The Moderating Role of Coping Strategies in The Relationship Between Marital Conflict and Depression Among Married Nurses

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Abstract

*The study investigated the moderating role of coping strategies in the relationship between marital conflict and depression among married nurses, eighty-seven (87) married nurses with a mean age of 31.20 and S.D of 6.32 were selected as participants with the aid of purposive sampling techniques from one federal and three private hospitals in Enugu state, Zung (1965) Self-rating Depression Scale (SDS), Omoluabi (1994) Marital stress inventory (MSI) and Carver et al. (1989) Brief-cope scale, a correlational design was adopted and moderated multiple hierarchy regression was used for data analysis, and findings revealed that problem focus dimension of coping strategies Stβ= .443*** and t= 4.522*** at p< .001 positively predicted depression among married nurses, emotional focus dimension of coping strategies Stβ= -.260** and t= -2.657** at p< .01 negatively predict depression. Marital conflict Stβ= -.288** and t= -2.945** at p< .01 negatively predicted depression among married nurses. Problem focus dimension of coping strategies Stβ= -1.410** and t= -2.767** at p< .01 negatively moderated the relationship between marital conflict and depression among married*

nurses, emotional focus dimension of coping strategies UnStβ= .605 and t= .928 at p< .05 failed to moderate the relationship between marital conflict and depression among married nurses. Hence, married nurses are advised to adopt emotional coping strategies, this will help them to address the day-to-day stress acquired.

Keywords: *coping strategies, Problem focus, Emotional focus, marital conflict, Depression, Married Nurses*

Introduction

Numerous theories of depression argue that low self-esteem is a defining feature of the condition (Beck, 1967; Brown & Harris, 1978: Mu et al., 2019). Notably, low self-worth constitutes one of the diagnostic criteria for depression in DSM-5 (APA, 2013). Empirical studies have established a strong association between the two constructs, with cross-sectional correlations ranging from –.24 to –.79, contingent on the samples and measures employed (Orth et al., 2008; Mu et al., 2019). Despite the well-established association between low self-esteem and depression, the nature of this relationship remains unclear. This knowledge gap has motivated researchers to investigate whether coping strategies, such as problem and emotional focus, can moderate the relationship between marital conflict and depression among married nurses.

Depression is a mental health disorder that is characterized by a persistent low mood that lasts for at least two weeks. This low mood tends to persist across most situations and is often accompanied by low self-esteem, a loss of interest in activities that are normally enjoyable, low energy, and unexplained pain (National Institute of Mental Health, NIMH 2016). It is a well-known fact that individuals who suffer from depression may experience delusions or hallucinations, which are not perceptible to others (NIMH, 2016). According to Robinson et al., (2020), depression is not a normal developmental stage of ageing, and it must be addressed with utmost care.

It is imperative that depression is recognized as a significant condition that may affect people of all ages. It is particularly concerning when an individual experiences false beliefs or hallucinations, as this may indicate a more severe mental health issue. As noted by Robinson et al., (2020), depression requires the attention and care it deserves, regardless of age. Substance abuse is a prevalent issue that can have serious implications on an individual's mental health. Specifically, several drugs of abuse have been reported to cause or exacerbate depression. This may occur during times of intoxication, withdrawal, or as a result of prolonged use. It is essential to acknowledge these risks and take necessary measures to address them promptly. The drugs that are commonly associated with causing or exacerbating depression include alcohol, sedatives like benzodiazepines, opioids (both prescription painkillers and illicit drugs like heroin), stimulants such as cocaine and amphetamines, hallucinogens, and inhalants. This information has been reported by the American Psychological Association (APA) in 2013. It is important to note that these drugs have varying effects on the brain and body, and some may have more severe consequences than others. Therefore, it is crucial to understand the potential risks associated with each substance to make informed decisions regarding their use.

