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Original Research

Relationship between the anxiety levels and coping attitudes of nurses working in a training hospital

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Abstract

Several studies have shown that stress due to workplace is common among nurses. In this study, we aimed to assess coping attitudes of nurses working in a university hospital according to their anxiety levels and to reveal the relationship between them. Eighty nurses working at Gulhane Military Faculty of Medicine Training Hospital and who has no psychiatric complaints were enrolled. All participants completed sociodemographic data form and self-reported Beck Anxiety Inventory (BAI) and Coping Attitudes Scale (COPE). Then the study group was divided into two groups according to their BAI scores. The relationship between anxiety levels and COPE subscale scores of the two groups was assessed. In the statistical analyses, for the comparisons of continuous variables between the two groups the Mann-Whitney U test was used. Significance level was set at $p < 0.05$. It was found that in the group of high level anxiety, active coping subscale scores of problem-focused coping were lower than the group with lower levels of anxiety. Denial and focus on and venting of emotions subscale scores of dysfunctional coping subscale were also found to be higher in the group of high level anxiety. According to the findings of this study, dysfunctional coping attitudes may be associated with anxiety symptoms. We concluded that determination of work-related stresses of nurses and coping with these stress situations by regulating the work conditions with specific intervals might be beneficial in terms of productivity. Further researches with larger sample size would provide more meaningful information on this subject.

INTRODUCTION

Stress was defined by Selye as, "the situation that the body's response to any undertaken request and internal balance (homeostasis) of the living being is forced by internal or external environment" [1]. People try to cope with their social, biological, and psychological resources against stressful situation or events [2, 3].

If the organism achieves adaptation, responses have become lost. However, if the stress continues for a long time and adaptation cannot be achieved, "burnout" starts [4]. Anxiety which has been brought by this stress at people living and working under intense stress directly affects the quality of life [5].

It was shown that occupational stress is common in nursing [6] and the workplace may put at risk the mental health of nurses [5, 7, 8]. Nursing is one of the professions that constantly expose to various

stressors [9]. Common psychological responses include fatigue, discomfort, distress, depression and perhaps most importantly anxiety. The features of workplace may also affect the type of psychological response and this disturbances may require therapeutic intervention [10, 11].

Stressful working environment and dissatisfaction from working hours are important factors [12, 13]. Developing new defence mechanisms is common among nurses for coping with chronic stress. Sometimes, when these defence mechanisms became insufficient, anxiety/depression or burnout syndrome may develop [14]. The social context within the work environment may impact emotional exhaustion [15].

Coping mechanisms has an important role in ensuring compliance with challenging situations. "Coping" is defined as, individuals' showing resistance to event or factors which creates stress and the whole cognitive, emotional and behavioral responses shown to withstand these conditions. Therefore, there is a close relationship between coping attitudes and the degree of stressor experienced [16].

Coping attitudes can change with a wide range of factors such as age, gender, culture, intelligence, life events, personality structure and illness and is specific to the individual [17]. In studies which have evaluated the relationship between coping attitudes and anxiety, individuals with anxiety symptoms or disorders have been found not to be using effective coping mechanisms adequately [18, 19]. Moreover, useful coping strategies may lead to lower depression and anxiety levels [20]. Some coping strategies may be more effective in terms of preventing emotional exhaustion [15].

It has been stated that there is relationship between dysfunctional coping attitudes and anxiety symptoms [21]. While coping attitudes which are being used to solve the problem are reducing the psychopathology; emotional-focused coping attitudes may enhance. However, whether coping attitudes are to adapt to the stressor can vary depending on the specific features of the stressor [22]. While emotion-oriented behaviors may provide benefit in response to some stressors, they are usually associated with severe psychopathology and the deterioration of functioning [22, 23]. Both studies at clinical [24, 25] as well as non-clinical [26] samples have specified that there is a relationship between emotional focused coping attitudes and the levels of anxiety and depression. The use of emotional-focused coping attitudes also poses a risk for the development of mood disorders [27]. It was found that panic disorder patients are using emotion focused coping attitudes more frequently than the healthy control group [28].

