

T.R.
YEDITEPE UNIVERSITY
INSTITUTE OF MEDICAL SCIENCES
DEPARTMENT OF PUBLIC HEALTH

**EVALUATION OF PSYCHOSOCIAL FACTORS AND
METHODS OF COPING WITH STRESS IN
HEALTHCARE WORKERS WORKING IN THE
PANDEMIC HOSPITAL DURING THE COVID-19
PANDEMIC**

MASTER'S THESIS

SAİBE MERVE KAZDAL

Istanbul-2022

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DECLARATION

I hereby declare that this thesis is my own work, I have not exhibited any unethical behavior at any stage from planning to writing, I have obtained all the information in the thesis within academic and ethical rules, I have cited all the information and comments not obtained with the thesis study and included these sources in the list of references, I have not violated patent and copyrights during the thesis study and writing.

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Saibe Merve KAZDAL

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LIST OF ABBREVIATIONS

COPSOQ	Copenhagen Psychosocial Questionnaire
MAOA	Monoaminoxidase A
PFC	Prefrontal Cortex
BDNF	Brain-Derived Neurotrophic Factor
HPA	Hypothalamus-Pituitary-Adrenal Axis
MERS	Middle East Respiratory Syndrome
SARS	Severe Acute Respiratory Syndrome
COVID	Coronavirus
COVID-19	Coronavirus Disease 2019
WCSS	Ways of Coping with Stress Scale
GHQ-12	General Health Questionnaire-12
CAS	Coronavirus Anxiety Scale

ABSTRACT

Kazdal, M. S. (2021). Evaluation of Psychosocial Factors and Methods of Coping with Stress in Healthcare Workers Working in the Pandemic Hospital During the COVID-19 Pandemic. Yeditepe University Institute of Health Sciences

This study aims to compare the anxiety, psychosocial risk, and general health levels experienced by healthcare workers working in all sections of a pandemic hospital before and after the COVID-19 pandemic and examine how the pandemic affects these factors and how the ways of coping with this stress influencing healthcare workers affect their psychological state. It was ensured that the consent form was read by 500 volunteer workers actively working in all areas of the institution serving as a pandemic hospital authorized by the Ministry of Health from the day of the beginning of the pandemic, such as workers and doctors, nurses, midwives, technicians, medical secretaries, cleaning-security-kitchen personnel, their consent was obtained, and the sociodemographic data form, COPSOQ, WCSS, GHQ-12, and Coronavirus Anxiety Scale were filled out. The chi-squared test, Mann-Whitney U test, and logistic regression analysis were conducted to evaluate these questionnaires. When the variables of sociodemographic data, job information, and active duty in COVID-19 areas were examined, the anxiety levels of those who took more duties in COVID-19 areas were found to be significantly higher. Furthermore, while the anxiety and psychosocial risk levels of those who exhibited a self-confident and optimistic approach in ways of coping with stress were found to be lower, these risks were revealed to be significantly higher in those who exhibited a desperate approach and a submissive approach. Healthcare workers' ways of coping with stress determine how much they will protect themselves against psychosocial risks during the pandemic. It can be stated that participants who define their general health risk levels as low are more resistant to the psychological effects of COVID-19 disease.

Keywords: COPSOQ, coronavirus anxiety, way of coping with stress, general health

ÖZET

Kazdal, M. S. (2021). Covid-19 Pandemisi Döneminde, Pandemi Hastanesinde Görevli Sağlık Çalışanlarının; Psikososyal Etmenleri Ve Stresle Baş Etme Yöntemlerinin Değerlendirilmesi . Yeditepe Üniversitesi Sağlık Bilimleri Enstitüsü

Bir pandemi hastanesinde her kesimde görev yapan sağlık çalışanlarının Covid-19 pandemisi öncesinde ve sonrasında yaşadığı anksiyete, psikososyal risk ve genel sağlık düzeylerini karşılaştırarak pandeminin bu faktörleri nasıl etkilediğini ve sağlık çalışanlarının etkisi altında kaldığı bu stresle başa çıkma tarzlarının psikolojik durumlarını nasıl etkilediğini incelemeyi amaçlar. Pandeminin başladığı günden itibaren Sağlık Bakanlığı'nın yetkilendirdiği pandemi hastanesi olarak hizmet veren kurumda çalışan ve doktor , hemşire , ebe, tekniker , tıbbi sekreter , temizlik-güvenlik-mutfak personelleri gibi tüm alanda aktif olarak çalışan 500 gönüllü çalışanın onam formu okutulup onay alınarak sosyodemografik veri formu , KOPSOR , SBÇTÖ , GSA-12 ve koronavirüs anksiyete ölçeği doldurulmuştur. Bu anketlerin değerlendirilmesinde ki-kare testi , Mann Whitney U testi ve lojistik regresyon analizi yapılmıştır. Sosyodemografik veriler, iş bilgileri ve covid-19 alanlarında aktif görev alma değişkenleri incelendiğinde Covid alanlarında daha fazla görev alanların anksiyete düzeyleri anlamlı olarak yüksek çıkmıştır. Ayrıca stresle başa çıkma tarzlarında kendine güvenli ve iyimser yaklaşım gösterenlerin anksiyete ve psikososyal risk düzeyleri daha düşük bulunurken çaresiz yaklaşım ve boyun eğici yaklaşım gösterenlerde bu riskler anlamlı oranda daha yüksek bulunmuştur. Sağlık çalışanlarının stresle başa çıkma tarzları; pandemi boyunca kendilerini psikososyal risk karşısında ne kadar koruyacağı konusunda belirleyici olmaktadır. Genel sağlık risk düzeylerini düşük olarak tanımlayan katılımcıların da Covid -19 hastalığının psikolojik etkilerine karşı daha dirençli olduğu söylenebilir.

Anahtar Kelimeler: kopsor, koronavirüs anksiyete, stresle başa çıkma tarzı, genel sağlık

1. INTRODUCTION

Healthcare workers are exposed to the risk of severe occupational accidents and occupational diseases due to working conditions. In addition to this, risks to which they are exposed can be sometimes contagious. Therefore, this becomes a situation that affects not only healthcare workers but also their immediate environment and society. Unlike other sectors, they continue to provide service under stress and psychosocial risk due to long working hours, the responsibility of providing service at a critical point, physical inadequacies originating from the workplace, and many similar reasons.

It is known that healthcare workers are one of the segments most affected by the COVID-19 pandemic, which has influenced the whole world and changed all the habits and lifestyles acquired to date psychologically, socially, and economically at a macro dimension. It is observed by the public that healthcare workers working in every field in the health sector selflessly fight against a contagious infectious disease, despite seeing the mortal effects of this disease and the sequelae it may cause on human health. It is natural that the psychosocial risk and anxiety levels felt by healthcare workers who show this self-sacrifice will also increase.

In the present study, we will attempt to compare the psychosocial risk anxiety and general health status of healthcare workers from all segments working in a pandemic hospital with the variables before and after the pandemic and examine how COVID-19 disease affects these variables.

2. GENERAL INFORMATION

2.1. Psychosocial Risk

Psychosocial risks, which explain the physical and mental losses that can be caused in employees by all kinds of negativities in working life, depending on managerial organizations and the methods applied, are the factors that can create psychological problems in the health of employees, whose psychological reactions to work and working conditions adversely affect them (1).

Rapid changes in working life and increasing competitive conditions increase employers' expectations and demands from employees. Long shifts, busy schedules, and performance-based wage systems brought about by increasing competitive conditions increase the pressure on employees. The widespread outsourcing in working life and the decreased job security of employees due to temporary contracts create psychological pressure on employees. These resulting pressures are a source of work-related stress (2).

2.1.1. Outcomes of Psychosocial Risks and Associated Conditions

Considering psychosocial risks in working life and their outcomes, work pace, quantitative, cognitive and emotional demands regarding work, control over work, opportunities for development at work, recognition, appreciation, role clarity and role conflict, leader characteristics, organizational culture, interpersonal relations in the workplace, social support and help provided by colleagues and managers, job insecurity, work-home conflict, etc. are some of the psychosocial hazards originating from the working environment and the job content. Issues such as work stress, burnout, depression, substance abuse and use, violence, and workplace suicide, which may occur in parallel with psychosocial hazards, are considered major problems for the field of occupational health and safety. As in other risk groups, psychosocial risks may have healing effects on the working life of employees in terms of their physical and mental health, attitudes and behaviors toward work, productivity, quality of the product produced or the service provided, etc., and also their family and social life.

Healthcare institutions are a workplace and also places of receiving and providing care. Millions of employees in healthcare institutions operating in every corner of the world are at risk every day in terms of various hazards that may threaten their health and

safety, such as biological, chemical, physical, ergonomic, psychosocial, electrical risks, fire, and explosion (3).

2.1.2. Relationship Between Psychosocial Risks and Health Problems

When the effect of psychosocial risks in working life on health is examined, there are pieces of evidence from studies indicating that psychosocial factors affect future sleep disturbances. While workplace social support, organizational justice, and control over work have been less likely associated with sleep disturbance, reduced control over work and social problems, e.g., bullying and exclusion, have been, on the contrary, associated with increased levels of sleep disturbance. Moreover, factors in theoretical concepts such as effort-reward and demand-control models and imbalances in these factors have been observed to be associated with sleep disturbances (4).

Healthcare workers struggle to overcome problems in resource deficiencies, deaths, a regular encounter with pain and suffering, excessive workload, the lack of autonomy, problems in communicating with people, the lack of participation in decisions, difficulties in career development, job insecurity, the uncertainty of duties in working life, and relationships with seniors and peers. These problems also cause burnout, anxiety, depression, musculoskeletal system and cardiovascular diseases (5).

A publication investigating the relationship between work stress and cardiovascular, musculoskeletal, and mental diseases in employees in Turkey showed that cardiovascular and musculoskeletal system diseases in healthcare workers were associated with high work stress. It is known that these diseases are important since they increase mortality and morbidity. It is thought that determining chronic diseases associated with work stress, especially in healthcare workers, will be important to reveal the burden of diseases attributed to stress (6).

2.1.3. Relationship Between Psychosocial Problems and Management Problems

In today's working life, conditions such as increased work intensity and tempo, irregular and long working hours, tensions originating from interpersonal relationships, role ambiguities, decreased job security, managerial attitudes, and career developments adversely affect the psychosocial health of employees (7).

Considering the psychological, social, and physical damages due to social and environmental impacts that change according to how the person is managed in the working life and the job he/she performs, his/her position in the organization and how it is managed, there may be adverse effects for employees. Today's working life adversely affects the health of employees due to the increased workload and working tempo, prolonged working hours, decreased job security, and unsupportive approaches of managers. These problems, which have been known for a long time but have not been emphasized much, influence enterprises indirectly and gradually reduce the commitment of employees to their jobs and institutions (8).

Healthcare workers are also exposed to various occupational risks during the provision of healthcare services. The main occupational risks of healthcare workers can be defined as chemical risks, biological risks, physical and psychosocial risks. It is important that these risks are addressed and managed by managers in healthcare institutions. Managers should develop action plans on issues such as perforating injuries, exposure to bodily fluids, infectious diseases, cancer drugs and high-risk drug exposure, and violence against healthcare workers, which are among the leading risks (9).

2.1.4. Relationship Between Psychosocial Risks and Economic Problems

Changes in working life due to globalization occur in a way that does not comply with the physical and psychosocial characteristics of workers, and it is expected that they will keep up with these changes by ignoring the personal characteristics of workers. This leads to the occurrence of occupational accidents, occupational diseases, and work-related diseases due to stress in workers. Problems such as unwillingness to come to work, difficulties in concentration, inattention, unhappiness, feeling of not belonging to the workplace, and substance abuse occur in workers due to stress. There may also be economic costs during diagnosis and treatment. These problems affect not only workers but also managers and enterprises. Managers experience problems with their workers, and unrest in the workplace increases. In enterprises, production decreases, and yield and profitability rates also decrease. This imposes a financial burden on both workers, employers, and the state (3).

2.1.5 Condition of Psychosocial Risks in the World

There are various legal regulations worldwide that aim to protect the health and safety of employees and contain the necessary regulations on these issues. The purpose of these regulations is to reduce work stress and psychological problems and prevent physical problems brought about by stress. It is expected that employers act within the framework of these regulations (10).

Many countries use different methods to monitor and evaluate psychosocial risks. The most frequently used method among them is face-to-face interviews. Furthermore, organizing interviews by phone and conducting survey studies at a particular frequency are other methods. The most evaluated criteria are working hours, the degree of participation in decision making, whether there is shift work, and the availability of specific working options. The most important social conditions used in the evaluation are salary, job security, environment of trust among colleagues, and whether there is a change of position in the workplace. The scope and sample sizes of studies performing these evaluations in different countries vary. In general, it is observed that European countries and Canada are more successful in psychosocial risk surveillance than other countries. On the other hand, it is concluded that studies in the sense of psychosocial risk surveillance are attempted to be developed in almost all countries worldwide (11).

Framework Directive 89/391, which includes psychosocial risks and evaluates all occupational risks, is used in the European Union countries (12). However, the level of implementation and follow-up are not carried out to the same extent in all countries. Studies conducted by interviewing employer representatives, worker representatives, and state authorities in European countries determined that the European Union Framework Directive was insufficient in stress management (13).

2.1.6. Condition of Psychosocial Risks and Legal Regulations in Turkey

In Turkey, necessary legal regulations are also made and updated for psychosocial risk assessment and management. While Law No. 6631 defines what risk assessment studies are, it is detailed in Risk Assessment Regulation No. 28512. In the article of the regulation titled “Risk Assessment,” the necessary stages “starting from the design or establishment stage for all workplaces...” are described as follows:

- a) Identifying hazards

- b) Identifying and analyzing risks
- c) Deciding on risk control measures
- d) Documentation
- e) Updating the work done and renewing it when necessary

As stated in this regulation, including risk assessment in planning from the establishment of workplaces and indicating that it will be renewed when necessary show that psychosocial risks are followed up seriously and preventive services are aimed to be carried out (14).

2.1.7. Psychosocial Risk Assessment Scales

Many scales can be used in psychosocial risk assessment. The main scales are the Copenhagen Psychosocial Questionnaire, effort-reward balance, general NORDIC questionnaire, health and safety indicator, job characteristics index, job content scale, job description survey, job stress survey, multidimensional organizational health scale, NOVA WEBA questionnaire, NIOSH generic job stress questionnaire, occupational stress indicator, occupational stress scale, occupational stress count, pressure management indicator, psychosocial working conditions, stress definition research, stress regulation scale, stress section, stress risk assessment scale, work and health, TRIPOD SIGMA questionnaire, question and work experience assessment, work environment scale, work conditions and control scale (15).

2.1.8. Copenhagen Psychosocial Questionnaire (COPSOQ)

The Copenhagen Psychosocial Questionnaire (COPSOQ) constitutes a step for providing a theoretical perspective on psychosocial risks, the tendency of employees and employers to this issue, their developing a new way of communication, providing a link between researchers and workplaces in the long term, and creating a legal basis for psychosocial risks in the workplace. Moreover, it is basically used to improve the working conditions of many employees and increase productivity in working life. The COPSOQ was developed approximately 20 years ago when Tage S.Kristensen and Vilhelm Borg started working with the psychosocial risks research group at the Danish National Institute of Occupational Health. This institute primarily addressed physical, chemical, and ergonomic risks in the workplace. At the following stages, it was observed that

occupational health professionals experienced significant problems in evaluating psychosocial factors in their workplaces, and although there were various assessment tools, it was revealed that these were not effective enough to create national data.

The COPSOQ ensures that many models (for example, demand-control-social support, effort-reward, job demands-resources, work-family conflict, social capital, vitamins, socio-technical) developed with regard to psychosocial risks in the workplace can be evaluated. When studies are reviewed, it is observed that there are important scientific data on the relationship between psychosocial risks and health. When the factors evaluated in the COPSOQ are examined, it is determined that they are sufficient and appropriate for risk assessment.

Briefly, the purposes of developing the COPSOQ are as follows:

- To create an environment for developing appropriate tools for the assessment of psychosocial risks in working life
- To facilitate performing national and international comparisons since reliability and validity studies are carried out in many countries and languages
- To improve the assessment of initiatives
- To facilitate monitoring and assessment
- To improve communication between workplaces, occupational health professionals, and researchers
- To facilitate the understanding of concepts and theories that are difficult for users to understand.

The Copenhagen Psychosocial Questionnaire is a scale with proven validity and reliability in Turkish and is briefly named the COPSOQ-TR.

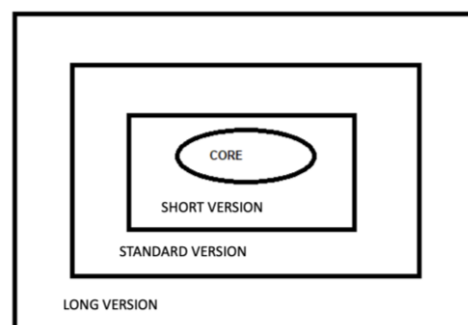


Figure 2.1. The COPSOQ-Tr structure

Short version: It covers the ‘core’ questions that the scale should include at least for psychosocial risk assessment and other questions deemed necessary.

Standard version: It covers questions in the 'short' version and questions added in the 'standard' version.

The short and standard versions are the COPSQ versions of different lengths for the purposes of workplace risk assessment and organizational structure improvement. Additionally, these versions can be used for research purposes if desired.

Long version: It covers all questions and dimensions. It is mainly for research purposes and provides opportunities for national adaptations depending on what is needed in this context.

The COPSQ should be adapted to the requirements and special conditions of different countries. When implemented in the workplace, it should be arranged in accordance with the terms and conditions of use that emerge here. The failure to comply with them indicates the improper use of the questionnaire.

The COPSQ-TR adapted to Turkish;

- Includes all questions in the '**standard**' version,
- Includes some questions in the '**long**' version,
- Includes a question present in the COPSQ-2 but not present in the COPSQ-3 and consists of 25 dimensions and 88 items (16).

2.2. Stress

Stress is a reaction to the physical or psychological pressure created by an action or event on a person. Stress, which is observed due to different reasons in working life, is now defined as a condition or disease that produces many consequences for employees and employers, such as a decrease in work efficiency, decreased concentration on work, behaviors disrupting work peace, etc. As a result, stress emerging in working life comes to the fore as an obstacle in the normal life flow of employees and causes people to react physically and emotionally (17).

2.3. Anxiety

Anxiety is a term that is attempted to be explained in many psychiatric theories. It takes an essential place in psychodynamic theory, neuroscience, and cognitive

behavioral theory (18). The boundaries between normal and pathological anxiety are not clear. Furthermore, anxiety is an important symptom in many psychiatric and medical diseases. In fact, foods and beverages that contain especially caffeine and alcohol can stimulate anxiety (19). Nowadays, anxiety disorders are examined under the following subheadings (20):

1. Separation anxiety disorder
2. Selective Mutism
3. Panic Disorder
4. Agoraphobia
5. Specific Phobia
6. Social Anxiety Disorder
7. Generalized Anxiety Disorder
8. Other Unspecified Anxiety Disorder
9. Anxiety disorder due to another medical condition
10. Substance or drug-induced anxiety disorder
11. Unspecified anxiety disorder

It is difficult to clearly draw the boundaries despite such sub-headings. Moreover, even the independent existence of generalized anxiety disorder, for example, is controversial. There are also data indicating that this disorder is basically related to depression (21).

Anxiety disorders are among the most common psychiatric disorders. According to the National Comorbidity Survey, one out of every four people meets the diagnostic criteria for anxiety disorder, and its 12-month prevalence is 17.7% (22). A study carried out to determine the prevalence of psychiatric diseases in Europe found their 12-month prevalence to be 3.8% in males and 17.5% in females (23). The reason for such prevalence is anxiety, which is the main pathology in neuroses according to psychoanalytic theory.

For example, anxiety can be displaced from its original source and transferred to another object or situation with the displacement mechanism, and thus, phobias and obsessions are formed. In some cases, it is first suppressed and then converted to bodily dysfunction, and conversion occurs. In some cases, anxiety is experienced as it is, with its subjective and objective symptoms (21). Generalized anxiety disorder has a worse prognosis in patients with poor treatment compliance, early onset, and in females (24). The risk of suicide is high, and such a high risk is often independent of the diagnosis of depression (25).

Studies investigating environmental factors in anxiety disorders have mostly drawn attention to the first years of life. Separation from parents in the first years of life, the lack of social interaction opportunities, and taking a relative with anxiety disorder as an example are considered risk factors (26).

There are many studies addressing anxiety from a neurobiological perspective and explanations of anxiety in psychodynamic, cognitive, existential, and behavioral schools. The amygdala is the most remarkable structure. The reciprocal relationship of the amygdala with the prefrontal cortex ensures the regulation of fear and anxiety. The PFC also regulates amygdala activation. The PFC activity increases in almost all anxiety disorders (19).

Anxiety disorders are disorders that cause significant pain and disabilities in individuals. In the treatment, factors such as the early initiation of treatment, good evaluation of alcohol-substance abuse comorbidity, good explanation of this disorder according to the patient's education level, and discussion of drug and psychotherapy options with the patient should be considered (27).

2.4. Depression

Depression is a syndrome characterized by a feeling of deep sadness and sometimes both sad and depressed mood, slowing down in thoughts, speech, movement, and physiological functions, stagnation, feelings and thoughts of worthlessness, smallness, powerlessness, reluctance, and pessimism (21). Although the term of depression has not been actually used, other terms describing depression are considerably older. For example, Hippocrates used the terms mania and melancholy. In the 30s A.D., the Roman physician Celsus De Re Medicina defined melancholia as a depression caused by black bile (18).

Nowadays, major depression is characterized by changes in appetite and weight, changes in sleep and activity, decreased energy, loss of interest, changes in psychomotor activity, feelings of worthlessness and guilt, difficulty in concentrating and maintaining attention, and thoughts of death, lasting for at least two weeks (28).

Major depression is a common disease with relapses, which causes high disability. Its 12-month prevalence has been reported as 6.6% and lifetime prevalence as 16.2% (29). It is important not only in terms of disability but also the risk of death. It is considered that 50-70% of all suicides are caused by mood disorders, including major depression (30).

There are a lot of studies conducted on the causes of depression in various fields. There are twin studies demonstrating that heredity is effective to varying degrees. It is thought that this transmission rate is between 31-42% and heredity plays a more significant role in recurrent and early-onset depression (31). It has been demonstrated that it may be associated with polymorphisms in many genes, such as the MAOA gene and the BDNF gene (32). The Hypothalamus-Pituitary-Adrenal Gland (HPA) axis also plays an essential role in the reaction of the organism to stress via glucocorticoids. Epigenetic studies have also demonstrated that silencing of the glucocorticoid receptor gene by methylation causes an exacerbation of the stress response (33).