Life events and changes that may precipitate depression include (but are not limited to): childbirth, menopause, financial difficulties, unemployment, stress (such as from work, education, family, living conditions etc.), medical diagnosis (cancer, HIV, etc.), bullying, loss of a loved one, natural disasters, social isolation, rape, relationship troubles, jealousy, separation, and catastrophic injury (Nwatu, 2022: Mao & Agyapong, 2021). Depression can be caused by various factors such as infectious diseases, nutritional deficiencies, neurological conditions, and physiological problems. These include hyperandrogenism in men, post-stroke depression, Parkinson's disease, chronic pain, and cognitive impairment. According to Murray et al., (2012), these conditions can lead to depression. When the feelings associated with depression begin to dominate to the extent that someone cannot function properly, it is considered as depression (Allen et al., 2014). Depression is a mental condition that affects an individual's ability to function in everyday life. Those who suffer from depression often experience physical, emotional, and mental exhaustion. Simple tasks that were once enjoyable may no longer hold any interest for them, and activities that require concentration and focus can be difficult and cause extreme fatigue. It can be a challenging condition to cope with that can take a toll on an individual's overall well-being.

Depression can manifest in various ways, including changes in sleeping patterns such as insomnia or excessive sleep. It can also affect one's appetite, resulting in sudden weight loss or gain, while some individuals may overeat. Those who suffer from depression may withdraw from social interactions and find it difficult to tolerate others. They may also experience unexplainable body pains, feelings of worthlessness, guilt, and talk about death or suicide. These symptoms can be debilitating and require professional help to manage. (Halla 2021; Muñoz 2020). Depression can affect individuals of any age and gender, and can be a significant factor in suicide risk. Health sciences students, in particular, face a variety of challenges, including pressure from theory and practical training, numerous exams and evaluations, random hospital training procedures, and decision-making responsibilities in nursing care. Witnessing different types of deaths can also be emotionally taxing. Students who struggle to balance or adjust to a new environment are at an increased risk of experiencing negative emotions and developing depression. It is important for universities and institutions to provide adequate support and resources to help students manage these challenges and promote their mental well-being. Studies have shown that nursing students have a higher prevalence of depression, with the majority of affected students being women (Kılınç, et al. 2020). Adjusting to higher education can be a challenging experience, particularly for students who are away from home for the first time. New environments require new adjustments, independence, and the pressure of meeting high academic demands can cause psychological distress. Financial issues, such as needing to work part-time while studying, can also add pressure and make it difficult for students to focus on their studies. It is crucial for universities and institutions to recognize these challenges and provide adequate support and resources to help students manage their mental well-being. The circumstances are much more distressful when the students study in different nation with different mother tongue (Meriläinen & Kuittinen 2013).

There are several risk factors associated with depression, including a family history of the condition, trauma, stress, major life changes, physical illnesses, death or loss of a loved one, and certain medications (NIMH, 2021; Fulghum 2019). Additional risk factors may include poverty, discrimination, social exclusion, illicit drug use, and maltreatment during childhood such as abuse and neglect (World Health Organization 2016). Other common indicators of risk

include being young, the field of study, year of study, academic failure, uneducated parents, poor parental relationships, academic pressures, excessive smartphone usage (Hamashaa et al. 2019), and being bullied (NHS 2021).

Marital conflict can be described as a struggle, clash, strife, disagreement, or quarrel between a husband and wife, and sometimes with other members of the household, over opposing needs, ideas, beliefs, values, or goals (Cummings & Olugbenga, 2018; Tasew & Getahun, 2021). Such conflicts can arise due to various reasons, including differences in personality and communication styles, financial stress, parenting styles, and infidelity. If not managed effectively, marital conflicts can lead to negative outcomes, such as emotional detachment, separation, and even divorce. It is important for couples to learn effective communication and conflict resolution skills to manage their conflicts and strengthen their relationship. Marital conflict is prevalent in many African countries, including Ethiopia (Bongaarts et al, 1984, as cited in Afework, 2010; Tasew & Getahun, 2021). Studies of six African countries have shown that, on average, a high proportion of first marriages experience marital conflict. Furthermore, research findings in rural Malawi have revealed that life table proportions of marital conflict range from 40 to 65 percent and are among the highest on the continent (Reniers, 2003). These statistics underscore the importance of addressing marital conflict in Africa and implementing interventions that promote healthy and sustainable relationships. Somit Prueksaritanond (2015) and Tasew and Getahun (2021) have reported that 89.3% of couples experienced conflict, which is higher than the prevalence of couple conflict in a previous study from Spain (80%). In Prueksaritanond's study, spousal conflict occurred every month (up to 1-2 events per month), and every week, it was found in approximately six out of ten couples (59.1%). These findings suggest that marital conflict is a common issue worldwide and highlight the importance of addressing this issue to promote healthy and sustainable relationships.

