

Nursing Students in Crisis Mode

Fluctuations in Anxiety During the COVID-19–Related Lockdown

Bella Savitsky, PhD; Yifat Findling, MA; Anat Ereli, MA; and Tova Hendel, PhD

ABSTRACT

Background: The COVID-19 pandemic initiated a period of new and difficult challenges for nursing students.

Purpose: The aim of this study was to assess the change in levels of anxiety and ways of coping when the lockdown was being lifted compared with the period of the most severe lockdown restrictions.

Methods: First- to fourth-year nursing students in Israel (N = 244) completed 2 surveys conducted during the initial lockdown and 5 weeks later.

Results: When the restrictions were lightened, the mean anxiety score decreased from 9.3 to 7.5 ($P < .0001$). Among Muslims students, the trend was the opposite, and anxiety levels increased. Stronger resilience was associated with lower odds for anxiety. Mental disengagement and information seeking were associated with higher anxiety levels.

Conclusions: The pandemic created unparalleled stressful situations for nursing students. Faculty should have heightened awareness of these stressors and act to implement innovative resolutions for the problems that arise.

Keywords: anxiety, coping, COVID-19, pandemic, nursing students

Cite this article as: Savitsky B, Findling Y, Ereli A, Hendel T. Nursing students in crisis mode: fluctuations in anxiety during the COVID-19–related lockdown. *Nurse Educ.* 2021;46(3):E33–E38. doi: 10.1097/NNE.0000000000000955

The coronavirus disease 2019 (COVID-19) began its devastation in Israel at the end of February 2020. From the beginning of March to the middle of May, Israel experienced a COVID-19–related mandatory lockdown. During this period, all universities, colleges, schools, and kindergartens were closed, and a stay-at-home order policy was introduced by the government, resulting in massive unemployment. The rate of unemployment doubled and reached 27.8%.¹ During the lockdown, the government forbade citizens from leaving their home area beyond a 100-m perimeter, and the most basic chores and activities became problematic. Almost all stores, businesses, and religious institutions were closed. During that period, a survey conducted in the nursing department of the Ashkelon Academic College revealed a high prevalence of moderate and severe anxiety, reaching 43% and 13%, respectively.² Researchers in other countries started to report high anxiety levels among nursing

students. In a study in China, conducted in March 2020, the prevalence of anxiety among almost 500 nursing students was 12.4%.³ A Turkish study indicated a 52% prevalence of anxiety among nursing students,⁴ although comparison between the studies is problematic because of different methodology.

Since the beginning of May, gradual steps easing the lockdown in Israel have been taken: restrictions on work and movement were reduced and then lifted, stores were reopened, and children returned to school following a 2-m distance restriction (kindergartens were still closed). After a short period of relief, the second wave of the pandemic started in Israel, and at the time of writing (end of September), the government introduced a new lockdown policy. Overall, since the pandemic started, 248 133 verified cases have been diagnosed in Israel and 1571 patients have died.⁵

The staff of all academic institutions, including Ashkelon Academic College, transferred to online teaching at the beginning of the lockdown, and nursing students continued the academic year with distance learning through the end of the academic year in July. In the beginning of May 2020, the students renewed their clinical practice in hospitals and community settings. In addition to distance learning and clinical practice, 41% of our students started to work in hospitals and community settings at the request of the Ministry of Health following the shortage in the nursing workforce. The college faculty made efforts to lower the anxiety level related to academic issues. The steps taken aimed at providing a stable educational structure.

Author Affiliation: Department of Nursing, School of Health Sciences, Ashkelon Academic College, Ashkelon, Israel.

The authors declare no conflicts of interest.

Correspondence: Dr Savitsky, Ashkelon Academic College, School of Health Sciences, Department of Nursing, Ashkelon, Yitshak Ben Zvi 12, Israel (savitskyb@gmail.com).

Supplemental digital content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article on the journal's Web site (www.nurseeducatoronline.com).

Accepted for publication: October 19, 2020

Published ahead of print: November 24, 2020

DOI: 10.1097/NNE.0000000000000955

The structured schedule was maintained; lectures were recorded to provide students the possibility of studying the material at their convenience. Students who were parents of children who also needed to participate in distance learning were excused from synchronous participation in lectures and classes. Online teaching workshops were delivered at the college for all lecturers to ensure high quality of distance teaching. Although multiple stressors, such as lack of childcare facilities, fear of infection following contact with patients, fear for health of family members, and challenges at the workplaces, were destabilizing, the faculty made every possible effort to relieve as much of the anxiety as possible.

