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[Original Article]

Emotional intelligence dimensions as predictors of coping reactions to stress in nursing practitioners

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Abstract

Stress is an inevitable part of nursing life. Nurses need to respond to their stressful environment contents to reduce negative consequences. We examined the role of dimensions of emotional intelligence in predicting coping reactions to stress in 201 college nursing practitioners in this cross-sectional study between November 2017 and January 2018. The nurses appraised their own emotions, but they were not sure that appraised others' emotions, regulated their and others' emotions. They could cope with new ideas and faced obstacles. Most of the nurses were moderately stressed. Those nurses were not able to regulate their own emotions were determined to have a higher level of perceived stress. Active coping, positive reframing and acceptance were the most prevalent coping mechanisms. The investigation showed that others' emotion appraisal was a predictor for self-blame reaction, and emotion utilization was the predictor for positive reframing and self-blame.

Keywords : emotional intelligence ; stress ; coping ; nursing

Registration Number : 12072017-5 on 12th, July 2017

Introduction

The nursing function is a central part of health teams given to responsibilities for coordination establishments for direct health care and communication between medical staff, patients, and families. Nursing has been reported to be a profession with a high risk of workplace stress owing to the high job demands, including workloads, health risks exerted by direct contact with patients, and the bulk of administrative duties¹. Nurses have to cope with job-related stress and a high clinical burden. These kinds of work stresses result in harm and have effects not only on nurses' health but also on their abilities to respond to job necessities. There is evidence that more than 40% of nurses suffer from moderate to severe levels of workplace stress².

With taking into account this high level of stress, the nurses need to implement the proper and prompt coping strategies for stress-relieving pur-

poses. It seems that the responses of nurses to stressful events and their choices of coping mechanisms are reflections of individual differences and organizational factors. Nurses need to be emotionally intelligent to harness the stresses because their abilities to respond have an impact on improving clinical performance and increasing an overall health³. Coping defined by Lazarus and Folkman⁴ as the cognitive and behavioral attempts to manage, decrease, or tolerate the external or internal demands created in an environment.

Stress has been considered a living fact and is unavoidable in this competitive world. "Stress, a phenomenon experienced within the individual, is a physiological and emotional experience which results from a requirement to change"⁵. It was shown that a person with a high emotional intelligence had a low perceived stress level, is healthier due to good control of their emotions and had high adaptability to the work environment⁶. It has been

emerged as a critical predictor to protect the nurses against the clinical environment, stress, and associated with decision making and the intra-professional relationship⁷.

In this study, emotional intelligence (EI) was defined as the nurse's ability to understand, appraise, and regulate its own emotions accurately to deal with the stress within the nursing environment⁸.

Different dimensions have argued for emotional intelligence. Some authors expressed five dimensions, but others devoted four emotional intelligence. Given this point, we considered five dimensions to the emotional intelligence, and these are an appraisal of own emotions ; appraisal of other's emotions ; regulation of own emotions ; regulation of other's emotions ; and utilization of emotions. Self and other's emotions appraisal refer to the nurse's ability to find out and indicates one's own and others' emotions. Regulation of emotions refers to the nurse's ability to manage emotions, and utilization is defined as its applicability in stress management⁹.

An association between emotional intelligence and work wellness within a nursing environment¹⁰ and a moderate role of emotional intelligence in job stress experience have been reported¹¹. Besides, increased work satisfaction, better health status, and a lower risk of workplace burnout have been correlated with emotional intelligence¹². Given the perspectives as mentioned above, the role of emotional intelligence in a reduction of work stress cannot be ignored in the nursing community.

EI is increasingly discussed as a factor with a significant role in nursing, medicine, and other healthcare professionals for its role in individual mental health and clinical performance. Although the correlation of EI with job stress has been documented in a nursing environment, there is a little information on the coping reactions of the nurses to the workplace stresses and less attention has been paid to this phenomenon in the literature¹³. It is important to understand that how the nurses respond to the available perceived or received stresses in their clinical settings, as these kinds of efforts are highly valuable to understand the realistic context of their working.

