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Erin E. Donovan
University of Texas at Austin

Mackenzie R. Greenwell
University of Texas at Austin

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Erin E. Donovan   Mackenzie R. Greenwell

University of Texas at Austin

Abstract

Nursing researchers have been investigating social support in the nursing profession with increasing interest, and the present manuscript reviews the state of the literature: methods, theories, and research findings related to social support in nursing. The aims of the existing research have focused primarily on understanding how the types, amount, and quality of social support received by nurses is associated with lower rates of professional stress, burnout, and intent to leave the profession. There is evidence that nurses in clinical settings value and are benefited by various forms of support from their supervisors. They also report lower distress when they have supportive personal relationships outside of work, although support from managers remains key. Support needs have been examined in different cultures and findings indicate that nursing in some parts of the world can be fraught because of cultural beliefs about the profession and about appropriate ways of enacting support. Less research has addressed the social support that nurses provide to patients and families. An agenda for advancing the literature is offered, with an emphasis on studying support from a communication perspective and learning more about what makes messages more or less supportive in nursing contexts.

Keywords: social support, nursing, supportive care, burnout, health communication

Introduction

The topic of social support has been of enduring interest to scholars of communication, health professions, social psychology, and their allied disciplines ever since evidence has demonstrated a connection between social interaction and humans' health, happiness, and longevity. Broadly speaking, social support is comprised of social ties and verbal and nonverbal communicative exchanges that help people to feel cared for, to manage uncertainty, and to experience a sense of personal control and connection to others (Albrecht & Goldsmith, 2003; Cohen, Underwood, & Gottlieb, 2000). Empirical investigations and theories of social support have proliferated since the 1970s. Scholarly and clinical attention to the nuances of social support has intensified as relevant data have grown in volume and sophistication, and as theorizing has revealed critical psychosocial and physiological outcomes of social support (or the lack thereof). Thus, the inclusion of social support in the inaugural issue of *Nursing Communication* is fitting, as the contents of these introductory pieces have been designed to review the scope of communication phenomena that are vital to nurses in their professional and personal lives. Support is both what nurses do, and what they need, as they complete their important, skilled, and life-changing work.

The objective of the present manuscript is to provide a review of the literature on social support with specific regard to the field of nursing. In the following sections, we summarize our procedures for identifying relevant literature, then describe the major foci of the research problems, the standard methodological and theoretical approaches, and the central conclusions that make up this body of work. We address the manners with which communication constructs have been situated in these investigations, and we conclude with an assessment of how nursing communication and social support research is poised to be advanced in theoretically driven, methodologically rich, and socially meaningful ways.

Scope of Literature Review

We used the following terms to conduct our search for articles related to social support in nursing: "social support and nurse," "social support and nursing," "social support and nurse and systematic review," "social support and nurse and communication," "social support and nurse and intervention," and "supportive care and nurse." These search terms were input into CINAHL (the Cumulative Index to Nursing and Allied Health Literature) to acquire articles from 1971 to June 2019. We included pieces presenting primary, original research as well as systematic and meta-analytic reviews. We also inspected the reference sections of relevant articles to confirm and broaden our search results. This process resulted in more than 3,100 articles. In order to narrow the results and capture pieces most germane to the present review, inclusion

criteria were set so that articles included in our corpus were published only in academic peer-reviewed journals and were directly related to social support and nurses, rather than peripheral themes such as social support for family caregivers of nursing home patients, for example.

This process yielded 55 articles published in journals including *Journal of Nursing Management, Journal of Advanced Nursing, Research in Nursing and Health, Western Journal of Nursing Research,* and *Journal of Clinical Nursing*. Widely used theoretical frameworks, conceptualizations, methodologies, and results were documented and are summarized in the next section. The scholars conducting the studies we reviewed were typically led by nursing research faculty at universities with strong nursing programs and comprised of interdisciplinary research team members from academic medical centers.

