors caused by the COVID-19 pandemic, people's shared experiences provide a salient case context for studying communal coping through a d/Discursive lens. In this paper, we iteratively examine peoples' coping strategies in response to the COVID-19 pandemic. Our analysis builds on T. D. Afifi et al.'s (2020) extended model of communal coping by applying a d/Discursive lens.

Stressors, cognitive appraisals, and coping

Theoretical models of coping characterize stress and coping as a dynamic interaction between an individual and their environment. Lazarus and Folkman (1986) explain that "stress refers to a relationship with the environment that the person appraises as significant for his or her wellbeing and in which the demands tax or exceed available coping resources" (p. 63). The cognitive appraisal of the stressor (i.e., how stressors are interpreted) affects an individual's coping ability, coping strategy choice, and coping efficacy. Most theoretical models of coping follow Folkman and Lazarus's (1980) definition: "the cognitive and behavioral efforts made to master, tolerate, or reduce external and internal demands and conflicts among them" (p. 223). This body of research often groups coping strategies based on their function to master, tolerate, or reduce stressors. For example, "emotion focused coping" reduces the emotional distress associated with a stressor, whereas "problem focused coping" describes efforts to master or resolve the root problem of the stressor (Stephenson & DeLongis, 2020). Many studies of coping focus either on people's cognitive processes or their behaviors.

However, T. D. Afifi et al. (2006) argue that communal coping "occurs through interactions with others and often is a collaborative meaning-making process with friends and family members or others who are experiencing similar stressors" (p. 382). Thus, communal coping requires discursive interaction – in both the shared appraisal of the stressor and in coordinating joint action to reduce it (W. A. Afifi et al., 2012; T. D. Afifi et al., 2018, 2020; Pederson & Faw, 2019). However, we argue that cognitive appraisals of stressors do not occur separately from the socially-constructed context in which they emerge, and are therefore influenced by Discourses or the ways of talking that represent taken-for-granted assumptions in a given context (Alvesson & Kärreman, 2000). The following section summarizes the contemporary theoretical framework for communal coping.

The theoretical model of communal coping

Past research has documented four types of coping: (a) individualism, (b) support seeking, (c) individual help, and (d) communal coping (T. D. Afifi et al., 2006; Lyons et al., 1998), each related to high/low shared appraisal and high/low joint action. However, T. D. Afifi et al. (2020) argued that communal coping "is most usefully conceptualized as two continuous dimensions in which stressors are more or less co-owned and jointly acted upon" (pp. 427–428; see also Basinger, 2019). When individuals perceive a stressor as more co-owned (i.e., "our problem") than individual (i.e., "my or your problem"), the appraisal is shared. When people engage in activities collectively to address the stressor – either in person with others or with an understanding that others are engaged in the same activity elsewhere (e.g., collective mask wearing, hand washing, social distancing) – this is joint action. To be considered communal coping, the activity should include both shared appraisals and joint action, indicating an "our problem, our responsibility" appraisal-action orientation in response to the stressor (T. D. Afifi et al., 2020).

Given that communal coping is characterized by an "our problem, our responsibility" stressor appraisal-action orientation, individuals must articulate shared ownership of the stressor through communication (i.e., d/Discourse) to engage in the collective action to address the collective stressor (T. D. Afifi et al., 2006). Moreover, an "our problem, our responsibility" appraisal-action orientation is especially likely to occur in the contexts of collective stressors like natural disasters, wars, pandemics, and even in post-divorce families, due to the necessity of collaborative action to resolve root causes of stressors (e.g., damage to community property, collective threat of violence, collective risk of exposure) (see T. D. Afifi et al., 2006, 2020). Therefore, the COVID-19 global pandemic presents a context where communal coping strategies should be easily observed.

Coping and cultural discourse

Building upon previous theory, we examine stressors and coping while considering the role of cultural Discourses. Few empirical studies address how cultural Discourse affects stressor appraisals and coping responses. That said, past research has established that cultural differences indeed exist: "in the degree to which individuals are exposed to certain types of stressors, how these events are appraised, which coping strategies are used, and whether these coping responses are considered effective" (Stephenson & DeLongis, 2020, p. 58). Moreover, T. D. Afifi et al.'s (2020) extended model of communal coping accounts for cultural influences by integrating studies that document the predictive, moderating, and mediating effects of culturally related constructs like interdependent-independent orientations (Kam et al., 2017), group norms, and power distribution (T. D. Afifi et. al., 2006, 2020). As an example, Chun et al. (2006) found that people from collectivist cultures versus individualistic cultures differ on cognitive appraisals of stressors, coping goals, and coping strategies. Likewise, Wlodarczyk et al. (2016) found that community members from collectivist cultures were more likely to engage in communal coping following a natural disaster.

Past research also indicates the important role of cultural Discourse in fostering communal coping. For example, in their study of community members recovering from Hurricane Ike, Richardson and Maninger (2016) found that people co-constructed a shared narrative about the unique abilities of their town to recover through their "bootstrap mentality" (p. 114) – a pervasive cultural Discourse in the U.S. associated with rugged individualism, neoliberalism, and

capitalism (Ewen, 2008). These findings suggest cultural Discourses transmit norms, beliefs, and values that provide prescriptions for behavior in relation to coping strategies, particularly in response to collective stressors like natural disasters or a global pandemic. However, past research has not theorized explicitly about how cultural d/Discourses function within individual and communal coping processes. A focused analysis of how d/Discourses function in relation to stressor appraisals and joint action could yield important insights for coping theory. Thus, the current study was guided by the following research questions:

RQ1: What stressors do participants describe in their pandemic experiences?

RQ2: Through a d/Discursive lens, in what ways do participants describe coping strategies in response to the stressors experienced in the global pandemic?

Method

To answer the research questions, we employed a constructivist, interpretive approach. Given that communal stressors and coping strategies are a socially constructed phenomenon grounded in the value-laden perceptions of participants, but also tied to the material and d/Discursive structures within culture and society (see T. D. Afifi et al., 2020), an interpretive approach is appropriate for the aims of study. This research was designed to document stories about a variety of U.S. pandemic experiences. In mid-March, the U.S. declared a national health emergency due to the global health threat created by the 2019 novel coronavirus (COVID-19). After obtaining approval from the university institutional review board, interview data were collected from April 4 to May 15 of 2020 over the video conferencing software Zoom©. During this time, several U.S. states enacted emergency shelter-in-place orders that varied in restrictions, recommendations, and enforcement. Many U.S. state shelter-in-place orders included the cancellation of public gatherings of 10 or more people (e.g., concerts, festivals, sporting events, schools), and the temporary closure, sanitization, and/or capacity restrictions of non-essential customer service businesses (e.g., salons, bars, restaurants, gyms) (Treisman, 2020). These shelter-in-place orders also created secondary economic and mental wellness crises, including job loss, a lack of childcare for working parents, and food and consumable goods shortages (Nicola et al., 2020; Torales et al., 2020). Taken together, these conditions created a wellspring of shared stressors.

