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level of nomophobia and mental health status at workplace among nursing professionals at selected nursing institute

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Abstract:

Introduction: Nomophobia is an abbreviated term used for 'no mobile phone phobia', coined during 2008 by a UK- based research organization evaluating anxieties suffered by mobile phone users. Nomophobia term is defined as irrational fear that takes place in a condition when one fails to reach his mobile phone or communicate through these mentioned mobile devices. It is used to describe a psychological condition when people have a fear of being detached from mobile phone connectivity. Nomophobia is a modern phobia related to the loss of access to information, the loss of connectedness, and the loss of communication abilities (King et al., 2013, 2014; Yildirim & Correia, 2015). Nomophobia has been interpreted as dependence on mobile phones or addiction.

Method and Material: the study used a nonexperimental descriptive design with probability simple random sampling to assess nomophobia and mental health status among 100 nursing professionals. Standardized tools, including The Nomophobia Questionnaire and the MMSE, were employed to collect and analyse data, providing a detailed understanding of these factors within the study sample.

Result: It sounds like the study found a significant positive correlation between the level of nomophobia (fear of being without a mobile phone) and the mental health status of nursing professionals. The statistical significance ($p < 0.01$) suggests that as nomophobia increases, mental health issues among nursing professionals also tend to increase. Regarding the cognitive assessment using the Mini Mental Status Exam (MMSE), the overall mean score for nursing professionals was 18.7 ± 3.01, which is approximately 62.33% of the maximum possible score. This indicates a moderate level of cognitive impairment among the participants. Specifically, the highest mean score (8.30 ± 0.48) was obtained in the orientation section of the MMSE, indicating that nursing professionals generally performed well in this area, scoring 83% of the maximum possible score. This suggests that they were able to maintain good orientation to time, place, and person. Conversely, the lowest mean score (0.08 ± 1.20), which is only 2.66% of the maximum possible score, was obtained in the recall section of the MMSE. This indicates significant difficulty among nursing professionals in recalling information presented to them, which is an important aspect of cognitive functioning. Overall, these findings suggest that while nursing professionals generally excel in orientation, they may struggle significantly with recall, reflecting a specific cognitive challenge that could impact their work and overall mental health.

Conclusion: The study highlights the intersection of nomophobia (fear or anxiety of being without a mobile phone) and mental health among nursing professionals. It underscores the significance of addressing these issues within the specific context of workplace environments. By raising awareness about nomophobia and its potential impact on mental health, healthcare institutions can take proactive steps to support nursing professionals. This support can include providing resources for managing stress related to constant connectivity expectations, fostering a healthy work-life balance, and offering interventions tailored to the unique challenges faced by nurses in their caregiving roles. Implementing targeted interventions, such as mindfulness programs, stress management workshops, or technology usage guidelines, can contribute significantly to the wellbeing and resilience of nursing professionals. These initiatives not only acknowledge the pressures and anxieties associated with nomophobia but also promote a supportive workplace culture that prioritizes mental health. In conclusion, by recognizing and addressing nomophobia alongside broader mental health concerns, healthcare institutions can enhance the overall wellbeing of nursing professionals, thereby improving their ability to provide quality care to patients.

Keywords: level, Nomophobia, Mental health status, Nursing, professionals, workplace ,Institute.

Introduction: Nomophobia is an abbreviated term used for 'no mobile phone phobia', coined during 2008 by a UK- based research organization evaluating anxieties suffered by mobile phone users. Nomophobia term is defined as irrational fear that takes place in a condition when one fails to reach his mobile phone or communicate through these mentioned mobile devices. It is used to describe a psychological condition when people have a fear of being detached from mobile phone connectivity. Nomophobia is a modern phobia related to the loss of access to information, the loss of connectedness, and the loss of communication abilities (King et al., 2013, 2014; Yildirim & Correia, 2015). Nomophobia has been interpreted as dependence on mobile phones or addiction to them in relevant researches. Although nomophobia does not appear in the current Diagnostic and Statistical Manual of Mental