Marital conflict can have serious consequences, with at least one-third of first marriages ending in divorce or separation due to this issue. Most of these separations take place within the first two years of marriage (Central Statistics Authority, 1991, 1993, as cited in Afework, 2010; Tasew & Getahun, 2021). Furthermore, according to Tilsen and Larson (2000), as cited in Yeshework et al. (2019), 45 percent of first marriages in Ethiopia end in divorce within 30 years due to marital conflict. These statistics highlight the need for interventions that promote healthy relationships and effective conflict resolution skills among couples in Ethiopia and beyond.

Marital conflict comes in different forms like spouse battering, spousal abuse, sexual abuse, marital irresponsibility, incest, rape, subtle struggle for control between the couple and other abusive behaviours and also caused by childlessness, forced marriage, incompatibility, communication gap, interference by in-laws, finances, infidelity, sex of children, lack of appreciation etc (Osarenren, 2013; Tasew & Getahun, 2021). Furthermore, researchers like Tiruwork (2015), and Meaza and Wobedel (2014) and Tasew and Getahun (2021) identified several major sources of marital conflict, i.e., violent behaviours of husbands, lack of cooperation in the family, inability to spend enough time together, issues related to children and other families, lack of effective communication, and financial problems. Also, a quantitative study of couples highlighted personal traits, communication skills, commitment, and family background as the most significant factors related to conflicts in marriages.

Regarding its consequences, marital conflict is not only the issue of the two spouses; its effect goes beyond the individuals who dissolve the marital union. Children and other relatives of the couples are the immediate victims who share the potential consequences and exposed to various psychosocial problems (Collins, 1988; Tasew & Getahun, 2021). Moreover, conflicts in marriages produce various personal, familial, physical, and psychological consequences. They can result in depression, anxiety, and eating disorders and others. Additionally, conflict in marriage can lead to poorer health conditions and the risk of certain diseases, such as heart disease, as well as cancer and chronic pains. Furthermore, conflicts in marriages can affect family life in different ways, e.g., it may decrease the performance of the parents and the compatibility of the children and increase conflicts among all family members (parents and children as well as between siblings). The use of coping strategies has a significant association with depression. Although avoidance is not a long-term successful coping strategy, it may reduce stress levels in the short term by escaping the situation which has caused stress (Huizink, et al., 2002; Firouzbakht, et al., 2022). Li's (2020) study showed that using problem-focused and emotional - focused coping was better for Psychological status. Guo et al. (2020) showed that using problem-focused coping decreased mental health problems and emotional -focused coping style increased mental disorders. In a study in Saudi-Arabia during COVID-19 emotional - focused coping related to increased depression, anxiety and sleep disorders in people (Guo, et al., 2020). Although people use the coping strategies in the face of stressful situation, but some of these strategies are related to increased psychiatric disorders (Firouzbakht, et al., 2022).