State of the Literature

Objectives and specific aims. Through our review, two fundamental objectives warranting the research on social support and nursing became apparent: (a) to improve nurses' job satisfaction and (b) to improve patient outcomes. These aims are intertwining; authors routinely acknowledged that mitigating the stress of nursing would be good for nurses and for patients alike, as the more that nurses were satisfied, the better and more consistent the care of their patients would be which, in turn, would be good for patients' health, recovery, and post-discharge success. The importance of studying social support was bolstered by researchers noting the evidence that social support is associated with nurses' psychological and physical health, as well as their occupational decision making. The objectives of the research studies we reviewed were highly practical and centered on the interrelated goals of minimizing occupational stress and burnout, increasing job satisfaction and engagement, and decreasing nurses' intent to leave the profession. In sum, the research on social support in nursing has followed an applied path with clear real-world implications. This focus is consistent with the mission of the National Institute of Nursing Research, a division of the U.S. National Institutes of Health, which is one of the major funding agencies that supports basic and clinical research on nursing practices.

The majority of research problems in this body of literature were designed to identify best practices for helping nurses to thrive as professionals in various clinical settings. Researchers regularly gathered input from key informant nurses who had the boots-on-the-ground experience of working in hospitals, assisted living facilities, hospices, and academic medical centers. Research teams sought to understand the support needs of nurses and describe the range of nurses' existing sources of social support. They also collected data so that they could test associations between levels of social support from different sources and nurses' quality of life, job satisfaction, and work-life balance. Some studies gauged nurses' perceptions of the effectiveness of enacted social support, including their preferences for the amount, type, and source, as well as their input on possible ways to attend to unmet needs (i.e., what would help, and who should provide it?). Most studies focused on North American or other western English speaking cultures; however, a sizable segment of the literature was intended to examine the role of culture in social support needs and provision. Some scholars wrote about the unique attributes of social support opinions and behaviors within particular cultures, for example, norms that might inhibit nurses from showing affection or providing nonverbal reassurances. Lim, Bogossian, and Ahren (2010) pointed out that "Confucian culture and traditional Chinese values" dictated nursing behaviors in China (p. 256). Singaporean nurses were found to practice self-restraint, agreeableness, and moderation in order to maintain harmony with other nurses and authority figures (Mak & Chan, 1995). Some researchers explained that the nature of nursing itself and attitudes about the profession were important features that gave context to the purpose and implications of the findings on support. For example, in Singapore, nursing is viewed as a career suited for individuals with unimpressive academic records and is equated to working as a hospital maid (Chan, Lai, Ko, & Boey, 2000; Koh, 2004). Whereas the aforementioned articles shed light on social support and nursing in an individual country or culture, other studies attempted cross-cultural comparisons between samples from different areas (e.g., Pal & Saksvik, 2008).

In addition to shedding light on nurses' support needs and practices, the available research has also addressed the matter of supportive care. As described by the Oncology Nursing Society, "Supportive care involves the provision of emotional support informally or through structured interventions. Support interventions include activities such as general counseling related to emotional and other issues, active listening, and presence." This cluster of studies was the minority, compared to the articles that focused on support for nurses themselves; however, it was a clear and ongoing matter of interest, even if fewer in number. In these studies, researchers attempted to understand the role of social support in patient care (Fitch, 1994, 2008). As suggested by the definition of supportive care, these studies tended to be social support interventions for patients that involved nurses in varying capacities. Some study designs had nurses provide patients with referrals to support groups or serve as facilitators of such groups (Alley & Foster, 1990; Jacobs & Goodman, 1989; Stewart & Tilden, 1995; Stewart, 1990). Alternatively, nurses might participate by providing information directly to patients who were assigned to treatment conditions that gave them access to nurse call lines (e.g., Bullock et al., 2009). Sometimes interventions were meant to give nurses strategies for enhancing the

patient's social support network beyond the nursing staff and other members of the hospital care team (Alley & Foster, 1990; Peterson, 2000; Stewart & Tilden, 1995). Results of these interventions generally indicated the benefits to patients of receiving supportive care, although some researchers contended that nurses should focus on encouraging patients to use and enrich their own personal social networks (e.g., Finfgeld-Connett, 2005) rather than rely on the nurses themselves. Indeed, multiple studies indicated that nonprofessional social support was preferred by patients (e.g., Finfgeld-Connett, 2005; Gurowka & Lightman, 1995).