In addition to all of these, brain structural and functional imaging studies have investigated biochemical factors, endocrine system, immune system, and neurophysiological studies have investigated the causes of depression, and results that may be significant at varying degrees have been obtained (19). Furthermore, the place of psychosocial factors such as economic problems, family crises, problems in working life, and losses cannot be underestimated in major depression (21). For example, it is well known that many psychiatric conditions, primarily major depression, increase during periods of economic crisis (34, 35).

In addition to treatment methods such as antidepressant drugs, antipsychotics, and psychotherapy, treatments such as electroconvulsive therapy and transcranial magnetic stimulation can be applied in some cases in the treatment of major depression, and methods such as phototherapy and sleep deprivation are tried in treatment-resistant cases (19, 21).

2.5. Coronavirus Structure Family Pathogenicity and Epidemiology

Coronaviruses are viruses that constitute one of the two subfamilies of the Coronaviridae family. The genetic material (genome) they contain consists of positive-polarity, single-stranded RNA. They are viruses with the largest RNA genome that has been detected to the present day, and they are named coronavirus in Latin due to their appearance under the microscope (36).

Viruses in the coronavirus family have the ability to cause disease in both humans and animals. HKU1-CoV, HCoV-229E, HCoV-OC43, and HCoV-NL63 are their subtypes that are known for a long time, present in humans, and usually cause self-limiting upper respiratory tract disease. Afterward, SARS-CoV and MERS-CoV subtypes emerged in 2003 and 2012, respectively, and caused Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS), respectively, which are more severe and fatal (37). It was found that SARS-CoV was transmitted to humans from civet cats and MERS-CoV from camels.

Firstly, at the end of 2019, 54 cases of viral pneumonia were observed simultaneously in the city of Wuhan in Hubei province of China, and as a result of the research, a new coronavirus belonging to the Coronaviridae family was identified. The virus belongs to the betacoronavirus genus such as SARS-CoV and MERS-CoV but comes from a different origin than SARS-CoV, the Serbecovirus subgenus. The RNA sequences closely resemble those of the two bat coronaviruses. Hence, it is thought that SARS-CoV-2 originates from bats (38).

Coronaviruses are important human and animal pathogens and viruses that cause disease by attaching to the upper and lower respiratory tract.

While human coronaviruses cause 5-10% of upper respiratory tract infections in the adult age group, this rate increases up to 20-25% in case of an epidemic for a single strain. In the advanced age group, they cause an exacerbation of chronic bronchitis and pneumonia in addition to influenza-like disease (39).

It was revealed that the new coronaviruses, which started to be seen since 2002, progressed in the form of respiratory tract infections with a more severe course than cold symptoms. SARS, a highly contagious atypical pneumonia that was originally thought to be transmitted from bats to civet cats and from them to humans, first appeared in November 2002 in the Guangdong Province of the People's Republic of China. The causative agent was named SARS-CoV. This infection affected 8000 people worldwide,

and approximately 750 deaths were reported, and no new cases were reported for SARS-CoV after 2004 (40).

The second of the new coronavirus infections was observed in Saudi Arabia in 2012. The virus agent thought to be transmitted from camels to humans was defined as MERS-CoV. From 2012 to the end of December 2018, the number of MERS-CoV cases worldwide was reported to the World Health Organization as 2279 and the number of deaths as 806, with a mortality rate of 35.36%. In Saudi Arabia, the starting point of cases, the mortality rate was 39%, with approximately 1901 confirmed cases and 732 related deaths (41). Although MERS-CoV infections are observed in every period of the year, there are findings indicating that they show seasonal distribution. An increase in the number of cases was detected in the spring months of 2013-2014 (42). Each of the factors, such as diabetes mellitus, heart disease, and smoking, has been found to be independently associated with MERS-CoV disease (43).

Although the coronavirus infection has a mild course in many people, the outbreaks of two beta-coronaviruses, severe acute respiratory syndrome coronavirus (SARS-CoV) and Middle East respiratory syndrome coronavirus (MERS-CoV), caused more than 10,000 cumulative cases in the last twenty years (44).

At the end of 2019, a new coronavirus was identified in Wuhan, a city in Hubei province of China, as the cause of a series of pneumonia cases. It spread rapidly and resulted in an epidemic throughout China. Afterward, an increasing number of cases was observed in other countries worldwide. In February 2020, the World Health Organization identified COVID-19 disease, which means coronavirus disease 2019 (45). The virus with the ability to be transmitted from person to person was first detected outside of China on January 13, 2020. It was observed in Taiwan. The disease spread from the Asian continent to the European and American continents in a short period of two months, and the World Health Organization (WHO) declared COVID-19 disease a "Pandemic" on March 11, 2020 (46).

The incubation period of the disease, which is known as the new type of coronavirus and also named SARS-CoV-2 and COVID-19, is known to be 14 days, and findings are usually observed within 2-5 days after contact (39).

Kohn evaluated SARS-CoV-2 cases in Wuhan in his study and found that more than half of the cases at the beginning of the outbreak were sellers working in the market

in Wuhan and their customers. With the increasing number of cases, the risk for healthcare workers has gradually increased. Especially emergency service and intensive care unit workers were infected more (47).

2.6 Stress, Depression, Anxiety, and Psychosocial Risks in Healthcare Workers

Healthcare workers usually suffer from work-related or occupational stress due to high expectations and insufficient time, skills, and/or social support in the workplace. This may cause severe distress, burnout, or physical illness and ultimately a decrease in quality of life and service delivery (48). Healthcare workers take place among the top six most stressful occupations.

The reasons for the stressful work life of healthcare workers can be listed as follows:

- 1) Stressors that originate from the nature of the profession, such as frequent ethical dilemmas and high demands of patients (49).
- 2) Stressors that originate from the working environment and are relatively independent of the patient and the person himself/herself (50).
- 3) Continuous interaction with patients and their relatives and sometimes not finding adequate solutions to problems (50).
- 4) Difficulty in access to psychiatric help (51).

The effects of stress on personnel can be listed in the following way (52):

- 1) Symptoms and disorders, such as depression, anxiety, consequences such as loss of empathy toward patients
- 2) Physical disorders that can be described as psychosomatic
- 3) Cardiovascular diseases
- 4) Conditions leading to behavioral changes such as irritability, alcoholism, and substance abuse

Psychological risk factors such as stress in working life differ from other risk factors because they differ from person to person and it is not known in advance who cannot cope with what. Likewise, the same stressor may cause different outcomes in different people (21, 52).

However, in general, it can be indicated that healthcare workers are exposed to higher psychosocial stress. A study showed that healthcare workers had a higher prevalence of mild mental disorders than general workers and had to work in a higher shift cycle, with longer working hours, heavier psychological work demands, higher job control, and more workplace violence (53).

Likewise, a study carried out in Italy showed that the general health problems of healthcare workers who had worked for more than 15 years were significantly lower than healthcare workers who had worked for a shorter period, and those who spent more time socializing had higher and better mental health scores (54).

The mental status of healthcare workers is also very important because it is easy for them to reach treatment on their own. Substance and drug abuse is more common in those working in fields such as emergency medicine, psychiatry, and anesthesia than in other fields, and it is thought that it is important to provide this training to healthcare workers in the early period so that this risk can be recognized early by workers (55).

Many studies have been carried out on the prevention and resolution of burnout and other mental disorders in the workplace. According to one of them, fair leadership, a positive social environment in the workplace, adequate support from superiors, and a reasonable workload seem to be important factors in preventing burnout. It may be helpful to establish peer support groups for the solution of the mental distress in relieving work-related stress and burnout.

2.6.1. Stress, Anxiety, and Psychosocial Risks in Healthcare Workers During the COVID-19 Pandemic

Pandemics from past to present have caused many deaths and physical and mental problems and created a severe public health threat. Healthcare workers have been affected by many different infectious diseases and are considered among the groups with the highest potential to be affected by future epidemics (56). The levels of exposure of healthcare workers to SARS-CoV-2 are evaluated as “very high” and “high” according to the risk category. In the SARS-CoV-2 exposure risk classification, interventions with close contact generating aerosols in known and suspected COVID-cases, sample collection and processing, autopsy of deceased cases are considered to have “very high” risk, while exposure to known or suspected COVID-19 patients in non-aerosolized

procedures with close contact is considered to have “high” risk. While branches with very high risk include doctors, nurses, dentists, paramedics, emergency medical technicians, health and laboratory personnel collecting samples, morgue workers performing autopsies, branches with high risk include doctors, nurses, and other hospital personnel who need to enter patient rooms (57).

During epidemics, healthcare workers are in close contact with infected individuals. In this period, healthcare workers who play an active role in struggling against the epidemic are at a high risk of transmission. At the beginning of the outbreak, the physical effects of the disease on people were emphasized, but not much importance was attached to its psychological effects. The mental health of healthcare workers working especially in intensive care and emergency services is adversely affected to a significant extent.

Studies performed in China during the COVID-19 pandemic also support that the level of anxiety of healthcare personnel has increased significantly. The increased level of anxiety was found to be associated with the high risk of being infected in the healthcare sector, the institution not providing a psychological support program at the required rate, the person's lack of knowledge about emergency response plans, and excessive workload (41).

3. MATERIALS and METHODS

The job requirements have changed significantly due to migration, technological developments, and changes in working conditions in recent years. Current studies have demonstrated that certain work and organizational characteristics, such as job requirements, level of control over work, role clarity, support and reward mechanisms, and interpersonal relationships, influence work-related stress and health. As a result of these conditions, psychosocial risks in working life have started to gain importance worldwide.

In addition to these, the whole world has started to struggle against the COVID-19 pandemic in the last year and a half. The psychological effects of this disease, in addition to its physical effects, have reached devastating levels. It is observed that healthcare workers who work actively during the pandemic are at high risk in psychosocial terms as a negative result of working long working hours at an intense tempo. Psychosocial factors have been previously evaluated in different occupational groups in the world and Turkey. However, this study will be the first one to measure the psychosocial factors of healthcare workers during the COVID-19 pandemic in Turkey.

Moreover, it is thought that a multidimensional informative study that evaluates the psychosocial factors, coronavirus anxiety levels, and general health status of employees according to their ways of coping with stress during the pandemic will emerge.

3.1. Objective

This study aims to measure the psychosocial factors of healthcare workers and assess their psychosocial factors, coronavirus anxiety levels, and general health status according to their ways of coping with stress.

The research objectives are as follows;

To reveal the effect of healthcare workers' sociodemographic data and working conditions during the COVID-19 pandemic on their general health status and coronavirus anxiety levels,

To reveal the effect of psychosocial factors to which healthcare workers are exposed on their general health status and coronavirus anxiety levels,

To reveal the effect of healthcare workers' ways of coping with stress on coronavirus anxiety levels and general health status,

To assess the relationship between healthcare workers' ways of coping with stress and psychosocial factors.

3.2. Type of Research

This is a cross-sectional and analytical study.

3.3. Region of Research

Ağrı Training and Research Hospital, which is the only hospital in the city center of Ağrı, and healthcare workers working in the annex buildings of the hospital were included within the scope of the research.

3.4. Duration of Research

After the Ethics Committee approval dated 09.11.2020 and numbered 16 was received from the Ağrı Provincial Health Directorate, the study was started by applying questionnaires. The data collection stage of the study was carried out between November 2020 and February 2021.

3.5 Research Population and Sample

The research population consists of a total of 908 employees, aged above 18 years and actively working in Ağrı Training and Research Hospital, such as doctors, nurses, midwives, technicians, assistant health personnel, medical secretaries, cleaning-kitchen-security and permanent workers. Sample selection was not performed in the study, and it was aimed to reach all employees. The inclusion criteria were determined as working at the hospital where the research was conducted, being older than 18 years, being literate, and volunteering to participate in the study. Necessary permissions were obtained from the workplaces where the research would be conducted. It was stated verbally and in writing that participation in the study was voluntary, and consent was obtained from the participants. Questionnaires were applied to the participants anonymously.

3.6. Variables

Scales;

- ◆ Psychosocial risk
- ◆ Coronavirus anxiety level
- ◆ Ways of coping with stress

◆ General health level

Sociodemographic Variables;

◆ Age

◆ Gender

◆ Marital status

◆ Educational background

◆ Presence of chronic disease

◆ Regular drug use

◆ The main duty in the hospital

◆ Managerial duty

◆ Status and duration of working in the COVID-19 field

◆ Family, relatives, and close friends being infected with COVID-19

◆ The death of the family, relatives, and close friends due to COVID-19

◆ Accommodation plan of people sharing the same house

◆ Status of consulting a psychiatrist before and after COVID-19

◆ Presence of a diagnosed mental illness

3.7. Definitions and Criteria of Variables

3.7.1. Scales

Variable	Definition	Source	Scale
Psychosocial Risk	The Copenhagen Psychosocial Questionnaire (COPSOQ), which is a medium-length version of the questionnaire, whose short, medium, and long versions were developed by Kristensen et al. (2005) and which was adapted to Turkish with a master's thesis of the public health expert Ceyda Şahan (2016), was used. The COPSOQ was developed approximately 20 years ago when Tage S. Kristensen and Vilhelm Borg started working with the psychosocial research group at the Danish National Institute of Occupational Health. Prior to this, the Institute primarily addressed physical, chemical, and ergonomic risks in the workplace. The short version covers the questions that the scale must include at least for psychosocial risk assessment. The standard version covers the questions in the 'Core' version and the questions added in the 'standard' version. The long version covers all dimensions and questions. The COPSOQ-3 adapted to Turkish includes all questions in the 'Standard' version, some questions in the 'Long' version, a question that is included in the COPSOQ-2 but not in the COPSOQ-3 and consists of 24 dimensions and 84 items. While assessing the scale, five-point Likert-type questions (0, 25, 50, 75, 100) and four-point Likert-type questions (0, 33.3, 66.6, 100) were converted into a hundred system in the form of points. The score of each dimension was calculated by taking the arithmetic mean of the response scores in the relevant dimension. When performing risk assessment, the median value (50% percentile) of the dimensions was taken as the cut-off point. While determining the risk situation, the cut-off point (median value) and above points are considered the high-risk group if an increase in the score in the relevant dimension represents the risk, and the cut-off point (median value) and below scores are considered the high-risk group if a decrease in the score indicates the risk. Other scores are included in the low-risk group. While risk decreases with a decrease in the scores obtained from the dimensions of work pace, qualitative demands, cognitive demands, emotional demands, demand to conceal feelings, role conflicts, quantitative job insecurity, qualitative job insecurity, work-home conflict, risk decreases with an increase in the scores obtained from the dimensions of influence at work, possibilities for development, degree of freedom at work, meaning of work, commitment to work, predictability, recognition, role clarity, leadership quality, social support from colleagues, social support from management, sense of community, trust, justice and respect, and job satisfaction (58).	Copenhagen Psychosocial Questionnaire	Ordinal/ Dichotomous
COVID Anxiety Level	It is a short mental health screening scale developed by Lee to identify possible cases of anxiety associated with the COVID-19 crisis. The validity and reliability studies in Turkish	Coronavirus Anxiet Scale	Ordinal/ Dichotomous

	were carried out by Cüneyt Evren et al. The CAS is a 5-point Likert-type scale. The scale consists of 5 questions and one dimension. The scoring of the scale is as follows: “0” indicates “never,” “1” “Rarely, less than one or two days,” “2” “A few days,” “3” “More than 7 days,” and “4” “Almost every day in the last two weeks.” The author states in his paper that “no official permission is required for the reproduction and use of the Coronavirus Anxiety Scale by others beyond proper reference to the study to promote its use in clinical evaluation and research.” With this explanation, the author permitted the researchers to use the scale (59).		
Types of approach in case of stress	The reliability coefficients of the subscales determined as a result of three separate studies of the Ways of Coping with Stress Scale vary between 0.62 and 0.80 for the self-confident approach, between 0.64 and 0.73 for the desperate approach, between 0.49 and 0.68 for the optimistic approach, between 0.47 and 0.72 for the submissive approach, and between 0.45 and 0.47 for the search for social support approach (60).	Ways of Coping with Stress Scale	Ordinal
Assessment of recent general health	It is a questionnaire filled out by the participants and developed by Goldberg (1972, 1978) to distinguish mental illness, especially in primary care. It has been adapted to many different languages and cultures to date. Its short forms consisting of 30, 28, and 12 questions, which were developed after the 60-question form, were found to be equally reliable. The GHQ used in this study contains 12 questions. Each question includes 4 options: never-as much as usual-more often than ever-very often. Responses can be scored on a Likert-type scale (0-1-2-3) or (0-0-1-1) as recommended in the GHQ handbook. After the participants fill out the questionnaire, the selected scoring method can be applied. We preferred to use the (0-0-1-1) scoring form in our study. Its Turkish validity and reliability study was conducted by Kılıç (1996). The cut-off point of the GHQ-12, with a sensitivity of 0.74 and a specificity of 0.84, recommended for patients presenting to the health center with any somatic complaint is 1/2, referring to a total GHQ score between 1-2 (61). The highest possible score is “12,” and the lowest score is “0.” A score of 4 and higher is considered as a “high” score, a score of 2-3 as a “moderate” score, and a score less than 2 as a “low” score. Those with a GHQ-12 score of 4 and higher are defined as the “risk group for mental illnesses” (62).	General Health Questionnaire-short form (GHQ-12)	Ordinal/ Dichotomous

3.7.2 Sociodemographic Variables

Variable	Definition	Source	Scale
Age	Calculated from the question about the date of birth in the questionnaire.	Questionnaire	Continuous
Gender	The participant's gender was defined.	Questionnaire	Dichotomous
Educational background	It is based on the response to the question What is your educational background according to the last school you graduated from? The variable consists of 7 categories.(Elementary school, Secondary school, High school, Associate degree, Undergraduate, Master's degree, Doctorate. While presenting the data.....)	Questionnaire	Ordinal
Presence of chronic disease	It is based on the response to the question Do you have any chronic disease diagnosed by a doctor? Options are presented in such a way that more than one option can be marked, such as heart disease, asthma, rheumatic diseases, hypertension, and disability. While presenting the data, they are arranged as there is a chronic disease, there is no chronic disease.	Questionnaire	Dichotomous
Regular drug use	It is based on the response to the question Do you use any drug regularly?	Questionnaire	Dichotomous
The main duty in the hospital	It is based on the response to the question What are the main duties you are responsible for in the	Questionnaire	Ordinal

	hospital? While presenting the data, the answers are arranged by classifying occupational groups into 4 categories.		
Managerial duty	It is based on the response to the question Do you have a managerial duty?	Questionnaire	Dichotomous
Status of working in the COVID-19 field	It is based on the response to the question Are you still actively working in the COVID-19 field?	Questionnaire	Dichotomous
Duration of working in the COVID-19 field	It is based on the response to the question How many days a week do you work in the COVID-19 field?	Questionnaire	Ordinal
Having a person infected with COVID-19 in the immediate surroundings	It is based on the response to the question Have any of your family, relatives, or close friends been infected with COVID-19?	Questionnaire	Dichotomous
The death of a person due to COVID-19 in the immediate surroundings	It is based on the response to the question Have any of your family, relatives, or close friends been infected and died due to COVID-19?	Questionnaire	Dichotomous
Status of making accommodation plans	It is based on the response to the question Have you made a plan for accommodation in case the person or people with whom you share the same house is infected with COVID-19?	Questionnaire	Dichotomous
Status of consulting a psychiatrist before COVID-19	It is based on the response to the question Have you consulted a psychiatrist	Questionnaire	Dichotomous

	before the COVID-19 pandemic?		
Status of consulting a psychiatrist after COVID-19	It is based on the response to the question Have you consulted a psychiatrist after the COVID-19 pandemic?	Questionnaire	Dichotomous
Presence of a diagnosed mental illness	It is based on the question In case you currently have a diagnosed mental illness, could you please indicate what it is? While presenting the data, the answers are arranged in 2 categories as "there is/there is no mental illness."	Questionnaire	Dichotomous

3.8. Exclusion Criteria of the Study

Among the individuals participating in our study, which was conducted between November 2020 and February 2021, those who were assigned outside the hospital, those on paid or unpaid leave, those who did not want to participate in the study, and those who did not want to fill out the consent form were not included in the sample.

3.9. Data Collection Method

The questionnaires consisting of 5 sections and 156 questions applied within the scope of the study were distributed by hand together with the consent form. Before distributing the questionnaires, a preliminary test study was performed on 10 people to determine deficiencies and faults in the questionnaires. Necessary explanations about the questionnaires were included in the consent form. In case of any misunderstanding that emerged while filling out the questionnaires, the healthcare workers participating in the study were informed by providing the necessary information. Questionnaires were collected from the healthcare workers who filled out the questionnaire.

3.9.1. Sociodemographic characteristics information form

This form was prepared to question the participants' personal information such as their marital status, age, gender, educational background, number of children, known chronic diseases and drug use, the content of the job in the workplace, whether they have taken part in the pandemic, whether there has been a change of duty after the pandemic, how often they have actively taken part in the COVID-19 field, to what extent they regard themselves at risk and to what extent they protect themselves, whether there are people among their family or friends diagnosed with COVID-19, hospitalized in the intensive care unit or losing their lives due to COVID-19, what kind of plan they have made for isolation if they are infected with COVID-19, whether they have consulted a psychiatrist before and after the pandemic or have a psychiatric illness.

3.9.2. Copenhagen Psychosocial Questionnaire (COPSOQ) Assessment Information Form

It is a scale used in the study for psychosocial risk assessment. The long version of the scale consists of 25 sub-dimensions. The twenty-four sub-dimensions of the scale were evaluated in our study. A total of 24 sub-dimensions, including work pace, quantitative demands, cognitive demands, emotional demands, concealing feelings, influence at work, lack of possibilities for development, lack of freedom at work, meaninglessness of work, lack of commitment to work, lack of predictability, lack of recognition, lack of role clarity, role conflicts, lack of leadership quality, lack of social support from colleagues, lack of social support from management, lack of sense of community, job insecurity, insecurity of working conditions, work-home conflict, lack of trust, lack of justice and respect, and lack of job satisfaction, are questioned with eighty-four questions.

3.9.2.1. Sub-dimensions of the COPSOQ

	Code of the dimension	Name of the dimension (Psychosocial risks)	Meaning of the dimension
1	WP	Work pace	It indicates the pace at which the employee must cope with his/her duties. It measures the work intensity.