Dealing with the stress within the nursing environment is essential, as it has been documented that work stress is highly related to health-associated indicators like depression, anxiety, and fatigue, and work outcomes such as turnover¹⁴. The nurses enable to overcome stressful conditions, solve the

conflicts, and make them successful team working through the EI. However the caution must be paid as if it poorly managed it can lead to stress, exhaustion, and frustration¹⁵ Importantly, under the best circumstance, intelligence quotient accounts for only 20% of a person's success, and the remaining 80% depends on emotional intelligence¹⁶.

The role of dimensions of emotional intelligence in predicting coping reactions to stress in nursing practitioners was examined in the present study. The authors expected that nurses take advantage of their colleagues' assistance as a coping strategy in relation to EI to deal with stressful situations.

Subjects and methods

Study design and sampling method

In the present cross-sectional study, a total of 201 college nursing practitioners working in main public hospitals were purposively and personally invited across the geographic locations of Duhok city in Iraqi Kurdistan in 2017. The nursing practitioners were recruited from seven public hospitals/medical centers following taking ethical clearance from the corresponded local department and official permission between November 2017 and January 2018. The hospitals were multi-specialty and comprehensive with a combination of clinical practices and teaching activities, including one teaching hospital for adult patients ; one pediatric hospital ; an emergency hospital ; one maternity, and one burn and plastic surgery hospital. The medical centers were one cardiac and one rehabilitation center.

The study objectives were clarified to the participants personally or in a small group included two to three subjects before filling the questionnaire at a calm and suitable environment to avoid the possible staff interruption. The measurement tools were self-administered, and the overall time required to fill all items of the questionnaires was 15 minutes only.

The data were collected from the nurses working in the heterogeneity of clinical settings, including medical and surgical ward, emergency room, cardiac center, operation room, and anesthesia. The nurse practitioners met eligibility criteria if they were male or female ; married or not ; with at least a Bachelor's Degree ; with at least two years' experience ; and irrespective of their socio-demographic aspects and job rank whether nursing officers, chief nurses, or assistant nurses. The subjects who were not available during the data collection or did

not show their willingness to participate were not included in the study.

Measurement Criteria

The general information of the subjects was collected through the self-reported technique and recorded in an anonymous pre-designed self-administered questionnaire. Smoking was categorized as smoker and non-smoker. Besides, sleeping patterns were measured as short sleeping (<6 sleeping hours /24 hours), normal sleeping (6-8 sleeping hours/24 hours), and long sleeping (>8 sleeping hours/24 hours); physical activity as yes or no and its patterns as regular or irregular.

Brief Emotional Intelligence Scale (BEIS-10) developed based on the 33-item Emotional Intelligence Scale (EIS) and according to the theory, was used to measure the level of emotional intelligence. The scale has ten questions to distinguish five categories of EI, including an appraisal from own emotions; appraisal from other's emotions; regulation of own emotions; regulation of other's emotions; and utilization of emotions. The scale rates on a 5-point Likert scale anchored by 1=strongly agree, 2=agree, 3=neutral, 4=disagree, and 5=strongly disagree. The proportion of agreement scores for items ranged from 89.2% to 96.4% within a ± 1 range⁹.

The **"Perceived Stress Scale (PSS)"** measures the perceived degree of a nurse for its experienced stress. The tool has ten items designed to find out how unpredictable, uncontrollable, and overloaded respondents find their lives. These items ask the person about feelings and thoughts for the last month. PSS measures a particular way of a person of its feeling. It is rated on a 5-point Likert scale anchored 0=never, 1=almost never, 2=sometimes, 3=frailty often, and 4=very often. To score the scale, the scores for questions 4, 5, 7, and 8 must be reversed as 0=4, 1=3, 2=2, 3=1, and 4=0. Subsequently, the scores are summed together to obtain a total score between 0 and 40, which higher scores indicating higher perceived stress. Scores ranging from 0-13 is considered as low stress, 14-26 as moderate stress, and 27-40 as high perceived stress¹⁷.

The different coping reactions were measured through the 14 scales **brief COPE** includes 28 items. The scales are self-distraction; active coping; denial; substance use; use of emotional support; use of instrumental support; behavioral disengagement; venting; positive reframing; planning; humor; acceptance; religion; self-blame.