Conceptual definitions of social support. Despite widespread use of the term "social support" in nursing literature, researchers often adopted differing conceptualizations in their studies of social support in nursing. While some characteristics and interpretations of social support overlap, overall definitions lacked broad application. Although evidence suggests that social support is associated with beneficial outcomes for nurses and patients, there is variation in what researchers mean by the term social support, in its relational and contextual parameters, and in explanatory mechanisms that scholars assume are driving the beneficial correlates of support.

Researchers (e.g., Jenkins & Elliot, 2004) have applied and tested both the main-effect model and buffering hypothesis of social support in nursing contexts (Cohen & Wills, 1985; House, 1981; Wheaton, 1985). The main-effect model conceptualizes social support as directly promoting overall health independent of stress, whereas the buffering hypothesis situates social support as a moderating variable, protecting individuals from the otherwise negative consequences of stressors on one's health (Cohen & Wills, 1985). Emerging from the buffering hypothesis, social support has also been conceptualized as a coping resource and coping strategy for nurses and as an inherent part of nursing practice (e.g., Boey, 1998; 1999; Hendel, Fish, & Aboudi, 2000). The conceptualization of social support as including multiple forms of aid (i.e., tangible, informational, emotional) also appears in the literature, for instance, in terms of nurses offering informational support to patients (Coco et al., 2012). Additionally, based on Cohen's (1988) conceptualization of social support as both structural and functional, definitions highlighting from *where* or from *whom* social support comes, such as "the at-work and non-work relationships that can enhance the well-being or coping abilities of the recipient", have been used to investigate the sources of social support nurses are receiving, along with the types of support being provided to them (e.g., AbuAlRub, 2010).

For studies related to social support provided by nurses to patients, Kahn's (1979) definition of social support has been useful in highlighting the role of

intent in social support behaviors: "intentional human interaction that involves one or more of the following elements: affect, which refers to appreciation, admiration, respect or love, as well as creating a sense of security; affirmation, which includes reinforcement, feedback, and influencing the individual's way of making decisions; and finally concrete aid, such as objects or money, and spending time in helping someone" (Tarkka & Paunonen, 1996, p. 1203). Conceptual and operational definitions of social support in nursing have also taken on context-specific descriptions (e.g., Adriaenssens, de Gucht, & Maes, 2015; Bullock et al., 2009; Othman & Nasurdin, 2013). In their study about nurse support provided to pregnant women, Bullock et al. (2009) adopted a pregnancy-oriented definition of social support: "provision of a non-judgmental listening ear discussing with women their pregnancy needs, giving information when asked to, and carrying out referrals when appropriate to other health and welfare professionals and voluntary and statutory agencies" (Oakley, 1994, p. 60). Another context-specific definition that has been used in social support and nursing research stems from Johnson and Hall's (1988) Job Demand Control Support model, which defines social support from an occupational perspective as the overall level of helpful social interaction on the job from both co-workers and supervisors (e.g., Adriaenssens, de Gucht, & Maes, 2015; Othman & Nasurdin, 2013).

Differentiating between constructs such as caring and social support has posed a challenge to scholars studying social support in nursing. Although similar, caring has been identified as one *aspect* of social support, whereas researchers note that not all social support is provided or experienced as caring (Finfgeld-Connett, 2005; Swanson, 1991). Research by communication scholars (e.g., Goldsmith & Fitch, 1997; Goldsmith, Linholm, & Bute, 2006) indicating that social support is often accompanied by multiple meanings and dilemmas may shed some light on this. For example, advice as informational social support may be interpreted as helpful, or as intrusive (Goldsmith & Fitch, 1997). Additionally, support provision may be perceived as controlling or critical, or may serve as an unwanted reminder of health issues and related stressors (Goldsmith et al., 2006). In the social support in nursing literature, caring has been conceptualized as encompassing expressions of love, reassurance, empathy, and compassion, which dovetails with the emotional support dimension of supportive behavior typologies (e.g., Cutrona & Suhr, 1994). However, a key characteristic distinguishing social support from caring is mutual reciprocity (Coffman & Ray, 2002; Finfgeld-Connett, 2005), which may be less relevant in nurse-patient relationships than other types of ties. Similarly, Norbeck (1981) attempted to make the distinction between job-related professional helping and social support in nursing by highlighting the reciprocal nature of social support and the unidirectional assistance associated with professional helping. Shumaker and

Brownell (1984) incorporated this bidirectional distinction in their definition of social support as a resource exchange between two individuals perceived by one or both to be intended to enhance the wellbeing of the recipient.