2	QD	Quantitative demands	It indicates the amount of work the employee is coping with to fulfill his/her duty. Quantitative demands can be used to assess the inconsistency between the amount of work and the time available to perform the duty.
3	CD	Cognitive demands	It indicates the demands that the employee must deal with using his/her cognitive abilities.
4	ED	Emotional demands	It indicates the demands that the employee must deal with when he/she has conflict with his/her own feelings or feelings of other people. Other people can be customers, patients or students, etc., with whom the employee does not work, and colleagues, superiors, or subordinates with whom he/she works in the workplace.
5	FC	Demand to conceal feelings	It indicates the presence of situations that require employees to conceal their feelings from other people in the workplace. Other people can be customers, patients or students, etc., with whom the employee does not work, and colleagues, superiors, or subordinates with whom he/she works in the workplace.
6	IW	Lack of influence at work	It indicates the extent to which the employee can influence his/her work. For example, this includes situations that may range from planning work to putting tasks in order. Lack of influence at work is a psychosocial risk.
7	PD	Lack of possibilities for development	The possibility for development addresses situations in which the employee's duties may change. If duties provide opportunities for learning, they support personal development as well as workplace development. The lack of development may create indifference, helplessness, and passivity. Lack of possibilities for development is a psychosocial risk.
8	FW	Lack of freedom at work	It addresses the extent to which the employee can affect situations such as holidays, length of working day or hours. Lack of freedom at work is a psychosocial risk.
9	MW	Meaninglessness of work	The meaning of work refers to all of the concerns about the purpose and content of the duties at work. The purpose is considered vertical significance and is associated with the general purpose of work, such as healing patients or obtaining useful products. The content is considered vertical significance and is related to how much the employee's work contributes to the overall product in his/her opinion. The meaninglessness of work is a psychosocial risk.
10	CW	Lack of commitment to work	Commitment to work refers to the extent to which an employee is committed to the workplace according to his/her experience. Here, the focus is on the commitment to the organization the employee works for, not the work he/she does on his/her own or the group he/she works for. Lack of commitment to work is a psychosocial risk.
11	P	Lack of predictability	It addresses avoiding uncertainty and insecurity. Predictability aims to ensure that employees receive appropriate and sufficient information at the right time. Lack of predictability is a psychosocial risk.

12	R	Lack of recognition	Recognition refers to the management's understanding of the employee's effort in the workplace. Lack of recognition is a psychosocial risk.
13	RC	Lack of role clarity	Role clarity addresses employees' understanding of their roles in the workplace, such as the content of their duties, expectations, and responsibilities that must be met. Lack of role clarity is a psychosocial risk.
14	RC	Role conflicts	Role conflicts have two sources. The first is related to the presence of demands within the duty that conflict with the nature of the duty. The second is related to the overlapping of priorities of different duties.
15	LQ	Lack of leadership quality	Leadership quality addresses the ability of the manager above the employee in different contexts and impact areas. Lack of leadership quality is a psychosocial risk.
16	SSC	Lack of social support from colleagues	It addresses employees' views on possibilities to receive support from their colleagues when they need it. Lack of social support from colleagues is a psychosocial risk.
17	SSM	Lack of social support from management	It addresses employees' views on the possibilities of receiving support from their superiors when they need it. Lack of social support from superiors is a psychosocial risk.
18	SC	Lack of sense of community	It is defined as the employee's feeling of being part of a community in the workplace when relations between employees are good and they work well together. Lack of sense of community is a psychosocial risk.
19	JI	Job insecurity	It defines the employee's view on job security in situations such as being fired or the possibility of finding a new job if fired.
20	IWC	Insecurity of working conditions	It defines the employee's view on job security in situations related to working conditions, such as the job content. For example, a decrease in working hours or wages in case of a change of the company's owner.
21	WHC	Work-home conflict	It addresses the possible outcomes of work on the family and personal life. It focuses on conflicts in the two domains related to energy (mental and physical) and time.
22	T	Lack of trust	Horizontal trust addresses whether employees trust each other in their daily work. Trust can be observed in communication between employees in the workplace. For example, employees can state their attitudes and feelings without fear of negative reactions. Vertical trust addresses employee trust in management. Vertical trust can be observed in communication between employees and management. Lack of trust is a psychosocial risk.
23	JR	Lack of justice and respect	Justice and respect are related to treating employees fairly in the workplace. It is addressed from four perspectives. The first is task distribution and recognition, the second is the sharing process, the third is the handling of conflicts, and the fourth is addressing

			employee suggestions. Lack of justice and respect is a psychosocial risk.
24	JS	Lack of job satisfaction	It indicates the satisfaction of employees in terms of various aspects of the job. Lack of job satisfaction is a psychosocial risk.

3.9.2.2. Scoring of the COPSOQ

COPSOQ-TR Assessment Questionnaire (Each question should be answered separately, and one option should be marked on each line.)						
Question No and Code*	Questions	Always	Frequently	Sometimes	Rarely	Never/ Almost never
1.WP-C	Do you have to work very fast?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
2.WP-C	Do you work at a high pace during the day?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
3. WP-L	Do you need to keep working at a high pace?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
4. QD-S	Does your workload pile up because it is not evenly distributed?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
5. QD-C	Do you get behind with your work?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
6. QD-C	How often does it happen that you do not have enough time to complete all your duties?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
7. CD-L	Do you have to pay attention to too many things while working?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
8. CD-L	Does your job require you to remember too many things?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
9. CD-L	Does your job require you to come up with new ideas?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
10. CD-L	Does your job require you to make difficult decisions?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
11. ED-S	Does your job put you in emotionally uncomfortable situations?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
12. ED-C	Does part of your job require you to deal with the personal problems of other people?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
13. ED-C	Does your job burden you emotionally?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
14. FC-S	Does your job require you to conceal your views?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
15. FC-S	Does your job require you to conceal your feelings?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
		Always	Frequently	Sometimes	Rarely	Never/ Almost never
16. FC-S	Is it expected from you to be open and polite to everyone, no matter how they treat you?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
17. IW-C	Do you have a significant influence on the decisions taken regarding your work?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
18. IW-L	Do you have a say in choosing your colleagues?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100

19. IW-S	Do you have an influence in determining the amount of work assigned to you?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
20. IW-S	Can you decide WHAT to do in your job?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
21. IW-S	Do you have an influence on HOW you do your work?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
22. PD-L	Do you have various duties in your job?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
23. PD-C	Do you have the opportunity to learn new things in your job?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
24. PD-C	Can you use your skills or expertise in your job?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
25. PD-S	Does your job provide you with the opportunity to develop your skills?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
26. FW-S	Can you decide when to take a break from work?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
27. FW-S	Is your annual leave time determined approximately according to your request?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
28. FW-S	Can you take a break from work for a short chat with your colleague?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
29. FW-S	Can you leave the workplace for half an hour without special permission for your personal business?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
30. FW-L**	~~Do you have to work overtime?~~	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
		To a very significant extent	To a significant extent	To a moderate extent	To a low extent	To a very low extent
31. MW-C	Do you find your work meaningful?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
32. MW-S	Do you feel that your work is important?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
33. MW***	Do you feel motivated and involved in your work?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
34. CW-L	Do you like telling others about your workplace?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
35. CW-L	Do you think your workplace is a very important place for you?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
36. CW-L	Are you proud to be a member of this workplace?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
37. P-C	Are you informed in advance of important decisions, changes, or future plans in your workplace?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
38. P-C	Do you receive the information you need to do your job well?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
39. R-C	Is your work recognized and appreciated by the management?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
40. R-L	Does the management respect you?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
41. R-L	Are you treated fairly at work?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
42. RC-C	Are the goals of your job clearly defined?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
43. RC-S	Do you know which areas are definitely your responsibility?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
44. RC-S	Do you know exactly what is expected of you in your job?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
45. RC-C	Are there conflicting demands from you in your job?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
46. RC-C	Do you sometimes have to do things that you think should have been done differently?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0

47. RC-S	Do you sometimes have to do things that seem unnecessary to you?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
To what extent does a superior...		To a very significant extent	To a significant extent	To a moderate extent	To a low extent	To a very low extent
48. LQ-S	Provide adequate development opportunities for each employee?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
49. LQ-L	Prioritize the job satisfaction of employees?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
50. LQ-C	Is good at job planning?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
51. LQ-C	Is good at resolving conflicts?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
		Always	Frequently	Sometimes	Rarely	Never/ Almost never
52. SSC-C	How often do you receive help and support from your colleagues?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
53. SSC-S	How often are your colleagues willing to listen to your work-related problems?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
54. SSC-L	How often do your colleagues talk to you about how you do your work?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
55. SSM-C	How often do you receive help and support from your immediate superior?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
56. SSM-S	How often is your immediate superior willing to listen to your work-related problems?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
57. SSM-S	How often does your superior talk to you about how you do your job?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
58. SC-C	Is the environment of friendship good at your workplace?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
59. SC-L	Is there good cooperation between your colleagues in the workplace?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
60. SC-S	Do you feel that you belong to a community in your workplace?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
Are you worried about the following		To a very significant extent	To a significant extent	To a moderate extent	To a low extent	To a very low extent
61. JI-C	Being unemployed?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
62. JI-L	Being unemployed due to the use of a new technology?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
61. JI-C	Difficulty finding a new job if you are unemployed?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
64. IWC-C	Being transferred to another job against your will?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
65. IWC-S	Your working time (shift, commuting, working days, etc.) being changed against your will?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
66. IWC-S	A decrease in your salary?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
		Always	Frequently	Sometimes	Rarely	Never/ Almost never
67. WHC-L	Are there times when you need to be at home and work at the same time?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
68. WHC-C	Do you feel that your job affects your private life adversely because it consumes most of your energy?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
69. WHC-C	Do you feel that your job affects your private life adversely because it takes most of your time?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0

70. WHC-L	Do the demands of your job disrupt your private and family life?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
71. WHC-L	Do you have to change your plans for family and private life activities due to work-related duties?	☐ 100	☐ 75	☐ 50	☐ 25	☐ 0
		To a very significant extent	To a significant extent	To a moderate extent	To a low extent	To a very low extent
72. T-S	Do employees in the workplace generally trust each other?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
73. T-C	Does management trust employees that they do their job well?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
74. T-C	Do employees trust the information provided by the management?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
75. T-S	Can employees express their views and feelings?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
76. JR-C	Are conflicts resolved fairly?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
77. JR-C	Is the workload evenly distributed?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
78. JR-L	Are employees appreciated when they do their jobs well?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
79. JR-L	Are all the suggestions of employees seriously considered by the management?	☐ 0	☐ 25	☐ 50	☐ 75	☐ 100
How satisfied are you with the following regarding your job?		Very satisfied	Satisfied	Not satisfied	Not satisfied at all	
80. JS-S	Your future expectations.	☐ 0	☐ 33.3	☐ 66.6	☐ 100	
81. JS-L	Physical working conditions.	☐ 0	☐ 33.3	☐ 66.6	☐ 100	
82. JS-L	The way your abilities are used.	☐ 0	☐ 33.3	☐ 66.6	☐ 100	
83. JS-C	Your job in general when everything is considered	☐ 0	☐ 33.3	☐ 66.6	☐ 100	
84. JS-S	Your salary	☐ 0	☐ 33.3	☐ 66.6	☐ 100	

3.9.3. Short Form of the Coronavirus Anxiety Scale (CAS)

During the COVID-19 pandemic, there has been an increase in the levels of fear, anxiety, and panic worldwide due to the high contagiousness of the disease, news, social media, and increased restrictions due to the disease. Accordingly, it is a scale consisting of a single factor and 5 questions to measure the anxiety level.

3.9.4. Ways of Coping with Stress Scale (WCSS)

When the scale is reduced to 30 items and brought to its final shortened form, it consists of 5 sections, including the self-confident approach, desperate approach, submissive approach, optimistic approach, and search for social support approach. It was included in the study to assess coping approaches in case of stress.

3.9.5. General Health Questionnaire (GHQ-12)

Mental health status was assessed using the 12-question form of the General Health Questionnaire. The most common method to identify mental disorders in primary

health care is the daily application of screening tests. The GHQ-12 was used in the study to identify individuals with a high probability of depression because the questions are short and understandable, its validity and reliability studies have been conducted, and sensitivity rates are high.

The questionnaire used in the study is presented in Appendix-1.

3.10. Reach Rate

The population of our study consists of health personnel aged above 18 years and working in Ağrı Training and Research Hospital. In the analyzed data, it was determined that the number of personnel actively working in the hospital during the period of our study was 908 people. Since our study is a psychosocial risk screening study, it was aimed to reach all employees in the hospital. However, it remained limited to the rate of reaching a total of 500 health personnel aged between 20-61 years.

3.11. Reasons for Non-Reach

In the study, the participants' identity information was obtained in the consent form distributed together with the questionnaire, and the questionnaires were responded. It is thought that this creates privacy concerns in the participants and decreases the participation rate in surveys.

The reach rate in our study remained limited to 55%. It is thought that the most important reason for this is that there are 4 scales in the questionnaire and time is required to fill out the questionnaire because there are many questions in the COPSOQ. It is thought that the rate of participation of healthcare workers in the study has decreased due to the workload during this period when the COVID-19 pandemic continues with great momentum.

Time stability could not be evaluated in our study since test-retest could not be applied.

3.12. Analysis

While performing statistical evaluation in the study, the chi-squared and Mann-Whitney U tests were conducted to evaluate the relationship between sociodemographic variables, job knowledge variables, COVID-19 status variables and the General Health Questionnaire-12, Coronavirus Anxiety Short Scale, and Ways of Coping with Stress Scale. Logistic regression analysis was carried out to examine the adjusted relationships between the Ways of Coping with Stress Scale and the COPSOQ.

4. RESULTS

4.1.Descriptive Findings

Of a total of the 500 volunteer participants consisting of hospital staff, 57.6% are male, and 42.4% are female (Tabl 1).

Table 4.1. Distribution of the research participants by gender

Gender	Number	%
Female	212	42.4
Male	288	57.6
Total	500	100.0

Table 4.2. Socioeconomic status variables of the research participants

	Number	%
Age distribution		
20-29 years	223	44.6
30-39 years	175	35.0
>40 years	102	20.4
Marital status		
Married	292	58.4
Single	208	41.6
Total	500	100.0
Number of children		
No children	277	55.4
1-2 children	61	29.2
>3 children	77	15.4
Total	500	100.0
Educational background		
Elementary school, Secondary school, High school	130	26.0
Associate degree	106	21.2
Undergraduate	189	37.8
Master's degree, Doctorate	75	15.0
Total	500	100.0

Of the research participants, 44.6% are in the 20-29 age range, 35.0% in the 30-39 age range, and 20.4% are in the >40 age range. Of the participants, 58.4% are married, and 41.6% are single. While 55.4% of the research participants do not have children, 29.2% have 1-2 children, and 15.4% have >3 children. In terms of educational background, 26.0% of the participants are elementary school, secondary school and high school graduates, 21.2% have an associate degree, 37.8% have an undergraduate degree, and 15.0% have a master's and doctorate degree.

Table 4.3.Health status variables of the research participants

	Number	%
Chronic Disease		
Available	94	18.8
Not available	406	81.2
Total	500	100.0
Regular Drug Use		
Yes	67	13.4
No	433	86.6
Total	500	100.0
General Health		
Good	373	74.6
Moderate	111	22.2
Poor	16	3.2
Total	500	100.0

When the presence of chronic disease was questioned to investigate the health status variables of the research participants, it was observed that 18.8% of them had a chronic disease, while 81.2% of them did not have a chronic disease. When the workers were asked about regular drug use, it was found that 13.4% of them used drugs regularly and 86.6% did not use drugs. When the workers were asked how they evaluate their general health, 74.6% stated it as good, 22.2% as moderate, and 3.2% as poor.

Table 4.4. Variables of the workplace working life status of the research participants

	Number	%
Time of starting working in the workplace		
Less than 10 years	417	83.4
Between 10 and 20 years	69	13.8
More than 20 years	14	2.8
Total	500	100.0
The main duty in the hospital		
Doctor	67	13.4
Dietitian, pharmacist, physiotherapist, psychologist, nurse	187	37.4
Secretary, technician	147	29.4
Personnel (security, cleaning staff, kitchen staff, worker)	99	19.8
Total	500	100.0
Managerial duty		
Yes	46	9.2
No	454	90.8
Total	500	100.0

Upon evaluating the variables of the workplace working life status, those who have worked for less than 10 years in this workplace constitute 83.4% of the participants, while the rate of those working for 10-20 years is 13.8%, and the rate of those working for more than 20 years is 2.8%. Concerning the main duties of the workers, 13.4% are doctors, 37.4% are dietitians-pharmacists-physiotherapists-psychologists-nurses, and

19.8% are personnel. When the workers were asked about the presence of managerial duties, 9.2% responded as yes, while 90.8% responded as no.

Table 4.5. Variables of the life status caused by COVID-19 of the research participants

	Number	%
Change of duty and place during the COVID-19 pandemic		
Yes	201	40.2
No	299	59.8
Total	500	100.0
Status of taking duty in the COVID-19 field		
Yes	272	54.4
No	228	45.6
Total	500	100.0
Status of still taking duty in the COVID-19 field		
Yes	246	49.2
No	254	50.8
Total	500	100.0
Working in the COVID-9 field for how many days a week		
None	212	42.4
1-3 days	170	34.0
4-7 days	118	23.6
Total	500	100.0
To what extent a person feels that he/she is protected from infection		
Little	115	23.0
Moderately	173	34.6
Well	209	41.8
Total	497	99.4
To what extent a person feels that he/she is at risk while working in the COVID-19 field		
Little	77	15.4
Moderately	82	16.4
A lot	229	45.8
Total	388	77.6
Having people among the family, relatives, and friends being infected with COVID-19		
Yes	416	83.2
No	84	16.8
Total	500	100.0
Having people among the family, relatives, and friends being infected with COVID-19 and followed up in the intensive care unit		
Yes	152	30.4
No	348	69.6
Total	500	100.0
Having people among the family, relatives, and friends being infected with COVID-19 and dying due to COVID-19		
Yes	112	22.4
No	388	77.6
Total	500	100.0
Making an accommodation plan with the people with whom they share the same house		
Yes	230	46.0
No	270	54.0
Total	500	100.0
Plan 1: Compliance with isolation rules in different rooms in the same house		

Yes	232	46.4
No	268	53.6
Total	500	100.0
Plan 2: Accommodation in a different house or hotel, etc.		
Yes	73	14.6
No	427	85.4
Total	500	100.0
Plan 3: Being treated at hospital		
Yes	16	3.2
No	484	96.8
Total	500	100.0
Plan 4: Non-compliance with isolation rules		
Yes	32	6.4
No	468	93.6
Total	500	100.0
Consulting a psychiatrist before the COVID-19 pandemic		
Yes	38	7.6
No	462	92.4
Total	500	100.0
Consulting a psychiatrist after the COVID-19 pandemic		
Yes	37	7.4
No	463	92.6
Total	500	100.0
Presence of a diagnosed mental illness		
Yes	67	13.4
No	433	86.6
Total	500	100.0

When the variables of the life status caused by COVID-19 disease of the research participants were examined, it was revealed that 40.2% had a change in duty and place during the COVID-19 pandemic, 54.4% of the participants worked in the COVID-19 field, 49.2% were still actively working in the COVID-19 field, 34.0% worked 1-3 days a week, and 23.6% worked in the COVID-19 field 4-7 days a week. Moreover, it was understood that 23.0% of the participants felt that they protected themselves little in terms of infection, 34.6% felt that they protected themselves moderately, and 41.8% felt that they protected themselves well. While 15.4% of those working in the COVID-19 field felt themselves at a low risk, 16.4% felt themselves at a moderate risk, and 45.8% at a high risk. Of the 500 survey respondents, 83.2% had people among their family, relatives, and friends who were infected with COVID-19, 30.4% had patients among their family, relatives, and friends followed up in the intensive care unit due to COVID-19, and 22.4% had a relative who died due to COVID-19. It was found that 46% of the workers made an accommodation plan with the people with whom they shared the same house and in this planning, 46.4% would comply with isolation rules in different rooms in the same house, 14.6% made an accommodation plan in a different house or hotel, 3.2% were isolated in the hospital, and 6.4% did not comply with isolation rules. It was understood that of the

500 volunteers who filled out the questionnaire, 7.6% consulted a psychiatrist before the COVID-19 pandemic, 7.4% consulted a psychiatrist after the COVID-19 pandemic, and 13.4% had a diagnosed mental illness.

4.2. Relationship Between Sociodemographic Variables and General Health Risk

Table 4.6. Relationship between the sociodemographic and general health status variables of the research participants

	GENERAL HEALTH				p-value*
SOCIODEMOGRAPHIC STATUS VARIABLES	Low risk		High risk		
	n (127)	% (25.5)	n (372)	% (74.5)	
Gender					0.539
Female (n=212)	51	52.4	161	47.6	
Male (n=287)	76	51.9	211	48.1	
Age					0.142
Between 20-29 years (n=222)	49	22.1	173	77.9	
Between 30-39 years (n=175)	45	25.7	130	74.3	
40 years and above (n=102)	33	32.4	69	67.6	
Marital status					0.015
Married (n=292)	86	29.5	206	70.5	
Single (n=207)	41	19.8	166	80.2	
Presence of children					0.230
None (n=276)	62	22.5	214	77.5	
1 and 2 children (n=146)	42	28.8	104	71.2	
>3 children (n=77)	23	29.9	54	77	
Presence of chronic disease					0.984
No (n=405)	103	25.4	302	74.6	
Yes (n=94)	24	25.5	70	74.5	
Presence of mental illness					0.015
No (n=432)	118	27.3	314	72.7	
Yes (n=67)	9	13.4	58	86.6	
Regular drug use					0.358
No (n=432)	113	26.2	319	73.8	
Yes (n=67)	14	20.9	53	79.1	
Educational background					0.257
Elementary school-Secondary school-High school (n=130)	28	21.5	102	78.5	
Associate degree (n=105)	28	26.7	77	73.3	
Undergraduate (n=189)	56	29.6	133	70.4	
Master’s degree/Doctorate/Post Doctoral (n=75)	15	20.0	60	80.0	

When the sociodemographic status variables and the General Health Questionnaire (GHQ-12) were compared, the relationship between marital status, presence of mental illness, and the General Health Questionnaire was found to be statistically significant ($p=0.015$; $p=0.015$). No significant relationship was detected between other variables ($p>0.05$).