Study design and participant recruitment during a global pandemic

Given that our six-person research team was collecting data in the first few days and weeks of a pandemic, rife with uncertainty and data collection restrictions, we opted for relationally appropriate and ethical sampling procedures (Ellis, 2007). We considered study design feasibility, yield of data, compatibility with researcher identities, and suitability of our research aims and context (Tracy, 2020). We employed a snowball sampling method with the intention of maximizing participant diversity within the constraints and goals of our study. Given the unprecedented ubiquity of the COVID-19 pandemic – and subsequent ubiquity of stressors – we sought a range of voices and pandemic experiences to understand the shared stressors and coping mechanisms among a variety of life-worlds. We first recruited participants through our social networks and then diversified our sample by asking current participants for focused referrals. This process enabled us to achieve diversity while maintaining rigor, including: (a) a high yield of timely data, (b) high rapport with, and candid disclosure by, interviewees due to previous relationships with research team members, (c) ability to document coping strategies unfold in situ in the early weeks of the pandemic, and (d) relationally ethical recruitment strategies (Ellis, 2007).

Data collection

The majority of the 44 total participants in this study participated in individual, in-depth, semi-structured interviews (n = 27). Individual interviews ranged from approximately 23 to 81 minutes (SD = 16.03, M = 51.97) and yielded 513 pages of single-spaced transcripts. To assess similarities, differences, chaining (i.e., (re)producing similar dramatized messages to converge on a shared reality; Bormann, 1985) in participants' perceptions of pandemic stressors and coping strategies, the team also conducted five focus groups ranging from 2 to 5 participants (n = 17). Discussions ranged from approximately 49 to 84 minutes (SD = 15.44, M = 61.78) and yielded an additional 132 pages of transcript data. The initial interview protocol included general and broad questions soliciting participants' stories about their pandemic experiences (e.g., *Is there something that has been personally special or interesting in your life [during the pandemic] that you could imagine telling a story about in the future?*). After listening to and discussing the first six interviews, the research team adapted the interview protocol (see Appendix A) to include specific questions related to the stressors and coping strategies utilized during the shelter-in-place orders (e.g., *How are you comforting yourself right now? Another way to think of this is, what are your coping strategies? How well are these working?*). Overlap among data analysis and collection indicates that the findings presented are data driven, which is a hallmark of high-quality qualitative research (Lincoln & Guba, 1985). Data collection continued until we approached theoretical saturation (i.e., the presence of several redundant responses to questions of theoretical interest; Tracy, 2020). After preliminary analysis was completed, the authors conducted six additional secondary interviews with participants ranging from 11.5 to 44 minutes, specifically focused on the *gendering health concern* Discourse found in the preliminary analysis (see Appendix B for

secondary interview protocol). These additional interviews served as member reflections (see Tracy, 2020) with the aim of increasing the interpretive credibility of the findings.

Participants

Through a purposive snowball sampling method, the research team sought to collect pandemic experiences from a diverse pool of U.S. adults, particularly in relation to occupation (e.g., nonessential vs. essential; virtual vs. in-person) and area of the country (e.g., rural vs. urban; West Coast, East Coast, Midwest, South). Table 1 reviews demographic characteristics of the sample. Participants lived in a variety of areas in the U.S. with 12 total states represented. Arizona (*n* = 12), California (*n* = 11), and Florida (*n* = 6) were the most prevalent states of residency. Participants also disclosed their current employment status with 55.8% of participants indicating they were fully employed or self-employed. Twelve participants indicated that they were unemployed or underemployed due to the global pandemic. Occupational industries varied among employed participants with 12 unique industries including: law enforcement, restaurant service, utility workers, fitness and wellbeing, and airline workers. The most prevalent industries represented were education/childcare (*n* = 10), healthcare (*n* = 8) and hospitality (*n* = 6). Participants also reported a variety of living situations during the early weeks of the pandemic. Participants' approximate square footage of living space during the shelter-in-place orders ranged from 501–1000 sq ft. (*n* = 7) to 2001 sq ft. or greater (*n* = 12), with 1001–1500 as the most frequent square footage range (*n* = 17). The number of members residing in participants' households ranged from single (*n* = 7) to five (*n* = 2), with two as the most frequent number of household occupants (*n* = 24). All but two participants had at least one pet.

Table 1. Participant demographic characteristics.

Characteristic	Underemployed or Unemployed *n* (%)	Employed or Retired *n* (%)	Total *n* %
Gender			
Female	5 (50.0)	12 (35.3)	17 (38.6)
Male	4 (40.0)	22 (64.7)	26 (59.1)
Trans	1 (10.0)	0 (0.0)	1 (2.27)
Race			
White	6 (60.0)	23 (67.6)	29 (65.9)
Black	0 (0.0)	1 (2.9)	1 (2.27)
Latinx	3 (30.0)	8 (23.5)	11 (25.0)
Asian	0 (0.0)	1 (2.9)	1 (2.3)
Native American	1 (10.0)	1 (2.9)	1 (2.3)
More than one	0 (0.0)	0 (0.0)	1 (2.3)
Income			
0–25,000	5 (50.0)	4 (11.8)	0 (0.0)
25,001–50,000	1 (10.0)	6 (17.6)	7 (15.9)
50,001–75,000	0 (0.0)	4 (11.8)	16 (36.4)
75,001–100,000	1 (10.0)	1 (2.9)	8 (18.2)
100,001–200,000	3 (30.0)	19 (55.9)	12 (27.3)
Did Not Disclose	0 (0.0)	0 (0.0)	1 (2.3)
Education			
High School	6 (60.0)	4 (11.8)	9 (20.5)
Associate Degree	1 (10.0)	5 (14.7)	5 (11.4)
Some College	0 (0.0)	0 (0.0)	2 (4.5)
Bachelor's Degree	2 (20.0)	8 (23.5)	10 (22.7)
Master's Degree	1 (10.0)	11 (32.4)	12 (27.3)
Juris Doctorate	0 (0.0)	2 (5.9)	2 (4.5)
Doctoral Degree	0 (0.0)	4 (11.8)	4 (9.1)
Living Space			
0–500	0 (0.0)	0 (0.0)	0 (0.0)
501–1000	2 (20.0)	5 (14.7)	7 (15.9)
1001–1500	6 (60.0)	11 (32.4)	16 (36.4)
1500–2000	0 (0.0)	8 (23.5)	8 (18.2)
2001- Above	2 (20.0)	10 (29.4)	12 (27.3)
Did Not Disclose	0 (0.0)	0 (0.0)	1 (2.3)

Data analysis

The process of data collection and analysis unfolded in a cyclic, iterative manner with the research team collecting and interpreting initial data, meeting to discuss initial findings and data of theoretical interest, and then refining the interview protocol to focus on coping. Based on preliminary findings, research team weekly discussions, and a review of the coping literature, the team developed and posed RQ1 to the dataset to identify specific stressors associated with the global pandemic. Guided by RQ1, we utilized a phronetic iterative method of analysis (Tracy, 2020) to determine the convergence among participants' pandemic stressors. First, we reduced the large corpus of data (Bisel et al., 2014) to focus on discussions and synonyms of "challenge," "stress," "frustration," and "hardship." Next, we engaged in a process of constant comparison by treating each stressor discussion as a unique data excerpt. That excerpt was then compared to the next stressor excerpt and, if the excerpts aligned, a new coding category was defined and created in the codebook. If the stressor excerpts differed, then two distinct coding categories were defined and created. Then, the next stressor excerpt was compared with the past data and coding categories in a similar process. Next, coding categories were compared with one another. During this process, codes such as "finance" and "decreased autonomy" were subsumed by the overarching coding categories "uncertainty" and "isolation." This process continued until all reduced data were coded and yielded three main stressors: (a) *isolation*, (b) *uncertainty*, and (c) *conflict.*

Guided by RQ2, a secondary-cycle of coding (Tracy, 2020) was completed to understand participant convergence among coping strategies related to each stressor. Employing a process of constant comparison, this secondary-cycle continued until all reduced data were coded. This process yielded nine distinct coping strategies. Next, after reviewing the communal coping literature (T. D. Afifi et al., 2006, 2020), a final hierarchical cycle of coding (Tracy, 2020) was completed to refine and understand the relationships among the coding categories (i.e., stressors, coping strategies, d/Discourse, as well as appraisal-action orientation for each strategy). During the process, some codes were subsumed by other codes in hierarchical coding families (e.g., a "managing connection" code was subsumed by the "bounded creativity" category).