The aim of this study was to assess the change in the level of anxiety and ways of coping at the end of lockdown that took place in May in comparison to the period of the lockdown among nursing students in the Ashkelon Academic College, Southern District, Israel. The new academic year will begin in October 2020 using distance learning; the conclusions of this study are highly important in ensuring the well-being of students.

Methods

Study Design

Two descriptive studies were conducted during the third week of the lockdown (March, 23-25, 2020)² and at the end of lockdown (5 weeks later, May 3-5, 2020) among all students in the nursing department (244 students), first to fourth year of study. The questionnaire was anonymous. The study received approval from the Ethical Board of the College and Department of Nursing.

Study Population

The total response rate for the first survey was 88% (215 of 244 students) and 79% for the second survey (192 of 244 students). The merging of data between the files of the first and the second surveys was based on age, gender, academic year, family status, ethnic group, occupational status, country of birth, level of religiosity, and number of children. The merged file included 113 students and comprised only students who took part in both surveys.

Study Variables

Demographic information collected included age (used as a continuous variable and as a dummy variable with the median of 25 years as the cutoff point), gender (female, male), family status (married/in relationship, single/divorced), parental status (does not have children, has children), country of birth (Israel, other countries), population group (Jewish, Muslim [Arabs and Bedouins], Christian), level of religiosity (secular [nonobservant], traditional [observes some religious commandments], and religious [observes all religious commandments]), and occupational status (salaried work in health care facilities, work in unrelated to the nursing field, does not work).

Anxiety level was assessed using the Generalized Anxiety Disorder 7-Item Scale (GAD-7).⁶ This is a 7-item, self-rated

scale developed by Spitzer and colleagues (2006)⁷ as a screening tool and severity indicator for GAD. Items are rated on a 4-point Likert-type scale (0 = not at all to 3 = nearly every day). GAD-7 items describe some of the most salient diagnostic features of GAD (ie, feeling nervous, anxious, or on edge and worrying too much about different things). Scores range from 0 to 21, with higher scores indicating more severe GAD symptoms. This questionnaire has been widely used and is reported to have high internal consistency and good test-retest reliability among adults,^{8,9} adolescents,⁷ and college students.¹⁰ GAD-7 was used with a suggested cutoff point of 10 for defining moderate anxiety and a cutoff point of 15 for defining severe anxiety.⁶ The Hebrew translation of the questionnaire was provided by the Clinical Psychology Professional Committee, Ministry of Health. Cronbach's α was found .93 for the first survey and .92 for the second survey, pointing to high internal consistency.

Coping strategies were defined using 8 items from the Coping Behavior Questionnaire (COPE)¹¹; 3 additional items were added to adapt the questionnaire to the current stressors and 4 items for resilience/self-esteem assessment.¹² Items are rated on a 4-point Likert-type scale (0 = not at all to 4 = true nearly all the time); scores range from 0 to 60, with higher scores indicating more usage of a specific coping strategy. Cronbach's α values for the Brief COPE subscales in previous studies range from .50 to .90.¹³

Statistical Analysis

Scores characterizing coping strategies were constructed using factor analysis with a varimax rotation and an unrestricted number of factors. Variables with factor loadings ≥ 0.5 were considered contributing variables to a given factor. A *t* test or analysis of variance test was used to assess an association between each factor and demographic variables and a logistic regression model to investigate the associations of each factor simultaneously with moderate and severe anxiety. The difference in the anxiety score among 113 students who participated in both surveys was assessed using Wilcoxon nonparametric test for paired samples. A difference in anxiety scores by students' characteristics was assessed using Mann-Whitney *U* or Kruskal-Wallis nonparametric tests. Statistical analysis was performed using the IBM SPSS Statistics for Windows, version 25 (IBM Corp, Armonk, New York). For all analyses performed, a value of $P < .05$ was considered statistically significant.