The responses in the brief COPE range from 0 (I have not been doing this at all); 1 (I have been doing this a little); 2 (I have been doing this a medium amount); and 3 (I have been doing this a lot)¹⁸.

Statistical analysis

The descriptive purposes of the investigation were determined through the frequency distribution, including mean and standard deviation for continuous and frequency and percentage for nominal variables. The predictors of perceived stress and coping mechanisms in nurses were examined in the univariate analysis of variance and multivariate analysis of variance (MANOVA), respectively. The normality of the distribution in the MANOVA test was examined in Box's Test of equality of Covariance metrics ($P=0.408$). In univariate analysis, the perceived stress level was considered a dependent variable and dimensions of emotional intelligence with adjustment for baseline information as independent variables. In the MANOVA analysis model, the coping mechanism was considered dependent variables and dimensions of EI with adjustment for baseline information as independent variables. The pairwise comparisons of significant difference were performed by Bonferroni Correction. The two-tailed P-value of less than 0.05 was considered to be substantial differences. SPSS version 25 was used for data analysis.

Ethical considerations

The ethical approval of the current investigation was taken from the corresponded local health ethics committee in Duhok registered as reference number: 12072017-5 on 12th, July 2017. The written consent form was obtained from all participants prior to the face-to-face interview. The nurses' right to reject the participation was protected throughout the study steps. The guarantee was given for confidentiality of the obtained information of nurses at the time of publication.

Results

The mean age of the total of 201 nurses participated in the study was 29.31 years. More than half of them were males (57.2%); the majority were married (64.7%) and live in urban areas (78.6%). The average number of family member was 5.51 persons. A small percentage of nurses was a smoker (11.40%). A considerable percentage of them was physically active (80.1%) with irregular patterns (84.5%). More than half of them were normal

Table 1. Baseline characteristics of the nursing practitioners

| Nurse Characteristics (n=201) | Frequency Distribution | |
|-----------------------------------|------------------------|--------------------|
| | Mean | Standard Deviation |
| Age, year | 29.31 | 4.15 |
| Gender | | |
| Male/Female | 115/86 | 57.2/42.8 |
| Family member | 5.51 | 2.74 |
| | Frequency | Percentage |
| Marital status | | |
| Single/Married | 71/130 | 35.3/ 64.7 |
| Residency | | |
| Urban/Rural | 158/43 | 78.6/ 21.4 |
| Smokers | 23 | 11.4 |
| Physically Active | 161 | 80.1 |
| Physical activity patterns | | |
| Regular/ Irregular | 25/136 | 15.5/ 84.5 |
| Sleeping patterns | | |
| Short sleepers | 58 | 28.9 |
| Normal sleepers | 114 | 56.7 |
| Long sleeper | 29 | 14.4 |

The bold numbers show the highest percentage.

sleepers (56.7%), Table 1.

The nurses slightly appraised their own emotion changes and recognized the practice in a convenient place and time (Mean [M]: 1.99). However, they were not sure that understood how other people feel and experience their emotions (M: 2.19) and were not sure that have a control on their own emotions (M: 2.33) and how to regulate the others' emotions, including events' arrangement (M: 2.24). However, the nurses slightly and successfully utilized their positive moods to face barriers in their life (M: 1.91), see Table 2.

In terms of perceived stress, the study revealed that most of the nurses had a moderate level of perceived stress (83.6%) followed by a low level of stress (11.9%). The study showed that the active coping (M: 3.66), positive reframing (M: 3.91), and acceptance (M: 4.00) were the most used coping reactions by nurses, see Table 2.