Guided by the definitions provided in the extended theoretical model of communal coping (T. D. Afifi et al., 2020), coping strategies were grouped into individual, communal, or Discursive coping (See Table 2) by coding participants' stressor appraisal orientation (i.e., more or less my problem versus our problem) and participants' action orientation (i.e., more or less

Table 2. Stressors during COVID-19 global pandemic.

Stressor	Definition
Isolation	A loss of physical and social connection due to restricted mobility and government-issued shelter-in-place mandates.
Uncertainty	Unpredictability of future events and stressors. Decreased perceptions of control over financial, social, and physical well-being.
Conflict	Increased conflict among interpersonal relationships due to increased interactions, as well as reduced autonomy and personal space

This table summarizes the stressors participants described as a result of the COVID-19 global pandemic.

my responsibility versus our responsibility). Through this process, the authors theorized and proposed the novel theoretical construct of *Discursive coping* (see Figure 1). The findings section provides detailed explanations of the coding categories and exemplar evidence.

Steps to ensure study rigor

Several steps were taken to ensure high quality qualitative research. First, we collected multiple types of data, at multiple points in time, with multiple co-researchers to "construct a multi-faceted, more complicated, and therefore more credible picture of the context" (Tracy, 2020, p. 276). This process, termed crystallization, "brings together multiple methods and multiple genres simultaneously to enrich findings . . . each partial account complements the others, providing pieces of the meaning puzzle" (Ellingson, 2009, p. 13). To do so, we collected multiple forms of data, (i.e., both focus groups and interviews) across the first few months of the pandemic with multiple co-researches (e.g., a six-person research team). We also sought multivocality (i.e., the inclusion of multiple voices) within our findings by "analyzing social action from a variety of participants' points of view" (Tracy, 2020, p. 277). After our preliminary findings were developed, we gathered member reflections (i.e., "sharing and dialoguing with participants about the study's findings, providing opportunities for questions, critique, feedback, affirmation" Tracy, 2010, p. 844) by interviewing six past participants. We used this approach to clarify and confirm the Discourse *gendering health concern* in particular. Member reflections were incorporated into the following section.

Findings

Guided by the primary research question, data indicated that participants associated three stressors with their initial experiences during the COVID-19 global pandemic: (a) *isolation*, (b) *uncertainty*, and (c) *conflict*.[1] In relation to these stressors, participants also described both intentional and unintentional coping strategies they employed. Guided by RQ2, our analysis revealed three levels of coping (a) individual coping (i.e., *seeking embodied wellbeing, self-kindness*), (b) communal coping (i.e., *serving others, bounded creativity, grateful comparison*), and (c) Discursive coping (i.e., *trusting fate, gendering health concern*) (see Tabe 3). The following sections describe the stressors participants experienced during the pandemic and provide evidence of participants' coping strategies.

Participant stressors resulting from COVID-19

Participants articulated three central stressors – *isolation, uncertainty, conflict* – in relation to the initial shelter-in-place orders and the residual effects of those orders. While each participant reported unique and changing appraisals of their specific environmental stressors, there was convergence captured within these three categories. See Table 2 for a full summary of stressor definitions and related data excerpts.

First, participants articulated the stressor of *isolation* as a loss of physical and social connection due to restricted mobility and government-mandated shelter-in-place mandates. Physical isolation was a result of the required temporary closure of nonessential businesses and schools, as well as canceled events, restricted travel, and general access to public spaces. Cathy, a 63-year-old retired business manager, explained how the stay-at-home orders exacerbated her feelings of isolation due to her underlying chronic depression. "I will be honest and say that I was really struggling when COVID hit," she explained, "already from being isolated for so long." Other participants described isolation as feeling "alone," experiencing "emotional distance," and as an impediment to their "freedom." Lukas, a 35-year-old restaurant server, reflected on the stress associated with being under-employed and subsequent social isolation. He explained, "you can't run away from the stress . . . Like you're used to being moving around and

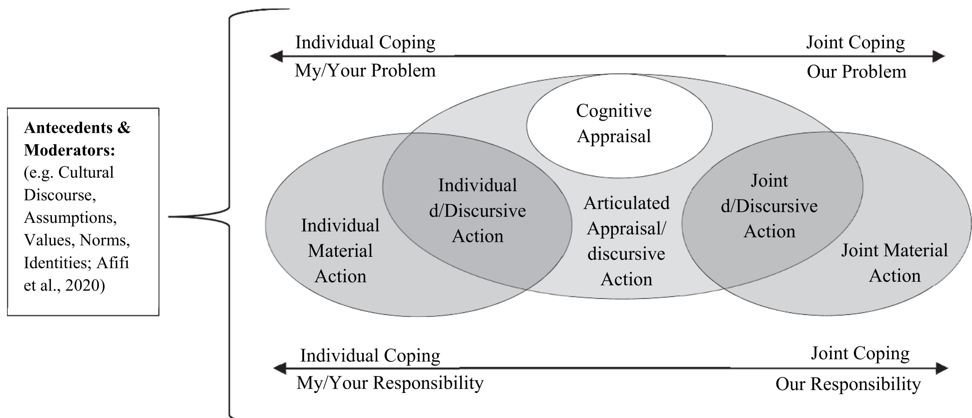

Figure 1. Individual and communal coping through a d/Discursive Lens. This figure illustrates the relationships among d/Discourse, appraisal, and action within individual and communal coping processes. This theorizing builds on T. D. Afifi et al. (2020) extended theoretical model of communal coping (TMCC).

Table 3. Individual, communal, and discursive coping strategies during COVID-19.

Level	Coping Strategy	Definition	Stressor
Individual	Embodied Comfort	Seeking physical and mental comfort in through embodied, material, and tactile activities	Conflict Isolation Uncertainty
	Self-kindness	Acceptance and understanding of oneself when faced with challenges, failure, or discomfort	Conflict Uncertainty
	Grateful Comparison	Discursive action in which a speaker engages in social comparison and articulates gratitude as well as guilt in response to the individual and collective suffering	Isolation Uncertainty
Communal	Serving Others	Framing work as service, and helping others through skills and expertise, imagining how their work might reduce others discomfort and suffering	Isolation Uncertainty
	Bounded Creativity	Social acts of creativity within the constraints of the pandemic that role model ingenuity and resilience	Isolation Uncertainty Conflict
Discursive	Trusting Fate Discourse	A Discourse that assumes and accepts predestination in relation to life trajectories and death	Uncertainty
	Gendering Health Concern Discourse	A Discourse that delegitimizes health concerns or precautions of others by characterizing them as weak and feminine	Uncertainty Conflict

This table summarizes the higher-level coping categories, defines each coping strategy and identifies the associated stressors articulated by participants.

communicating with so many people. And then being isolated in your home." Here, Lukas highlights the stressors "nonessential" workers negotiated – not only in terms of financial hardship, but also from restrictions surrounding work and relationships.