Disorders, Fifth Edition (DSM-5), it has been proposed as a "specific phobia," based on the definitions given in DSMIV. According to Bianchi and Philips,2005 "Psychological factors are involved in the excessive use of a mobile phone". These could include low self-esteem; when individuals are looking for reassurance, use mobile phones in inappropriate ways and extroverted personality; when individuals socially use the mobile phone to excess. It is also highly possible that nomophobia symptoms may be caused by other underlying and pre-existing mental disorders, including social phobia or social anxiety disorder and panic disorder. Nomophobia is situation specific such that it is evoked by situations that engender the unavailability of one's smartphone (Yildirim & Correia, 2015). As a situation-specific phobia, Nomophobia has recently been suggested to lead to strong perceptions of anxiety and distress (Cheever, Rosen, Carrier, & Chavez, 2014; Choy, Fyer, & Lipsitz, 2007; Yildirim & Correia, 2015). In fact, some suggested that Nomophobia could be so stressful that it warrants to be considered a psychopathology (Bragazzi & Del Puente, 2014).

A typical nomophobic individual can be identified by some characteristics such as never turning off the phone, obsessively checking missed texts and calls, bringing the phone everywhere, using phone at inappropriate times and missing opportunities for face-to-face interaction while preferring over the phone contact. Many studies suggested that all age group people are having chances of getting addicted to the smartphone. Mobile phone addiction is also counted as a phobia; here addicted person will experience more or less similar physical characteristics like fatigue, poor eye vision, eye pain, poor body posture along with severe psychological symptoms. Many research studies have shown that majority of nomophobia cases is caused by addiction towards social networking sites where they make an online friend and live in their own fantasy world with the prompt messaging system, second pornography which is again a prevailing factor among university- level students, next is the majority of group students are using their mobiles for fast texting and calls to their loved ones. Nomophobia not only disturbs the person physically and psychologically but also have social impact on us and it also results in loss of confidence in life with challenging self-respect. Smartphone's popularity has risen to such an extent in recent years that it is unimaginable for the people to stay away from it for a minute. The excessive usage has given rise to a condition termed as nomophobia or a feeling of discomfort or anxiety experienced whenever unable to use the smartphone. Study to assess the level of nomophobia and mental health status at workplace among nursing professionals at selected nursing institute. In some severe cases, people may also face physical side effects such as panic attacks, shortness of breath, trembling, sweating, accelerated heart rate, pain in hand joints, neck and back pain, etc. when their phone dies or is otherwise unusable. Nomophobia affects the mind as well as the social relationships, where a person is physically present but mentally absent. "Phone dependency may also cause work problems if people are unable to resist checking smartphone or answering calls when at work. This will impact their work performance by reducing their attention and focus. Multitasking is also a big problem as it impairs concentration. It can add about 2 hours of the working time and decrease work completion that leads to stress and impaired mental health overtime". A growing trend in corporate environments is to require employees to leave their communication devices, especially smartphones, outside the meeting room (Forbes, 2014). This well intended policy is often meant to create more productive and respectful work contexts in which employees are not constantly distracted by technological interruptions (e.g., checking and writing e-mails via smartphones). However, an argument raises that such a policy may have unintended consequences for employees and organizations alike because smartphone withdrawal may create a new social phobia: Nomophobia or the fear of not being able to use one's smartphone and the services it offers (Kang & Jung, 2014; King, Valença, & Nardi, 2010a, 2010b; King et al., 2013; Park, Kim, Shon, & Shim, 2013). Nomophobia, if not identified and corrected at the earliest phase possible, can emerge as a significant public health issue in the coming years. We are faced with a very recent problem that is typical of the digital age and caused by the rise of mobile technology in people's daily lives. For this reason, this research aims to assess the knowledge about nomophobia among people.