Coping is defined as the thoughts and behaviours mobilized to manage internal and external stressful situations (Folkman, & Moskowitz 2004 as cited in Algorani & Gupta, 2021). It is a term used distinctively for conscious and voluntary mobilization of acts, different from 'defence mechanisms' that are subconscious or unconscious adaptive responses, both of which aim to reduce or tolerate stress (Venner 1988 as cited in Algorani & Gupta, 2021).When individuals are subjected to a stressor, the varying ways of dealing with it are termed 'coping styles, which are a set of relatively stable traits that determine the individual's behaviour in response to stress. These are consistent over time and across situations (de Boer et al., 2017). Generally, coping is divided into reactive coping (a reaction following the stressor) and proactive coping (aiming to neutralize future stressors). Proactive individuals excel in stable environments because they are more routinized, rigid, and are less reactive to stressors, while reactive individuals perform better in a more variable environment (Coppens, de Boer, & Koolhaas 2010 as cited in Algorani & Gupta, 2021). Coping is generally categorized into four major categories which are (Folkman, & Moskowitz 2004 as cited in Algorani & Gupta, 2021): Problem-focused, which addresses the problem causing the distress: Examples of this style include active coping, planning, restraint coping, and suppression of competing activities. Emotion-focused, which aims to reduce the negative emotions associated with the problem: Examples of this style include positive reframing, acceptance, turning to religion, and humour. Meaning-focused, in which an individual uses cognitive strategies to derive and manage the meaning of the situation. Social coping (support-seeking) in which an individual reduces stress by seeking emotional or instrumental support from their community. Many of the coping mechanisms prove useful in certain situations. Some studies suggest that a problem-focused approach can be the most beneficial; other studies have consistent data that some coping mechanisms are associated with worse outcomes (Stoeber, & Janssen 2011: Folkman, & Moskowitz 2004 as cited in Algorani & Gupta, 2021). Maladaptive coping refers to coping

mechanisms that are associated with poor mental health outcomes and higher levels of psychopathology symptoms. These include disengagement, avoidance, and emotional suppression (Compas el at. 2017). The physiology behind different coping styles is related to the serotonergic and dopaminergic input of the medial prefrontal cortex and the nucleus accumbens (Coppens, de Boer, & Koolhaas 2010 as cited in Algorani & Gupta, 2021). The neuro-peptides vasopressin and oxytocin also have an important implication relative to coping styles. On the other hand, neuroendocrinology involving the level of activity of the hypothalamic-pituitary-adrenocortical axis, corticosteroids, and plasma catecholamines were unlikely to have a direct causal relationship with an individual's coping style (Koolhaas, de Boer, & Coppens 2010 as cited in Algorani & Gupta, 2021). Coping strategies can play an important role in person daily activities because this may lead to positive or negative mental health outcomes (Thai, et al., 2021). Coping strategies include cognitive and behavioural efforts an individual uses to solve problems and to reduce the stress caused by these problems (Algorani & Gupta 2021). On one hand, the proper use of coping strategies will help to manage stressful events and reduce negative emotions. On the other hand, inappropriate selection of coping strategies leads to severe stress or even suicide (Thai, et al., 2021).Folkman and Lazarus (1986) as cited in Önder and Reyhan (2018) divide coping methods in two groups as problem focused and emotion-focused. Problem-focused coping comprises a more active and planned logical analysis that leads to action. The purpose is to cope with the problems that cause trouble. As for emotion-focused coping, it is a passive method which involves the effort for eliminating emotions that developed due to an unwanted event. Both coping methods coexist in individuals' coping patterns, and the method used changes during interaction. While problem-focused behaviours involve active, logical, and conscious efforts for changing the situation; emotion-focused approaches generally involve being away, controlling self, seeking social support, and accepting. Seiffe-Krenke (1993) as cited in Önder and Reyhan (2018) found that there was an increase in the use of both emotion-focused and problem-focused coping strategies in adolescence years. Gibson et al (1992) as cited in Önder and Reyhan (2018) found that adolescents from 17 countries used problem-focused coping strategies more frequently. Compas, Orosan, and Grant (Compas, Orosan, & Grant 1995 as cited in Önder & Reyhan) state that use of emotion-focused coping strategies increases in adolescence. Beck, (1967) is adopted as the theoretical framework because it emphasises people's beliefs system rather than their behaviour. The theory postulated that the meaning an individual gives to events matters a lot, if a positive meaning is perceived in the marital environment a less stressful situation will be experience but if the reverse a negative interpretation is perceived, it might lead to marital stress. Coping strategies are the thing of the mind, if one development a negative mechanism, along with marital stressful situations might lead to depression among nurses. Hence, the following hypotheses

Coping (problem and emotional focus) strategies will independently and jointly predict depression among nurses

Marital conflict will significantly predict depression among married nurses.