A second salient stressor described by participants was *uncertainty* of future events. Several participants described stress related to loss of control over financial, social, and physical well-being. Many participants experienced the stress of unpredictable financial security. Of the 44 participants included in this study, 12 (27.3%) were fired or furloughed due to the pandemic. Chantalle, a 48-year-old massage therapist and yoga instructor, disclosed her biggest pandemic stressor as "the financials. I constantly have to readjust." Similarly, Kayla, a 27-year-old unemployed restaurant server, shared, "I'm worried about how I'm gonna pay my rent, my car bill, my insurance, all of that, like, I'm about to be out of health insurance since I'm out of a job." Additionally, several participants expressed distress in response to missing socio-cultural bonding events – such as graduations, sports, school plays, and quilt shows – and uncertainty about when or how their social lives will return to "normal." Sally, a 31-year-old chiropractor and Canadian citizen, lamented missing her grandparents' 60th wedding anniversary celebration and worried about when she might see her family again. She shared, "I've chosen to live far away. And with borders closing, you really feel that distance. . . . I'm not even allowed in the country that I was born in." In terms of health uncertainty, several participants worried about contracting COVID-19. TJ, a 29-year-old nurse, compared COVID-19 to getting bed bugs: " . . . COVID-19 seems to be very similar," he shared, "where you don't necessarily know you have it . . . and it's already too late."

A final stressor described by participants was increased interpersonal *conflict*. Due to the stay-at-home orders and subsequent pivot to remote work, more people were forced to remain home with only their housemates or families, and with little to no interaction with the outside world. Kevin, a 42-year-old hotel manager, shared that while he and his family generally enjoy their time together,, "you start getting on each other's nerves." He lamented that, especially with the increased interaction of assisting two children in virtual learning, "you love your family, your spouse . . . but man, I mean, this sucks. You're always around each other. It's just, it could be a bit much." Many participants experienced conflict with the lack of space and solitude. Luiz, a 53-year-old police lieutenant, shared that his station was receiving more calls related to domestic violence. He explained, "a lot of people are home right now. We get a lot of calls throughout the day for family fights." While the general stressors of *isolation, uncertainty*, and *conflict* were shared by many, they were appraised differently by participants, resulting in different coping strategies.

Individual coping during COVID-19

Individual coping strategies were determined by assessing participants' appraisal-action orientation through their descriptions of their coping strategies. All individual strategies explicitly or implicitly indicated a "my problem, my responsibility" stressor appraisal-action orientation (T. D. Afifi et al., 2006, 2020). "My problem" indicates participants' individual stressor appraisal and "my responsibility" indicates participants' individual action to reduce or cope with the stressor. T. D. Afifi et al. (2020) argue that stressor appraisals and coping actions are on a continuum where they are "more or less co-owned" and more or less "jointly acted upon" (p. 428), rather than residing in distinct categories. Given the interpretivist lens of the current study, the authors utilized participants' self-report descriptions of their coping to categorize their appraisal-action orientations.

Seeking embodied comfort

A primary individual coping strategy was seeking *embodied comfort*. This strategy is defined as seeking physical and mental comfort through physical, material, and tactile activities in response to a stressor. In response to isolation, uncertainty, and conflict, many participants described engaging in increased physical activity such as working out (e.g., running, biking, yoga), "getting some fresh air," and "playtime." Several participants also described additional hands-on activities such as cooking and baking for personal enjoyment. Linda, a 61-year-old retired educator, shared that she was relaxing by "baking, baking, baking and baking a lot." Similarly, Lukas, a 35-year-old underemployed restaurant server, explained that because of his reduced hours, he had "just been cooking every single night, and it feels good to make dinner." Participants used embodied comfort to tolerate – rather than master or reduce – COVID-19

stressors (see Krohne, 2002). Therefore, while embodied comfort helped participants cope with the discomfort, this strategy did not directly reduce or transform the root stressors.

Participants also described seeking embodied comfort by overindulging in food and drink. Rhonda, 32-year-old underemployed restaurant server, explained her change in eating as a result of being isolated at home. She stated, "I catch myself eating gluttonously . . . I've got nowhere to go, nobody to see me. And there's nobody here in my house to tell me, 'Bitch, are you eating again? Like didn't you just have a snack? [Laughter]." Similarly, participants reported an increase in their alcohol consumption, explaining (sometimes with embarrassment in their voice) that they were "drinking every night," "drinking a lot worse," "seeing an increase in, you know, drinking at home," and "looking too forward every day to 5:00–6:00 o'clock cocktail hour." Similarly, Rhonda explained, "If I'm gonna have to sit on the couch, I might as well not be sober . . . that has been my coping mechanism." As evidence of the convergence around this coping strategy during the pandemic, Barbie, a 36-year-old assistant professor, explained, "I'm home and I'm bored. So, let me have a drink. So, it's kind of a joke that alcohol's the comfort . . . that's a common joke that's going around is you know, the 'Quarantini.' Everybody's drinking 'Quarantinis.'" In this excerpt, Barbie's wordplay and humorous use of the portmanteau "Quarantini" indicates the cultural pervasiveness of alcohol indulgence during the first few weeks of the pandemic. Given that these strategies are related to temporary, individual relief from stressors, they represent a "my problem, my responsibility" stressor appraisal-action orientation (Lyons et al., 1998).

Engaging in self-kindness

Another individual coping strategy participants described was *self-kindness*. Well-documented in past research as a component of self-compassion, self-kindness is "the tendency to be caring and understanding with oneself rather than being harshly critical or judgmental" (Neff, 2009, p. 212). In the context of the global pandemic, participants engaged in their own mindful acceptance and understanding of themselves (i.e., an individual action) when faced with the various stressors. Here, participants first recognized and acknowledged that the pandemic challenged their daily lives. When discussing her new routine and how much work she is (un)able to accomplish in light of COVID-19 stress, 59-year-old nurse, Piper, acknowledged, "I can understand it's not going to be perfect." Second, participants responded by creating time for self-care rather than adhering to strict work norms. Diddy, a 79-year-old retired professor, expressed with glee that her new routine allowed her to "gift" herself with "two and a half hours straight of reading lying on the sofa in the sunroom" – something that would have seemed impossible to her pre-pandemic.

After recognizing the need to re-adjust expectations, several participants explained that they tried to let go of self-criticism, judgment, and guilt associated with decreased productivity. Instead, participants reported "gravitating toward sort of [a new] routine." Barbie described it like this: "[my] reward system is, if I get my work done today, I can play out in the yard tomorrow without guilt." Self-kindness enabled participants to tolerate and reduce pandemic stressors by reframing self-expectations and (re)adjusting perceptions of essential responsibilities to the self and others. Thus, self-kindness represents a "my problem, my responsibility" (Lyons et al., 1998) appraisal-action orientation of pandemic stressors. Specifically, participants were (a) able to recognize they were experiencing increased stress due to the pandemic (i.e., individual stressor appraisal), and (b) take cognitive action (i.e., letting go of self-judgment and guilt) and material action (e.g., engaging in self-care, rejuvenating individual activities) to cope.