The perceived stress level (as a continuous variable) was considered a dependent variable and dimensions of emotional intelligence with adjustment for baseline information as independent variables in the univariate analysis of variance. The analysis showed that the nurses who were not able

Table 2. Emotional intelligence, perceived stress levels, coping strategies in nursing practitioners

| Scales (n=201) | Frequency Distribution | |
|--------------------------------|------------------------|--------------------|
| | Mean | Standard Deviation |
| Emotional Intelligence | | |
| Appraisal of own emotions | 1.99 | .78 |
| Appraisal of others' emotions | 2.19 | .81 |
| Regulation of own emotions | 2.33 | .75 |
| Regulation of others' emotions | 2.24 | .71 |
| Utilization of emotions | 1.91 | .73 |
| Perceived stress* | 19.34 | 4.43 |
| Low stress | 24 | 11.9 |
| Moderate stress | 168 | 83.6 |
| High stress | 9 | 4.5 |
| Coping Mechanism | | |
| Active Coping | 3.66 | 1.08 |
| Denial | 3.02 | 1.57 |
| Emotional Support | 2.99 | 1.24 |
| Instrumental Support | 3.18 | 1.40 |
| Positive Reframing | 3.91 | 1.05 |
| Planning | 3.42 | 1.24 |
| Acceptance | 4.00 | 1.35 |
| Self-Blame | 2.68 | 1.28 |
| Religion | 3.53 | 1.71 |
| Self-Distraction | 3.43 | 1.36 |
| Substance Use | 1.12 | 1.37 |
| Behavioral Disengagement | 1.82 | 1.39 |
| Venting | 2.52 | 1.17 |
| Humor | 2.52 | 1.69 |

*The perceived stress categories were presented in frequency and percentage.

to regulate their own emotions were more likely to have a higher level of perceived stress ($P=.008$, stress difference: 10.6%), Table 3.

In the MANOVA analysis model, the coping mechanisms (in continuous type) were considered dependent variables and dimensions of EI with adjustment for baseline information as independent variables. The baseline information that predicted the coping mechanisms were gender (males predicted to express and escape from unpleasant feelings; $P=0.018$); residency (the nurses who live in urban areas tried to see the stress differently and find the positive aspects; $P=.002$). In addition, non-smoker nurses attempted to come up with a strategy and make the appropriate steps ($P=.034$) and physically active nurses tried to express and escape from unpleasant feelings more than physically inactive subjects ($P=.048$). Similarly, the normal sleepers

Table 3. Correlation of emotional intelligence with perceived stress in nursing practitioners

| Dependent variable : Perceived stress level | | | | |
|---|-------------|-------|-------------|---------------------|
| Predictors | Mean Square | F | Sig. | Partial Eta Squared |
| Gender | .751 | .041 | .840 | .000 |
| Marital Status | 5.748 | .314 | .576 | .002 |
| Residency | 2.111 | .115 | .735 | .001 |
| Smoking | 32.735 | 1.787 | .183 | .012 |
| Physical Activity | 58.633 | 3.200 | .076 | .020 |
| Sleeping Hours | 50.308 | 2.746 | .067 | .035 |
| Chronic Disease | 20.934 | 1.142 | .287 | .007 |
| Own Emotion Appraisal | 13.832 | .755 | .626 | .033 |
| Others Emotion Appraisal | 26.045 | 1.421 | .200 | .061 |
| Own Emotion Regulation | 55.613 | 3.035 | .008 | .106 |
| Others Emotion Regulation | 20.217 | 1.103 | .364 | .048 |
| Emotion Utilization | 9.065 | .495 | .837 | .022 |
| Age | 11.622 | .634 | .427 | .004 |
| Family Member | .006 | .000 | .986 | .000 |

The bold number shows the predictor.

were more likely to attempt to come up with a strategy and make the appropriate steps ($P=.025$), Table 4a.

In addition, the analysis showed that nurses with chronic disease were less likely to seek emotional support from others ($P=.022$). The nurses with a higher level of stress were more likely to deny the stress ($P=.002$); seek the emotional support ($P<0.001$); seek help and advice from others ($P=.030$); to not criticize themselves for the circumstances that happened ($P=.002$); to not make jokes about the situation ($P=.002$), and turn to other activities to take their mind off or think less about it ($P=0.002$); and those with a larger family members were more likely give up trying to deal with it ($P=.008$), Table 4a.

Concerning dimensions of EI as the predictors of the coping mechanisms, the study showed that those nurses who were not able to appraise others' emotion and utilize their own emotions were more likely to criticize themselves ($P=.007$ and $P=.008$, respectively), see Table 4a.