Another line of social support in nursing involves the *supportive care* framework introduced by Fitch (1994). Supportive care was introduced as a tool to assist healthcare professionals in assessing, planning, and delivering help to patients with cancer. Specifically, supportive care is defined as "the provision of the necessary services for those living with or affected by cancer, to meet their physical, emotional, social, psychological, informational, spiritual, and practical needs during the diagnostic, treatment, and follow-up phases, encompassing issues of survivorship, palliative care, and bereavement" (Fitch, 2008, p. 11). The supportive care concept describes patient and family care beyond medical, surgical, and treatment plans and aims to improve and maintain quality of life and autonomy while enhancing patient wellbeing. Although this concept is defined in an illness-specific way, Fitch (2008) went on to position the supportive care framework for broader application to health concerns beyond cancer. In nursing research, the supportive care framework has been explored in relation to individuals living with various cancers (e.g., breast, esophageal) across different life stages (e.g., pediatric, parents, caregivers), as well as in terms of issues related to pregnancy (e.g., labor, miscarriage).

Some researchers have attempted to distinguish supportive care from social support by characterizing supportive care as an overarching description of all the help patients may require beyond medical, surgical, and treatment-related procedures (Fitch, 2008). Although it is clear that the supportive care framework includes social support such as emotional support and information provision, some definitions continue to be imprecise, ambiguous, and inconclusive about the specific attributes differentiating these similar concepts. For instance, Viklund, Wengstrom, and Lagergren (2006) define supportive care as "comprising not only physical and symptom support, but also instrumental and social care, provision of information, psychological support, and attention to spiritual needs," while defining support as "imply[ing] support in its general sense" (p. 355). Similar to efforts put forth by scholars examining the impact of social support on stress and burnout in nursing, scholars interested in supportive care address the challenges (i.e., demanding care, detachment, emotion labor) nurses may experience while engaging in caring relationships and establishing supportive care environments for their patients (Bakke & King, 2000; Evans, 2012).

Specific theoretical models. Recognizable throughout the literature on social support in nursing are three theoretical commitments that guide research well beyond the scope of nursing communication. Many nursing researchers interested in the influence of social support on nurses' health and occupational outcomes have adopted Cohen's (1988) framework of social support (e.g., Bullock et al., 2009; Othman & Nasurdin, 2013). This framework distinguishes between structural (i.e., social relationships) and functional (i.e., material aid) social support, and proposes generic, stress-centered, and psychosocial process models for the direct and moderating roles of social support on physical health. Other studies have been framed by Lazarus and Folkman's (1984) transactional theory of stress and coping, which scholars have used to explore the types and sources of social support desired by and provided to nurses (e.g., Boey, 1998; Jenkins & Elliott, 2004). Lazarus and Folkman's approach assumes that nurses are coping with stressors (e.g., of their workload) and that use of social support is a form of problem-focused and emotion-focused coping. The theory emphasizes how support (among other coping strategies) factors into people's cognitive appraisal processes, more specifically their primary appraisals (i.e., assessments of how threatening and severe a stressor is) and secondary appraisals (i.e., assessments of the resources available to manage a stressor). A third perspective, social support as a communication phenomenon (Albrecht & Adelman, 1987; Albrecht & Goldsmith, 2003), has not been adopted frequently by nursing scholars, although it does make appearances in the literature (e.g., Peterson et al., 1995). It defines social support as communication between recipients and providers that manages uncertainty about the situation, the self, the other, or the relationship and functions to enhance a perception of personal control in one's life experience. This perspective assumes that social support is a communicative process, rather than simply the structure of one's social network, and that supportive communication helps people to more effectively engage cognitively, emotionally, and behaviorally with stressors. Furthermore, supportive communication is a means of expressing care, concern, and beliefs about worth to one's relational partners.