Table 4.7. Relationship between the job information and general health status variables of the research participants

	GENERAL HEALTH				p- value*
JOB INFORMATION STATUS VARIABLES	Low risk		High risk		
	n (127)	% (25.5)	n (372)	% (74.5)	
Job seniority					0.834
<10 years (n=416)	108	26.0	308	74.0	
10-20 years (n=69)	16	23.2	53	76.8	
>20 years (n=14)	3	21.4	11	78.6	
Managerial duty					0.188
Yes (n=46)	8	17.4	38	82.6	
No (n=453)	119	26.3	334	73.7	
Duty in the hospital					0.778
Doctor (n=67)	14	20.9	53	79.1	
Nurse, Pharmacist, Dietitian, Physiotherapist, Psychologist (n=187)	50	26.7	137	73.3	
Medical Secretary, ATT, Technician (n=146)	39	26.7	107	73.3	
Personnel (Cleaning, Security, Kitchen, Worker) (n=99)	24	24.2	75	75.8	

Upon comparing the research participants' job information data and the GHQ-12, no statistically significant relationship was revealed ($p>0.05$).

Table 4.8. Relationship between the COVID-19 status variables and general health status variables of the research participants

	GENERAL HEALTH				p-value*
COVID-19 STATUS VARIABLES	Low risk		High risk		
	n (127)	% (25.5)	n (372)	% (74.5)	
Place change during the COVID-19 pandemic					0.508
Yes (n=201)	48	23.9	153	76.1	
No (n=298)	79	26.5	219	73.5	
Taking a duty in the COVID-19 field					0.281
Yes (n=272)	64	23.5	208	76.5	
Nor (n=227)	63	27.8	164	72.2	
Taking an active duty in the COVID-19 field					0.029
Yes (n=246)	52	21.1	194	78.9	
No (n=253)	75	29.6	178	70.4	
Weekly working days in the COVID-19 field					0.133
None (n=211)	63	29.9	148	70.1	
1-4 days (n=208)	48	23.1	160	76.9	
5-7 days (n=80)	16	20.0	64	80.0	
Protection against infection					0.086
Low (n=114)	22	19.3	92	80.7	
High (n=385)	105	27.3	280	72.7	

Upon comparing the COVID-19 status variables and the GHQ-12, when the status of taking an active duty in the COVID-19 field was questioned, this rate was 78.9% in

those still working in the COVID-19 field upon examining those in the high-risk category, while this rate decreased to 70.4% among those not working in the COVID-19 field, and this value was statistically significant ($p=0.029$). No significant relationship was detected among the other variables ($p>0.05$).

4.3. Relationship Between Sociodemographic Variables and Coronavirus Anxiety Level

Table 4.9. Relationship between the sociodemographic status and coronavirus anxiety status variables of the research participants

	CAS				p-value*
SOCIODEMOGRAPHIC STATUS VARIABLES	Low		High		
	n (430)	% (86.0)	n (70)	% (14.0)	
Gender					0.661
Female (n=212)	184	86.8	42	14.6	
Male (n=288)	246	85.4	28	13.2	
Age					0.886
Between 20-29 years (n=223)	192	86.1	31	13.9	
Between 30-39 years (n=175)	146	85.1	26	14.9	
40 years and above (n=102)	89	87.3	13	12.7	
Marital status					0.818
Married (n=292)	252	86.3	40	13.7	
Single (n=208)	178	85.6	30	14.4	
Presence of children					0.909
None (n=276)	239	86.3	38	13.7	
1 and 2 children (n=146)	126	86.3	20	13.7	
>3 children (n=77)	65	84.4	12	15.6	
Presence of chronic disease					0.024
No (n=406)	356	87.7	50	12.3	
Yes (n=94)	74	78.7	20	21.3	
Presence of mental illness					0.000
No (n=433)	384	88.7	49	11.3	
Yes (n=67)	46	68.7	21	31.3	
Regular drug use					0.322
No (n=433)	375	86.6	58	13.4	
Yes (n=67)	55	82.1	12	17.9	
Educational background					0.302
Elementary school-Secondary school-High school (n=130)	112	86.2	18	13.8	
Associate degree (n=106)	92	86.8	14	13.2	
Undergraduate (n=189)	157	83.1	32	16.9	
Master’s degree/Doctorate/Post doctoral (n=75)	69	92.0	6	8.0	

When the sociodemographic status variables and the Coronavirus Anxiety Brief Scale were compared, it was observed that coronavirus anxiety was high in those with chronic diseases, and this rate decreased in those without chronic diseases. This difference was statistically significant ($p=0.024$). In the presence of mental illness, the rate of feeling coronavirus anxiety was approximately 3 times higher, and this value was considered

statistically significant ($p=0.000$). Upon comparing the other parameters, no statistically significant finding was found ($p>0.05$).

Table 4.10. Relationship between the job information status and coronavirus anxiety variables of the research participants

	CAS				p-value*
JOB INFORMATION STATUS VARIABLES	Low		High		
	n (430)	% (86.0)	n (70)	% (14.0)	
Job seniority					0.038
<10 years (n=417)	366	87.8	51	12.2	
10-20 years (n=69)	53	76.8	16	23.2	
>20 years (n=14)	11	78.6	3	21.4	
Managerial duty					0.823
Yes (n=46)	39	84.8	7	15.2	
No (n=454)	391	86.1	63	13.9	
Duty in the hospital					0.150
Doctor (n=67)	62	92.5	5	43.3	
Nurse, Pharmacist, Dietitian, Physiotherapist, Psychologist (n=187)	156	83.4	31	16.6	
Medical Secretary, ATT, Technician (n=147)	123	83.7	24	16.3	
Personnel (Cleaning, Security, Kitchen, Worker) (n=99)	89	89.9	10	10.1	

Upon comparing the job information status variables and the Coronavirus Anxiety Scale, it was observed that as the job seniority in the institution increased in years, coronavirus anxiety was approximately 10% in those working for less than 10 years, while it increased to around 20% in those working for 10 years and more. This difference was found to be statistically significant for the study ($p=0.038$). No statistically significant value was detected in other comparisons made in this category ($p>0.05$).

Table 4.11. Relationship between the COVID-19 status and coronavirus anxiety variables of the research participants.

	CAS				p-value*
COVID-19 STATUS VARIABLES	Low		High		
	n (430)	% (86.0)	n (70)	% (14.0)	
Place change during the COVID-19 pandemic					0.061
Yes (n=201)	180	89.6	21	10.4	
No (n=299)	250	83.6	49	16.4	
Taking a duty in the COVID-19 field					0.019
Yes (n=272)	243	89.3	29	10.7	
No (n=228)	187	82.0	41	18.0	
Taking an active duty in the COVID-19 field					0.529
Yes (n=246)	214	87.0	32	13.0	

No (n=253)	216	85.0	38	15.0	
Weekly working days in the COVID-19 field					
None (n=212)	181	85.4	31	14.6	0.023
1-4 days (n=208)	187	89.9	21	10.1	
5-7 days (n=80)	62	77.5	18	22.5	
Protection against infection					
Low (n=115)	92	80.0	23	20.0	0.035
High (n=385)	338	87.8	47	12.2	

Upon comparing the COVID-19 status variables and the Coronavirus Anxiety Scale, the coronavirus anxiety rate of those working in the COVID-19 field in the hospital was found to be higher than those who did not work in the COVID-19 field. This result is statistically significant ($p=0.019$). While the coronavirus anxiety rate was 14.6% in those who did not work in the COVID-19 field, this rate was 22.5% in those who worked in the COVID-19 field for 5-7 days a week. In case of working in the COVID-19 field, it was observed that the coronavirus anxiety rate increased significantly as the number of days increased ($p=0.023$). It was revealed that those who felt that they protected themselves at a high level against infection had lower coronavirus anxiety ($p=0.035$). Significant results were also obtained in the categories of the number of working days in the COVID-19 field and protection against infection. No significant results were obtained when other COVID-19 status variables were compared ($p>0.05$).

4.4 Relationship Between Sociodemographic Variables and Ways of Coping with Stress

Table 4.12. Relationship between the mean scores of the methods according to the sociodemographic characteristics of the research participants

Characteristics	Self-confident approach	Optimistic approach	Desperate approach	Submissive approach	Search for social support
Gender					
Female (n=285)	20.63± 0.21	14.14±0.18	18.82±0.26	13.45±0.20	10.73±0.12
Male (n=210)	21.03± 0.20	14.58±0.15	17.93±0.24	12.95±0.18	11.06±0.10
P-value	0.086	0.028	0.009	0.063	0.072
Age					
Between 20-29 years (n=219)	20.57±0.22	14.38±0.17	18.68±0.25	13.35±0.20	10.59±0.13
Between 30-39 years (n=175)	21.21±0.25	14.69±0.19	17.96±0.32	13.12±0.23	11.16±0.12
40 years and above (n=101)	20.91±0.33	14.05±0.28	18.10±0.40	12.82±0.31	11.22±0.14
P-value	0.382	0.211	0.149	0.462	0.016
Marital status					
Married (n=291)	21.00±0.18	14.42±0.16	18.27±0.24	13.24±0.18	11.14±0.09
Single (n=204)	20.67±0.24	14.36±0.17	18.37±0.26	13.05±0.20	10.60±0.14
P-value	0.36	0.45	0.662	0.557	0.020

Presence of children					
None (n=273)	20.80±0.19	14.36±0.14	18.55±0.22	13.16±0.17	10.63±0.11
1 and 2 children (n=145)	20.76±0.27	14.44±0.24	18.26±0.34	13.37±0.25	11.29±0.13
>3 children (n=77)	21.28±0.42	14.45±0.32	17.54±0.51	12.76±0.39	11.25±0.18
P-value	0.634	0.394	0.151	0.418	0.003
Presence of chronic disease					
No (n=401)	20.87±0.16	14.40±0.13	18.26±0.20	13.14±0.15	10.90±0.09
Yes (n=94)	20.82±0.34	14.38±0.26	18.50±0.38	13.22±0.30	10.03±0.17
P-value	0.581	0.957	0.706	0.604	0.458
Presence of mental illness					
No (n=428)	21.06±0.16	14.52±0.12	18.17±0.19	12.99±0.14	10.92±0.08
Yes (n=67)	19.58±0.38	13.59±0.35	19.22±0.49	14.25±0.37	10.91±0.22
P-value	0.000	0.013	0.048	0.004	0.981
Regular drug use					
Yes (n=67)	21.00±0.38	14.31±0.33	18.52±0.49	12.86±0.35	11.08±0.21
No (n=428)	20.84±0.16	14.41±0.12	18.28±0.19	13.21±0.15	10.89±0.08
P-value	0.875	0.777	0.880	0.392	0.194
Educational background					
Elementary school- Secondary school-High school (n=130)	21.23±0.34	14.55±0.28	18.20±0.39	13.30±0.27	11.06±0.16
Associate degree (n=101)	20.47±0.34	14.22±0.28	19.10±0.40	13.27±0.31	10.72±0.20
Undergraduate (n=189)	20.91±0.20	14.51±0.16	18.28±0.26	13.11±0.21	10.77±0.12
Master's degree/Doctorate/Post doctoral (n=75)	20.65±0.37	14.06±0.22	17.50±0.42	12.89±0.35	11.34±0.20
P-value	0.189	0.152	0.026	0.858	0.093

When the methods of coping with stress preferred by the workers were compared, it was determined that the optimistic approach in males and the desperate approach in females were significantly higher ($p=0.028$, $p=0.009$, respectively). Upon comparing the methods of coping with stress according to the age range, it was observed that the participants preferred more social support-seeking behavior as their age increased ($p=0.016$). When the adopted approach was investigated in terms of marital status, it was understood that married individuals exhibited significantly more social support-seeking behavior than single individuals ($p=0.020$). When evaluated in terms of the presence of children, it was found that individuals who had children preferred social support-seeking behavior at a higher rate than those who did not have children ($p=0.003$). When the stress coping techniques preferred in the presence of mental illness were evaluated, it was understood that individuals without mental illness adopted significantly more self-confident and optimistic approaches, while those with mental illness adopted desperate and submissive approaches at a significantly higher rate ($p=0.000$, $p=0.013$, $p=0.048$, $p=0.004$, respectively). When an evaluation was performed between the ways of coping with stress according to educational background, it was revealed that the desperate approach was adopted at significantly the lowest level in the areas of master's, doctorate

and post-doctoral education, while the desperate approach was preferred at a higher rate in the elementary school-secondary school-high school, undergraduate and associate degree education areas, respectively ($p=0.026$)

Table 4.13. Relationship between the mean scores of the methods of coping with stress according to the job information status data of the research participants

Characteristics	Self-confident approach	Optimistic approach	Desperate approach	Submissive approach	Search for social support
Job seniority					
<10 years (n=413)	20.82±0.16	14.49±0.12	18.15±0.19	13.06±0.14	10.85±0.09
10-20 years (n=68)	21.04±0.44	14.00±0.39	19.26±0.55	13.79±0.41	11.14±0.18
>20 years (n=14)	21.21±0.72	13.57±0.46	18.42±1.11	13.00±0.90	11.92±0.39
P-value	0.996	0.147	0.127	0.163	0.063
Managerial duty					
Yes (n=46)	21.60±0.45	14.65±0.34	17.71±0.62	12.76±0.39	10.91±0.28
No (n=449)	20.79±0.15	14.37±0.12	18.37±0.18	13.30±0.14	10.92±0.08
P-value	0.180	0.433	0.289	0.375	0.640
Duty in the hospital					
Doctor (n=67)	21.05±0.37	14.22±0.24	17.25±0.42	12.83±0.36	11.32±0.22
Nurse, Pharmacist, Dietitian, Physiotherapist, Psychologist (n=187)	20.64±0.20	14.21±0.17	18.64±0.28	13.22±0.22	10.78±0.12
Medical Secretary, ATT, Technician (n=142)	20.76±0.30	14.50±0.24	18.64±0.33	13.39±0.24	10.64±0.16
Personnel (Cleaning, Security, Kitchen, Worker) (n=99)	21.30±0.40	14.71±0.30	17.92±0.45	12.93±0.33	11.32±0.17
P-value	0.185	0.066	0.023	0.569	0.016

Upon comparing the methods of coping with stress according to the job information status data, when the approaches in the stress situation were evaluated according to duties in the hospital, significance was observed in the dimensions of the desperate approach and search for social support ($p=0.023$, $p=0.016$, respectively). While the group that exhibited the desperate approach at least was the doctor group, the group that exhibited this approach at most was the medical secretary-ATT-technician group. It was revealed that the occupational group that used the social support-seeking behavior at most was doctors, while the group that exhibited the social support-seeking behavior at least was personnel (Cleaning, Security, Kitchen, Worker).

Table 4.14. Relationship between the mean scores of coping with stress methods according to the COVID-19 status data of the research participants

Characteristics	Self-confident approach	Optimistic approach	Desperate approach	Submissive approach	Search for social support
Place change during the COVID-19 pandemic					
Yes (n=199)	20.45±0.23	14.30±0.18	19.01±0.25	13.39±0.20	11.08±0.13
No (n=296)	21.14±0.19	14.46±0.15	17.84±0.24	13.00±0.18	10.82±0.10
P-value	0.013	0.239	0.001	0.125	0.066
Taking a duty in the COVID-19 field					
Yes (n=269)	20.82±0.21	14.28±0.16	18.28±0.24	13.06±0.18	11.13±0.10
No (n=226)	20.92±0.20	14.52±0.17	18.34±0.25	13.27±0.20	10.68±0.12
P-value	0.734	0.319	0.956	0.453	0.006
Taking an active duty in the COVID-19 field					
Yes (n=242)	20.67±0.22	14.25±0.17	18.45±0.25	13.18±0.19	11.11±0.11
No (n=253)	21.02±0.20	14.53±0.15	18.17±0.25	13.14±0.19	10.73±0.11
P-value	0.188	0.351	0.312	0.859	0.025
Weekly working hours in the COVID-19 field					
None (n=211)	21.02±0.21	14.55±0.18	18.17±0.27	13.15±0.21	10.59±0.12
1-3 days (n=170)	20.65±0.25	14.30±0.19	18.51±0.30	13.25±0.23	11.30±0.12
4-7 days (n=114)	20.88±0.34	14.26±0.27	18.28±0.37	13.05±0.28	10.98±0.17
P-value	0.311	0.484	0.614	0.805	0.002
Protection against infection					
Low (n=114)	20.51±0.34	14.14±0.27	18.86±0.40	13.51±0.29	10.52±0.19
High (n=381)	20.97±0.16	14.47±0.13	18.14±0.20	13.05±0.15	11.04±0.08
P-value	0.176	0.338	0.095	0.125	0.016

While the workers who did not change their place in the workplace during the COVID-19 pandemic exhibited the self-confident approach significantly more, those with a change of place exhibited a desperate approach ($p=0.013$, $p=0.001$, respectively). It was revealed that the employees working in the COVID-19 field and those still working in the COVID-19 field used the social support-seeking behavior significantly more ($p=0.006$, $p=0.025$, respectively). Those who worked in the COVID-19 field for 1-3 days a week adopted the social support-seeking behavior at a significantly higher level than those who had never worked in the COVID-19 field and those who worked for 4-7 days a week ($p=0.002$).

4.5. Relationship Between Psychosocial Risks and General Health Risk Level

Table 4.15. Relationship between F1. Demands at work sub-dimensions and general health status variables of the research participants

	GENERAL HEALTH				p-value*
F1. DEMANDS AT WORK SUB-DIMENSIONS	Low risk		High risk		
	n	%	n	%	
Work pace					0.000
High (n=270)	50	18.5	220	81.5	
Low (n=229)	77	33.6	152	66.4	
Total (n= 499)	127	25.5	372	74.5	
Quantitative demands					0.012
High (n=244)	50	20.5	194	79.5	
Low (n=251)	76	30.3	175	69.7	
Total (n=495)	126	25.5	369	74.5	
Cognitive demands					0.028
High (n=262)	56	21.4	206	78.6	
Low (n=237)	71	30.0	166	70.0	
Total (n= 499)	127	25.5	372	74.5	
Demand to conceal feelings					0.003
High (n=273)	55	20.1	218	79.9	
Low (n=226)	72	31.9	154	68.1	
Total (n= 499)	127	25.5	372	74.5	
Emotional demands					0.000
High (n=238)	36	15.1	202	84.9	
Low (n=261)	91	34.9	170	65.1	
Total (n=499)	127	25.5	372	74.5	
F1: DEMANDS AT WORK					0.000
High (n=241)	36	14.9	205	85.1	
Low (n=254)	90	35.4	164	64.6	
Total (n=495)	126	25.5	369	74.5	

Upon evaluating the title of demands at work and its sub-dimensions, it was found that while the general health risk level of those with a high work pace was 81.5%, this rate decreased to 66.4% in those with a low work pace ($p=0.000$). Again, as quantitative demands, cognitive demands, the demand to conceal feelings, and emotional demands in the workplace increased, the general health high risk level increased significantly ($p=0.012$, $p=0.028$, $p=0.003$, $p=0.000$, respectively). Upon evaluating the total results, when F1 demands at work dimension and the General Health Questionnaire were correlated, it was observed that the general health risk level in those with the high demands at work dimension was higher than those with the low demands at work dimension and this difference was significant ($p=0.000$).

Table 4.16. Relationship between F2. Influence and development and general health status variables of the research participants

	GENERAL HEALTH				p-value*
F2: INFLUENCE AND DEVELOPMENT	Low risk		High risk		
	n	%	n	%	
Lack of influence at work					0.322
Low (n=264)	72	27.3	192	72.7	
High (n=235)	55	23.4	180	76.6	
Total (n=499)	127	25.5	372	74.5	
Lack of possibilities for development					0.720
Low (n=274)	68	24.8	206	75.2	
High (n=225)	59	26.2	166	73.8	
Total (n=499)	127	25.5	372	74.5	
Lack of freedom at work					0.287
Low (n=239)	66	27.6	173	72.4	
High (n=260)	61	23.5	199	76.5	
Total (n=499)	127	25.5	372	74.5	
Meaninglessness of work					0.134
Low (n=217)	48	22.1	169	77.9	
High (n=282)	79	28.0	203	72.0	
Total (n=499)	127	25.5	372	74.5	
Lack of commitment to work					0.548
Low (n=259)	63	24.3	196	75.7	
High (n=240)	64	26.7	176	73.3	
Total (n=499)	127	25.5	372	74.5	
F2: INFLUENCE AND DEVELOPMENT					0.584
Low (n=241)	64	26.6	177	73.4	
High (n=258)	63	24.4	195	75.6	
Total (n=499)	127	25.5	372	74.5	

* Pearson's chi-squared test

When F2: Influence and development dimension and the lack of influence at work, lack of possibilities for development, lack of freedom at work, meaninglessness of work, and lack of commitment to work sub-dimensions were compared with the General Health Questionnaire, no significant result was obtained ($p>0.05$).

Table 4.17. Relationship between F3. Interpersonal relations and leadership dimension and general health status variables of the research participants

	GENERAL HEALTH				p-value*
F3: INTERPERSONAL RELATIONS AND LEADERSHIP DIMENSION	Low risk		High risk		
	n	%	n	%	
Lack of predictability					0.676
Low (n=271)	71	26.2	200	73.8	
High (n=228)	56	24.6	172	75.4	
Total (n=499)	127	25.5	372	74.5	
Lack of recognition					0.055
Low (n=258)	75	29.1	183	70.9	
High (n=241)	52	21.6	189	78.4	
Total (n=499)	127	25.5	372	74.5	
Lack of role clarity					0.730

Low (n=199)	49	24.6	150	75.4	
High (n=300)	78	26.0	222	74.0	
Total (n=499)	127	25.5	372	74.5	
Role conflicts					0.012
Low (n=216)	67	58.8	149	41.2	
High (n=279)	59	39.8	220	60.2	
Total (n=495)	126	25.5	369	74.5	
Lack of leadership quality					0.524
Low (n=244)	59	24.2	185	75.8	
High (n=255)	68	26.7	187	73.3	
Total (n=499)	127	25.5	372	74.5	
Lack of social support from colleagues					0.506
Low (n=290)	77	26.6	213	73.4	
High (n=209)	50	23.9	159	76.1	
Total (n=499)	127	25.5	372	74.5	
Lack of social support from management					0.493
Low (n=258)	69	26.7	189	73.3	
High (n=241)	58	24.1	183	75.9	
Total (n=499)	127	25.5	372	74.5	
Lack of sense of community					0.513
Low (n=208)	54	26.0	154	74.0	
High (n=290)	73	25.2	217	74.8	
Total (n=498)	127	25.5	371	74.5	
Lack of trust					0.772
Low (n=242)	63	26.0	179	74.0	
High (n=257)	64	24.9	193	75.1	
Total (n=499)	127	25.5	372	74.5	
Lack of justice and respect					0.106
Low (n=256)	73	28.5	183	71.5	
High (n=239)	53	22.2	186	77.8	
Total(n=495)	126	25.5	369	74.5	
F3: INTERPERSONAL RELATIONS AND LEADERSHIP DIMENSION					0.089
Low (n=250)	72	28.8	178	71.2	
High (n=244)	54	22.1	190	77.9	
Total (n=494)	126	25.5	368	74.5	

* Pearson's chi-squared test

When F3: Interpersonal relations and leadership dimension, the lack of predictability, lack of recognition, lack of role clarity, lack of leadership quality, lack of social support from colleagues, lack of social support from management, lack of sense of community, lack of trust, and lack of justice and respect sub-dimensions were evaluated one by one, no significant result was found ($p>0.05$). However, while it was determined that the general health high risk level was 40.2% in those with low role conflict in the workplace, it was observed that the high risk level increased to 60.2% in those with high role conflict, and this result was considered statistically significant ($p=0.012$).