The study revealed that the subjects living in urban areas were more likely to reframe their plan positively ($P=0.002$) compared to those living in rural locations. In addition, the normal sleepers were more likely to have active coping compared to long sleepers ($P=0.032$) and emotional support was more prevalent in subjects without chronic diseases ($P=0.022$), see Table 4b.

Discussion

In this study, types of coping responses to the stressful situations in a sample of nursing practitioners in Iraqi Kurdistan were examined. The study found that the nurses appraised their own emotions, but they were not sure that appraised others' emotions, regulating their and others' emotions. They were able to cope with new ideas and faced obstacles. Most of the nurses were moderately stressed. Those nurses who were not able to regulate their own emotions were determined to have a higher level of perceived stress. Active coping, positive reframing and acceptance were the most prevalent coping mechanisms. The study showed that others' emotion appraisal was a predictor for self-blame reaction, and emotion utilization was the predictor for positive reframing and self-blame.

Coping experts have different opinions on reporting coping mechanisms. Lazarus and Folkman⁴ conceptualize it as an interactive process between a subject and the environment.

Planning and positive reframing for a response

The study showed that the utilization of emotions is a predictor for the nurses to see the stress in a different light and find its positive aspects (positive reframing), which is a positive way of coping reactions. However, the problem here is that the participated subjects were not sure how to recognize and express their emotions, how others feel, and how to utilize their own and others' emotions. In

Table 4. Predictors of coping reactions to stress in nursing practitioners

a) Predcitors

| Predictors | Dependent Variables | Mean Square | F | Sig. | Partial Eta Squared |
|---------------------------|--------------------------|-------------|--------|-------|---------------------|
| Gender | Venting | 7.725 | 5.717 | .018 | .030 |
| Marital Status | Emotional Support | 5.383 | 3.884 | .050 | .021 |
| Residency | Positive Reframing | 10.332 | 9.750 | .002 | .051 |
| Smoking | Planning | 7.096 | 4.568 | .034 | .024 |
| Physical Activity | Venting | 5.377 | 3.980 | .048 | .021 |
| Sleeping Hours | Active Coping | 4.285 | 3.781 | .025 | .040 |
| Chronic Disease | Emotional Support | 7.369 | 5.317 | .022 | .028 |
| Perceived Stress | Denial | 22.618 | 9.707 | .002 | .051 |
| | Emotional Support | 19.823 | 14.303 | <.001 | .073 |
| | Instrumental Support | 9.433 | 4.766 | .030 | .026 |
| | Self-Blame | 14.677 | 10.199 | .002 | .053 |
| | Self-Distracton | 22.159 | 13.354 | <.001 | .068 |
| | Humor | 26.124 | 9.830 | .002 | .051 |
| Own Emotion Appraisal | <u>No Factor</u> | | | | |
| Others Emotion Appraisal | Self-Blame | 10.837 | 7.531 | .007 | .040 |
| Own Emotion Regulation | <u>No Factor</u> | | | | |
| Others Emotion Regulation | <u>No Factor</u> | | | | |
| Emotion Utilization | Positive Reframing | 5.284 | 4.986 | .027 | .027 |
| | Self-Blame | 10.318 | 7.170 | .008 | .038 |
| Age | No Factor | | | | |
| Family Member | Self-Blame | 5.608 | 3.897 | .050 | .021 |
| | Behavioral Disengagement | 13.635 | 7.094 | .008 | .038 |

The predictors were shown in this table only.