Taken together, *embodied comfort* is physical in nature, whereas *self-kindness* is a mental practice and action. Embodied comfort and self-kindness appear recursively related. For example, taking a bubble bath may allow a person to decompress and create the space for self-kindness. Similarly, the mental practice of self-kindness may allow people to give themselves permission to stop work and take that bubble bath.

Grateful comparison

A final individual coping strategy participants engaged in was *grateful comparison*. This strategy occurred when participants expressed gratitude when comparing oneself with real and generalized others' struggles during the pandemic. This coping strategy was described in every interview and focus group. Michelle, a 27-year-old project manager, explained that viewing her own stressors in comparison to others helped her cultivate a general feeling of gratitude rather than fear or stress. She shared that "understanding what is going on in the world has made me, again, kind of change my approach to this, even if it is scary and stressful personally . . . considering others and gratitude." Similarly, Dean, a 68-year-old business owner, explained that an internal reorientation of perspective helped him cope. He stated, "If we don't have perspective, and we [don't] tie that perspective to gratitude, we're really missing the boat . . . If you have what you need, be thankful, because probably you have way more than most of the people." For some participants, however, gratitude gave way to guilt in response to the d/Discourse of collective suffering.

For example, Lisa, a 34-year-old lawyer, highlighted the tension between guilt and gratitude when she explained, "Sometimes even the gratitude ends up leading to guilt. Because you have a job, you have a home, you have – there's not a lot that I have to be worried about. I even felt guilty about the stimulus check." Here Lisa reveals a common response to the cultural Discourse of collective suffering during this time, while her life has been affected by the global pandemic, she compares her suffering to others. Cassandra, a-34-year-old salesperson, echoed Lisa's sentiments about the tension between gratitude and guilt:

> I think anytime you feel a lot of people suffering . . . you can go guilty versus like, I'm just grateful. And so, I've been trying to shift to that. I'm just really grateful I'm in this place and versus kind of taking in more of what the negative part is.

Here, Cassandra articulated the common coping strategy of shifting her focus away from her own stressors by comparing her pandemic experiences to the collective suffering of others. This comparison can be problematic because it can actually

exacerbate feelings of anxiety and despair (O'Connor et al., 2002). Differing from other forms of survivor guilt (Brockner et al., 1986), participants explained that their comparative guilt may be compounded by exposure to mediated stories of collective suffering. These excerpts highlight the "my problem, my responsibility" appraisal-action of pandemic stressors within *grateful comparison* coping, but indicate a lack of agency to master or reduce the stressors for others, leading to guilt. Specifically, participants (a) recognized their individual increased stress due to the pandemic (i.e., individual stressor appraisal), and (b) took individual discursive action (i.e., reframing their own stressors, challenges, and hardships by verbally comparing their own stressors with others') to cope.

Communal coping during COVID-19

A key finding in our study was participants' communal coping strategies in response to stressors. These strategies emerged in participants' descriptions of their appraisal-action orientations toward stressors. Specifically, communal coping was identified when participants explicitly or implicitly indicated an "our problem, our responsibility" stressor appraisal-action orientation (see T. D. Afifi et al., 2006, 2020). An "our problem" appraisal orientation took place when participants' articulated that they assessed the stressor as shared, and communicated a shared call to action (e.g., "we all have to do our part"). An "our responsibility" action orientation took place when participants actually engaged in joint action (e.g., making and donating masks). To summarize, an "our problem" appraisal orientation demonstrates that the stressor is *framed* as a collective issue and an "our responsibility" action orientation demonstrates a collective *pursuit*.

Serving others

A primary communal coping strategy employed by participants was *serving others*. Based on participants' pandemic experiences, we define *serving others* as framing collective stressors (i.e., joint appraisal) and the joint use of specialized skills and expertise to help others (i.e., action). This strategy delineates how participants publicly made sense of their work as altruistic service that contributed to the overall pandemic-related relief. For example, 59-year-old nurse, Piper, worked as a care coordinator for cardiac patients. While answering our interview questions, she alongside her sister and daughter sewed surgical fabric into masks for a neighboring hospital experiencing shortages of personal protective equipment. This action exemplified a *serving others* coping strategy. Piper explained that if she were to be called in to support the pandemic response on the frontlines, then that is "what I'm supposed to do. That's what I have the skillset for." Similarly, 39-year-old nurse, Jenny, insisted that her occupational responsibility as a nurse to help others outweighed the risk of COVID-19 exposure. She stated, "I still have to go and be exposed to my co-workers and patients' families and knowing … that's the risk I've taken. That's what I signed up for." By citing the occupational moral code implicit in nursing, both Jenny and Piper's comments demonstrate an "our problem, our responsibility" appraisal-action orientation related to the pandemic. Non-essential workers also demonstrated the *serving others* communal coping strategy. For example, Linda, a 61-year-old retired educator, explained how she gave her neighborhood garbage collector one of her hand-sewn masks. She explained that sewing and distributing masks, "makes me feel powerful … It feels like I'm giving them a tool to fight this battle." Reflecting on the garbage collector's reaction, Linda said, "I told them, even if they didn't want to wear it, if they could pass it along to somebody else who might need it, then at least it would get out there in the community and be helpful to somebody." Here, Linda demonstrates an "our problem, our responsibility" appraisal-action by taking it upon herself to support collective change in others' health behaviors. Her service to the community was twofold: she (a) created and provided a mask to an essential worker in her community, and (b) encouraged the essential worker to serve others by passing the mask along if unneeded.

Bounded creativity

Another communal coping strategy participants described was *bounded creativity*. According to past research, when individuals encounter boundaries for problem solving, they often respond with creativity to find a solution within those boundaries (Santanen et al., 2004). For this study, we define *bounded creativity* as social performances of creativity within the constraints of the global pandemic. Given the regulations, mandates, and restrictions in the early days of this contagious, deadly, airborne virus, participants found ways to creatively cope with the isolation. For example, Kevin, a 42-year-old hotel manager, recounted a Sunday afternoon:

> It sounds silly, but we decided to barbecue outside on the front lawn, not the back lawn. Hear what I'm saying? We could have done it in the back. We've got a huge backyard. But for some reason, I told my wife, I said, I brought the grill up front to the garage. … Look, I can admit it looked kind of crazy. But we had a cookout out there … .I wanted people to see us … ..our neighbors having parties, drinking beer … having a good old time. I wanted it. It was weird … .I want that camaraderie. Even though I knew they weren't gonna come over. I just wanted that.

In this excerpt, Kevin describes this activity as "silly" or "weird," indicating that his front lawn performance of a family barbeque was out of the ordinary. Given that his families' front lawn barbecue served as a performance of sociality for his neighbors – while still respecting social distancing restrictions – this strategy demonstrates bounded creativity within an "our problem, our responsibility" appraisal-action. Other examples of bounded creativity included (a) video conference celebrations, (b) planning drive-by birthday parades, and (c) coordinating volunteers for free bicycle deliveries for take-out from local restaurants. Importantly, because these creative acts were later shared through (re)telling of stories, they reproduced a cultural Discourse of ingenuity and resilience.