Operational definitions of social support. The conceptual definitions and theoretical commitments used by researchers become manifest in the instrumentation that they use to gather data on social support. Much of the research on social support in nursing includes cross-sectional data collected from nurses through questionnaires and through interviews. Questions tend to be concerned with identifying sources of support for nursing staff (e.g., supervisors, spouses, co-workers) along with types of support (e.g., informational, emotional) and amount of support provided to nurses. Researchers have employed a span of methodologies to investigate social support in nursing. Sample sizes vary widely, with quantitative studies recruiting anywhere from a few dozen to a few thousand participants, although the average sample size for a questionnaire study is around

200. Studies using interpretive methods tend to have samples between 15 and 50 individuals.

Various self-report measurement tools have been used to capture adequacy of social support for both nurses and patients, social support as a coping mechanism and effects of social support on profession-related outcomes. Many survey and questionnaire instruments have been developed specifically for the context and variables of interest in particular studies, resulting in limited psychometric testing or widespread, general use (e.g., Boey, 1998; 1999; Coco et al., 2012; de Boer, van Rikxoort, Bakker, & Smit, 2013). On the other hand, several studies employed social support inventories that were developed for diverse samples and contexts. Social support measures developed, validated, and used by nursing researchers include the Norbeck Social Support Questionnaire (NSSQ), which is based on attachment theory and captures affect, affirmation, aid, network size, duration of relationships, frequency of contact, and recent relationship losses (Norbeck, 1983). Additionally, the 25-item Personal Resource Questionnaire (PRQ) was developed by Brandt and Weinert (1981, 1987) to measure intimacy, social integration, nurturance, worth, informational support, emotional support, and material assistance. The PRQ also includes a set of measures examining details and descriptive information about individuals' social networks. Lastly, the 39-item Tilden Interpersonal Relationship Inventory (Tilden, Nelson, & May, 1990) takes a social-exchange approach to social support, reciprocity, and conflict by measuring costs and benefits of support.

The Arizona Social Support Interview Schedule (ASSIS; Barrera, 1981) includes 24 items intended to assess desire for more or less social support and frequency of receipt of social support from various others in personal and professional roles in the following social support categories: private feelings, material aid, advice and guidance, positive feedback, physical assistance, and social participation. To assess nurses' experiences of social support from various relational partners, researchers have relied on Sargent and Terry's (2000) 30-item measure of co-worker and family/friend social support, as well as House and Wells' (1978) instrument evaluating social support from supervisors, co-workers, partners, friends, and relatives. Social support has also been measured as a coping strategy (Hendel, Fish, & Aboudi, 2000). Monat and Lazarus' (1977) 15-item questionnaire has been used to capture frequency and effectiveness of coping strategies, including seeking social support. The 35-item Coping Strategy Scale, based on the transactional model of stress and coping from Folkman and Lazarus (1984), has also been used to assess support seeking and receipt among Singaporean nurses (Boey, 1998, 1999).

Interview-based data collection has involved questions emphasizing (a) support received, (b) need for support, (c) by whom support was provided, and (d) unmet needs for support, in other words, what support nurses found to be missing (de Boer et al., 2013). Additionally, to explore the capacity of nurses to support patients and colleagues, nurse responses to hypothetical clinical vignettes have been collected and content analyzed (e.g., Peterson, Halsey, Albrecht, & McGough, 1995; Turner et al., 2009). Few studies have employed experimental designs to explore effects of social support in nursing, with a few exceptions. For example, in one controlled trial, patients were randomly assigned to groups that received either nurse-delivered telephone support or educational booklets or both to investigate which method(s) of support were most effective on smoking cessation in low-income rural pregnant women (Bullock et al., 2009). Nursing interventions emphasizing social support, whether geared toward nurse provision of support to patients or enhancing supportive care, have been evaluated with pre- and post-intervention measures. For example, to assess an educational intervention to help nurses provide supportive care to parents with cancer, measures of stress, burnout, confidence and attitudes toward providing supportive care, and responses to clinical scenarios were administered pre- and post-educational training (Turner et al., 2009). It is worth noting here the uneven emphasis of research agendas and findings: questionnaire and interview studies of social support tend to focus on nurses' professional needs, whereas experimental studies tend to evaluate supportive care interventions for patients delivered by nurses.