Results

Demographic and Occupational Characteristics, 2 Surveys

The demographic characteristics of the study population are presented in Supplemental Digital Content, Table 1, <http://links.lww.com/NE/A862>. The distribution of academic year, gender, level of religiosity, and occupational status was similar among the participants of both surveys and among the matched sample. There was overrepresentation

of Jews in the matched sample and underrepresentation of students who were not born in Israel, married students, and parents of children. For example, the sample of the first and the second surveys included 19% of the students who were not born in Israel, but their proportion in the matched sample was lower (14%). The proportion of Muslims was similar, but the percentage of Jews was 86% and 88%, respectively, in the first and second surveys, whereas in the matched sample, Jews comprised 92%. During the lockdown, 50% of students working in health care facilities encountered a lack of PPE at work; at the end of lockdown, the proportion of students reporting a lack of PPE at work decreased to 16%.

Anxiety Scores at 2 Time Points

The percentage of students with GAD-7 of 10 or greater (moderate anxiety) was 42.8% (n = 92) at the first time point and 34.9% (n = 67) at the second. The frequency of severe anxiety was higher at the first time point in comparison with the end of the lockdown (13.0% vs 11.5%). Assessing the change in the anxiety score among the matched sample showed that at the beginning of the lockdown, the mean anxiety score was 9.3 (SD, 5.6), with median of 9 (interquartile range [IQR], 5-13), and at the end 7.5 (SD, 5.6), with median of 7 (IQR, 3-11.5) ($P < .0001$). In the first survey, females had significantly higher anxiety scores in comparison to males (mean, 9.7 vs 6.5); in the second survey, the mean anxiety score was similar among females and males (mean anxiety score was 7.5 among both genders).

At the end of lockdown, a significant difference was found among the population groups: Muslims had the highest anxiety score (mean, 13.0 [SD, 6.8]; median, 11.5; IQR, 7.25-21.0) compared with Jews (mean, 7.1 [SD, 5.2]; median, 6.0; IQR, 3.0-11.0) and Christians (mean, 7.25 [SD, 6.4]; median, 6.5; IQR, 1.0-14.0) ($P = .016$). Figure 1 depicts the change in the mean anxiety score among the 3 population groups. Whereas the mean anxiety score of Jews and Christians decreased between 2 time points, the mean anxiety score of Muslims increased.

Similar to the first survey, parents of young children who did not feel a burden following kindergarten and school closures had a lower mean anxiety score (mean, 5.1

[SD, 4.2]) than those who experienced a burden (mean, 9.2 [SD, 7.1]) ($P = .05$).

Change in Students' Strategies of Coping Results of Factor Analysis

Five factors were created following the first survey (resilience, seeking information and consultation, mental disengagement, spiritual support, and humor); together, these explained 60% of the variance, and only 3 factors (resilience, mental disengagement, and seeking information and consultation) were created as a result of the second survey; together, they explained 46% of the variance (Supplemental Digital Content, Figure, <http://links.lww.com/NE/A865>). The components of each factor are depicted in Supplemental Digital Content, Table 2, <http://links.lww.com/NE/A863>. Logistic regression was used to identify the association between each of the factors, representing coping strategies and levels of anxiety (with 10 and 15 cutoff points, respectively) as an outcome.

Supplemental Digital Content, Table 3, <http://links.lww.com/NE/A864>, presents the role of each factor in association with moderate and severe anxiety. The factor of *resilience* was found significantly and negatively associated with moderate and severe anxiety: with an elevation of 1 SD of this factor, odds for moderate anxiety decreased by 68% in the first and by 63% in the second survey, and odds for severe anxiety were twofold lower at both time points. The factor of *mental disengagement* became more meaningful in the second survey; during the lockdown, it explained 9% of the variance, but at the end of the lockdown, 16%. This factor was found to be significantly associated with moderate anxiety at both time points and with severe anxiety during the first survey. The odds for moderate anxiety were 2 times higher for every elevation of 1 SD of this factor. The factor of *seeking information and consultation* became less meaningful in the second survey; during the lockdown, it explained 13% of the variance, and at the end of lockdown, 9.8%. This factor was not significantly associated with moderate and severe anxiety at the first time point, but during the second survey became significantly associated with moderate anxiety; the more this strategy was in use, the odds for moderate anxiety were 50% higher with every elevation of 1 SD of this factor.