Coping through the (re)production of d/Discourse

By integrating the theoretical constructs of individual and communal coping as delineated by T. D. Afifi et al. (2020) with a discursive perspective (see Alvesson & Kärreman, 2000), we also found that participants (re)produced particular

cultural Discourses to cope with the stressors of the pandemic. We term this phenomenon *Discursive coping*, defined as the (re)production of d/Discourse as a coping response to a given stressor. We argue that Discursive coping is related to the TMCC, given that (re)produced Discourses (i.e., ways of talking, therefore ways of thinking, Alvesson & Kärreman, 2000) may inhibit or foster individual and communal coping through both (a) an articulated appraisal of a stressor – a discursive action and (b) the (re)production of macro cultural Discourses (see Figure 1). Whether individual or communal coping strategies are employed, the co-construction of shared appraisals does not occur in isolation. Rather this co-construction is situated within larger cultural Discourses and past experiences of a collective (i.e., termed as "cultural influences" within TMCC, see T. D. Afifi et al., 2020). Indeed, past research indicates that reproducing a cultural Discourse in response to a stressor is an action, and can be a joint action if others also (re)produce that Discourse as a means of coping (e.g., Richardson & Maninger, 2016). Ideologies do not exist only on an intrapersonal level. People share ideologies through everyday talk, which is an action, and as a result they become taken-for-granted and (re)produced by others – which is a collective action.

Discursive coping during COVID-19: Gendering health concern

One Discourse that participants employed as a Discursive coping strategy in response to COVID-19 stressors was *gendering health concern*. Gendering health concern is a Discourse that delegitimizes health concerns and precautions of others by characterizing their concern as feminine (e.g., fragile, weak, and emotional), while rendering a lack of concern as masculine (e.g., tough, strong, and rational). When asked how he was coping with the pandemic, Jerry, a 59-year-old food truck owner, replied, "About the same as everybody else. Well, no, I won't say that. I find that the female population is way more worried than the male population." Jerry explained that, based on experiences with female employees, customers, essential workers, and his wife, he believes women are more worried about COVID-19 risks. This excerpt reveals deeply held assumptions about gendered performances of health behaviors, namely that women are permitted to express worry, stress, and apprehension related to health risk, whereas men – who perform stereotypical masculinity – must downplay and rationalize health risk (Samulowitz et al., 2018). These gender assumptions are rooted in a cisgender, heteropatriarchal view of culturally acceptable health behavior (Hoffmann & Tarzian, 2001; Samulowitz et al., 2018). Given that Jerry shared these views with a female researcher, this excerpt reveals the taken-for-granted and often unquestioned nature of gender assumptions.

During preliminary analysis, *gendering health concern* was only apparent in the above participant interview. However, participant member reflections collected through secondary interviews (see Appendix B) highlighted and confirmed *gendering health concern* as a more broadly experienced Discursive coping strategy for multiple participants. In a second interview with Don, a 52-year-old choir teacher, he stated that "women definitely seemed to have more concern, for whatever reason" during the early stages of the pandemic. He reflected that, while he knew he was generalizing, his experience was that compared to women, men tended to be "less risk averse" when it came to COVID-19. He explained that some men viewed themselves as "invulnerable" and able "to weather the storm" if they contracted the virus, whereas women did not share these views. Similarly, Mack, a 65-year-old retired principal, within his second interview explained that many men were coping with their stress by relying on Discourses of stereotypical masculinity. He stated: "I think that some men look [at] mask-wearing as if it's sissifying you. You know, 'you're not manly with that mask on.' And 'are you afraid of these little tiny viruses?'" In response, the researcher asked if he believed that this perspective is related to coping, and he responded:

> I think it is. Like stare your fears down. Like a stare down. It's pretty hard to look strong and tough when you got a mask on. And I'm guilty of it and it always looks funny when our [male] governor is up there with the mask. It's a little off-putting.

Taken together, the above participant interviews reveal how the *gendering health concern* Discourses of stereotypical masculinity performance (e.g., "stare your fears down;" "weather the storm") serve as a coping mechanism to reduce fear and uncertainty associated with COVID-19.

Discursive coping during COVID-19: Trusting fate

A final strategy several participants shared was accepting their lack of control. This strategy was influenced by the Discourse of *trusting fate* – a cultural Discourse that accepts predestination in relation to life trajectories. Rooted in Calvinist thought on predestination, trusting fate, or fatalism, is a cultural Discourse (re)produced through a lens of American protestant ideology (Cort & Matthews, 2000). Jenny, a 39-year-old nurse, explained that she copes with challenges by "having faith that things will work out or that ... everything happens for a reason." Jenny articulated a common cliché in coping rhetoric: that while people may not know why stressors occur, they can take solace in the idea that there is a predetermined plan destined to result in a positive outcome. Kevin, a 42-year-old hotel manager, reflected on the stress he felt when laying off most of his staff and taking on their responsibilities. His faith in "God's plan" helped him cope. He stated, "I'm honestly grounded by my faith in God and Christ and ... I'm not worried about too much. Even in my work, I don't worry too much. So, I'm just kind of holding strong in my faith." Kevin reproduced the *trusting fate* Discourse by highlighting how his faith in God provides him with the confidence to not worry about the financial uncertainty experienced by both his company and his family in response to the pandemic.

Finally, Cathy, a 63-year-old retired business manager, explained that, due to her faith and lack of control over future events, she does not worry about the health consequences of COVID-19. She shared, "I never have felt fear in this situation ... your days are numbered from the time we're born and God knows how he's gonna end it. And if this is it, then this is it." This excerpt reveals Cathy's ability to cope with uncertainty and fear through her faith in a higher power and the predetermined plan God has for her own and other's lives. Cathy's (re) production of the *trusting fate* Discourse reflects acceptance of

the inevitability of death. Consequently, this Discourse rejects peoples' agency in their health behaviors and outcomes. On the one hand, the *trusting fate* Discourse enables participants to reduce their fear and anxiety created by the pandemic. On the other hand, this Discourse may undermine perceptions of responsibility in regard to public health messaging and health behavior change (e.g., mask wearing, avoiding large crowds) (see Cort & Matthews, 2000).

Discussion

The purpose of this study was to first document the stressors experienced by U.S. adults during the initial COVID-19 pandemic shelter-in-place orders and to collect their descriptions of coping strategies employed in response to these stressors. Participants described three stressors related to the pandemic (i.e., *isolation, uncertainty*, and *conflict*) and multiple coping strategies at the individual level (i.e., *embodied comfort, self-kindness, grateful comparison*) and communal level (i.e., *serving others, bounded creativity*). Our study builds on the extended theoretical model of communal coping (T. D. Afifi et al., 2020) by applying a d/Discursive lens to coping strategies employed during the COVID-19 global pandemic (see Figure 1). Through this lens, we proposed the novel theoretical concept of *Discursive coping*. By reproducing Discourses that delegitimize the agency of others and themselves, *Discursive coping* was evidenced through participants' articulation of *trusting fate* and *gendering health concern* Discourses. The following sections discuss the theoretical contributions and practical implications of these findings.