Coping strategies (problem and emotional focus) will moderate the relationship between marital conflict and depression among married nurses

Method

Participants

Eighty-seven (87) married nurses with a mean age of 31.20 and SD of 6.32 were selected as participants with the aid of purposive sampling techniques from one federal and three private hospitals in Enugu state. The hospitals are twenty-three (23) from Divine Blessed Assurance Medical Center, Coal Camp, twelve (12) from Balm of Gilead Hospital, Maryland, eleven (11) from Hansa Clinic, Independent Layout, and forty-one (41) from National Orthopedic Hospital Enugu, Enugu-Abakaliki expressway, all from Enugu State.

Instrument

Three sets of instruments will be used, namely:

I. Zung (1965) Self-rating Depression Scale (SDS)
II. Carver et al. (1989) Brief-cope scale
III. Braiker and Kelley (1979) Braiker & Kelley Marital Conflict Scale

Self-rating Depression Scale

Zung (1965) Self-rating Depression Scale was developed to measure depression as a clinical disorder. It is a 20-item inventory that is designed to assess the cognitive, affective, psychomotor, somatic and social-interpersonal dimensions of depression. It is scored directly by adding together the values of the numbers shaded in all the 20 items to give you the mean score. The normative cut-off point or mean scores established by Zung (1965) in categorizing the participants where the level of depression are thus; 50 – 59 = mild depression, 60 – 69 = moderate depression, 70 – 80 = severe depression. For the Nigeria sample, the norms obtained by Obiora (1995) with a population of secondary school students for male and female are 48.77 and 47.87 respectively. A coefficient of concurrent validity of .79 was obtained by Zung (1965), a three-day interval test-retest coefficient of reliability of .93 was obtained by Obiora (1995), between SDS and Hamilton rating scale (HRS) Hamilton (1960) between SDS and the depression scale of MMPI, the coefficient of .70 was obtained. The researcher carried a pilot study with thirty (30) participants from the University of Nigeria Enugu campus nursing students using purposive sampling techniques and obtained a Cronbach alpha of .86 which showed that the scale was reliable.

Carver et al., (1989) The Brief-Cope Scale

The Brief-Cope scale was developed as a short version of the original 60-item COPE scale (Carver et al., 1989). It is a 28-item self-report measure that assesses the effective and ineffective ways to cope with stressful life events. Items are rated on a 4-point frequency. It was discovered by Carver (1997). Cronbach's alpha for the total scale is adequate because all values exceed the minimum of 0.60 suggested by Nunnally and Bernstein (1995) for research purposes. Evaluation shows that higher coefficients are observed between instrumental support and emotional support (r =0.65) and between active coping and planning (0.56). Using 73 participants, the researcher obtained a Cronbach alpha of .78. A pilot study conducted using 30 thirty nursing students from the University of Nigeria Enugu campus as participants with the aid of purposive sampling techniques, yielded a reliability Cronbach alpha coefficient of .63 and standardized item coefficient of .68.

Braiker and Kelley (1979) Braiker & Kelley Marital Conflict Scale

Braiker & Kelley Marital Conflict Scale is a 5-point scale developed to assess the amount of overt behavioural conflict and communication of negative affect within the marital relationship. Participants indicate the amount of conflict and negativity in their relationships on a 5-point Likert scale, it has an internal consistency reliability in PMBC (alpha=0.81). A pilot study conducted using 30 thirty nursing students from the University of Nigeria Enugu campus as participants with the aid of purposive sampling techniques, yielded a reliability Cronbach alpha coefficient of .76

Procedure

The researcher adopted a purposive sampling technique to select participants who are married nurses who had the mean score from the self-rating depression administered from one federal and three private hospitals in Enugu State. The researcher employed the help of research assistants whom are matrons working in the selected hospitals to administer and collect the instrument, the participants who are married nurses were selected with the aid of purposive sampling techniques; because being a married nurse qualified them to participate in the research, then the selected ones were asked to respond to the items by shading one of the boxes in front of the statements which best reflects to what degree they agree or disagree with the statement. one hundred and eleven copies of questionnaire were distributed, one hundred and four copies were returned of which eight were wrongly responded, nine carries multiples initials, leaving only eighty-seven copies properly responded to which was used to carry out analysis; the wrongly responded once were discarded.