Coping Strategies and Student Characteristics

Resilience was not significantly associated with any demographic characteristics in the first survey. In the second survey, this factor was found to be significantly and positively associated with male gender ($P = .023$) and with work in health care facilities ($P = .002$). This factor was significantly and negatively associated with population group Muslims ($P = .001$). In the first survey, *mental disengagement* was significantly associated with family status not married ($P = .024$), with parental status no children ($P = .013$), and with level of religiosity secular ($P = .001$). In the second survey, *mental disengagement* was significantly and positively associated with occupational status work unrelated

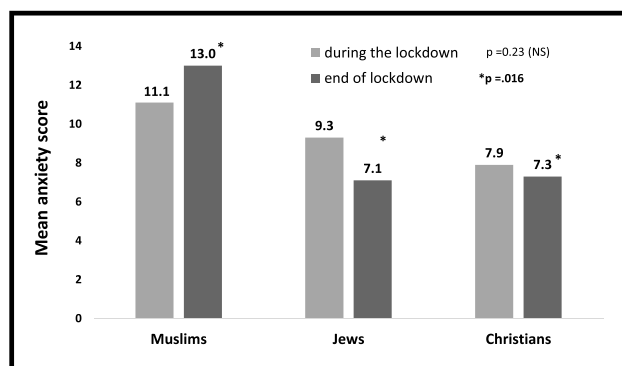


Figure 1. Anxiety score change between 2 time points: During the lockdown and in the end of lockdown, by population group.

to the nursing field ($P = .047$) and level of religiosity secular ($P < .0001$). *Seeking information and consultation* was significantly and positively associated in both surveys with the female gender ($P = .031$), work in health care facilities ($P = .05$), and birth country Israel ($P = .028$).

The coping strategy of *spiritual support* was not extracted from the data following the second survey. In the first survey, this factor was significantly associated with age ≤ 25 years ($P = .005$), female gender ($P < .0001$), birth country of Israel ($P = .001$), population group Muslims ($P = .004$), and religiosity levels traditional and religious ($P < .0001$). The factor of *humor* was not extracted from the data in the second survey. In the first survey, it was significantly associated with the population group Jews ($P < .0001$) and with religiosity level secular ($P = .01$).

Satisfaction With Communication With Faculty

During the lockdown, 30% of students reported that they had approached a faculty with a problem related to their studies and 20% with a personal problem. Among those who approached, 61% and 62%, respectively, reported high or very high levels of satisfaction with the response. In general, 47.8% of students reported high and very high satisfaction levels with the connection with the faculty, and 34.6% reported medium levels of satisfaction.

Discussion

The current study aimed at assessing the level of anxiety among the nursing students at the end of the lockdown, which had been extremely high during the lockdown. The proportion of moderate and severe anxiety decreased, and a significant decrease in the anxiety level was found. This decrease may be explained by the end of lockdown, by the efforts taken by the faculty to help students during this challenging period to relieve the anxiety of the students and by the return to some academic activities (eg, clinical practice had been suspended).¹⁴

This trend of decrease in anxiety level between the 2 time periods was similar among all demographic subgroups, except for the population group Muslims. At the end of lockdown, a significantly higher anxiety score was found among Muslim students in comparison with other students. This finding may be explained by several factors. The Arab sector in Israel experienced a later onset of corona-related awareness. Significant delay in the government's dissemination of instructions in Arabic led to severe gaps in the level and scope of the information reaching much of the Arab public.¹⁵ This delay in information delivery (and pandemic-related panic) may explain lower anxiety level among Arab students during the lockdown. An additional factor may be difficulties related to distance learning among Muslim students. As the college closure extended, distance learning probably became a heavier burden for this group. Distance learning demands infrastructure at home, such as available computers and internet connection, and this creates an untenable situation for students from unrecognized villages in the Negev, which are not connected to the power

grid and have no Internet.¹⁶ Home computer use may be challenging in the Arab sector. It has been estimated that 43% of Arab Israelis used a computer at home, compared with 77% of Jewish Israelis.¹⁶ A report prepared by Israel's Internet Association indicated the need to upgrade the Internet and cellular infrastructure in Arab towns because without a stable and up-to-date infrastructure, it is not possible to enable adequate access to educational resources for students and teachers.¹⁷