Integrating a d/Discourse perspective within the theoretical model of communal coping

A primary contribution of these findings is the novel theoretical concept of *Discursive coping* and the integration of d/Discourse within the extended theoretical model of communal coping (see Figure 1). *Discursive coping* is a coping strategy whereas cultural Discourse (i.e., ways of talking that reveal ideologies and taken-for-granted assumptions) is a contextual factor that influences coping. As T. D. Afifi et al. (2020) explained, communication, or shared d/Discourse, functions within communal coping as "a basic level of interaction detailing the circumstances around the stress and … communication about the meaning of the situation" (p. 428). Building on the extended TMCC (T. D. Afifi et al., 2020), we argue that *Discursive coping* strategies can function as individual or communal coping.

As Figure 1 summarizes, individual and communal coping processes all function through d/Discourse. Even individual cognitive appraisals of stressors do not occur in isolation; they are influenced by cultural Discourse and ideologies in relation to the stressor (T. D. Afifi et al., 2020). For example, a person from a culture that (re) produces individualistic cultural Discourses may assess government mask-wearing mandates as a stressor that inhibits free will, rather than assessing the pandemic health risk as a joint problem that may be resolved through joint action like collective mask wearing. In addition, articulated stressor appraisals (i.e., stressor appraisals that are shared through discourse or everyday talk) function as discursive actions that can be more or less jointly or individually owned. For example, if an underemployed restaurant worker said "we are all really worried about our job security" this is a discursive appraisal of a joint stressor related to the financial uncertainty created by the global pandemic.

Past coping research suggests that these appraisals often result in actions to master, tolerate, or reduce the stressor (Stephenson & DeLongis, 2020). We argue that in addition to these actions being more or less individual and collective (T. D. Afifi et al., 2020), they can be further delineated into d/Discursive action (i.e., resulting in d/Discursive coping) and/or material action (see Figure 1; see also Richardson & Maninger, 2016). For example, if a restaurant worker's said "we are all really worried about our job security," their coworker replied, "let's brainstorm about how we might increase takeout orders," this interaction would likely lead to joint material action and communal coping (e.g., coordinating volunteers for free bicycle deliveries). Alternatively, if a restaurant worker said "we're all really worried about our jobs, but everything happens for a reason," and their coworker replied, "Yes, God has a plan, and we can only wait and see," this interaction would be an example of *Discursive coping* where the conversational partners are engaging in joint d/Discursive action by (re)producing the *trusting fate* Discourse.

Similarly, research and public health campaigns conducted during the global pandemic suggest that *gendering health concern* is a prominent cultural Discourse within the U.S. that affects health behaviors. For example, Capraro and Barcelo (2020) found in a sample of U.S. adults that significantly fewer men than women believed they would be harmed by contracting COVID-19, and this belief mediated gender differences in mask wearing. The study also found that significantly more men reported that "wearing a face covering is shameful, not cool, a sign of weakness, and a stigma" (p. 1). In addition, some health campaigns have tried to mitigate this Discourse by using slogans like "Tougher than COVID." One such example is a health campaign in Arizona. The black-and-white image of a male, mask-wearing bodybuilder reads, "Go ahead. Tell me my mask looks weak," (Arizona Governor's Office, 2020; See Figure 2). These examples substantiate the influence of *gendering health concern* as a culture Discourse in the United States and provide evidence of the effect of this Discourse on health behaviors.

In the current study the (re)production of the *gendering health concern* and *trusting fate* Discourses, functioned as *Discursive coping*. Although the (re)production of Discourses can, in the short term, ameliorate stress, these actions may have problematic consequences as they fail to address the root stressor. Indeed, in the context of COVID-19, Discursive coping reduced perceptions of agency, health risk, and subsequent health behaviors. In contrast with past research that found the (re)production of cultural Discourses aided communal coping and collective action (e.g., "a bootstrap mentality" Richardson & Maninger, 2016, p. 115), the current findings have implications for how cultural d/Discourse can undermine collective material action to resolve

Figure 2. Arizona public health campaign: #ToughertThanCOVID. This image originated from a social media public health campaign commissioned by the Arizona Governor's Office. Imagery of the American Flag, a male body builder, and the overlay of the quotation "Go ahead. Tell me my mask looks weak" all serve to challenge a *gendering health concern* Discourse prevalent within the state, such that taking health precautions is weak and feminine. These images were paired with a video that compared a boxer wearing gloves to mask wearing. Original source information can be found here: https://twitter.com/dougducey/status/1286479535337218048?s=20

stressors. Given the importance of communal coping for individual and collective resilience (T. D. Afifi et al., 2020), future public health interventions should consider how to overcome problematic cultural Discourses in general, and specifically for communal coping.

Transforming coping from individual to communal

A second contribution of this study is demonstrating the possible implications of transforming coping strategies from individual to communal. Our findings show that *grateful comparison* is a d/Discursive action that can serve as either individual or communal coping. However, this approach may be more productive in its communal form. As an individual strategy, *grateful comparison* was triggered in response to others' suffering, and then expressed outwardly to others. Certainly, when people reframe hardship by verbalizing gratitude, this type of social gratitude promises cathartic benefits (Amaro, 2017; Wood et al., 2007). However, research has also documented the negative psychological and behavioral consequences of social comparison (e.g., Mussweiler & Strack, 2000). For example, past survey research in has demonstrated that upward social comparison (i.e., with others that are perceived as better off than the self) can reduce self-esteem and overall wellbeing (Wang et al., 2017), whereas downward social comparison (i.e., with others that are perceived as worse off than the self) can increase perceptions of wellbeing (Gerber et al., 2018). Our findings indicate that this relationship is likely more complex. In the context of COVID-19, when participants utilized *grateful comparison* as an emotional coping strategy alone (Krohne, 2002), it led to feelings of guilt and shame (e.g., "you go guilty versus just grateful"). However, when participants paired *grateful comparison* with collective joint-action like *bounded creativity* or *serving others*, participants did not articulate shame or guilt. This finding suggests that individual coping strategies can be transformed into collective coping strategies via joint-action, and that this integration may better serve both the individual and the collective to reduce stressors and suffering.

Cultivating communal coping through bounded creativity

A third contribution of our study is the identification of a novel communal coping strategy, *bounded creativity*. While past research has established the presence of communal coping strategies in response to collective traumatic events like natural disasters, wars, and the AIDS epidemic (W. A. Afifi et al., 2012; T. D. Afifi et al., 2018; Brashers et al., 2002; Nuwayhid et al., 2011; Richardson & Maninger, 2016), *bounded creativity* emerged in the context of the COVID-19 pandemic. On the whole, past research indicates the positive benefits of communal coping on health outcomes and stress reduction (Hobfoll, 2002; Kowal et al., 2003). The current study shows that *bounded creativity* produces similar benefits in the context of COVID-19.

Creativity is the "act of producing new ideas, approaches, or actions" often in the context of creative problem solving (Tillander, 2011, p. 39). *Bounded creativity*, then, is the ability to produce new ideas, approaches, or actions given the constraints created by the problems individuals face. As a problem-oriented (Krohne, 2002) communal coping strategy, *bounded creativity* helped participants master or reduce the stressors associated with COVID, and the constraints and subsequent stressors created by the pandemic (e.g., Kevin felt less isolated by holding his family barbeque in the front yard). Given that *bounded creativity* is an interactive coping mechanism in the context of COVID-19, this strategy has implications for the coping efficacy of social performances of creativity in response to future collective health challenges. Public acts of invention could provide hope and support by role modeling to others how to be creatively resilient in the face of challenges and stressors. Researchers agree that creativity is related to a set of skills that can be taught (Scott et al., 2004). In relation to performing creativity, groups with just one member skilled in creativity training can foster collective inventiveness and result in enhanced problem-solving (Puccio et al., 2020). Holistically, these findings suggest that *bounded creativity*: (a) can be taught and promoted and (b) could be a mechanism to foster stress reduction and positive health outcomes at the communal level.