Methodology:

The research design used for the study was Nonexperimental descriptive research design In the present study the Research variable is nomophobia among Nursing professionals. study was conducted at the selected nursing institutes. population in this study was the nursing professionals at selected nursing institute. sample of the study was the nursing professionals at selected nursing institute and available during data collection. Target population in this study in the nursing professionals. The accessible population in this study in the nursing professionals at selected nursing institute and available during data collection. The sample size for the present study was 100. Simple Random sampling is the simplest of the probability sampling techniques. In this technique, the researcher randomly selects the sample from a sampling frame. Each member of the accessible population has an

equal chance of being chosen as a subject. Standardized tools was used for data collection the Nomophobia Questionnaire which consist of 20 question in 7 point rating scale . (Yildirim, C. & Correia, A. 2015) and Mini-mental status examination which include 30 question each for 1mark under 5 main section i.e. orientation, registration, attention, recall, and language .both of which are well-known for their accuracy and reliability in collecting data.

The combination of descriptive and inferential statistics allowed the study to not only describe the characteristics of nomophobia and mental health status but also to explore relationships and associations with demographic variables. This comprehensive approach helps in drawing meaningful conclusions about the impact of nomophobia on mental health and how it varies across different groups within the study population. Descriptive and inferential statistics was used for data analysis. The collected data was organized and tabulated by using descriptive statistics, i.e., mean percentage, mean and SD. The inferential statistics i.e., chi square test was used to associate the study findings with the selected demographic variables. The data was planned and was presented in the form of tables and figures.

Result:

Table:1 Frequency and percentage distribution of people as per their sociodemographic characteristics (n=100)

SN	Demographic variables		Frequency	Percentage
1	**Age in years**	20-25 years	10	10%
		26-30 years	40	40%
		31-35 years	30	30%
		36-40 years	10	10%
		Above 50 years	10	10%
2	**Gender**	Male	30	30%
		Female	70	70%
3	**Educational Qualification**	ANM	05	05%
		GNM	20	20%
		BSc. Nursing	30	30%
		PB. BSc. Nursing	30	30%
		MSc. Nursing	15	15%
4	**Work Experience**	1 to 5 years	40	40%
		6 to 10 years	40	40%
		11 to 15 years	10	10%
		15 years & above	10	10%
5	**Institute**	Private	70	70%
		Government	30	30%
		Corporate	00	00%
		Others	00	00%
6	**Monthly income**	Rs.11,000-15,000	00	00%
		Rs.16,000-20,000	10	10%
		Rs.21,000-25,000	30	30%
		Rs.26,000-30,000	40	40%
		Rs.31,000-35,000	10	10%
		Rs.36,000-40,000	10	10%
		More than Rs.40,000	00	00%
7	**Marital status**	Married	70	70%
		Unmarried	25	25%
		Divorced	03	03%
		Widow	02	02%
8	**Live with family ?**	Yes	70	70%
		no	30	30%
9	**Types of work or designation**	Staff nurse	25	25%
		Clinical instructor	40	40%
		Assistant Professor	30	30%
		Associate Professor	03	03%
		Professor	02	02%
10	**Residential area**	Urban area	30	30%

		Rural area	60	60%
		Semi-urban	10	10%
11	**Types of family**	Joint	50	50%
		Nuclear	40	40%
		Extended family	10	10%
		Blended family	00	00%
12	**Source of information**	Media	70	70%
		Newspaper	10	10%
		Colleague	20	20%