b) Pairwise comparisons (Bonferroni Correction)

| Pairwise Comparisons | | | | | | | |
|----------------------|--------------------|-----------------------|-----------------------|------|-------------------|------------------------------------|-------------|
| Dependent Variable | (I) nurse category | (J) nurse category | Mean Difference (I-J) | SE | Sig. ^b | 95% CI for Difference ^b | |
| | | | | | | Lower Bound | Upper Bound |
| Venting | Male | Female | .439* | .183 | .018 | .077 | .800 |
| Emotional Support | Single | Married | -.356 | .181 | .050 | -.713 | .000 |
| Positive Reframing | Urban | Rural | .580* | .186 | .002 | .213 | .946 |
| Planning | Smoker | Non-Smoker | -.644* | .302 | .034 | -1.239 | -.050 |
| Venting | Physically Active | Non-Physically Active | .443* | .222 | .048 | .005 | .881 |
| Active Coping | Less Than 6 Hours | 6-8 Hrs. sleeping | .040 | .179 | 1.000 | -.394 | .474 |
| | | Sleeping > 8 Hrs. | .630* | .250 | .038 | .026 | 1.234 |
| | 6-8 Hours | Sleeping < 6 Hrs. | -.040 | .179 | 1.000 | -.474 | .394 |
| | | Sleeping > 8 Hrs. | .590* | .229 | .032 | .038 | 1.142 |
| | More Than 8 Hours | Sleeping < 6 Hrs. | -.630* | .250 | .038 | -1.234 | -.026 |
| | | 6-8 Hrs. sleeping | -.590* | .229 | .032 | -1.142 | -.038 |
| Emotional Support | Chronic Disease | No Chronic Disease | -.955* | .414 | .022 | -1.772 | -.138 |

Based on estimated marginal means

*The mean difference is significant at the .05 level.

^bAdjustment for multiple comparisons : Bonferroni.

addition, the negative point is that they were more likely to criticize themselves for the circumstances in their clinical settings when they cannot utilize the emotions to come up with new ideas and face to obstacles.

There is a piece of evidence that the persons with a higher level of EI are more possibilities to commit seeking external helping, turn to active coping and religious affairs, and cognitive reconstructing¹⁹⁾. We did not find that the dimensions of EI are predictors for seeking emotional support from the external bodies. However, we showed that the nurses have a higher level of stress attempt to find assistance and advice for the external persons.

We showed that normal sleepers were more likely to have active coping compared to long sleepers. The exact amount of sleep required by healthy adults has not been determined yet, however, the impacts of inadequate sleep have been well documented. The review studies have shown that insufficient sleep has been shown to associate with cognitive issues, mood alterations, reduction of job performance, reduction of motivation, rising safety risks, and psychological alterations²⁰⁾. Moreover, extended sleep has not been determined to improve mood or health and may be related to poor health. The sleep deprivation has negative effect on performance of hospital staff nurses²¹⁾. Even the nurses who sleep 6 or fewer hours in 24 hours are 3.4 percent change of an error²²⁾. Since active coping could include clinical decision-making in medical settings have an intimate role in the quality of care that nurses present to patients. It is estimated that up to 65% of adverse events could be prevented when the nurses made better decisions^{23,24)}.

Social support

The investigations emphasized on the importance of the availability of organization support in stressful situations²⁵⁾. The patient care is not the only aspect of nursing. Nurses are involved in interrelation with their colleagues and administrative staff in their daily occasions. It has been documented that organizational and management characteristics have an impact on workplace stress among nursing practitioners²⁶⁾. Those nurses with low organizational support experience a higher level of burnout²⁷⁾. A considerable percentage of potential sources of stress among nurses are organizational, whether psychological, social, or physical²⁶⁾. Social support is one of the most significant mechanisms that nurses can enhance their resilience²⁸⁾. It has a role in assisting professionals against burnout and

compassion fatigue²⁹⁾ as well as it can be a stress-diminishing tool for its feeling control. The individuals with insufficient ability to recognize their emotions are less engaged in social adaptation³⁰⁾.

It is important to mention that nurses experience stress within their work environment when they accept that job load outweighs their abilities³¹⁾. Therefore, they look for assistance from the external sources to deal with the stress. The stressful events are changeable over time and in different situations. Hence the nurses apply different coping strategies, as reflected in the present study. Moreover, their cognitive abilities to cope with the stressful situations may be related to some other factors such as age, sex, coping skills, previous experience of stress, and personality of the nurses.