In addition to a decrease in general anxiety level, the current study found an interesting change in coping strategies of students. *Resilience* stayed as the most important coping strategy during both time points, associated positively with male gender (as in other studies¹⁸), with working in health care facilities, and with lower odds for moderate and severe anxiety. *Resilience* is "a dynamic process encompassing positive adaptation within the context of significant adversity."¹⁹ Characteristics associated with resilience include those related to altruism, optimism, social interaction, and the capacity to attract and use support provided by others.²⁰⁻²² Previous studies have shown the contribution of resilience in lowering stress and anxiety levels.²² This study suggests that work in health care facilities is associated with stronger resilience. Although stressors have a negative impact, they may provide growth and increase resilient qualities.²² We believe that students' exposure to work in health care settings provided them with experience and qualities that are needed for building professional abilities and self-confidence. In our study, the factor of *resilience* was negatively and significantly associated with the population group Muslim. Our findings are similar to those of previous studies conducted in Israel, which found that Israeli Arab students scored lower than their Jewish counterparts on the national resilience scale.^{23,24} The explanation of lower resilience among Israeli Arabs²⁴ may be related to the complex political and cultural situation in Israel, where Arabs comprise approximately 21% of the Israeli population²⁵ but face continuous tensions of being outsiders in their own country.

While students' *resilience* was found as a major factor during the lockdown and at the end of lockdown, *mental disengagement* (usage of alcohol, sedative drugs, and excessive eating) becomes more important at the end of the lockdown. We believe that this change is related to the possibility of getting out of the house and meeting friends, which was impossible during the lockdown. The tendency to increase alcohol consumption after exposure to terrorist attacks, natural disasters, or accidents was previously found in several studies.²⁶ During the COVID-19 pandemic in the United Kingdom, sales in alcohol stores in March had increased by 31%.²⁷ A study from Poland reported that in a sample of 1097 adults, nearly 52% reported eating and snacking more, and 15% increased their alcohol consumption.²⁸ Coping strategies, which included consumption of alcohol and overeating, were associated in our study, on the one hand, with a secular lifestyle and, on the other hand, with higher odds of moderate anxiety. As our methodology is cross-sectional,

we cannot conclude that higher alcohol consumption leads to moderate anxiety, but the association found between alcohol consumption and higher anxiety is known.²⁹

Seeking information and consultation is a positive coping strategy, but in this research, it was associated with higher odds for moderate anxiety. Probably this finding reflects the effect of the “too much information” phenomenon studied for over 20 years by Bawden and Robinson.³⁰ The COVID-19 situation has been accompanied by a relentless flood of information, stated by the World Health Organization as a massive infodemic: “an overabundance of information, some accurate and some not, that makes it hard for people to find trustworthy sources and reliable guidance when they need it.”³¹ Massive and repeated sharing of unauthenticated and sometimes dangerously incorrect information has had very negative consequences.³² The overflow of the information leads people to feel overwhelmed and powerless and causes anxiety, fatigue, and paralysis of action.³³

Limitations

We cannot draw conclusions about the causality of the associations found in the study. Another limitation is that as both surveys were anonymous and as no identification data were collected, merging the files of the first and the second surveys was based on several demographic variables. This resulted in a modest number of the students in the merged sample. Finally, the small sample from one college may suggest that the results cannot be generalized to the country as a whole. On the other hand, the diverse multicultural participants accurately reflect the demographics of the country, and as such, this increases the validity of the results.

Conclusions and Recommendations

There are a number of steps that nursing departments should consider based on lessons learned from the current pandemic. We recommend that resilience-building be incorporated into the nursing curriculum, and we will introduce it into the department's curriculum in the upcoming academic year. Our study found that resilience is an important mechanism in the process of coping and adaptation. Individuals with higher resilience have strong beliefs, perceptions of life, and the ability and flexibility to adapt to change.³⁴ The influence of the work environment is evidently a key factor in professional resilience.³⁵ Additionally, students should get updated information regarding medical news as part of their curriculum, as lack of relevant knowledge may result in fear of infection and higher levels of anxiety.³⁶ The most accurate and reliable information available should come from the department.