Design/Statistics

The study is correlation research that will employ correlation design based on observation and measurement of variables cross-sectional survey design; while a moderated multiple hierarchical regression analysis will be adopted based on one moderating variable Coping Strategies, one predictor variable marital conflict, and one dependent variable depression.

Result

Table I: descriptive statistics of the moderating role of coping strategies in the relationship between marital conflict and depression among married nurses.

S/N	variable	M	SD	1	2	3	4	5	6	7	8	9
1	depression	58.73	15.41	1	.395	-.180	-.367	.355	.109	.396	-.033	-.341
2	Problem focus	20.43	5.600		1	.181	-.070	-.033	.059	.090	.646	.044
3	Emotional focus	47.01	11.25			1	.308	-.186	-.152	-.090	.352	.758
4	Marital conflict	12.91	3.903				1	-.059	.020	-.145	.699	.843
5	Age	31.19	6.307					1	-.290	.711	-.070	-.149
6	Gender	1.8046	.3988						1	-.105	.065	-.058
7	Years of marriage	3.6552	4.114							1	-.058	-.143

8	Moderator (problem focus marital conflict)	262,	105.3								1	.659
9	Moderator emotional focus and marital conflict	620.	275.9									**1**

Table I above shows that problem focus r= .395 dimension of coping strategies positively relate to depression, this indicates that an increase in problem focus dimension of coping strategies will cause an increase in depression among married nursing. Marital conflict r= -.355 negatively relates to depression. Age r= .355 positively related to depression, this implies that increase in age will cause an increase in depression among married nurses. Years of marriage r= .396 positively relates to depression, this implies that an increase in years of marriage will cause an increase in depression among married nurses. Emotional focus moderating marital conflict r= .-.341 negatively relates to depression, this indicates that an increase in emotional focus dimension of coping strategies can moderate marital conflict to cause a decrease in depression among married nurses.

Table II: moderating statistics of coping strategies in the relationship between marital conflict and depression among married nurses

Model	**R**	**R^2**	**UnStβ**	**Stβ**	**t**
1	.471**	.222**			
Problem focus			1.218***	.443***	4.522***
Emotional focus			-.356**	-.260**	-2.657**
2	.544**	.295**			
Marital conflict			-1.136**	-.288**	-2.945**
Age			.848**	.347**	2.744**
Gender			7.474*	.193*	2.183*
Years of marriage			.243	.065	.537
Moderator (Problem focus* marital conflict)			-.206**	-1.410**	-2.767**
Moderator (emotional focus*marital conflict)			.034	.605	.928

Dependent variable= depression, at p< .05*, at p< .01, at p< .001***. R= relation, r^2= relationship square, UnStβ= unstandardized beta, Stβ= standardised beta**

Table II above shows that problem focus dimension of coping strategies Stβ= .443*** and t= 4.522*** at p< .001 positively predicted depression among married nurses, this indicates that an increase in problem focus will cause an increase in depression among married nurses. Emotional focus dimension of coping strategies Stβ= -.260** and t= -2.657** at p< .01 negatively predict depression, this implies that an increase in the use of emotional focus coping strategies will cause a decrease in depression among married nurses. Coping strategies (problem and emotional focus) jointly related to depression at r= .471 at p< .01, and they contributed 22.2% variance to depression at r^2= .222, problem and emotional focus dimensions of coping strategies jointly predicted depression at p< .01.

Marital conflict Stβ= -.288** and t= -2.945** at p< .01 negatively predicted depression among married nurses, this implies that an increase in marital conflict among married nurses will cause a decrease in depression. Age Stβ= .193** and t= 2.744** at p< .01 positively predicted

depression among married nurses, this implies that an increase in age will cause an increase in depression among married nurses. Gender Stβ= .193* and t= 2.183* at p< .05 positively predicted depression among married nurses.

Problem focus dimension of coping strategies Stβ= -1.410** and t= -2.767** at p< .01 negatively moderated the relationship between marital conflict and depression among married nurses, this implies that an increase in the use of problem focus dimension of coping strategies will negatively moderate marital conflict to cause a decrease in depression married nurses. Emotional focus dimension of coping strategies UnStβ= .605 and t= .928 at p< .05 failed to moderate the relationship between marital conflict and depression among married nurses.