Table 4.18. Relationship between F4. Work-individual interface sub-dimensions and general health status variables of the research participants

	GENERAL HEALTH				p-value*
F4: WORK-INDIVIDUAL INTERFACE	Low risk		High risk		
	n	%	n	%	
Job insecurity					0.189
Low (n=246)	69	28.0	177	72.0	
High (n=253)	58	22.9	195	77.1	
Total (n=499)	127	25.5	372	74.5	
Insecurity of working conditions					0.013
Low (n=224)	69	30.8	155	69.2	
High (n=275)	58	21.1	217	78.9	
Total (n=499)	127	25.5	372	74.5	
Work-home conflict					0.002
Low (n=246)	78	31.7	168	68.3	
High (n=253)	49	19.4	204	80.6	
Total (n=499)	127	25.5	372	74.5	
Lack of job satisfaction					0.149
Low (n=249)	70	28.1	179	71.9	
High (n=249)	56	22.5	193	77.5	
Total (n=498)	126	25.3	372	74.7	
F4: WORK-INDIVIDUAL INTERFACE					0.000
Low (n=248)	82	33.1	166	66.9	
High (n=250)	44	17.6	206	82.4	
Total (n=498)	126	25.3	372	74.7	

Upon comparing F4: Work-individual interface sub-dimensions and the General Health Questionnaire, it was observed that the general health high risk level increased significantly as the insecurity of working conditions and work-home conflict increased ($p=0.013$, $p=0.002$). When F4: Work-individual interface dimension was evaluated, it was found that as the risk level increased, the general health high risk value increased in direct proportion to this, and this result was considered statistically significant ($p=0.000$).

4.6. Relationship Between Psychosocial Risks and Coronavirus Anxiety Level

Table 4.19. Relationship between F1. Demands at work sub-dimensions and coronavirus anxiety level variables of the research participants

	CAS				p-value*
F1. DEMANDS AT WORK SUB-DIMENSIONS	Low		High		
	N	%	n	%	
Work pace					0.000
Low (n=230)	214	93.0	16	7.0	
High (n=270)	216	80.0	54	20.0	
Total (n= 500)	430	86.0	70	14.0	
Quantitative demands					0.000
Low (n=252)	232	92.1	20	7.9	
High (n=244)	194	79.5	50	20.5	
Total (n= 496)	426	85.9	70	14.1	
Cognitive demands					0.392
Low (n=238)	208	87.4	30	12.6	

High (n=262)	222	84.7	40	15.3	0.044
Total (n= 500)	430	86.0	70	14.0	
Demand to conceal feelings					
Low (n=227)	203	89.4	24	10.6	
High (n=273)	227	83.2	46	16.8	
Total (n= 500)	430	86.0	70	14.0	0.000
Emotional demands					
Low (n=262)	241	92.0	21	8.0	
High (n=238)	189	79.4	49	20.6	
Total (n= 500)	430	86.0	70	14.0	
F1: DEMANDS AT WORK					0.000
Low (n=255)	235	92.2	20	7.8	
High (n=241)	191	79.3	50	20.7	
Total (n= 496)	426	85.9	70	14.1	

* Pearson's chi-squared test

When F1. Demands at work sub-dimension and coronavirus anxiety level were mutually evaluated, the coronavirus anxiety levels of those with a high work pace were also revealed to be high. When evaluating the quantitative demands and emotional demands sub-headings, the coronavirus anxiety level was high in individuals with high scores. Coronavirus anxiety levels were also determined to be low in those with a low demand to conceal their feelings. Upon comparing the sum of the scores obtained from F1. Demands at work sub-dimension with the Coronavirus Anxiety Scale, the anxiety levels of those with high scores were also observed to be high. While these evaluations were considered statistically significant ($p=0.000$, $p=0.000$, $p=0.044$, $p=0.000$, $p=0.000$, respectively), no significant difference was observed between only cognitive demands and coronavirus anxiety level ($p>0.05$).

Table 4.20. Relationship between F2. Influence and development and coronavirus anxiety level variables of the research participants

	CAS				p-value*
F2: INFLUENCE AND DEVELOPMENT	Low		High		
	n	%	n	%	
Lack of influence at work					0.598
Low (n=264)	225	85.2	39	14.8	
High (n=236)	205	86.9	31	13.1	
Total (n=500)	430	86.0	70	14.0	
Lack of possibilities for development					0.517
Low (n=275)	234	85.1	41	14.9	
High (n=225)	196	87.1	29	12.9	
Total (n=500)	430	86.0	70	14.0	
Lack of freedom at work					0.380
Low (n=240)	203	84.6	37	15.4	
High (n=260)	227	87.3	33	12.7	
Total (n=500)	430	86.0	70	14.0	
Meaninglessness of work					0.097
Low (n=217)	193	88.9	24	11.1	

High (n=283)	237	83.7	46	16.3	0.947
Total (n=500)	430	86.0	70	14.0	
Lack of commitment to work					
Low (n=259)	223	86.1	36	13.9	
High (n=241)	207	85.9	34	14.1	
Total (n=500)	430	86.0	70	14.0	0.335
F2: INFLUENCE AND DEVELOPMENT					
Low (n=241)	211	87.6	30	12.4	
High (n=259)	219	84.6	40	15.4	
Total (n=500)	430	86.0	70	14.0	

* Pearson's chi-squared test

When F2: Influence and development sub-dimension, the lack of influence at work, lack of possibilities for development, lack of freedom at work, meaninglessness of work, and lack of commitment to work sub-dimensions were separately compared with coronavirus anxiety level and the total result was compared, no statistically significant result was achieved ($p=0.598$, $p=0.517$, $p=0.380$, $p=0.097$, $p=0.947$, $p=0.335$) ($p>0.05$).

Table 4.21. Relationship between F3. Interpersonal relations and coronavirus anxiety level variables of the research participants

F3: INTERPERSONAL RELATIONS AND LEADERSHIP DIMENSION	CAS				p-value*
	Low		High		
	n	%	n	%	
Lack of predictability					0.201
Low (n=271)	238	87.7	33	12.2	
High (n=229)	192	83.8	37	16.2	
Total (n=500)	430	86.0	70	14.0	
Lack of recognition					0.421
Low (n=258)	225	87.2	33	12.8	
High (n=242)	205	84.7	37	15.3	
Total (n=500)	430	86.0	70	14.0	
Lack of role clarity					0.009
Low (n=199)	181	91.0	18	9.0	
High (n=301)	249	82.7	52	17.3	
Total (n=500)	430	86.0	70	14.0	
Role conflicts					0.052
Low (n=216)	193	89.4	23	10.6	
High (n=280)	233	83.2	47	16.8	
Total(n=496)	426	85.9	70	14.1	
Lack of leadership quality					0.283
Low (n=244)	214	87.7	30	12.3	
High (n=256)	216	84.4	40	15.6	
Total (n=500)	430	86.0	70	14.0	
Lack of social support from colleagues					0.144
Low (n=290)	255	87.9	35	12.1	
High (n=209)	175	83.3	35	16.7	
Total (n=499)	430	86.0	70	14.0	
Lack of social support from management					0.066
Low (n=258)	229	88.8	29	11.2	
High (n=242)	201	83.1	41	16.9	
Total (n=500)	430	86.0	70	14.0	
Lack of sense of community					0.176
Low (n=208)	184	88.5	24	11.5	
High (n=291)	245	84.2	46	15.8	

Total (n=499)	429	86.0	70	14.0	0.129
Lack of trust					
Low (n=242)	214	88.4	28	11.6	
High (n=258)	216	83.7	42	16.3	
Total (n=500)	430	86.0	70	14.0	0.174
Lack of justice and respect					
Low (n=257)	226	87.9	31	12.1	
High (n=239)	200	83.7	39	16.3	
Total (n=496)	426	85.9	70	14.1	0.008
F3: INTERPERSONAL RELATIONS AND LEADERSHIP DIMENSION					
Low (n=245)	200	81.6	45	18.4	
High (n=250)	225	90.0	25	10.0	
Total (n=495)	425	85.9	70	14.1	

* Pearson's chi-squared test

When F3: Interpersonal relations and leadership dimension was compared with coronavirus anxiety level and evaluated, the coronavirus anxiety levels were found to be higher in individuals with the low lack of role clarity. When the lack of predictability, lack of recognition, role conflicts, lack of leadership quality, lack of social support from colleagues, lack of social support from management, lack of sense of community, lack of trust, and lack of justice and respect sub-dimensions were examined separately, no significant difference was revealed. The evaluation between only the lack of role clarity among the sub-dimensions and coronavirus anxiety level was found significant ($p=0.009$). Furthermore, upon comparing the total results for F3: Interpersonal relations and leadership dimension and coronavirus anxiety levels, the coronavirus anxiety levels of individuals with high scores from F3 sub-dimension were significantly higher ($p<0.05$).

Table 4.22. Relationship between F4. Work-individual interface and coronavirus anxiety level variables of the research participants

	CAS				p-value*
F4: WORK-INDIVIDUAL INTERFACE	Low		High		
	n	%	n	%	
Job insecurity					0.007
Low (n=246)	222	90.2	24	9.8	
High (n=254)	208	81.9	46	18.1	
Total (n=500)	430	86.0	70	14.0	
Insecurity of working conditions					0.052
Low (n=225)	201	89.3	24	10.7	
High (n=275)	229	83.3	46	16.7	
Total (n=500)	430	86.0	70	14.0	
Work-home conflict					0.238
Low (n=247)	217	87.9	30	12.1	
High (n=253)	213	84.2	40	15.8	
Total (n=500)	430	86.0	70	14.0	
Lack of job satisfaction					0.191
Low (n=250)	220	88.0	30	12.0	

High (n=249)	209	83.9	40	16.1	0.021
Total (n=499)	429	86.0	70	14.0	
F4: WORK-INDIVIDUAL INTERFACE					
Low (n=249)	223	89.6	26	10.4	
High (n=250)	206	82.4	44	17.6	
Total (n=499)	429	86.0	70	14.0	

Upon comparing F4: Work-individual interface dimension and the Coronavirus Anxiety Scale, it was observed that those with high F4: Work-individual interface and job insecurity had high coronavirus anxiety ($p=0.007$, $p=0.021$).



4.7. Relationship Between Covid-19 Status and Psychosocial Risks

Table 4.23. Relationship between Covid-19 status variables and demands at work sub-dimensions (F1).

COVID-19 STATUS VARIABLES		Work pace (%)		n	Quantitative demands (%)		n	Cognitive demands (%)		n	Demand to conceal feelings (%)		n	Emotional demands (%)		n	F1: DEMANDS AT WORK (%)		n
		Low	High		Low	High		Low	High		Low	High		Low	High		Low	High	
Place change during the COVID-19 pandemic	Yes	41.8	58.2	201	47.7	52.3	199	43.8	56.2	201	41.3	58.7	201	45.8	54.2	201	42.7	57.3	199
	No	48.8	51.2	299	52.9	47.1	297	50.2	49.8	299	48.2	51.8	299	56.9	43.1	299	57.2	42.8	297
n	Total	46	54	500	50.8	49.2	496	47.6	52.4	500	45.4	54.6	500	52.4	47.6	500	51.4	48.6	496
p		0.122			0.263			0.161			0.130			0.015			0.002		
Taking a duty in the COVID-19 field	Yes	40.8	59.2	272	48.3	51.7	269	48.3	56.3	272	42.6	57.4	272	45.6	54.4	272	45.7	54.3	269
	No	52.2	47.8	228	53.7	46.3	227	52.2	47.8	228	48.7	51.3	228	60.5	39.5	228	58.1	41.9	227
n	Total	46	54	500	50.8	49.2	496	47.6	52.4	500	45.4	54.6	500	52.4	47.6	500	51.4	48.6	496
p		0.011			0.229			0.060			0.177			0.001			0.006		
Taking an active duty in the COVID-19 field	Yes	37.4	62.6	246	46.7	53.3	242	43.1	56.9	246	38.6	61.4	246	43.9	56.1	246	43	57	242
	No	54.3	45.7	254	54.7	45.3	254	52	48	254	52	48	254	60.6	39.4	254	59.4	40.6	254
n	Total	46	54	500	50.8	49.2	496	47.6	52.4	500	45.4	54.6	500	52.4	47.6	500	51.4	48.6	496
p		0.000			0.074			0.047			0.003			0.000			0.000		
Weekly working days in the COVID-19 field	None	55.7	44.3	212	55.7	44.3	212	53.8	46.2	212	53.3	46.7	212	61.8	38.2	212	61.8	38.2	212
	1-3 days	37.1	62.9	170	44.7	55.3	170	41.2	58.8	170	37.1	62.9	170	42.4	57.6	170	41.2	58.8	170
	4-7 days	41.5	58.5	118	50.9	49.1	114	45.8	54.2	118	43.2	56.8	118	50	50	118	47.4	52.6	114
n	Total	46	54	500	50.8	49.2	496	47.6	52.4	500	45.4	54.6	500	52.4	47.6	500	51.4	48.6	496
p		0.001			0.104			0.045			0.006			0.001			0.000		
Protection against infection	Low	36.5	63.5	115	38.3	61.7	115	44.3	55.7	115	29.6	70.4	115	34.8	65.2	115	38.3	61.7	115
	High	48.8	51.2	385	54.6	45.4	381	48.6	51.4	385	50.1	49.9	385	57.7	42.3	385	55.4	44.6	381
n	Total	46	54	500	50.8	49.2	496	47.6	52.4	500	45.4	54.6	500	52.4	47.6	500	51.4	48.6	496
p		0.02			0.002			0.426			0.000			0.000			0.001		

Table 4.24. Relationship between Covid-19 status variables and influence and development sub-dimensions (F2).

COVID-19 STATUS VARIABLES		Lack of influence at work		n	Lack of possibilities for development		n	Lack of freedom at work		n	Meaninglessness of work		n	Lack of commitment to work		n	F2: INFLUENCE AND DEVELOPMENT		n
		Low	High		Low	High		Low	High		Low	High		Low	High		Low	High	
Place change during the COVID-19 pandemic	Yes	44.8	55.2	201	58.7	41.3	201	42.8	57.2	201	41.8	58.2	201	47.3	52.7	201	42.8	57.2	201
	No	58.2	41.8	299	52.5	47.5	299	51.5	48.5	299	44.5	55.5	299	54.8	45.2	299	51.8	48.2	299
n	Total	52.8	47.2	500	55	45	500	48	52	500	43.4	56.6	500	51.8	48.2	500	48.2	51.8	500
p		0.003			0.172			0.056			0.552			0.096			0.047		
Taking a duty in the COVID-19 field	Yes	49.3	50.7	272	57	43	272	41.9	58.1	272	44.1	55.9	272	50.4	49.6	272	43.8	56.3	272
	No	57	43	228	52.6	47.4	228	55.3	44.7	228	42.5	57.5	228	53.5	46.5	228	52.5	46.5	228
n	Total	52.8	47.2	500	55	45	500	48	52	500	43.4	56.6	500	51.8	48.2	500	48.2	51.8	500
p		0.084			0.33			0.003			0.724			0.484			0.03		
Taking an active duty in the COVID-19 field	Yes	50	50	246	57.7	42.3	246	40.2	59.8	246	42.3	57.7	246	49.2	50.8	246	43.9	56.1	246
	No	55.5	44.5	254	52.4	47.6	254	55.5	44.5	254	44.5	55.5	254	54.3	45.7	254	52.4	47.6	254
n	Total	52.8	47.2	500	55	45	500	48	52	500	43.4	56.6	500	51.8	48.2	500	48.2	51.8	500
p		0.217			0.228			0.001			0.618			0.25			0.050		
Weekly working days in the COVID-19 field	None	54.2	45.8	212	51.9	48.1	212	55.2	44.8	212	42.9	57.1	212	54.7	45.3	212	51.4	48.6	212
	1-3 days	48.8	51.2	170	57.1	42.9	170	37.6	62.4	170	43.5	56.5	170	50	50	170	43.5	56.5	170
	4-7 days	55.9	44.1	118	57.6	42.4	118	50	50	118	44.1	55.9	118	49.2	50.8	118	49.2	50.8	118
n	Total	52.8	47.2	500	55	45	500	48	52	500	43.4	56.6	500	51.8	48.2	500	48.2	51.8	500
p		0.423			0.484			0.003			0.979			0.529			0.30		
Protection against infection	Low	41.7	58.3	115	49.6	50.4	115	37.4	62.6	115	42.6	57.4	115	53	47	115	34.8	65.2	115
	High	56.1	43.9	385	56.6	43.4	385	51.2	48.8	385	43.6	56.4	385	51.4	48.6	385	52.2	47.8	385
n	Total	52.8	47.2	500	55	45	500	48	52	500	43.4	56.6	500	51.8	48.2	500	48.2	51.8	500
p		0.007			0.182			0.009			0.845			0.761			0.001		

Table 4.25 (a). Relationship between Covid-19 status variables and interpersonal relations and leadership sub-dimensions (F3).

COVID-19 STATUS VARIABLES		Lack of predictability		n	Lack of recognition		n	Lack of role clarity		n	Role conflicts		n	Lack of leadership quality		n	Lack of social support from colleagues		n
		Low	High		Low	High		Low	High		Low	High		Low	High		Low	High	
Place change during the COVID-19 pandemic	Yes	54.2	45.8	201	52.2	47.8	201	35.3	64.7	201	41.7	58.3	199	47.8	52.2	201	56.2	43.8	201
	No	54.2	45.8	299	51.2	48.8	299	42.8	57.2	299	44.8	55.2	297	49.5	50.5	299	59.2	40.8	299
n	Total	54.2	45.8	500	51.6	48.4	500	39.8	60.2	500	43.5	56.5	496	48.8	51.2	500	58	42	500
p		0.992			0.815			0.094			0.499			0.703			0.508		
Taking a duty in the COVID-19 field	Yes	50.7	49.3	272	47.8	52.2	272	40.1	59.9	272	44.2	55.8	269	48.9	51.1	272	58.8	41.2	272
	No	58.3	41.7	228	56.1	43.9	228	39.5	60.5	228	42.7	57.3	227	48.7	51.3	228	57	43	228
n	Total	54.2	45.8	500	51.6	48.4	500	39.8	60.2	500	43.5	56.5	496	48.8	51.2	500	58	42	500
p		0.089			0.063			0.891			0.736			0.962			0.684		
Taking an active duty in the COVID-19 field	Yes	48.8	51.2	246	45.9	54.1	246	37	63	246	44.2	55.8	242	50	50	246	59.3	40.7	246
	No	59.4	40.6	254	57.1	42.9	254	42.5	57.5	254	42.9	57.1	254	47.6	52.4	254	56.7	43.3	254
n	Total	54.2	45.8	500	51.6	48.4	500	39.8	60.2	500	43.5	56.5	496	48.8	51.2	500	58	42	500
p		0.017			0.013			0.207			0.77			0.597			0.547		
Weekly working days in the COVID-19 field	None	58.5	41.5	212	59	41	212	41.5	58.5	212	42.9	57.1	212	49.1	50.9	212	58	42	212
	1-3 days	48.2	51.8	170	38.8	61.2	170	35.3	64.7	170	44.1	55.9	170	47.1	52.9	170	54.1	45.9	170
	4-7 days	55.1	44.9	118	56.8	43.2	118	43.2	56.8	118	43.9	56.1	114	50.8	49.2	118	63.6	36.4	118
n	Total	54.2	45.8	500	51.6	48.4	500	39.8	60.2	500	43.5	56.5	496	48.8	51.2	500	58	42	500
p		0.132			0.000			0.321			0.97			0.815			0.280		
Protection against infection	low	46.1	53.9	115	44.3	55.7	115	34.8	65.2	115	34.8	65.2	115	42.6	57.4	115	50.4	49.6	115
	high	56.6	43.4	385	53.8	46.2	385	41.3	58.7	385	46.2	53.8	381	50.6	49.4	385	60.3	39.7	385
n	Total	54.2	45.8	500	51.6	48.4	500	39.8	60.2	500	43.5	56.5	496	48.8	51.2	500	58	42	500
p		0.047			0.076			0.21			0.031			0.130			0.061		

Table 4.26 (b). Relationship between Covid-19 status variables and interpersonal relations and leadership sub-dimensions (F3).