Main Findings

The majority of findings from the literature we reviewed reflect research conclusions about the wellbeing of nurses and patients. Like other streams of research on social support, results provide evidence that more and better social support is associated with positive physical and mental health outcomes and acts as a buffer for negative effects of stressors in the general population. Results related to the adequacy of received support as well as findings specific to supportive care and nursing interventions related to social support are summarized next.

Largely, social support in nursing literature is interested in the relationship among of various types, amounts, and sources of social support on nurses' individual and occupational outcomes, including stress, burnout, and confidence in providing support to patients. There is consistent evidence that support from managers and coworkers helps to bolster registered nurses' self-efficacy, resilience, and quality of working life; and minimize turnover (e.g., Ghouligaleh, Farahani, Karahroudy, Pourhoseingholi, & Mojen, 2018; Wang, Zhang, Tao, Bowers, & Brown, 2018; Yang & Kim, 2016). For example, social support from nursing supervisors

was found to be the best predictor of nurses' intent to stay working in the nursing field (AbuAlRub, 2010). Nurses who reported feeling supported by nurse managers were also more likely to share innovative ideas concerning unit management and patient care (Albrecht & Halsey, 1991). Both staff and home health nurses reported receiving physical assistance (tangible support) and social participation (network support) more frequently than advice and positive feedback from nursing administrators (Ihlenfeld, 1996). Clearly, the actual and ideal roles of supervisors is a priority of researchers, and with good reason, considering the practical outcomes of this topic.

In terms of sufficient social support from nurse managers, findings suggested that staff nurses and home health nurses desired more social support from their supervising nurses or nurse managers, although nursing faculty did not. Specifically, staff and home health nurses wanted more social support in the forms of positive feedback, material aid, physical assistance, social participation, exchange of private feelings, and advice (Ihlenfeld, 1996). Similarly, findings from a study of intensive care nurses indicated that they felt as though they had received insufficient support after a critical incident within the unit (de Boer et al., 2013). Another study situated in a national crisis discovered that nurse managers focused on providing informational and emotional social support to help buffer their staff nurses' stress (Hendel, Fish, & Aboudi, 2000). In a study comparing working adults' experiences of coworker social support and its relationship with burnout, there was no difference in burnout among nurses when compared to other occupations. Overall negative correlations between coworker support and emotional exhaustion and depersonalization (i.e., negative attitudes toward patients) were reported for all occupations, and a positive correlation was found between coworker support and feelings of personal accomplishment (Kay-Eccles, 2012).

One way the nursing literature has accommodated the contextual features and variability of social support is by exploring social support in nursing in various cultures. Samples from across Asia, Europe, and the Americas are represented. For example, a cross-cultural exploration of Norwegian and Indian nurses indicates that predictors of job stress differ across culture (Pal & Saksvik, 2008). For nurses in Norway, work-family conflict, high job demands, and low work flexibility predicted job stress, whereas for nurses in India, high family-work conflict and low social support from coworkers were predictors of job stress. Nursing researchers have also situated their studies within the cultural norms and perceptions of nursing in Eastern cultures (Chan et al., 2000; Koh, 2004; Lim et al., 2010). In terms of nurses engaging in social support seeking and social support use as a coping mechanism, one study of Singaporean nurses

found that approximately 75 percent sought help from a colleague or senior staff member when they needed someone to talk to in relation to experiences of work-related stress (Lateef, Ng, & Anantharaman, 2001). In multiple studies of Singaporean nurses, nurses reported primarily engaging in problem-focused coping strategies including information seeking and instrumental help seeking (Boey, 1998, 1999; Chan et al., 2000; Lateef et al., 2001). Nurses with high job satisfaction under high work stress (stress-resistant nurses) were found to engage in approach coping tactics, such as seeking support, more so than nurses with low job satisfaction under high work stress (distressed nurses; Boey, 1998). Stress-resistant nurses also perceived greater support from family members than did distressed nurses (Boey, 1998). In another study, the highest level of social support received was reported to be from nurses' spouses (AbuAlRub, 2010). Nurses with above average support from family members were found to have fewer symptoms of poor health than nurses with average or below average family support (Chan et al., 2000).