In addition to curricular changes, nursing departments should maintain a stable educational framework, personal connection with students, and a high standard of teaching as important ways to maintain emotional stability.³⁷ Furthermore, some students may face technical obstacles, preventing them from full and active participation in distance learning, thus causing delays and gaps in their involvement in the program, contributing to elevation of anxiety

levels. These students need special consideration from the faculty. The role of coordinator of Arab students was established in our nursing department for this reason. The assessment of students' learning conditions should also be focused on parents of school-aged children struggling to continue distance learning while several learners must share the same hardware.

Workshops for online teaching methods for the faculty members were conducted during the semester break, and this approach of improving teaching in the new reality of distance education should be an integral part in every academic institution. Assessment of quality of teaching and satisfaction with connection with the faculty should be performed at all times, but particularly during special circumstances such as an extended period of distance education.

Acknowledgments

The authors thank Susan Holzman for her professional editing advice and her valuable support on this project.

References

1. Israeli Employment Service. *Monthly Update on the Workforce in Israel*. 2020. <https://www.taasuka.gov.il/he>. Accessed May 14, 2020.
2. Savitsky B, Findling Y, Erel A, Hendel T. Anxiety and coping strategies among nursing students during the COVID-19 pandemic. *Nurse Educ Pract*. 2020;46:102809. doi:10.1016/j.nepr.2020.102809
3. Sun Y, Wang D, Han Z, Gao J, Zhu S, Zhang H. Disease prevention knowledge, anxiety, and professional identity during COVID-19 pandemic in nursing students in Zhengzhou, China. *J Korean Acad Nurs*. 2020;50(4):533-540. doi:10.4040/jkan.20125
4. Cici R, Yilmazel G. Determination of anxiety levels and perspectives on the nursing profession among candidate nurses with relation to the COVID-19 pandemic. *Perspect Psychiatr Care*. 2020. doi:10.1111/ppc.12601
5. Ministry of Health. Ministry of Health Daily COVID-19 Update. <https://govextra.gov.il/ministry-of-health/corona/corona-virus/>. Accessed October 1, 2020.
6. Löwe B, Decker O, Müller S, et al. Validation and standardization of the Generalized Anxiety Disorder Screener (GAD-7) in the general population. *Med Care*. 2008;46(3):266-274. doi:10.1097/MLR.0b013e318160d093
7. Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. *Arch Intern Med*. 2006;166(10):1092-1097. doi:10.1001/archinte.166.10.1092
8. Zhong QY, Gelaye B, Zaslavsky AM, et al. Diagnostic validity of the Generalized Anxiety Disorder-7 (GAD-7) among pregnant women. *PLoS One*. 2015;10(4):e0125096. doi:10.1371/journal.pone.0125096
9. Rutter LA, Brown TA. Psychometric properties of the Generalized Anxiety Disorder Scale-7 (GAD-7) in outpatients with anxiety and mood disorders. *J Psychopathol Behav Assess*. 2017;39(1):140-146. doi:10.1002/cncr.27633.Percutaneous
10. Bártolo A, Monteiro S, Pereira A. Factor structure and construct validity of the Generalized Anxiety Disorder 7-item (GAD-7) among Portuguese college students. *Cad Saude Publica*. 2017;33(9):e00212716. doi:10.1590/0102-311x00212716
11. Carver CS, Scheier MF, Weintraub JK. Assessing coping strategies: a theoretically based approach. *J Pers Soc Psychol*. 1989;56(2):267-283.
12. Connor KM, Davidson JR. Development of a new resilience scale: the Connor-Davidson Resilience Scale (CD-RISC). *Depress Anxiety*. 2003;18(2):76-82. doi:10.1002/da.10113
13. Mohanraj R, Jayaseelan V, Kumar S, et al. Cultural adaptation of the Brief COPE for persons living with HIV/AIDS in southern India. *AIDS Behav*. 2015;19(2):341-351. doi:10.1007/s10461-014-0872-2
14. Dewart G, Corcoran L, Thirsk L, Petrovic K. Nursing education in a pandemic: academic challenges in response to COVID-19. *Nurse Educ Today*. 2020;92:104471. doi:10.1016/j.nedt.2020.104471