Although there are some differences based on provinces and the populations studied, many studies have supported a high prevalence of anxiety among nurses [29-32]. Considering the previous studies and data from international labor organization; anxiety levels of nurses are affected from several factors such as shift hours, family responsibilities, conflicts with supervisors and patients, excessive workload, emotional stress due to the problems of their patients and working with dying patients or patients with a need of intensive care [33-36].

In this study, we aimed to assess coping attitudes of nurses working in a university hospital according to their level of anxiety and to explore the relationship between them.

METHODS

Research design and Sample

This study was conducted in Gulhane Military Faculty of Medicine and Training Hospital, Ankara, Turkey. In this questionnaire study, first the sociodemographic data collection form and the Beck Anxiety Inventory (BAI) were applied to participants, after than the study group was divided into two subgroups according to their anxiety scores. Both subgroups were compared in terms of COPE Inventory scores.

The questionnaires were applied to 96 nurses by face to face interview by the first author. Seven cases were excluded due to missing data and 9 cases were excluded because of receiving psychiatric treatment for any illness. As a result, 80 nurses working in various clinics of Gulhane Military Faculty of Medicine and Training Hospital who has no psychiatric complaints were enrolled. Data collection form, the Beck Anxiety Inventory (BAI) and the COPE Inventory was asked to complete to all participants. Participants with a chronic illness, current psychiatric treatment or follow-up were excluded from study. The sample were divided into two subgroups as those BAI score is under 17 and those equal or over 17.

Measurements

An interview was made by the first author with nurses who agreed to participate in the study at their workplace. They were informed about the study and it was stated that the identity of participants will not be shared with any person or organization other than the aim of study and approvals were taken. Questionnaires were filled in an appropriate place

and enough time were given for filling each scale.

Sociodemographic data form: It was created by the researchers to determine the demographic data. Data collection form was consisted of multiple choice questions to determine the participants' age (yr), educational status (yr), marital status, years of employment, department, number of children, cigarettes (yes/no or number of cigarettes a day) and alcohol (yes/no or number of drinks per day) use and perceived level of stress at the business environment.

Beck Anxiety Inventory (BAI): It is a Likert-type self-assessment scale consisting of 21 items, scored 0-3 that is being used to find the severity of anxiety symptoms of the individual. It questions anxiety symptoms occurring over the last month and higher scores indicate that more anxiety symptom have been experienced last month. It was developed by Beck and colleagues and validity and reliability study of Turkish form was made by Ulusoy and colleagues (1998).

COPE Inventory: The scale developed by Carver and colleagues in 1989 is a self-report scale consisting of a total of 60 questions (1989). It includes 15 sub-scales that each sub-scale consists of four questions (Table I). The reliability and validity study of the scale was made by Agargun et al (2005). Sixty different states are being answered over four options. The scale consisted of 60 questions and 15 subscales. Each subscale consists of four questions. Each of these sub-scales provides information about separate coping attitudes. As a result, height of sub-scale scores taken gives the possibility to comment which coping attitude is used mostly by people. COPE inventory was used for the investigation of coping strategies of nurses' against job stress [37]. The scale begins with a description paragraph as follows: “with the help of this scale, we aim to investigate how people respond at their daily lives when they encounter problems or events which are difficult or giving anxiety. A large number of ways may be present that people deal with problems. But, however, try to fill options by thinking about what you are doing or how you behave in general when you experience a problem. Make sure you fill in the options thinking independently from the previous one. "

Statistical analysis

In descriptive statistics, frequency distributions, mean and standard deviations for continuous analysis were calculated. Results are presented as arithmetic mean ± standard deviation. Kolmogorov-Smirnow test was applied in order to determine that data was complying with normal distribution. For comparisons between two subgroups of continuous variables, the Mann-Whitney U test was used because parametric test assumptions were not met and Spearman's correlation test was made to investigate the relationship between two variables. The level of error was chosen as $\alpha = 0.05$ and "statistically significant difference" comments were made for p values equal to or smaller than this.