Coping mechanisms types

The coping mechanisms are divided into two basic frameworks, including problem and emotion-based coping. Problem-focused coping aims to solve the issue, and emotion-focused coping are aimed to regulate the emotions of a person under stress or increase stress skill management³²⁾. Some other investigators added avoidance as a third basic coping dimension called as delay solving³³⁾. In the new classification, the coping styles were categorized as logical, detached, emotional, and avoidant kinds. The problem-focused strategy is considered as a logical coping. In a detached coping, a person tends to be far from away from the issue to decrease the potential impacts of emotions. Generally, logical and detached coping strategies are considered as efficient styles and emotional and avoidance style as inefficient coping³⁴⁾.

It is possible that the same person uses both of the mentioned response mechanisms against stressful situations. The problem-based strategies are more likely used by a person when it feels that it can be constructive, while emotion-based strategies are practiced when a person feels that can stress tolerable³²⁾.

According to cognitive evaluation theory model, a person is subjected to respond to stress from the environment with the assistance of the available resources and way of approach the situation as explained it as an interaction between an individual and the environment⁴⁾.

Denial strategy

The study showed that a higher level of perceived stress is a predictor of denial in nursing practitioners. Possibly, denial of the stress occurring in

a work setting is a confusing phenomenon³⁵. It is unclear that it is a maladaptive, passive, or negative coping, or maybe they are normal and reasonable reactions to the life-threatening situations. The nurses maybe do not see the stress as a threat to their real situation. Lazarus and Folkman⁴ mentioned that stress passes through three stages. In the primary appraisal, the person perceives stress as a threat to itself. In the secondary appraisal, the person brings in its mind to consider a response to the threat, and in the coping stage, the person starts to execute a response. The nurses may see that there is a response to the present threat in the work setting, forcing them to consider as less threatening because they realize the available response is not or less effective than expected. They may bring in their mind to reappraise the threat level or reappraise what coping reaction would be more appropriate.

Nursing practitioners attempt to distance from patients and avoid involvement, reflecting the inability in dealing with the emotional burden of daily contact in clinical settings, in particular in oncology units¹³. In this regard, the nurses need continuous preparation to deal with feelings and patients to develop protective mechanisms as the hospital is accompanied by suffering. It seems that nurses attempt to deal with the stressful situations through avoiding stressful events as much as possible, and sometimes tie up their efforts with religious beliefs to reduce the stress, as shown in this study.

Experience and nursing responses to stress

The nurses participated in the present study were young (mean : 29.31 years), indicating non-experienced practitioners in clinical practices. The nurses with more experiences with stressful situations are more prone to engage in active coping responses. In contrast, those persons with fewer experiences who are inclined to passive-based coping strategies as it is claimed the young persons have greater sensitivity to stressful agents owing to lack of workplace adaptability³⁶. Most importantly, the EI aspects are developed through the life experience and training³⁷. We did not find that age is a predictor for coping mechanism in this study.

Limitations of the study

The nurses who participated in the current study were only from one geographic location precluding us to generalize the findings across the country. The nurses who participated in this study were from different clinical departments. It has

been documented that the intensive care unit and emergency departments have a higher substantial level of stress³⁶.

Recommendations

It is recommended that nurses who work in clinical settings receive the educational sessions on emotional intelligence components to recognize their own and other's emotions and how to deal with their colleagues and patients' emotions to obtain the viable adaptation in the stress-based environments due to its seminal role in forming a successful human relationship and establishing a therapeutic nurse-patient relationship³⁸. Particularly that nurses who do not have sufficient interpersonal skills make two-fold the importance of EI development through the training programs in the nursing workplace.

Conclusions

The study suggests that others' emotion appraisal and emotion utilization predict the way nurses blame themselves and how they positively see stress and criticize themselves. The study documented that nurses have difficulties in recognizing and regulating their own and others' emotions in a positive way. However, they try to respond to the stresses through active coping, positive reframing, and acceptance. Inability in regulating their own emotions was responsible for a high level of stress in nursing practitioners.

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Sources of support

The authors were the only financial supporters of the study.

Conflicts of interest

The authors declare that there is no conflict of interest.

Authorship

The corresponding author declares that all authors have sufficiently participated in study design, assessment, review, data collection, analysis, and interpretation.

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