Limitations and future directions

As is the case with all empirical research, this study is not without limitations. Data collection took place in the first five weeks of the global pandemic. Therefore, our data provide a time-bound glimpse of stressors, appraisals, and coping strategies at the beginning of the pandemic in a small sample of U.S. adults. Moreover in our sampling process we prioritized exploring a wide breadth of participant experiences by interviewing healthcare workers, college students, parents, retirees, essential workers, all in the same study. Given the breadth of participant identities, it is likely there are differences within these sub-groups that we were not able to capture. We recognize that we were unable to capture depth within each group's experience and we encourage future research to tease out these nuances. As an example, in the preliminary round of interviews, Jerry was the only participant that reproduced the cultural Discourse of *gendering health concern*, leading us to engage in member reflections with other participants. Future research should continue to investigate the prevalence and behavioral effects of the (re)production of this particular gendered Discourse. Additionally, future research could extend this work by capturing the progression and management of collective stressors over an extended length of time. Moreover, these findings are based on the experiences of a non-representative sample of U.S. adults, from a Western, privileged lens of the COVID-19 global pandemic. Therefore, these findings should be transferred to other contexts with care and reflexivity.

Note

1. The stressors that emerged within our U.S. adult dataset generally represent a privileged experience of the COVID-19 pandemic from a Western cultural lens. Some participants articulated this privileged experience, which has been developed in our findings section on "grateful comparison."

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Appendix A

Semi-Structured Interview Protocol:

We are talking with you today because we are interested in peoples' stories and sensemaking during the time of COVID-19. We would like to audio-record this interview and additionally video record it if we are conducting it via ZOOM. We have a form of consent for you to read over first (provide time and respond to questions).

(1) The COVID-19 pandemic has created an unusual situation for many people. How are you feeling about the situation?
  a. What are the bright spots?
  b. What are the challenges, worries, or upsets?

* O.k., next we are going to be asking about how you're managing your work life, but before we do that, will you confirm:

Your industry (name it; interviewer enter into demographic form later) __________

Your job position (name it; interviewer enter into demographic form later). ___________

Are you employed, fully employed, under-employed or unemployed? _______________

If unemployed, is it due to COVID? ______

(1) What is the structure of a typical day for you right now (with both home and work)?
  a. What is different than what it was before the pandemic?
  b. What is the same?
(2) We are especially interested in the stories that people will take with them from this situation? Is there something that has been personally special or interesting in your life (perhaps something others wouldn't know about but find interesting) that you could imagine telling a story about in the future?
  a. prompts, who were the characters? And what happened then? How did it get resolved?

* the next questions are really focused on how you are dealing with this . . .

(1) How are you comforting yourself right now?
  a. Another way to think of this is, what are your coping strategies?
  b. How well are these working?
(2) To you, what does resilience in the face of COVID-19 mean?
(3) When you think about how other people are managing, in comparison, do you feel you are coping better, about the same, or worse than others?
  a. What are your considerations for saying this?
  b. [prompt: have them also compare themselves to LIKE others . . . e.g., other people who are in their same job or life position]
(4) Next, I'm going to ask you to consider a specific behavior and then ask yourself to rate yourself. Consider the following behavior: "The ability to withstand or recover quickly from difficult conditions." On a scale of 1–10, with 1 being not very much of this behavior, and 10 being the most of this behavior, where would you rate yourself?
  a. To what do you attribute your rating? Examples might be, your genetics/biology, certain activities, your faith, your spirituality, your community. To what do you attribute your rating?

* The next two questions are kind of fun, but have provided us with some really interesting answers!

(1) If COVID-19 had a color, what color would it be and why?
(2) If COVID-19 were an animal, what animal would it be and why?

* As communication scholars, we are really interested in the various ways people are interacting right now.

(1) Are you interacting with people more or less than you did before the pandemic? How so?
  a. What, if anything, are things that are the things that you like better about your interactions with other people right now?
  b. What are things that you miss (or can't get)? Said another way . . . what are the things you're looking forward to most?
  c. [prompt them if time to think about a variety of interactions with work, family, friends, neighbors, strangers . . .]
  d. Are there *surprising* ways that you are making community and creating connection – things that are working for you that you haven't really heard of others doing?
(2) Are you turning to social media more or less right now compared to before the pandemic?
  a. By what percentage would you say it is different (e.g., higher by 20%)?
  b. After you have been on social media, what is its effect on your mood and general wellbeing?
(3) Research says that much of our well-being comes from embodied interaction. But other research challenges this assumption. In what ways do you feel that your wellbeing has been affected specifically by the decrease in embodied interaction?
  a. Compared to others, do you think you crave embodied communication more, less, or about the same as other people?
  b. Would you consider yourself to be a "hugger"? Yes or NO?

** O.k., the final set of questions has to do with you looking into the future.

(1) What are the lessons that you think **society** will take from this situation?
  a. [prompt]: about humanity? About connection? About community?
(2) What lessons have **you** learned?
  a. [prompt]: about humanity? About connection? About community?
(3) If you had a crystal ball, what do you think the long-term impact of this pandemic will have on people?
(4) What regrets do you think people (or you) will have from this time?
(5) Is there anything you have not said so far that you think it's important to know about how you're making sense of this crisis, or issues of community and connection during this pandemic?

Appendix B

Member Reflection Interview Protocol

Script: Thank you for agreeing to talk with me again today. We greatly appreciate your investment in this research. The purpose of this interview is to check our initial findings and see if we are faithfully relaying and capturing the lived experiences of our participants during the initial weeks of the pandemic. For this particular interview we are focused on the messages you shared to help one another cope during the pandemic.

Do you have any questions for me? Great, let's get started:

(1) During the early weeks of this pandemic what messages do you remember hearing about mask wearing and social distancing? Do you remember saying messages to help others cope with these recommendations and mandates? Do you remember what others said to you about these recommendations and mandates?
(2) As a (self-identifying) man/woman, how did you feel about COVID safety precautions? Did you observe any examples of couples that did not agree about COVID-19 precautions? If so, how did these couples talk about their disagreement?
(3) During the early weeks of the pandemic, were you in a committed relationship with a significant other?
  a. If so, in what ways did you help or support your partner during COVID?
  b. Did you have any disagreements in relation to COVID safety precautions? If so, can you tell the story of the disagreement?

(4) Generally, in your early pandemic experience were men or women more concerned with COVID safety precautions? Or both equally? Why do you think this is?
(5) We've had some participants say that men were less concerned about COVID-19 safety precautions than women. What do you think about this observation?
   a. Did you ever hear other people make this observation? If so, can you tell us of the context in which you heard this observation?
(6) In your early pandemic experiences, did you ever hear any messaging about either men or women being overly concerned about COVID-19? (Prompt: for example, one gender group is hysterical, overreacting)
(7) Within media like COVID-19 campaigns, did you ever hear messages like "real men wear masks" or similar messaging about gender and health precautions?
(8) Did you hear or say anything else that was intended to help others cope during the early weeks of the pandemic?

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