RESULTS

Mean age of subjects (başka patient varsa subject olacak) was 29.45 ± 4.43 yr and 46.2% of them was married, 33.7% have children (21.3% having at least two children), 91.2% was university graduates, 41.3% was working as a nurse for 1-5 years and 17.5% was working for 6-9 years. It was found that 21.2% of the nurses was working at emergency department, 37.8% at surgical clinics and the remaining nurses were working at internal clinics; 25% was smoking, 36.3% were found to be satisfied with the level of income. At the question asked at data collection questionnaire, “Do you find your work environment stressful?” 61.3% of the nurses' gave the response "very stressful", while 3.8% gave the answer "mild stress". None of the participants answered this question as "I don’t find it stressful". The sample were divided into two subgroups as those BAI score is under 17 (lower anxiety subgroup) and those equal or over 17 (higher anxiety subgroup). Descriptive characteristics of the two subgroups are summarized in Table II. Coping attitudes of two subgroups were presented in Table III. There was found that in the subgroup of high level anxiety, active coping subscale scores of problem-focused coping were lower than the subgroup with normal levels of anxiety and denial and focus on and venting of emotions subscale scores of dysfunctional coping subscale were found to be higher. In addition, negative correlation was (rho = -0.48) detected between BAI score and suppression of the other -occupations subscales of the problem- focused coping subscale score in the subgroup with high levels of anxiety.

Table-I. COPE Inventory Main Design

QUESTİONS (1-60)	ANSWERS			
	1 = I never do such a thing	**2 = I do it that way rarely**	**3 = I do it that way moderately**	**4 = I usually do it that way**
SUBSCALES	1.Positive reinterpretation	2.Mental disengagement	3.Focus on and venting of emotions	4.Using beneficial social support
	5.Active coping	6.Denial	7.Religion	8.Humor
	9.Behavioral disengagement	10.Restraining	11.Use of emotional social support	12.Substance abuse
	13.Acceptance	14.Suppression of other occupations		15.Planning.

Table-II. Evaluation of socio-demographic data according to anxiety levels

Sociodemographic Feature	**Anxiety level**		X^2	**P**
	<17 (n=41)	**≥17 (n=39)**		
Education (n, %)				
Licence	35	38	3.647	.056
Prelicence (2 years)	6	1		
Child				
Yes	14	13	.006	.939
No	27	26		
Smoking				
Yes	8	12	1.351	.245
No	33	27		
Working years				
<5 yr	27	20	1.751	.186
≥5 yr	14	19		
Marital status				
Married	17	20	1.575	.455
Single	23	19		

Table III. Comparison of coping attitudes of subgroups according to their anxiety levels.

Coping methods	BAI<17 (n=41)	BAI≥17 (n=39)	Z	p
Active coping	**12.1±1.9**	**11.2±1.7**	**.126**	**.041**[1]
Planning	11.9±2.3	12.3±2.1	.475	.451
Restraint coping	9.2±2.2	9.4±2.2	.530	.773
Using beneficial social support	12.3±2.5	12.6±1.8	1.486	.275
Suppression of other-occupations	10.0±2.2	9.9±2.0	1.121	.877
Total problem focused coping	55.4±8.5	55.6±7.1	1.357	.943
Positive reinterpretation	12.2±1.8	12.5±2.1	.444	.185
Religious coping	11.0±5.6	9.9±2.8	.785	.271
Humor	7.2±2.2	8.1±3.1	1.445	.137
Acceptance	9.7±2.1	10.3±2.1	.544	.236
The use of emotional social support	11.2±2.0	11.7±2.4	2.700	.307
Total emotion focused coping	51.5±8.1	53.0±6.9	1.187	.381
Focus on and venting of emotions	**11.2±1.8**	**12.3±1.9**	**2.555**	**.014**[1]
Denial	**5.8±1.8**	**7.0±3.0**	**1.152**	**.037**[1]
Behavioral disengagement	6.9±2.6	7.2±2.6	.337	.669
Mental disengagement	9.3±2.3	10.2±2.2	1.374	.098
Substance abuse	5.6±2.6	6.9±6.6	2.178	.252
Total dysfunctional coping	40.2±7.6	42.5±9.2	2.271	.235

DISCUSSION

In this study, coping attitudes and anxiety levels of nurses working in a university hospital were measured and their relationship was investigated. In summary, the findings of the study shows that nurses with higher levels of anxiety use active coping method of problem-focused coping methods less than those with normal levels of anxiety and they use denial and focus on and venting of emotions methods of dysfunctional methods more often. In addition, negative correlation between BAI score and suppressing other-occupations subscales of problem-focused coping was found at the subgroup with high levels of anxiety.