The above-mentioned table deals with the demographic data of sample with regard to age, gender shown in male (30%),in female(70%), educational qualifications shown ANM(05%), GNM(20%), PB. BSc Nursing (30%), BSc. Nursing (30%), and MSc. Nursing(15%) work experience shown,1 to 5years (40%),6 to 10 years(40%),11 to 15 years(10%),15years& above(10%),institute shown in private section(70%),government section (30%),corporate (00%)and other(00%) ,monthly income shown the Rs 11,000-15,000(00%) ,Rs16,000-20,000(10%)Rs21,000-25,000(30%)Rs26,000-30,000(40%)Rs31,000-35,000(10%)and in more than Rs40,000(00%), marital status shown in married (70%) unmarried (25%)divorced(03%)and widow(02%), live with family shown yes(70%) and no (30%), type of work shown staff nurse (25%) ,clinical instructor (40%), assistant professor(30%), associate professor (03%) and professor(02%), residential area shown in urban are(30%),rural area(60%)and semi-urban area shown(10%) ,type of family shown joint (50%),Nuclear(40%),extended (10%),blended(00%)and source of information shown media(20%), Newspaper(10%), colleague(20%).

Table: 2 Distribution of study participants according to degree of nomophobia (n=100)

SN	Level of Nomophobia	Frequency (%)
1	Absence of nomophobia (0-20)	20 (20%)
2	Mild nomophobia (21-59)	50 (50%)
3	Moderate nomophobia (60-99)	20 (20%)
4	Sever nomophobia (100-140)	10 (10%)

1. Absence of nomophobia (0-20): This category indicates individuals who exhibit very low levels of nomophobia. They are likely to feel minimal anxiety or discomfort when separated from their mobile phones or when unable to use them. In the provided data, 20 individuals, constituting 20% of the total sample, fall into this category.

2. Mild nomophobia (21-59): Individuals in this category experience mild levels of nomophobia. They may feel some discomfort or anxiety when they cannot access their mobile phones but are generally able to manage without significant distress. In the data, 50 individuals, making up 50% of the total sample, are classified under this category

3. Moderate nomophobia (60-99): This category includes individuals with moderate levels of nomophobia. They experience noticeable anxiety and discomfort when separated from their mobile phones or unable to use them for extended periods. In the data, 20 individuals, representing 20% of the total sample, fall into this category.

4. Severe nomophobia (100-140): Individuals in this category exhibit severe levels of nomophobia. They experience significant distress, panic, or anxiety when they cannot access their mobile phones or use them. Their dependence on mobile devices for emotional security and communication is profound. In the provided data, 10 individuals, constituting 10% of the total sample, are classified under this category. Overall, the data categorizes individuals based on the severity of their nomophobia, ranging from the absence of nomophobia to severe nomophobia, with varying percentages representing each category within the sample population.

Table:3 Distribution of study participants according to Mental health status (n =100)

SN	Area	Maximum score	Mini mental status score		
			Mean	SD	Mean%
1	Orientation	10	8.30	0.48	83.00
2	Registration	03	2.13	1.43	47.66
3	Attention	05	1.99	1.25	39.8
4	Recall	03	0.08	1.20	2.66
5	Language	09	6.23	1.07	69.22
Total		**30**	**18.7**	**3.01**	**62.33**

Distribution of mean, SD, and mean percentage of Mini mental status score of nursing professionals shows that the overall mean Mini mental status score was (18.7 ± 3.01) which is 62.33 of maximum score. It indicates that nursing professionals had moderate cognitive impairment. The highest mean score which is (8.30 ± 0.48) 83 % of total score was obtained in relation to orientation it shows that the elderly had good at orientation. The lowest mean score which is (0.08 ±1.20) 2.66% was obtained in recall. **It showed that nursing professionals had moderate cognitive impairment.**

Table:4 To find association between level of nomophobia with the selected demographic variables (n=100)

SN	Variables	$_{\gamma}2$	Level of Significance
1	Age in years	1.45	Not Significant
2	Gender	0.44	Not Significant
3	Educational Qualification	1.45	Not Significant
4	**Work Experience**	**8.62**	**Significant**
5	Institute	2.93	Not Significant
6	Monthly income	1.45	Not Significant
7	Marital status	2.87	Not Significant
8	Live with family?	0.30	Not Significant
9	**Type of work or designation**	**11.23**	**Significant**
10	Residential area	2.18	Not Significant
11	Type of family	1.23	Not Significant
12	Source of information	1.13	Not Significant

df-1, table = 3.84, p≥ 0.05, not significant Chi square values were calculated to find out the association between the level of nomophobia with the selected demographic variables. The findings revealed that there was significant association between level of nomophobia and demographic variables such as work experience and type of designation ($_{\gamma}2$ =8.62 and 11.23).