Discussion

The study aimed to explore the relationship between coping strategies, specifically problem and emotional focus, and depression among married nurses. The first hypothesis was tested, which stated that coping strategies would independently and jointly predict depression. The study found that the hypothesis was confirmed, indicating that coping strategies have a significant impact on depression levels among married nurses. The results showed that emotional focus had a negative interaction with depression, while problem focus had a positive interaction. This implies that married nurses who relied more on emotional coping strategies experienced a decrease in depression levels. In contrast, those who relied more on problem-focused coping strategies tended to experience an increase in depression levels.

The finding of a negative interaction between emotional focus and depression suggests that emotional coping strategies may be particularly beneficial for reducing depression levels among married nurses. Emotional coping strategies refer to managing emotions related to stressors, including seeking support from others, engaging in relaxation techniques, or using positive self-talk. On the other hand, the finding of a positive interaction between problem-focus and depression suggests that the use of problem-focused coping strategies may lead to an increase in depression levels among married nurses. Problem-focused coping strategies refer to engaging in activities aimed at solving the problem that causes stress, including seeking information, planning, or taking action. In conclusion, the study highlights the importance of adopting appropriate coping strategies to manage stress and reduce depression levels among married nurses. The findings suggest that emotional coping strategies may be more effective in reducing depression levels, while problem-focused coping strategies may need to be used cautiously, as they may exacerbate depression levels.

The results indicate that the second hypothesis was confirmed, which was designed to examine the relationship between marital conflict and depression among married nurses. The findings suggest that marital conflict has a significant impact on depression among nurses, with a negative correlation being observed. This means that the more marital conflict a nurse experiences, the less likely they are to suffer from depression. These results suggest that marital conflict may help to reduce depression among married nurses. It is important to note, however, that further research is needed to fully understand the complex relationship between marital conflict and mental health outcomes among nurses.

The third hypothesis that was tested in the study aimed to investigate how coping strategies, specifically problem-focused and emotional-focused coping, would affect the relationship

between marital conflict and depression among married nurses. The results of the study partially confirmed the hypothesis, revealing that only the problem-focused coping strategy had a negative moderating effect on the relationship between marital conflict and depression among married nurses. In other words, when married nurses used problem-focused coping strategies to deal with marital conflict, it led to a decrease in depression. However, the emotional-focused coping strategy did not have a moderating effect on the relationship between marital conflict and depression. These findings suggest that using problem-focused coping strategies can be an effective way to reduce depression among married nurses by moderating the effects of marital conflict.

Limitations of the study

Many factors militated against this study, one of such is the drawn participants. The busy nature of nurses discourages some of them from participating, so the researchers have to allow the participants to go home with a questionnaire to give room for them to attend to it during their resting time.

Most participants refused to fill in their correct details, this reduces the number of questionnaires used for the analysis because it is only the correctly filled ones that were used for data analysis.

The constant increase in inflation also worked against this study, the inflation affected the purchasing strength of the researchers. Because what budget was stretched, additional resources were re-added which was not in the initial budget for the study.

Suggestions for further studies

Future researchers should consider sampling nurses from other states and locations outside the one used by these researchers. This will increase the number of participants.

Other means of extracting demographic variables should be considered by future researchers, this will enable the participants to fill the necessary information box.

Backup funds should be made available in case of necessity, this will enable the free flow of the study.

Summary and conclusion

The study investigated the moderating role of coping strategies (problem and emotional focus) in the relationship between marital conflict and depression among married nurses, findings revealed that coping strategies (problem and emotional focus) independently and jointly predicted depression, marital conflict also predicted depression, while problem focus negatively moderated the relationship between marital conflict and depression. Hence, married nurses are advised to adopt emotional coping strategies, this will help them to address the day-to-day stress acquired. While problem focus coping strategies can be adopted by married nurses in addressing the stress from their marital life, because problem focus will help to cause negative occurrence of marital conflict for depression to reduce among them.

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