Using less active coping methods of problem-focused coping methods of individuals with high levels of anxiety than the control subgroup shows that these individuals do not hassle enough in order to eliminate the problem or reduce the effects of the problem and they did not think enough about dealing with the problem [38]. In nurses with high levels of anxiety, using denial, focus on and venting of emotions methods more usually suggests that these individuals are acting as if there was not a problem or while they are focusing to the problem they are giving emotional responses rather than focusing on the solution [38]. Similar to the results of previous studies, a correlation between anxiety levels and non-functional coping strategies was found in this study. Results of our study was consistent with Carver and his colleagues study results [38] at 162 people with high levels of anxiety and Kelly and colleagues [39] study of 107 persons with no Axis I diagnosis. Coolidge and colleagues found that elderly individuals with a high level of anxiety are using dysfunctional coping attitudes more than those with normal anxiety levels and found that there was a relationship between levels of anxiety and dysfunctional coping methods [21]. In another study

conducted with Generalized Anxiety Disorder cases, it has been identified that they were using dysfunctional coping attitudes more than healthy controls [40].

In some studies - identifying job stress, violence and approaches to cope with them- it was determined that nurses were experiencing job stress more [41]. Nurses working in intensive care units were at greater risk of depression and job stress [42] and nurses who have insatisfaction about their jobs have higher levels of stress [43] and therefore, social support had a positive effect on coping with job stress [41, 42, 44] and nurses were using this approach more [45-47].

When the relationship between coping strategies for stress and marital status and status of having a children of nurses was evaluated, it was found that both married and unmarried nurses used more problem-focused coping, dysfunctional coping attitudes was being used more by married nurses a significant difference have been identified especially in terms of denying. Also, nurses who have children were found to have significantly ($p< 0.05$) higher scores in terms of denial and behavioral disregard subscales of dysfunctional coping attitudes than those without children. In study of Tasci and his colleagues (2007) no significant difference was detected between marital status and having children and coping attitudes and this was interpreted to be because having more responsibilities of married nurses with children about their families than others and they could have developed different ways of solutions for stress because of having more possibilities for meeting a stressor. In the study of Isikhan and his colleagues (2003), it was reported that marital status is affecting the job stress. Also, in another study, being married and having children was affecting the stress in the business environment [48]. It is known fact that the status of being married and having children increases social responsibility of the person and the employees who are married or having children are more advanced in terms of age and years of working in the profession. This was also implicated in another study which found that stress resistant nurses perceived greater family support than did the distressed nurses [49]. This social responsibility and fatigue that old age brings can be a symptom of social burnout and the reason of using dysfunctional coping attitudes more.

Limitations

The limitations of our study includes; consisting of a small study sample, lack of control group, using of test batteries with relatively lower reliability which were self-reported.

CONCLUSION

The findings of the present study suggest that nurses with higher levels of anxiety use less active problem-focused coping methods than those with normal levels of anxiety. They also use more denial and focus on and venting of emotions methods of dysfunctional methods. Our study shows that dysfunctional coping attitudes may be associated with anxiety symptoms. Using more functional coping attitudes might be helpful for decreasing anxiety level and improving satisfaction and productivity of nurses. Our findings suggest that determination of work-related stress and coping with these stress situations of nurses' with specific intervals and to perform regulations on the work conditions according to these results will be beneficial in terms of productivity. Further researches with larger samples would provide more meaningful information on this subject.

CONFLICT OF INTEREST

None declared

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ETHICAL APPROVAL

Ethical approval was given by the Ethics Committee of the Gulhane Military Medical Faculty (date/reference number:21.12.2009/1491-613-09/1539)

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