COVID-19 STATUS VARIABLES		Lack of social support from management		n	Lack of sense of community		n	Lack of trust		n	Lack of justice and respect		n	F3: INTERPERSONAL RELATIONS AND LEADERSHIP DIMENSION		n
		Low	High		Low	High		Low	High		Low	High		Low	High	
Place change during the COVID-19 pandemic	Yes	50.7	49.3	201	41	59	200	51.2	48.8	201	52.8	47.2	199	49	51	198
	No	52.2	47.8	299	42.1	57.9	299	46.5	53.5	299	51.2	48.8	297	51.5	48.5	297
	n Total	51.6	48.4	500	41.7	58.3	499	48.4	51.6	500	51.8	48.2	496	50.5	49.5	495
p		0.754			0.800			0.297			0.729			0.582		
Taking a duty in the COVID-19 field	Yes	51.8	48.2	272	41.3	58.7	271	49.6	50.4	272	51.3	48.7	269	50	50	268
	No	51.3	48.7	228	42.1	57.9	228	46.9	53.1	228	52.4	47.6	227	51.1	48.9	227
	n Total	51.6	48.4	500	41.7	58.3	499	48.4	51.6	500	51.8	48.2	496	50.5	49.5	495
p		0.907			0.861			0.547			0.803			0.807		
Taking an active duty in the COVID-19 field	Yes	49.6	50.4	246	42.4	57.6	245	44.3	55.7	246	47.1	52.9	242	48.1	51.9	241
	No	53.5	46.5	254	40.9	59.1	254	52.4	47.6	254	56.3	43.7	254	52.8	47.2	254
	n Total	51.6	48.4	500	41.7	58.3	499	48.4	51.6	500	51.8	48.2	496	50.5	49.5	495
p		0.377			0.733			0.072			0.041			0.304		
Weekly working days in the COVID-19 field	None	52.8	47.2	212	40.1	59.9	212	50.9	49.1	212	56.6	43.4	212	53.3	46.7	212
	1-3 days	48.8	51.2	170	41.2	58.8	170	45.3	54.7	170	46.5	53.5	170	46.5	53.5	170
	4-7 days	53.4	46.6	119	45.3	54.7	117	48.3	51.7	118	50.9	49.1	114	51.3	48.7	113
n Total		51.6	48.4	500	41.7	58.3	499	48.4	51.6	500	51.8	48.2	496	50.5	49.5	495
p		0.669			0.648			0.547			0.140			0.406		
Protection against infection	Low	47.8	52.2	115	38.3	61.7	115	42.6	57.4	115	49.6	50.4	115	41.7	58.3	115
	High	52.7	47.3	385	42.7	57.3	384	50.1	49.9	385	52.5	47.5	381	53.2	46.8	380
	n Total	51.6	48.4	500	41.7	58.3	499	48.4	51.6	500	51.8	48.2	496	50.5	49.5	495
p		0.356			0.396			0.157			0.582			0.032		

Table 4.27. Relationship between Covid-19 status variables and work-individual interface sub-dimensions (F4).

COVID-19 STATUS VARIABLES		Job insecurity		n	Insecurity of working conditions		n	Work-home conflict		n	Lack of job satisfaction		n	F4: WORK-INDIVIDUAL INTERFACE		n
		Low	High		Low	High		Low	High		Low	High		Low	High	
Place change during the COVID-19 pandemic	Yes	48.3	51.7	201	39.8	60.2	201	43.3	56.7	201	44.3	55.7	201	43.8	56.2	201
	No	49.8	50.2	299	48.5	51.5	299	53.5	46.3	299	54.0	46.0	298	54.0	46.0	298
n	Total	49.2	50.8	500	45.0	55.0	500	49.4	50.6	500	50.1	49.9	499	49.9	50.1	499
p		0.730			0.050			0.025			0.033			0.025		
Taking a duty in the COVID-19 field	Yes	51.8	48.2	272	45.2	54.8	272	45.6	54.4	272	49.3	50.7	272	50.4	49.6	272
	No	46.1	53.9	228	44.7	55.3	228	53.9	46.1	228	51.1	48.9	227	49.3	50.7	227
n	Total	49.2	50.8	500	45.0	55.0	500	49.4	50.6	500	50.1	49.9	499	49.9	50.1	499
p		0.197			0.914			0.063			0.683			0.819		
Taking an active duty in the COVID-19 field	Yes	52.4	47.6	246	45.1	54.9	246	46.7	53.3	246	48.8	51.2	246	50.8	49.2	246
	No	46.1	53.9	254	44.9	55.1	254	52.0	48.0	254	51.4	48.6	253	49.0	51.0	253
n	Total	49.2	50.8	500	45.0	55.0	500	49.4	50.6	500	50.1	49.9	499	49.9	50.1	499
p		0.154			0.957			0.243			0.561			0.687		
Weekly working days in the COVID-19 field	None	49.1	50.9	212	46.7	53.3	212	54.7	45.3	212	49.3	50.7	211	49.8	50.2	211
	1-3 days	44.7	55.3	170	40.6	59.4	170	47.1	52.9	170	50.0	50.0	170	48.8	51.2	170
	4-7 days	55.9	44.1	118	48.3	51.7	118	43.2	56.8	118	51.7	48.3	118	51.7	48.3	118
n	Total	49.2	50.8	500	45.0	55.0	500	49.4	50.6	500	50.1	49.9	499	49.9	50.1	499
p		0.172			0.349			0.102			0.916			0.890		
Protection against infection	Low	27.8	71.3	115	34.8	65.2	115	40.9	59.1	115	38.3	61.7	115	31.3	68.7	115
	High	55.3	44.7	385	48.1	51.9	385	51.9	48.1	385	53.6	46.4	384	55.5	44.5	384
n	Total	49.2	50.8	500	45.0	55.0	500	49.4	50.6	500	50.1	49.9	499	49.9	50.1	499
p		0.000			0.012			0.037			0.004			0.000		

Upon comparing the COVID-19 status variables and F1 demands at work sub-dimensions, workers who changed their workplace during the COVID-19 pandemic and take a duty in the COVID-19 field exhibited significantly higher risk emotional demands ($p=0.015$, $p=0.001$). Moreover, workers taking active duty reveal higher risk demands in all dimensions except for quantitative demands. Regarding weekly working days status, ones working 1-3 days pointed higher risk demands in all sub-dimensions apart from quantitative and cognitive demands subdimensions. The psychosocial risk was found to be significantly higher in all sub-dimensions except for the cognitive demands sub-dimension, for those who evaluated the contamination protection as low (Table 4.23).

When evaluating the relationship between COVID-19 status variables and F2 influence and development sub-dimensions, workers who changed their workplace during the COVID-19 pandemic showed higher risk in lack of influence and freedom at work. Furthermore, in all status variable groups higher risk in lack of commitment and total F2 dimension is found to be significant (Table 4.24).

Upon comparing the COVID-19 status variables and F3 interpersonal relations and leadership sub-dimensions, workers taking active duty in the COVID-19 field revealed lack of predictability and lack of recognition as well as lack of justice and respect. Moreover, It was observed that healthcare professionals who stated low contamination protection showed significantly higher psychosocial risk in the dimensions of lack of predictability, lack of role clarity, role conflict and F3 dimensions (Table 4.25).

Finally, the relationship between COVID-19 status variables and F4 work-individual interface is analyzed. Workers who changed their workplace during the COVID-19 pandemic revealed significantly higher risk insecurity of working conditions, work-home conflict and lack of job satisfaction as well as total F4 demand. Workers having low protection against the infection exhibited significantly higher psychosocial risk values in all subdimensions of F4 (Table 4.26).

4.8. Adjusted Relationship Between Psychosocial Risks and Ways of Coping with Stress

Table 4.28. Adjusted relationship between the demands at work sub-dimensions and ways of coping with stress

Ways of Coping with Stress Scale	Work pace		Quantitative demands		Cognitive demands		Demand to conceal feelings		Emotional demands		F1: DEMANDS AT WORK	
	OR(95% CI)		OR(95% CI)		OR(95% CI)		OR(95% CI)		OR(95% CI)		OR(95% CI)	
	Low	High	Low	High	Low	High	Low	High	Low	High	Low	High
Self-confident approach	1.00	0.96 (0.91-1.02)	1.00	0.91 (0.86-0.96)	1.00	1.009 (0.95-1.06)	1.00	0.99 (0.94-1.05)	1.00	0.96 (0.91-1.01)	1.00	0.96 (0.91-1.01)
p	0.24		0.001		0.74		0.87		0.17		0.17	
Optimistic approach	1.00	0.94 (0.88-1.01)	1.00	0.91 (0.85-0.97)	1.00	0.95 (0.89-1.01)	1.00	0.97 (0.91-1.04)	1.00	0.96 (0.90-1.03)	1.00	0.95 (0.89-1.02)
p	0.10		0.01		0.16		0.47		0.29		0.21	
Desperate approach	1.00	1.03 (0.99-1.08)	1.00	1.09 (1.04-1.14)	1.00	0.98 (0.94-1.02)	1.00	1.05 (1.00-1.10)	1.00	1.05 (1.00-1.10)	1.00	1.08 (1.03-1.13)
p	0.10		0.000		0.42		0.02		0.01		0.01	
Submissive approach	1.00	1.05 (0.99-1.12)	1.00	1.09 (1.03-1.16)	1.00	0.95 (0.90-1.01)	1.00	1.04 (0.98-1.10)	1.00	1.06 (1.00-1.13)	1.00	1.07 (1.01-1.13)
p	0.06		0.003		0.13		0.16		0.03		0.01	
Search for social support	1.00	0.98 (0.89-1.08)	1.00	0.90 (0.82-0.99)	1.00	1.07 (0.97-1.18)	1.00	0.98 (0.89-1.08)	1.00	0.94 (0.85- 1.04)	1.00	0.94 (0.85-1.03)
p	0.82		0.04		0.15		0.71		0.26		0.24	

Table 4.29. Adjusted relationship between the influence and development sub-dimensions and ways of coping with stress

Ways of Coping with Stress	Lack of influence at work		Lack of possibilities for development		Lack of freedom at work		Meaninglessness of work		Lack of commitment to work		F2: INFLUENCE AND DEVELOPMENT	
	OR(95% CI)		OR(95% CI)		OR(95% CI)		OR(95% CI)		OR(95% CI)		OR(95% CI)	
	Low	High	Low	High	Low	High	Low	High	Low	High	Low	High
Self-confident approach	1.00	0.94 (0.89-0.99)	1.00	0.94 (0.89-1.00)	1.00	1.05 (0.99-1.11)	1.00	0.90 (0.85-0.95)	1.00	0.93 (0.88-0.99)	1.00	0.91 (0.86-0.96)
p	0.02		0.04		0.05		0.000		0.02		0.001	
Optimistic approach	1.00	0.96 (0.90-1.03)	1.00	0.96 (0.90-1.03)	1.00	1.06 (0.99-1.14)	1.00	0.90 (0.84-0.97)	1.00	0.92 (0.86-0.98)	1.00	0.93 (0.87-1.00)
p	0.29		0.26		0.05		0.005		0.02		0.055	
Desperate approach	1.00	1.08 (1.03-1.13)	1.00	1.03 (0.99-1.08)	1.00	1.02 (0.97-1.06)	1.00	1.07 (1.02-1.12)	1.00	1.06 (1.01-1.11)	1.00	1.09 (1.04-1.14)
p	0.000		0.10		0.33		0.002		0.007		0.000	
Submissive approach	1.00	1.05 (0.99-1.12)	1.00	1.03 (0.97-1.09)	1.00	0.95 (0.90-1.01)	1.00	1.08 (1.02-1.15)	1.00	1.05 (0.99-1.12)	1.00	1.05 (0.99-1.11)
p	0.05		0.23		0.12		0.007		0.06		1.10	
Search for social support	1.00	1.00 (0.90-1.10)	1.00	0.97 (0.88-1.07)	1.00	1.08 (0.98-1.19)	1.00	0.82 (0.74- 0.91)	1.00	0.88 (0.80-0.98)	1.00	0.98 (0.89-1.08)
p	1.00		0.67		0.09		0.000		0.01		0.71	

Table 4.30. Adjusted relationship between the interpersonal relations and leadership sub-dimensions and ways of coping with stress

Ways of Coping with Stress	Lack of predictability		Lack of recognition		Lack of role clarity		Role conflicts		Lack of leadership quality		Lack of social support from colleagues	
	OR(95% CI)		OR(95% CI)		OR(95% CI)		OR(95% CI)		OR(95% CI)		OR(95% CI)	
	Low	High	Low	High	Low	High	Low	High	Low	High	Low	High
Self-confident approach	1.00	0.93 (0.89-0.99)	1.00	0.95 (0.91-1.01)	1.00	0.85 (0.80-0.91)	1.00	0.90 (.0.85-0.95)	1.00	0.92 (0.88-0.98)	1.00	0.97 (0.92-1.03)
p	0.02		0.12		0.000		0.001		0.007		0.38	
Optimistic approach	1.00	0.96 (0.90-1.03)	1.00	0.98 (0.91-1.04)	1.00	0.86 (0.80-0.93)	1.00	0.87 (0.81-0.94)	1.00	0.93 (0.87-1.00)	1.00	0.97 (0.91-1.04)
p	0.35		0.59		0.000		0.000		0.05		0.48	
Desperate approach	1.00	1.07 (1.02-1.12)	1.00	1.06 (1.01-1.11)	1.00	1.12 (1.07-1.18)	1.00	1.05 (1.00-1.09)	1.00	1.07 (1.02-1.12)	1.00	1.09 (1.04-1.14)
p	0.002		0.01		0.000		0.03		0.002		0.000	
Submissive approach	1.00	1.06 (1.00-1.13)	1.00	1.04 (0.98-1.10)	1.00	1.11 (1.05-1.18)	1.00	1.01 (0.95-1.07)	1.00	1.07 (1.01-1.14)	1.00	1.08 (1.02-1.14)
p	0.02		0.13		0.000		0.67		0.01		0.008	
Search for social support	1.00	0.95 (0.87-1.05)	1.00	0.94 (0.86-1.04)	1.00	0.89 (0.80-0.98)	1.00	0.85 (0.77-0.95)	1.00	0.89 (0.80-0.98)	1.00	0.97 (0.88-1.07)
p	0.39		0.26		0.02		0.003		0.02		0.55	

Table 4.31. Adjusted relationship between the interpersonal relations and leadership sub-dimensions and ways of coping with stress

Ways of Coping with Stress	Lack of social support from management		Lack of sense of community		Lack of trust		Lack of justice and respect		F3: INTERPERSONAL RELATIONS AND LEADERSHIP DIMENSION	
	OR(95% CI)		OR(95% CI)		OR(95% CI)		OR(95% CI)		OR(95% CI)	
	Low	High	Low	High	Low	High	Low	High	Low	High
Self-confident approach	1.00	0.95 (0.90-1.00)	1.00	0.88 (0.83-0.93)	1.00	0.98 (0.93-01.04)	1.00	0.99 (0.94-1.05)	1.00	0.92 (0.87-0.98)
p	0.07		0.000		0.67		0.93		0.007	
Optimistic approach	1.00	0.96 (0.89-1.02)	1.00	0.89 (0.83-0.96)	1.00	1.02 (0.96-1.09)	1.00	0.99 (0.92-1.05)	1.00	0.94 (0.88-1.01)
p	0.22		0.003		0.43		0.79		0.10	
Desperate approach	1.00	1.09 (1.04-1.14)	1.00	1.12 (1.07-1.17)	1.00	1.04 (0.99-1.08)	1.00	1.05 (1.01-1.10)	1.00	1.15 (1.09-1.21)
p	0.000		0.000		0.78		0.14		0.000	
Submissive approach	1.00	1.10 (1.03-1.17)	1.00	1.09 (1.03-1.16)	1.00	1.03 (0.98-1.10)	1.00	1.04 (0.99-1.11)	1.00	1.12 (1.05-1.19)
p	0.001		0.002		0.20		1.10		0.000	
Search for social support	1.00	0.93 (0.84-1.02)	1.00	0.82 (0.74-0.91)	1.00	0.94 (0.85-1.04)	1.00	0.98 (0.89-1.02)	1.00	0.87 (0.79-0.96)
p	0.14		0.000		0.25		0.72		0.10	

Table 4.32. Adjusted relationship between the work-individual interface sub-dimensions and ways of coping with stress

Ways of Coping with Stress	Job insecurity		Insecurity of working conditions		Work-home conflict		Lack of job satisfaction		F4: WORK-INDIVIDUAL INTERFACE	
	OR(95% CI)		OR(95% CI)		OR(95% CI)		OR(95% CI)		OR(95% CI)	
	Low	High	Low	High	Low	High	Low	High	Low	High
Self-confident approach	1.00	0.92 (0.87-0.97)	1.00	0.95 (0.90-1.00)	1.00	0.93 (0.88-0.99)	1.00	0.94 (0.89-0.99)	1.00	0.86 (0.81-0.91)
p	0.004		0.06		0.02		0.03		0.000	
Optimistic approach	1.00	0.93 (0.87-1.00)	1.00	0.95 (0.89-1.02)	1.00	0.88 (0.82-0.94)	1.00	0.89 (0.83-0.95)	1.00	0.83 (0.77-0.89)
p	0.04		0.17		0.001		0.002		0.000	
Desperate approach	1.00	1.10 (1.05-1.15)	1.00	1.10 (1.05-1.15)	1.00	1.05 (1.00-1.10)	1.00	1.06 (1.01-1.11)	1.00	1.09 (1.04-1.14)
p	0.000		0.000		0.01		0.008		0.000	
Submissive approach	1.00	1.12 (1.06-1.19)	1.00	1.07 (1.01-1.14)	1.00	1.04 (0.98-1.10)	1.00	1.05 (0.99-1.11)	1.00	1.06 (1.00-1.12)
p	0.000		0.01		0.18		0.07		0.03	
Search for social support	1.00	0.95 (0.86-1.05)	1.00	0.93 (0.84-1.02)	1.00	0.90 (0.82-0.99)	1.00	0.83 (0.75-0.92)	1.00	0.85 (0.77-0.94)
p	0.35		0.15		0.04		0.000		0.002	

When the adjusted relationship between the approach types in the Ways of Coping with Stress Scale and the work pace sub-dimension of the COPSOQ was investigated, a significant difference was detected ($p>0.05$). As the self-confident approach, optimistic approach, and search for social support approach in the quantitative demands sub-dimension increased, a decrease in terms of psychosocial risks was observed ($p<0.05$). It was revealed that an increase in those exhibiting the desperate approach and the submissive approach in the quantitative demands sub-dimension also increased psychosocial risks in direct proportion ($p<0.05$). It was found that an increase in the desperate approach increased the psychosocial risk in the sub-dimension of the demand to conceal feelings in the workplace by 1.05 (1.00-1.10) times ($p<0.05$). It was determined that an increase in the desperate and submissive approach types in the emotional demands sub-dimension increased psychosocial risks ($p<0.05$). It was observed that an increase in the desperate approach and submissive approach types in F1. Demands at work dimensions increased psychosocial risks ($p<0.05$) (Table 4.27).

In the lack of influence at work sub-dimension, it was revealed that each unit increase in those who adopted the desperate approach increased psychosocial risks by 1.08 times, whereas the risk decreased when the self-confident approach increased. In the lack of possibilities for development, it was found that each unit increase in those who adopted the self-confident approach reduced psychosocial risks ($p<0.05$). In the meaninglessness of work sub-dimension, an increase in the self-confident approach, optimistic approach, and social support-seeking behaviors reduces psychosocial risks. It was found that when the desperate and submissive approaches increased, psychosocial risks increased ($p<0.05$). In the lack of commitment to work sub-dimension, it was observed that when the self-confident approach, optimistic approach, and the search for social support approach increased, psychosocial risks decreased, and when the desperate approach increased, the risk also increased. In F2: influence and development dimension including the total risk of all these sub-dimensions, while the self-confident approach increased, psychosocial risks decreased, while an increase in the desperate approach increased psychosocial risks ($p<0.05$). No significant results were obtained for lack of freedom at work ($p>0.05$) (Table 4.28).

In the lack of predictability sub-dimension, it was revealed that an increase in the self-confident approach reduced psychosocial risks by 7%, while an increase in the desperate and submissive approaches increased psychosocial risks by 1.07 and 1.06 times, respectively ($p<0.05$). It was observed that an increase in the desperate approach in the lack of recognition

sub-dimension increased psychosocial risks. In the lack of role clarity, while an increase in self-confident, optimistic, and search for social support approaches reduced psychosocial risks, an increase in the desperate approach increased the risk by 1.05 times ($p < 0.05$). In case of role conflict in the workplace, while an increase in self-confident, optimistic, and search for social support approaches reduced psychosocial risks, an increase in the desperate approach increased the risk by 1.05 times ($p < 0.05$). It was observed that while an increase in the self-confident and search for social support approaches reduced psychosocial risks in the leadership quality sub-dimension, an increase in the desperate and submissive approaches increased the risk by 1.07 times ($p < 0.05$). In the lack of social support from colleagues dimension, an increase in the desperate and submissive approaches increased psychosocial risks ($p < 0.05$) (Table 4.29).

In the lack of social support from management, it was found that the desperate and submissive approaches increased psychosocial risks. In the lack of sense of community dimension, while an increase in self-confident, optimistic, and search for social support approaches significantly reduced psychosocial risks, an increase in the desperate and submissive approaches increased the risk ($p < 0.05$). It was revealed that an increase in the self-confident approach in F3: Interpersonal relations and leadership dimension reduced psychosocial risks by 8%, an increase in the desperate and submissive approaches significantly increased the risk ($p < 0.05$). No significant relationship was found for the lack of trust and the lack of justice and respect sub-dimensions ($p > 0.05$) (Table 4.30).

In the case of job insecurity, it was found that psychosocial risks decreased as the self-confident and optimistic approaches increased, and the risk increased significantly as the desperate and submissive approaches increased. It was revealed that as the desperate and submissive approaches increased in the insecurity of working conditions, psychosocial risks increased ($p < 0.05$). In the case of work-home conflict, it was observed that while self-confident, optimistic, and social support-seeking behaviors reduced psychosocial risks, an increase in the desperate approach increased the risk by 5% ($p < 0.05$). While an increase in self-confident, optimistic, and social support-seeking behaviors in the lack of job satisfaction sub-dimension reduced psychosocial risks, an increase in the desperate approach increased psychosocial risks ($p < 0.05$). When F4: Work-individual interface was evaluated, while an increase in self-confident, optimistic, and search for social support approaches reduced the risk significantly, an increase in the desperate and submissive approaches increased psychosocial risks ($p < 0.05$) (Table 4.31).

5. DISCUSSION

In a study carried out by Özfirat and Pehlivan in 2007, 91.7% of students with pre-existing mental illness and 67.4% of those without pre-existing mental illness evaluated their general health status as “below normal.” A significant difference was detected between students’ previous mental disorder status and their general health status ($p < 0.05$) (58). The General Health Questionnaire is a scale used to identify groups at risk for mental illness. The results show that individuals with previously diagnosed mental illnesses have higher scores from the General Health Questionnaire (59). In the thesis study, similar results to the previous studies were determined in the statistical evaluation made between the presence of mental illness among sociodemographic data and the GHQ-12. While 86.6% of those with pre-existing mental illness were in the group at risk with the general health status below normal, the general health status of 72.2% of those without pre-existing mental illness was below normal, and they were considered in the group at risk in terms of mental illnesses, and this result is statistically significant ($p < 0.05$) (58).

The study carried out by Özkan et al. 2012 found that as the age increased, scores obtained by individuals from the GHQ-12 also increased. Thus, the relationship between age and the GHQ-12 mean score was revealed to be statistically significant ($p < 0.05$) (60). However, the thesis study did not obtain a significant result for age ($p > 0.05$). Considering the reasons for this, it is thought that the distribution of duties among hospital workers regardless of age and the inclusion of individuals from every occupational group over the age of 14 in the compared study affected the result.