Studies investigating nurses' provision of social support to patients suggest that nurses provided tangible aid most often and affective support least often to recent mothers on maternity wards (Tarkka & Paunonen, 1996). Nurses were also found to provide informational support to traumatic brain injury patients' families, outlining treatment and nurses' responsibilities but not necessarily addressing prevention of secondary injuries (Coco et al., 2012). In a randomized control trial of nurses providing individualized support to rural pregnant women, there was a four percent increase in smoking cessation rates for the intervention groups who either received educational materials and/or individualized telephone support from nurses as compared to the control group (Bullock et al., 2009).

From social support provision to nurses enacting supportive care for patients, Gagnon and Waghorn (1996) found that nurses on labor and delivery units spent 6.1 percent of their time providing supportive care (i.e., physical comfort, emotional support, instruction, advocacy) to patients. Nurses with less labor and delivery experience spent 2.7 percent more time providing supportive care to patients than did nurses with seven or more years of experience on a labor and delivery unit. Nurses also perceived providing information about the process and physical aspects of breast cancer critical to engaging in supportive care for women with breast cancer. Nurses perceived emotional support provision as essential to supporting women with breast cancer, but nurses indicated that they themselves lack the time and skills to offer emotional support to patients (Wilkes, White, Beale, Cole, & Tracy, 1999).

In efforts to assist nurses in providing supportive care to patients, Turner et al. (2009) conducted a study examining an educational intervention to enhance the capacity of nurses to provide supportive care to patients with cancer. The researchers found that after completing

a self-directed educational manual and participating in brief communication skills training, there were no changes in nurses' stress and burnout levels; however, there were significant increases in nurses' confidence about providing support, giving information, and discussing emotional issues with patients. Kruijver et al. (1999) explored nurses' communicative behaviors toward patients with cancer in a review of literature and found that nurses do value empathy, touch, comforting, and supporting in caring for patients with cancer; however, challenges present in cancer care such as the life-threatening nature of the disease and adverse effects of medical treatment can result in barriers to providing affective communication to patients.

In another study incorporating a communicative element, specifically a message design logics framework (O'Keefe, 1988), Peterson et al. (1995) found that when nurse managers communicate in a so-called "rhetorical" way, meaning a more sophisticated and nimble style, staff nurses reported high levels of perceived support and the lowest levels of stress and burnout as compared to staff nurses whose nurse managers were less sophisticated in their message design logics (Peterson et al., 1995). However, nurse manager-staff nurse dyads in which both nurses were rhetorical communicators expressed the highest levels of stress and burnout (Peterson et al., 1995). Although there is clearly some interest among nursing researchers in utilizing theoretical perspectives from communication research, these limited findings indicate a need to incorporate additional communication theory into social support and nursing research to fill gaps and broaden our understanding of how support is communicated to and between nurses and patients and the effects on individual, relational, and health outcomes.

Commentary on the Literature

The scientific literature on social support in nursing seeks to solve the practical problem of "How can we minimize burnout and maximize patient outcomes in clinical nursing?" more so than to make heavily theoretical contributions to literature on social support. Suggestions for improving nurses' professional lives are offered, although a clear action plan is not necessarily apparent from the research. For example, some experts argue that interventions ought to focus on improving the quantity and quality of social support that is provided to nurses (e.g., de Boer, van Rikxoot, Bakker, & Smit, 2013; Lim et al., 2010). This could include creating space (perhaps physical, perhaps more in terms of shifting the organizational culture) where nurses can turn to each other for help, or training nurse managers how to offer effective social support to nursing staff. On the other hand, some authors recommend anti-burnout interventions

that increase nurse engagement and satisfaction in other ways (e.g., structural changes to staffing/schedules; e.g., Kay-Eccles, 2012) that effectively minimize the need for more or better support. Either way, these lines of reasoning assume that social support is a coping resource, which is consistent with the broader literature on social support.