Hence the stated null hypothesis is accepted as there was significant association between level of nomophobia and demographic variables such as work experience and type of designation.

Table:5 To find association between Mental status with the selected demographic variables (n=100)

SN	Variables	$_{\gamma}2$	Level of Significance
1	Age in years	0.45	Not Significant
2	Gender	1.23	Not Significant
3	**Educational Qualification**	**8.16**	**Significant**
4	**Work Experience**	**9.12**	**Significant**
5	Institute	1.93	Not Significant
6	Monthly income	0.15	Not Significant
7	Marital status	3.87	Not Significant
8	Live with family?	0.36	Not Significant
9	**Type of work or designation**	**8.13**	**Significant**
10	Residential area	1.58	Not Significant
11	Type of family	2.06	Not Significant
12	Source of information	1.13	Not Significant

df-1, table = 3.84, p≥ 0.05, not significant Chi square values were calculated to find out the association between the level of nomophobia with the selected demographic variables. The findings revealed that there was significant association between level of mental status and demographic variables such as educational qualification, work experience and type of designation ($_{\gamma}2$ =8.16, 9.12 and 8.13). Hence the stated null hypothesis is accepted as there was significant association between level of mental status and demographic variables such as educational qualification, work experience and type of designation.

Table:6 To determine correlation between nomophobia &mental health status in nursing professionals.
Correlation between job satisfaction and Job performance of nurses in study group

SN	Variables	Level of Nomophobia	Mental status	P Value
1	Level of Nomophobia		**0.80**	
2	Mental status	**1**		0.001

p = ≤0.05

A strong positive correlation was observed between Level of nomophobia and mental health status in the nursing professionals. (p < 0.01)

Conclusion:

In conclusion finally, the study sheds light on the intersection of nomophobia and mental health among nursing professionals, emphasizing the importance of addressing these issues within the context of workplace environments. By fostering awareness, providing support, and implementing targeted interventions, healthcare institutions can contribute to the wellbeing and resilience of nursing professionals in their caregiving roles. The study highlights the intersection of nomophobia (fear or anxiety of being without a mobile phone) and mental health among nursing professionals. It underscores the significance of addressing these issues within the specific context of workplace environments. By raising awareness about nomophobia and its potential impact on mental health, healthcare institutions can take proactive steps to support nursing professionals. This support can include providing resources for managing stress related to constant connectivity expectations, fostering a healthy work-life balance, and offering interventions tailored to the unique challenges faced by nurses in their caregiving roles. Implementing targeted interventions, such as mindfulness programs, stress management workshops, or technology usage guidelines, can contribute significantly to the wellbeing and resilience of nursing professionals. These initiatives not only acknowledge the pressures and anxieties associated with nomophobia but also promote a supportive workplace culture that prioritizes mental health. In conclusion, by recognizing and addressing nomophobia alongside broader mental health concerns, healthcare institutions can enhance the overall wellbeing of nursing professionals, thereby improving their ability to provide quality care to patients.

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Research Implications: Students can be taught about hazardous effects of long mobile phone use. Centres of learning (schools and colleges) and public places should establish smart phone-free zone. Early screening and appropriate interventions are required with nomophobic to avoid psychological and physical problems in future. In nursing practice, usage of smartphone 128 should be prohibited as this can create hindrance in patient care. The special implications of nursing administration in community are educating them regarding a healthy balance of life, work, and technology**.**

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