The study conducted by Tezcan et al. found that 20.2% of married individuals had a mental illness, while 7.8% of single individuals had symptoms of mental illness. When examined, mental illness was revealed to be statistically significantly higher in married individuals than single ones, and it was thought that since married women had more responsibilities than other groups, the psychological pressure created by these responsibilities on individuals might cause this result (61). On the contrary, another study with a sample consisting of women determined statistical significance upon comparing the participants’ marital status and general health levels and revealed that the general health status of widowed and single individuals was at risk in comparison with married ones (62).

In the thesis study, upon examining the group with a high general health risk status, in other words, the group highly susceptible to mental illness, it was observed that while this rate

was 70.5% in married individuals, it increased to 80.2% in single people ($p<0.05$). In Turkey, which is in the category of developing countries, unemployment and economic problems have been triggered by the pandemic, and marriage is regarded as a source of social security in our society (63). Although the level of awareness on this issue continues to differ in our age, it is considered that the risk of individuals with increased economic security due to marital status continues at a lower level since the necessary economic progress has not been achieved yet.

The study performed by Çağan et al. in 2012 revealed that 69.4% of students had a GHQ score of 2 and above. This score, reflecting the general mental health status as risky, was identified to be significantly higher in female students (75.2%) than in male students (64.5%) (64-66). Likewise, when other studies were reviewed, it was observed that the general health risk level was high, although the gender factor was not at a significant level in females (59). The study obtained no significant results in the gender category, and evaluating the older age group not the same age group with the compared studies, carrying out the study in a field of employees with social security instead of student groups, and the high mental resilience factor of healthcare workers can be considered as the reasons for this ($p<0.05$).

It was observed that the stress caused by the increased workload in the working area and the fear that the people in their immediate surroundings would be affected and the loss of attention due to this were the main problems that healthcare workers had to cope with during the pandemic. It was understood that prolonged working hours, uncertainty and inadequacies in terms of physical resources required for protection triggered depression, concerns, anxiety, etc., and general health status of health personnel (67). Healthcare workers serving in working environments under such difficult conditions are at risk of infection and illness during the COVID-19 pandemic and are at risk of mental disorders related to trauma and stressors (68). During the SARS epidemic in 2004, when healthcare workers had similar experiences before, it was revealed that anxiety was common in healthcare workers during the rapid spread of the epidemic and depression and trauma-related behavioral disorders were common after the epidemic was taken under control (69). The thesis study compared the COVID-19 status variables and the General Health Questionnaire, and when taking an active duty in the COVID-19 field in a pandemic hospital during the pandemic was questioned and those in the high risk category were examined, it was determined, in parallel with similar studies, that individuals still working in the COVID-19 field had significantly higher risk levels ($p<0.05$).

Upon comparing sociodemographic status variables and the Coronavirus Anxiety Brief Scale in the thesis study, it was found that those with chronic and mental illnesses had higher coronavirus anxiety, while this rate decreased in individuals without chronic and mental illnesses ($p < 0.05$). The level of anxiety caused by coronavirus increased by 3 times, especially in case of an increase in mental illnesses. When similar research with the study was reviewed, parallel results were observed. The study carried out by Bayülgen et al. in 2021 on nurses during the pandemic found that when the presence of chronic disease was questioned, coronavirus anxiety increased in those with the disease, although not at a significant level (70). Again the study conducted by Hoşgör et al. in 2020 and investigating the relationship between anxiety and performance in emergency healthcare workers in terms of descriptive variables showed that coronavirus anxiety level increased with the disease, although not significantly, in the presence of chronic disease (71). It was observed that as a result of the news made by both the written and visual media and the social media about the COVID-19 virus, anxiety and fear levels increased in the whole society, with healthcare workers being the primary group, and the COVID-19 pandemic created a stepping stone for mental disorders such as schizophrenia, anxiety, depression, and acute stress disorders (72, 73).

Since healthcare workers are an occupational group that affects human life directly, they have to do their work meticulously and carefully. Job-specific situations, such as long shifts and working hours in shift workers, satisfaction of patients waiting for service and their relatives, may cause healthcare workers to be more nervous and stressed. During the pandemic, when the deadly COVID-19 virus was added to all these, the services for the pandemic had to be rendered, on the one hand, and it was necessary to continue routine healthcare services, on the other hand. Healthcare workers, who actively served in areas such as filiation, contact follow-up, diagnosis, treatment, and post-treatment care during the pandemic, continued to fulfill their duties at the cost of worsening of their own health and even losing their lives. As a result, significant increases were observed in their existing depression, stress, and anxiety levels (74, 75). In the thesis study, when the COVID-19 status variables and the Coronavirus Anxiety Scale were compared, similarly, the coronavirus anxiety rate of those who actively worked in the field of COVID-19 was higher than the rate of those who did not work in that field, and this result was statistically significant ($p = 0.019$). Those who felt safer in terms of transmission were found to have less anxiety ($p = 0.035$).

In a study conducted by Otrar et al. in 2002 on students, in the evaluation of ways of coping with stress according to gender, it was observed that the self-confident and optimistic approaches were prominent in males, whereas no difference was detected in the desperate and search for social support approaches according to gender ($p < 0.05$) (76). In another study conducted on nursing students in 2010, when the relationship between the WCSS and independent variables was analyzed, male students were observed to prefer social support-seeking behavior significantly more than female students ($p < 0.05$) (64). In the study performed by Ergin et al. in 2014, it was observed that males adopted optimistic and self-confident approaches significantly more (77). In the study, when the methods of coping with stress preferred by the employees were compared by gender, it was revealed that the optimistic approach in males and the desperate approach in females were significantly higher ($p < 0.05$). Upon evaluating differences between the studies, it can be thought that the differences between the time of the studies and the groups studied may be the cause of changes in the results.

A study conducted on teachers in 2019 found no significant relationship between the ways of coping with stress and age (78). In the thesis study, when the methods of coping with stress were compared according to the age range, it was observed that the participants preferred the social support-seeking behavior more as their ages increased ($p < 0.05$). The reason for this preference can be shown as the physical and psychological wear of the healthcare personnel during the time they spend in the profession, and thus the motivation of the personnel to seek social support. In a study carried out by Şen et al. (2012) and evaluating the techniques of a group of physicians to cope with stress, it was concluded that marital status did not affect the type of approach ($p > 0.05$) (79). In the study, when the type of approach adopted in case of stress was analyzed in terms of marital status, married people were found to exhibit social support-seeking behavior significantly more than single people ($p < 0.05$). In a study conducted by Sülemiş and Dönmez in 2016 on female personnel working in a university hospital, it was observed that those with a low number of children adopted a self-confident approach, while those with a high number of children adopted a submissive approach ($p < 0.05$) (80). In the thesis study, in the evaluation based on the presence of children, those who had children preferred the social support-seeking behavior at a higher rate than those who did not have children ($p < 0.05$).

In a study in which Güngör and Nehir examined psychosocial problems and ways of coping with stress in 2019, the relationship between the sub-dimensions of nurses' hospital anxiety, depression, and ways of coping with stress was investigated. As a result, it was

observed that those who did not have depression and those with low anxiety levels adopted self-confident and optimistic approaches, whereas those with depression and high anxiety levels exhibited a submissive approach and social support-seeking behavior (81). When the investigation was performed in terms of disease characteristics in the study conducted by Arslan in 2017, participants with diseases whose diagnosis was not psychotic (depression, bipolar disorder, anxiety disorders, alcohol and substance use disorder) were found to use the "desperate approach" among the ineffective methods more ($p<0.05$) (82). In the present study, when the stress-coping techniques preferred in the presence of a mental illness were evaluated, it was observed that those without mental illnesses adopted self-confident and optimistic approaches significantly more, while those with mental illnesses adopted desperate and submissive approaches at a significantly higher rate ($p<0.05$).

When an evaluation is made among the ways of coping with stress according to educational background, it is observed that the desperate approach is adopted at the significantly lowest level by those receiving master's, doctorate, and post-doctoral education. However, there is a higher preference for the desperate approach among those receiving elementary school, secondary school, high school, undergraduate and associate degree education ($p<0.05$).

When the descriptive characteristics of the participants were compared with differences in both COVID-19 anxiety levels and the values they received from the averages of professional performance within the scope of a study conducted by Hoşgör et al., the results obtained showed that the COVID-19 anxiety levels of women who had 11 years or greater professional experience and those who stated that they did not like their profession were relatively and significantly higher (71). In the thesis study, coronavirus anxiety was determined significantly higher in those who worked for more than 10 years compared to those who worked for less than 10 years ($p<0.05$).

It is an undeniable fact that this responsibility and stress have increased during the pandemic. Furthermore, there are studies in which doing watch duties and working in shifts adversely affected the physiological and psychological health, social life, personal work safety, and patient safety of employees (83). Periodic changes in the ratios of the number of healthcare personnel-patients during the COVID-19 pandemic, providing care to a risk group, the risk of transmission of the disease to healthcare personnel, the lack of treatment and vaccine for the disease for a long time, the constant change in the working order, taking care of patients with

protective equipment during long working hours, and the possibility of transmitting the virus to other patients or their close circles have caused healthcare personnel to experience feelings such as stigma, fear, anger, anxiety, helplessness, and burnout (84). In the thesis study, it was observed that employees who did not change their places in the workplace during the pandemic rather exhibited a self-confident approach, while those who changed their places exhibited a desperate approach. Likewise, it was revealed that the employees who worked in the COVID-19 field and those who were still working in the COVID-19 field significantly resorted to the social support-seeking behavior ($p < 0.05$).

Considering work-related reasons during the COVID-19 pandemic, causes such as an increase in social isolation and loneliness, increase in work pace, increase in exposure to high strain, work insecurity and uncertainty about financial concerns, and fear of being infected, etc. will continue to increase and harm the health of workers (85). Over the last few years, work-family conflict has received increasing attention in labor sciences as an important evaluation topic. In addition to the effect of this conflict situation on work outcomes such as job satisfaction, job performance, and intention to leave, various effects on the individual's physical or mental health and quality of life have been reported (86). The variable with the most significant effect on the individual's emotional demands has been determined as the meaning of work and commitment to work. It can be said to be a logical result that individuals who find their work meaningful and are committed to their work devotedly are also attached to their jobs emotionally, and they have demands in this direction. When analyzed in terms of cognitive demands, the factor of role conflict has been found to be the most influential factor. Determining what each individual's job is, responsibilities and limitations is a natural demand that administrative personnel may request. In this context, it can also be said to be a logical result that role conflict among employees is determined as an effective factor on their cognitive demands. In this sense, it is possible to mention that managers also bear a burden in terms of controlling the responsibilities and roles of the administrative personnel well (87). In the study, similarly, it was observed that as F1: demands at work, work pace, quantitative demands in the workplace, cognitive demands, demand to conceal feelings, emotional demands, role conflict in the workplace, F4: Work-individual interface, insecurity of working conditions, and work-home conflict increased, the general health high risk level increased significantly ($p < 0.05$). The situations that adversely affect psychosocial risks in the workplace were also observed to affect

the general health risk level negatively, and it is predicted that the improvements to be made in institutions in this regard will positively motivate employees.

In a study conducted by Hacimusalar et al., an increase was observed in the hopelessness levels of healthcare workers due to the situations they experienced in the workplace, and this caused an increase in the anxiety level (88). In the study conducted by Arnetz et al. in 2020 on the COVID-19 pandemic, it was revealed that providing care to COVID-19 patients for longer work hours and inadequacy of personal protective equipment caused depression, anxiety, and post-traumatic stress disorder in nurses (70).

In the present study, when F1: demands at work sub-dimension and coronavirus anxiety level were evaluated correspondingly, those with high risk levels in F1: demands at work, work pace, quantitative demands, and emotional demands and F3: Interpersonal relations and leadership sub-dimension were found to have high levels of coronavirus anxiety. Coronavirus anxiety levels were also observed to be low in those who had a low demand to conceal their feelings ($p < 0.05$). Upon evaluating the study, emotional psychosocial risk sources were observed to have an increasing effect on anxiety in the workplace.

In a study carried out by Sturm et al. in 2019, it is found that working hours and workload increase, resulting in an increase in role conflicts and emotional demands. In the study, it was revealed that the stress levels of doctors and nurses increased due to the imbalance in the division of labor in working environments and incompatibilities related to the working environment, their work efficiency decreased, and their feeling of burnout increased (89). In such situations, readily available social support is thought to promote motivation and commitment (90).

When, to mention psychosocial risk factors, Karasek's demand-control model was mentioned primarily in the theoretical background, in the model, the work demand (workload) of employees and the level of decision-making (control) on the work done were emphasized, and the ratio of workload to work control was referred to as “work strain.” According to this model, jobs with high demands and offered with a low-level right to control increase job-related stress, while high demands balanced with a high level of control pose less risk in terms of stress (91). In the study performed by Yuanyuan et al. in 2020, it was observed that nutrition and sleep disorders, imbalances in working hours, and occupational difficulties increased the stress

burden of nurses, people felt anxious and desperate due to the high number of patients, and there was an increase in these cases (92).

In the present thesis study, when the COPSOQ and the Ways of Coping with Stress Scale were evaluated together, all sub-dimensions were compared separately in each of the 5 approaches of the WCSS, and the results were assessed statistically. When the sub-dimensions that were found statistically significant were examined, the psychosocial risk of those who exhibited self-confident and optimistic approaches was found to be low at varying rates, while the psychosocial risk was observed to increase at varying rates in those who exhibited desperate and submissive approaches. It is clear that people with self-confident and optimistic approaches will keep their self-confidence high and act under the leadership of science and reason regarding what kind of attitudes they will exhibit in duty areas during the pandemic. Therefore, it is possible that they will feel more secure psychologically owing to their belief that they can protect themselves by keeping the conditions they are in at the most optimal level and the plans they have prepared against negative situations that may arise. Otherwise, it is obvious that people who feel desperate and submit to the conditions of the environment cannot easily take precautions to feel secure and keep their self-confidence high in the case of a pandemic. For this reason, the emerging statistical result has not only a numeric equivalent but also a real one.

For example, in the quantitative demands sub-dimension, as the adoption of the self-confident approach, optimistic approach, and search for social support approach increased, the psychosocial risk was found to decrease. Meanwhile, the increase in those adopting desperate and submissive approaches increased the psychosocial risk in direct proportion. The increase in the desperate approach was observed to increase psychosocial risks in the sub-dimension of demand to conceal feelings in the workplace. The increase in the desperate and submissive approaches in F1. demands at work dimension and the emotional demands sub-dimension was found to increase psychosocial risks ($p < 0.05$). When these results are evaluated, it is meaningful that those who exhibit self-confident and optimistic approaches in the analyzed sub-dimensions have lower psychosocial risks compared to those who exhibit desperate and submissive approaches, considering that they evaluate the situation they are in more realistically and can struggle against the negative conditions that may arise.

In another example, it was revealed that psychosocial risk increased in those who adopted a desperate approach in the sub-dimension of lack of influence at work, whereas the

risk was found to decrease in those who exhibited a self-confident approach. It was observed that psychosocial risks decreased in individuals who adopted a self-confident approach in the lack of possibilities for development and in those who exhibited a self-confident approach, optimistic approach, and social support-seeking behavior in the sub-dimensions of meaninglessness of work and lack of commitment to work. Upon evaluating F2: Influence and development dimension, the psychosocial risk was observed to decrease in all sub-dimensions in those who exhibited a self-confident approach and increase in those who exhibited a desperate approach ($p < 0.05$).

6. CONCLUSION

When the impact of the COVID-19 pandemic, which has affected the entire world, on healthcare workers is evaluated, it is found that those with low general health risk levels feel themselves at a lower psychosocial risk, whereas the psychosocial risks of those with high general health risk levels are elevated. In the sub-dimensions of the COPSOQ, it was understood that the general health risk level increased as demands at work increased, and the psychosocial risk levels of those who exhibited a desperate approach and a submissive approach increased. Likewise, in the interpersonal relations and leadership sub-dimension, the self-confident approach decreases psychosocial risks, while the desperate and submissive approaches increase the risk.

It was observed that in the presence of mental illnesses, coronavirus anxiety was much higher, the general health risk level was high, and the desperate and submissive approaches were adopted more among the ways of coping with stress.

When the sub-dimensions of the COPSOQ were evaluated together with the Coronavirus Anxiety Scale, the level of anxiety increased significantly as demands at work increased, the score obtained in the interpersonal relations and leadership sub-dimension increased, and the score obtained in the work-individual interface sub-dimension increased.

In consequence, the ways of coping with stress of healthcare workers determine how much they will protect themselves against psychosocial risks during the pandemic. Participants who define their general health risk levels as low can be said to be more resistant to the psychological impacts of COVID-19 disease.

Comparisons to be made after similar studies have been conducted in hospitals in different regions of Turkey and in other countries worldwide and similar results likely to be

attained will reveal the necessity to regulate the way healthcare professionals work in extraordinary situations such as pandemics.



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8. APPENDICES

8.1.APPENDIX-1



AĞRI İL SAĞLIK MÜDÜRLÜĞÜ BİLİMSEL ARAŞTIRMA PROTOKOLÜ

Taraflar:

Bu protokol Ağrı İl Sağlık Müdürlüğü ile Saibe Merve KAZDAL arasında düzenlenmiştir.

Çalışmanın Gerçekleştirileceği Kurum/Kuruluşlar:

Ağrı Eğitim ve Araştırma Hastanesi

Çalışmanın Adı:

COVID-19 Pandemisi döneminde, Pandemi Hastanesinde Görevli Sağlık Çalışanlarının; Psikososyal Stresörleri ile Stresle Baş Etme Yöntemlerinin Değerlendirilmesi

Bu Çalışmayı Yürütecek Kişi / Kişiler:

Saibe Merve KAZDAL

Protokolün Hükümleri

- Bu protokol; Ağrı İl Sağlık Müdürlüğü'ne bağlı kurum ve kuruluşlarda verilen tüm hizmetlerin ve üretilen hizmetlere ilişkin istatistik verilerinin kullanımı ile ilgilikurum personeli ve /veya kuruma başvuran özel ve/veya tüzel kişi/kişilerle yapılacak anket çalışmalarını kurala bağlamak amacı ile düzenlenmiştir.
- Yapılacak olan bilimsel çalışma proje aşamasında iken Ağrı İl Sağlık Müdürlüğü tarafından değerlendirilecektir.
- Çalışma uygulanırken kapsam dışı hiçbir veri toplanmayacaktır.
- Veri toplama sırasında Müdürlük personelinde de destek alınması gerekiyorsa bunun için de ayrıca Müdürlük onayı alınacaktır.
- Çalışma yayın/tez haline getirilmeden önce Müdürlük ilgili birimi tarafından veri analiz çalışmaları değerlendirilecektir. Toplum sağlığı açısından sakıncalı verilerin yayınlanması kısıtlanabilecektir.
- Çalışma üniversite veya kurum tarafından kabul edildikten sonra bir nüshası kitapçık halinde Ağrı İl Sağlık Müdürlüğü'ne teslim edilecektir.
- Çalışma yapacak olan kişi "e"ve "f" maddelerini yerine getirmediği takdirde kurumumuza ait veriler yayın/proje/tez vs. gibi bilimsel bir çalışmada kullanılmayacaktır.
- Çalışma esnasında her türlü ilaç uygulaması ve/veya girişim için hem hastanın kendisi ya da yasal vasisinden hem de etik kuruldan onay alınacaktır.
- Araştırma verileri, sözel ya da yazılı olarak kullanıldığında ilgili kurum/kurumların (Hastane, Sağlık Müdürlüğü vs) ismi zikredilmeyecektir.
- Kullanılan tüm veriler 6698 sayılı Kişisel Verilerin Korunması ve Kişisel Verilerin işlenmesi ve Mahremiyeti Yönetmeliği çerçevesinde ve kimlik bilgilerinden arındırılmış olarak kullanılması gerekmektedir.

Protokolün Süresi:

- Bu çalışmanın yürütücüsü Kurumumuzda 3 ay süre ile çalışmasını yürütecektir.
- Başlangıç Tarihi:**16.11.2020
Bitiş Tarihi:16.02.2021
- Protokol, çalışmanın taraflarca planlanan ve kabul edilen süresi ile sınırlıdır. Uzatılması ancak yeni bir protokolle bağlıdır.



**AĞRI İL SAĞLIK MÜDÜRLÜĞÜ
KOMİSYON TOPLANTI TUTANAĞI**

TOPLANTININ TARİHİ : 09.11.2020

SAYISI : 16

Müdürlüğümüzün Bilimsel Araştırma İzin Komisyonu, 09.11.2020 günü saat 10.00'da toplantı salonunda toplanarak aşağıdaki kararlar alınmıştır.

Sayı	Tez/Proje/Makale Konu	Karar
1.	Covid-19 Pandemisi döneminde, Pandemi Hastanesinde Görevli Sağlık Çalışanlarının; Psikososyal Stresörleri ile Stresle Baş Etme Yöntemlerinin Değerlendirilmesi. Araştırmayı Yapan Kişi: Ağrı Eğitim ve Araştırma Hastanesi: DYT. Saibe Merve KAZDAL.	Onaylandı.

Oy birliği ile karar verildi.

KOMİSYON BAŞKANI

ÜYE

Uzm. Dr.Arzu GEDİK

ÜYE

Op. Dr.Dilek IŞIK ALPTEKİN

AĞRI EĞİTİM VE ARAŞTIRMA HASTANESİ***ARAŞTIRMA ÖN İZİN BELGESİ**

Araştırmamı Kurumunuzda yapabilmem için gerekli ön iznin verilmesi hususunda, gereğini arz ederim.