We acknowledge that we were somewhat surprised to learn that the focus of the literature was so heavy on nurse-nurse social support. We expected more attention to nurses providing support to patients and families, given the fact that nursing is a vocation characterized by expectations for information provision, caring, and emotion labor. This characterization was acknowledged, but mainly presented as the backdrop and warrant for learning more about how to provide support to nurses to help them cope with the duties of caring. To a certain extent, this may be an artifact of authorship; nursing researchers would have a specialized awareness of the pressures that nurses face and a natural inclination toward mitigating them. This points to the value of interdisciplinary research, so that we can enrich the literature by bringing our different perspectives to bear on these research problems.

Connecting Communication Scholarship to Nursing Research on Social Support

With that in mind, it is important to consider how further interdisciplinary work can be conducted that will improve not only the professional lives of nurses and the health outcomes of patients, but also advance theorizing about social support in nursing and beyond. As interpersonal health communication scholars, we have a particular lens that directs our attention toward the symbolic and interactive nature of social support and the relational and message features that contribute to how helpful, sensitive, and supportive it ultimately is (Goldsmith, McDermott, & Alexander, 2000). For example, communication scholars have been documenting for years the importance of understanding how and when people seek and provide support and acknowledging that interactants assign multiple meanings to the same messages (Goldsmith, 2004; Goldsmith et al., 2006). Communication theories that focus on the multiple goals, purposes, and interpretations of messages will be valuable for explaining why some attempts at support in nursing contexts are more effective than others. Examining message features should become an increasing priority, so that studies can advance beyond inquiring about how much support was provided, what types, and by whom; and dive more deeply into *what* was said and *how* it was said. Exploring the dynamic nature of social support across contexts of culture and professional specialties should help us to learn more about what benefits nurses and patients and how those lessons might generalize to other health care settings. It is fitting that research unveiling the numerous dilemmas

of communicating support has been worthwhile in communication studies, because the concept of dilemmas seems highly pertinent to communication in nursing. A question that emerged throughout our review of the literature was this: Where is the line between social support and professional/routine responsibilities of nursing work?

In other words, at what point is social support a part of a nurse's job description, and how might nurses best evaluate the tradeoffs of their tasks and manage those demands? The studies indicating that informational support is central to nursing work (e.g., Coco et al., 2012) and emotional burnout is common, raise the issue of whether and how nurses ought to be providing emotional support. For researchers, part of what this means is that it will be useful to investigate the juxtaposition of support and "other" nursing profession behaviors, as well as the multiple meanings of carrying out nursing duties. For instance, does removing an IV line in a kind and competent manner constitute tangible support? Future research could draw from literatures on emotion labor (Way & Tracy, 2012) and communication work (Donovan-Kicken et al., 2012) to acknowledge that communicating support competently and compassionately is not easy, but it is learnable, performable, and worthwhile. Nurses are seen as having a "special responsibility" (Tarkka & Paunonen, 1996) to provide knowledgeable and compassionate patient care, which influences the way that social support is conceptualized and studied in the field of nursing. Consequently, it will be important for the next generation of research on social support in nursing to be extremely clear about what is being measured in investigations of support, and how it fits with other streams of research.

Reviewing the nursing literature on social support has helped us to organize the research problems and findings that have received attention thus far, and also has suggested opportunities for broadening our own understanding of support as health communication researchers. The findings from current and future studies of social support on nursing have the potential to lead to interventions that could improve the communication of nurses and managers, decrease burnout and intent to leave the profession, and benefit patient health outcomes. As evidence builds for best practices, it will be important to critically reflect on calls for social support training (e.g., Peterson et al., 1995) and identify what might make a meaningful impact. Additional data are needed, as are a wider set of outcome variables; for example, despite the communication perspective that social support is designed to enhance a sense of mastery and control, those constructs are rarely explored as outcomes for nurses or patients. Many opportunities for research and theory development remain. Given the great potential for evidence-based, theoretically-driven solutions to real challenges faced in nursing practice, it is essential to make sure that our evidence is good and our theorizing about social support as communication is sound.

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