Ad Soyad: SaibeMerve KAZDAL

Tarih

İmza:

Araştırmanın;

Adı:	COVID-19 Pandemisi döneminde, Pandemi Hastanesinde Görevli Sağlık Çalışanlarının;Psikososyal Stresörleri ile Stresle Baş Etme Yöntemlerinin Değerlendirilmesi
Amacı:	COVID-19 Pandemisi başta sağlık sistemi olmak üzere, bütün alanlarda önemli değişikliklere yol açmıştır. Bu çalışmanın amacı ise; sağlık çalışanlarında COVID-19 nedeniyle çeşitli derecelerde oluşabilecek anksiyetenin; psikososyal stresörler ve kişinin stresle baş etme yöntemleri ile ilişkisinin incelenmesidir.
Yöntemi:	Çalışmaya Ağrı Eğitim ve Araştırma hastanesi'nde görevli ve gönüllülük esasına göre çalışmaya katılmayı kabul eden doktor, hemşire, hasta bakıcı, tıbbi sekreter, güvenlik görevlisi, idari personel alınacaktır. Tüm katılımcılara; 1)Sosyodemografik veri formu 2)KoronavirüsAnksiyete Ölçeği Kısa Formu 3)Stresle Başa Çıkma Tarzı Ölçeği 4)Kopenhag Psikososyal Risk Değerlendirme Ölçeği 5)Genel sağlık anketi bilgi formu(GSA-12) uygulanacaktır
Uygulanacağı Yerler:	Ağrı Eğitim ve Araştırma Hastanesi
Varsa Destekleyen (Hibe destek, fon vb)	-
Kurum/Kuruluş Adı:	
Başlama Tarihi ve Süresi:	Etik Kurul onayı alındıktan sonra 3 ay içinde bitirilmesi planlanmaktadır.
Tez Çalışması ise Danışman Öğretim Üyesi Ad Soyadı:	Dr. Öğr. Üyesi Hale ARIK TAŞYIKAN

Klinik / Birim Eğitim Sorumlusu

Klinik / Birim Branş Uzman Hekimi

BAŞHEKİM

*ADSM/TSM/ASM başvurularında ilgili sorumlu hekimin tek imzası yeterlidir.

8.3.APPENDIX-3

KOPSOR-III Anket Formu

Formun doldurulduğu tarih:

- Bu çalışma, COVID-19 Pandemisi döneminde, Pandemi Hastanesinde Görevli Sağlık Çalışanlarının; Psikososyal Stresörleri ile Stresle Baş Etme Yöntemlerinin Değerlendirilmesi için Yeditepe Üniversitesi Tıp Fakültesi Halk Sağlığı Anabilim Dalı araştırması olarak yürütülmektedir.
- Çalışmaya katılmak gönüllülük esasına göredir. Kurumsal / kişisel bilgileriniz hiç kimse ile paylaşılmayacaktır. Bu nedenle isim ve adres bilgileri sorulmamaktadır. Size sorulan tüm soruları yanıtlamaya çalışınız. Yeterince anlamadığınız sorularda açıklama yapmamızı isteyiniz. Bu çalışmadan elde edilecek veriler bilimsel amaçlar dışında kullanılmayacaktır.

SOSYODEMOGRAFIK ÖZELLİKLER BİLGİ FORMU

Doğum tarihiniz ve cinsiyetiniz nedir?	(Sadece yıl giriniz.)		☐ Erkek ☐ Kadın
Medeni durumunuz nedir?	☐ Evli ☐ Bekar	☐ Diğer	
Çocuğunuz var mı?	☐ Evet (Varsa kaç tane?.....)		☐ Hayır
En son bitirdiğiniz okula göre eğitim durumunuz nedir?	☐ Lisans ☐ Yüksek Lisans	☐ Doktora	
	☐ Ön lisans ☐ Lise	☐ Ortaokul	
	☐ İlkokul		
Doktor tarafından tanısı konulmuş herhangi bir kronik hastalığınız var mı? (Birden fazla seçenek işaretleyebilirsiniz.)	☐ Kalp Has. ☐ Astım ☐ Romatizma Has.	☐ Psikolojik Has.	
	☐ Yüksek Tansiyon ☐ Engel veya sakatlık ☐ Sara ☐ Depresyon	☐ Felç	
	☐ Kanser ☐ Şeker ☐ Diğer	(Lütfen belirtiniz.)	
Düzenli olarak kullandığınız bir ilaç var mı?	☐ Evet ☐ Hayır	(Evet ise lütfen belirtiniz.)	
Genel olarak sağlığını nasıl değerlendirirsiniz?	☐ Çok iyi ☐ İyi ☐ Orta ☐ Kötü ☐ Çok Kötü		
Bu işyerinde çalışmaya ne zaman başladınız?	(AA/YYYY tarih olarak belirtiniz.)		
Hastanede sorumlu olduğunuz temel görevler nelerdir?	(biriminizi belirtebilirsiniz.)		
Yöneticilik göreviniz var mı? (Varsa kaç kişi?)	☐ Evet ☐ Hayır	(Var ise kişi sayısını belirtiniz.)	
Covid-19 salgını öncesi hangi birimde çalışıyordunuz?			
Covid-19 salgını sırasında görev veya yer değişikliğiniz oldu mu?	☐ Evet ☐ Hayır		
Covid-19 salgını sırasında yer değişikliğiniz sonucunda Covid alanında görev aldınız mı?	☐ Evet ☐ Hayır		
Hala aktif olarak Covid alanında görev yapıyor musunuz?	☐ Evet ☐ Hayır		
Covid alanında haftada kaç gün çalışıyorsunuz?	☐ hiç ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7		
Kendinizi bulaş açısından ne kadar koruduğunuza inanıyorsunuz? (1 en az...5 en fazla)	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5		
Covid alanında çalışıyorsanız, bu alanda çalışırken kendinizi ne ölçüde risk altında hissediyorsunuz?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5		
Aile, akraba veya yakın arkadaşlarınızdan Covid-19 a yakalanan oldu mu?	☐ Evet ☐ Hayır		
Aile, akraba veya yakın arkadaşlarınızdan Covid-19 a yakalanıp yoğunbakımda takip edilen oldu mu?	☐ Evet ☐ Hayır		
Aile, akraba veya yakın arkadaşlarınızdan Covid-19 a yakalanıp ölen oldu mu?	☐ Evet ☐ Hayır	(Var ise kim ve ne zaman öldü?)	
Aynı evi paylaştığınız kişi, kişilerin yada sizin Covid 19 a yakalanması durumunda konaklama ile ilgili bir plan yaptınız mı?	☐ Evet ☐ Hayır		
Aynı evi paylaştığınız kişi, kişilerin yada sizin Covid 19 a yakalanması durumunda konaklama ile ilgili nasıl bir plan yaptınız?(seçeneklerden yapmış olduğunuzun bir veya birkaçını işaretleyebilirsiniz)	☐ aynı evde farklı odada izolasyon kurallarına uyduk ☐ farklı ev veya otel vs konaklama yaptık ☐ hastanede tedavi gördük ☐ izolasyon kurallarına uymadık		
Covid-19 salgını öncesinde psikiyatri hekimine başvurunuz olmuş muydu?	☐ Evet ☐ Hayır		
Covid-19 salgını başladıktan sonra psikiyatri hekimine başvurunuz oldu mu?	☐ Evet ☐ Hayır		
Şuan tanı almış bir ruhsal rahatsızlığınız var ise ne olduğunu belirtir misiniz?	☐ Depresyon ☐ Anksiyete ☐ Bipolar Bozukluk ☐ Obsesif-kompulsif bozukluk ☐ Şizofreni ☐ Diğer(.....)(Lütfen şikayetinizin ismini yazınız)		

KOPENHAG PSİKOSOSYAL RİSK DEĞERLENDİRMESİ ÖLÇEĞİ-3(2019)

(Her soru aynı gün yanıtlanmalı ve her soru için yalnızca 1 seçenek işaretlenmelidir.)

SORULAR	Her zaman	Sıklıkla	Bazen	Nadiren	Asla/ Neredeyse hiç
Q1-C Çok hızlı çalışmak zorunda kalır mısınız?					
Q1-C Gün boyunca yüksek bir hızda mı çalışıyorsunuz?					
Q1-L Yüksek bir hızda çalışmaya devam etmeniz gerekiyor mu?					
HT-3 İş yükünüz eşit dağılmadığı için birikir mi?					

Lütfen bir sonraki sayfaya geçiniz.

101-C	İşlerinizin gerisinde kalıyor musunuz?					
102-C	Tüm görevlerinizi tamamlamak için zamanınızın yetmediği ne sıklıkla olur?					
103-C	Çalışırken çok fazla şeye dikkat etme zorunluluğunuz var mı?					
104-C	İşiniz çok fazla şeyi hatırlamanızı gerektirir mi?					
105-C	İşiniz yeni fikirler ortaya koymanızı gerektirir mi?					
106-C	İşiniz zor kararlar vermenizi gerektirir mi?					
107-C	İşinizi sizi duygusal olarak rahatsız edici durumlara sokar mı?					
108-C	İşinizin bir parçası başkasının kişisel sorunları ile uğraşmanızı gerektirir mi?					
109-C	İşiniz size duygusal olarak bir yük getirir mi?					
110-C	İşiniz görüşlerinizi saklamanızı gerektirir mi?					
111-C	İşiniz duygularınızı saklamanızı gerektirir mi?					
112-C	Size davranışları nasıl olursa olsun herkese karşı açık ve nazik olmanız beklenir mi?					
113-C	İşinize ilişkin büyük oranda etki gücünüz var mı?					
114-C	Çalışma arkadaşını seçme konusunda söz hakkınız var mı?					
115-C	Size verilen iş miktarını belirlemede etkiniz olur mu?					
		Her zaman	Sıklıkla	Bazen	Nadiren	Asla/ Neredeyse hiç
116-C	İşinizde NE yapacağınızı siz karar verebiliyor musunuz?					
117-C	İşinizi NASIL yapacağınız konusunda sizin bir etkiniz oluyor mu?					
118-C	İşinizde çeşitli görevleriniz var mıdır?					
119-C	İşinizde yeni şeyler öğrenme olanığınız var mıdır ?					
120-C	İşinizde becerilerinizi yada uzmanlığınızı kullanabiliyor musunuz?					
121-C	İşiniz size becerilerinizi geliştirme fırsatı veriyor mu?					
122-C	İşe ne zaman ara vereceğiniz karar verebiliyor musunuz?					
123-C	Yıllık izin zamanınız yaklaşık olarak isteğiniz doğrultusunda mı belirlenir?					
124-C	Arkadaşınızla kısa bir sohbet için işinize ara verebiliyor musunuz?					
125-C	Kendi işiniz için yarım saatliğine özel bir izin almadan işyerinden ayrılabilir misiniz?					
126-C	Fazla mesai yapmak zorunda kalır mısınız?					
		Çok fazla ölçüde	Büyük ölçüde	Orta ölçüde	Az ölçüde	Çok az ölçüde
127-C	İşinizi anlamlı buluyor musunuz?					
128-C	Yaptığınız işin önemli olduğunu hissediyor musunuz?					
129-C	Kendinizi işinizde motive ve ilgili hissediyor musunuz?					
130-C	Başkalarına işyerinizi anlatmaktan hoşlanır mısınız?					
131-C	İşyerinizin sizin için çok önemli bir yer olduğunu düşünüyor musunuz?					
132-C	Bu işyerinin bir üyesi olmaktan gurur duyuyor musunuz?					
133-C	İşyerinde önemli kararlar, değişiklikler veya gelecek planlarına ilişkin önceden size bilgi verilir mi?					
134-C	İşinizi iyi yapabilmeniz için gerek duyduğunuz bilgiyi alıyor musunuz?					
135-C	Yaptığınız iş yönetim tarafından farkediliyor ve takdir ediliyor mu?					
136-C	Yönetim size saygı duyuyor mu?					
137-C	İşyerinde size adil davranılıyor mu?					
138-C	İşinizin amaçları belli midir?					
139-C	Hangi alanların kesin olarak sizin sorumluluğunuzda olduğunu biliyor musunuz?					
140-C	İşinizde sizden beklenenleri tam olarak biliyor musunuz?					

Lütfen bir sonraki sayfaya geçiniz.

İK-C	İşinizde size çelişkili talepler geliyor mu?					
İK-C	Bazen başka türlü yapılması gerektiğini düşündüğünüz şeyleri yapmak zorunda kalıyor musunuz?					
İK-S	Bazen size gereksizmiş gibi görünen şeyleri yapmak zorunda kalıyor musunuz?					
Bir üst amiriniz size ne ölçüde		Çok fazla ölçüde	Büyük ölçüde	Orta ölçüde	Az ölçüde	Çok az ölçüde
İK-S	Her bir çalışan için yeterli gelişme fırsatı sağlar?					
İK-C	Çalışanların işinden memnun olmasına öncelik verir?					
İK-C	İş planlaması konusunda iyidir?					
İK-C	Çatışmaları çözme konusunda iyidir?					
		Her zaman	Sıklıkla	Bazen	Nadiren	Asla/ Neredeyse hiç
İK-S	İş arkadaşlarınızdan ne sıklıkta yardım ve destek alırsınız?					
İK-S	İş arkadaşlarınız sizin işle ilgili sorunlarınızı dinlemeye ne sıklıkta istek duyar?					
İK-S	İşinizi nasıl yürüttüğünüz ile ilgili olarak amiriniz sizinle ne sıklıkta konuşur?					
AK-S	Bir üst amirinizden ne sıklıkta yardım ve destek alırsınız?					
AK-S	Bir üst amiriniz sizin işle ilgili sorunlarınızı dinlemeye ne sıklıkta istek duyar?					
AK-S	İşinizi nasıl yürüttüğünüz ile ilgili olarak amiriniz sizinle ne sıklıkta konuşur?					
İK-C	İşyerinde arkadaşlık ortamınız iyi midir?					
İK-S	İşyerinde arkadaşlarınız arasında iyi bir işbirliği var mıdır?					
İK-S	İşyerinizde kendinizi bir topluluğa ait hissediyor musunuz?					
Aşağıdakilerden kaygı duyuyor musunuz		Çok fazla ölçüde	Büyük ölçüde	Orta ölçüde	Az ölçüde	Çok az ölçüde
İK-C	İşsiz kalmaktan?					
İK-S	Yeni bir teknolojinin kullanımı ile işsiz kalmaktan?					
İK-C	İşsiz kalırsanız yeni bir iş bulmanız zor olmasından?					
İK-C	İsteğiniz dışında başka bir işe transfer olmaktan?					
İK-S	Çalışma zamanlarınızın(vardiya, işe geliş-gidiş, çalışma günleri vb) isteğiniz dışında değiştirilmesinden kaygı duyuyor musunuz?					
İK-S	Maaşınızın azalacağından kaygı duyuyor musunuz?					
		Evet , kesinlikle	Evet, bir noktaya kadar	Kararsızım	Evet ,ama çok az	Hayır, asla
İK-C	Aynı zamanda hem evde hemde işte bulunmanız gereken zamanlar oluyor mu?					
İK-S	İşiniz enerjinizin çoğunu tükettiği için özel yaşamınızı olumsuz etkilediğini hissediyor musunuz?					
İK-S	İşiniz zamanınızın çoğunu aldığı için özel yaşamınızı olumsuz etkilediğini hissediyor musunuz?					
İK-C	İşinizin gerektirdikleri özel ve aile yaşamınızı aksatıyor mu?					
İK-C	İşle ilgili görevler nedeniyle, aile ve özel yaşam aktiviteleri için yaptığınız planları değiştirmek zorunda kalıyor musunuz?					
		Çok fazla ölçüde	Büyük ölçüde	Orta ölçüde	Az ölçüde	Çok az ölçüde
İK-S	İşyerinde çalışanlar genel olarak birbirlerine güvenir mi?					
İK-C	Yönetim işlerini iyi yaptıkları konusunda çalışanlarına güven duyuyor mu?					
İK-C	Çalışanlar yönetim tarafından verilen bilgilere güveniyor mu?					
İK-S	Çalışanlar görüş ve duygularını ifade edebiliyor mu?					
İK-C	Çatışmalar adil bir şekilde çözülüyor mu?					

Lütfen bir sonraki sayfaya geçiniz.

10-1	İş yükü eşit bir şekilde dağılır mı?					
10-2	Çalışanlar işlerini iyi yaptıklarında takdir ediliyor mu?					
10-3	Çalışanların tüm önerileri yönetim tarafından ciddi bir şekilde değerlendirilir mi?					
İşinizle ilgili aşağıda yazılanlardan ne kadar memnunsunuz?		Çok memnun	Memnun	Memnun değil	Hiç memnun değil	
10-4	İleriye yönelik beklentilerinizden.					
10-4	Fiziksel çalışma koşullarınızdan.					
10-4	Yeteneklerinizin kullanılma şekliinden.					
10-5	Herşey dikkate alındığında genel olarak işinizden.					
10-5	Maaşınızdan.					

KORONAVİRÜS ANKSİYETE ÖLÇEĞİ

(Her soru ayrı ayrı yanıtlanmalı ve her soru için yalnızca 1 seçenek işaretlenmelidir.)

Son 2 hafta boyunca aşağıdaki aktiviteleri ne sıklıkla yaşıyorsunuz?	Hiç	Nadiren, bir veya iki günden az	Birkaç gün	7 günden fazla	Son 2 haftada neredeyse her gün
1 Koronavirüs ile ilgili haberleri okuduğumda veya dinlediğimde başım döndü, sersemlemiş veya baygın hissettim.	0	1	2	3	4
2 Koronavirüs hakkında düşündüğüm için uykuya dalmaya veya uykuda kalma konusunda sorun yaşadım.	0	1	2	3	4
3 Koronavirüs hakkında düşündüğümde veya bilgiye maruz kaldığımda felç olmuş veya donmuş gibi hissettim.	0	1	2	3	4
4 Koronavirüs hakkında düşündüğümde veya bilgiye maruz kaldığımda yemek yemeye ilgimi kaybettim.	0	1	2	3	4
5 Koronavirüs hakkında düşündüğümde veya bilgiye maruz kaldığımda mide bulantısı hissettim veya mide problemleri yaşadım.	0	1	2	3	4
10-6 Sütun Toplamları					

STRESLE BAŞA ÇIKMA TARZI ÖLÇEĞİ

(Her soru ayrı ayrı yanıtlanmalı ve her soru için yalnızca 1 seçenek işaretlenmelidir.)

Bir sıkıntı olduğunda,	Hiç uygun değil	Uygun değil	Uygun	Tamamen uygun
1 Kimsenin bilmesini istemem.				
2 İyimser olmaya çalışırım.				
3 Bir mucize olmasını beklerim.				
4 Olayı/ Olayları büyütmeyp üzerinde durmamaya çalışırım.				
5 Başa gelen çekilir diye düşünürüm.				
6 Sakin kafaayla düşünmeye ve öfkelenmemeye çalışırım.				
7 Kendimi kapana sıkışmış gibi hissedirim.				
8 Olayın değerlendirilmesini yaparak en iyi kararı vermeye çalışırım.				
9 İçinde bulunduğum kötü durumu kimsenin bilmesini istemem.				
10 Ne olursa olsun direnme ve mücadele etme gücünü kendimde hissedirim.				
11 Olanları kafama takıp sürekli düşünmekten kendimi alamam.				
12 Kendime karşı hoşgörülü olmaya çalışırım.				
13 İş olacağına varır diye düşünürüm.				
14 Mutlaka bir yol bulabileceğime inanır, bu yolda uğraşırım.				
15 Problemin çözümü için adak adarım.				
16 Herşey yeniden başlayacak gücü bulurum.				

Lütfen bir sonraki sayfaya geçiniz.

17	Elimden hiçbir şeyin gelmeyeceğine inanırım.				
18	Olaylardan olumlu birşey çıkarmaya çalışırım.				
19	Herşeyin istediğim gibi olmayacağına inanırım.				
20	Problemi adım adım çözmeye çalışırım.				
21	Mücadeleden vazgeçerim.				
22	Sorunun benden kaynaklandığını düşünürüm.				
23	Hakkımı savunabileceğime inanırım.				
24	Olanlar karşısında kaderim buymuş derim.				
25	Keşke daha güçlü bir insan olsaydım diye düşünürdüm.				
26	Bir kişi olarak iyi yönde değiştiğimi ve olgunlaştığımı hissedirim.				
27	Benim suçum ne diye düşünürüm.				
28	Hep benim yüzümden oldu diye düşünürüm.				
29	Sorunun gerçek nedenini anlayabilmek için başkalarına danışırım.				
30	Bana destek olabilecek kişilerin varlığını bilmek beni rahatlatır.				

GENEL SAĞLIK ANKETİ BİLGİ FORMU(GSA-12)

(Her soru ayrı ayrı yanıtlanmalı ve her soru için yalnızca 1 seçenek işaretlenmelidir.)

Son Zamanlarda	Hiçbir zaman	Her zamanki kadar	Her zamankinden çok	Çok sık
1	Kaygılarınız nedeniyle uykusuzluk çekiyor musunuz?			
2	Kendinizi sürekli zorluk çekiyor hissediyor musunuz?			
3	Yaptığınız işe dikkatinizi verebiliyor musunuz?			
4	Çevrenizde yararlı bir rol oynadığınızı düşünüyor musunuz?			
5	Sorunlarınızla başa çıkabilmek için kendinizi yeterli görüyor musunuz?			
6	Karar vermekte güçlük çekiyor musunuz?			
7	Karşılaştığınız güçlüklerin üstesinden gelemediğinizi hissediyor musunuz?			
8	Değişik yönlerden baktığınızda kendinizi mutlu hissediyor musunuz?			
9	Günlük işlerinizden zevk alabiliyor musunuz?			
10	Kendinizi mutsuz ve çökkün hissediyor musunuz?			
11	Kendinize güveninizde azalma var mı?			
12	Kendinizi değersiz biri olarak görüyor musunuz?			

ANKETİMİZ BİTMİŞTİR.KATILIMINIZ İÇİN TEŞEKKÜR EDERİZ.

Lütfen bir sonraki sayfaya geçiniz.

9. CURRICULUM VITAE

Personal Information

Name	Saibe Merve	Surname	KAZDAL
Place of Birth		Date of Birth	
Nationality		T.R. Identification Number	
E-mail		Phone number	

Educational Background

Degree	Department	Name of the Institution Graduated From	Year of Graduation
Doctorate			
Master's Degree			
Undergraduate	Nutrition and Dietetics	Ondokuz Mayıs University	2013
High School	-	Ahmet Kabaklı Anatolian Teacher High School	2009

Foreign Languages Known	Foreign Language Exam Grade (#)
English	61,250

Work Experience (Sort from present to past)

Position	Institution	Duration (Year - Year)
Dietitian	Güneysu Tenzile Erdogan District State Hospital	2021-currently
Dietitian	Ağrı Training and Research Hospital	2019-2021
Dietitian	Eyup State Hospital	2016-2019
Dietitian	G.O.P. Taksim Training and Research Hospital	2015-2016
Dietitian	Agri State Hospital	2013-2015

Computer Skills

Program	Usage skill
Microsoft Office	Good
Spss	Good

Scientific Works

Others (Projects/Certificates/Rewards)

June 2013-Hacettepe University Nutrition and Dietetics Days IV. Postgraduate Training Course
April 2017-Turkey Health and Sports Forum , Sports Nutrition Weekend
May 2017-Summit in Probiotics and Plan D of Healthy Living