15. Lavie E, Elran M, Sawaed K, Abu Mokh M, Dallashi M. Israel's Arab society and the coronavirus challenge. *Inst Natl Secur Stud*. 2020;1288. <https://www.inss.org.il/publication/coronavirus-and-the-israeli-arabs/>
16. Kadari-Ovadia S. *For Many Arab Israelis in the Coronavirus Age, Online Learning Is Not Even an Option*. Haaretz; 2020.
17. Abraham Initiatives. Digital gaps and repercussions for remote learning for Arab students. Position Paper Presented to the Ministry of Education, March 24th, 2020. 2020. Available at <https://abrahaminitiatives.org/wp-content/uploads/2020/03/Position-Paper-Digital-Gap-Effecting-Online-Learning-in-Arab-Society.pdf>. Accessed November 5, 2020.
18. Robertson HD, Elliott AM, Burton C, et al. Resilience of primary healthcare professionals: a systematic review. *Br J Gen Pract*. 2016; 66(647):e423-e433. doi:10.3399/bjgp16X685261
19. Jackson D, Firtko A, Edenborough M. Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: a literature review. *J Adv Nurs*. 2007;60(1):1-9. doi:10.1111/j.1365-2648.2007.04412.x
20. Masten AS, Coatsworth JD. The development of competence in favorable and unfavorable environments. Lessons from research on successful children. *Am Psychol*. 1998;53(2):205-220. doi:10.1037//0003-066x.53.2.205
21. Bell CC. Cultivating resiliency in youth. *J Adolesc Health*. 2001; 29(5):375-381. doi:10.1016/s1054-139x(01)00306-8
22. Richardson GE. The metatheory of resilience and resiliency. *J Clin Psychol*. 2002;58(3):307-321. doi:10.1002/jclp.10020
23. Kimhi S, Dror G. Resilience among students from the majority and minority group: the Israeli case. *J Psychol Behav Sci*. 2017. doi: 10.15640/jpbs.v5n1a5
24. Marciano H, Kimhi S, Eshel Y. Predictors of individual, community and national resiliencies of Israeli Jews and Arabs. *Int J Psychol*. 2019;55:553-561. doi:10.1002/ijop.12636
25. Brookdale Institution. *The Arab Population in Israel: Facts and Figures*. 2018. Available at <https://brookdale.jdc.org.il/wp-content/uploads/2019/07/ARAB-2019-Facts-and-Figures-ENG3.pdf>. Accessed November 5, 2020.
26. García-álvarez L, Fuente-tomás L, Sáiz PA, et al. Will changes in alcohol and tobacco use be seen during the COVID-19 lockdown? *Adicciones*. 2020;32(2):85-89.
27. The Lancet Gastroenterology Hepatology. Drinking alone: COVID-19, lockdown, and alcohol-related harm. *Lancet Gastroenterol Hepatol*. 2020;5(7):625. doi:10.1016/S2468-1253(20)30159-X
28. Sidor A, Rzymiski P. Dietary choices and habits during COVID-19 lockdown: experience from Poland. *Nutrients*. 2020;12(6):1657. doi:10.3390/nu12061657
29. Smith JP, Randall CL. Anxiety and alcohol use disorders: comorbidity and treatment considerations. *Alcohol Res*. 2012;34(4):414. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3860396/>
30. Bawden D, Robinson L. The dark side of information: overload, anxiety and other paradoxes and pathologies. Vol 8206 2020. *J Inform Sci*. 2008;XX(X):1-12. doi:10.1177/0165551508095781
31. World Health Organization. *Understanding the Infodemic and Misinformation in the Fight Against COVID-19 What Is the Infodemic?*; 2020. Available at <https://www.paho.org/en/documents/understanding-infodemic-and-misinformation-fight-against-covid-19>. Accessed November 5, 2020.
32. Rathore FA, Farooq F. Information overload and infodemic in the COVID-19 pandemic. *J Pak Med Assoc*. 2020;70 (5)(suppl 3): S162-S165. doi:10.5455/JPMA.38
33. City University London. COVID-19 information overload leads to simple but unhelpful choices. <https://phys.org/news/2020-04-covid-overload-simple-unhelpful-choices.html>. Published 2020. Accessed June 21, 2020.
34. Amsrud KE, Lyberg A, Severinsson E. Development of resilience in nursing students: a systematic qualitative review and thematic synthesis. *Nurse Educ Pract*. 2019;41:102621. doi:10.1016/J.NEPR.2019.102621
35. Louise Duncan D. What the COVID-19 pandemic tells us about the need to develop resilience in the nursing workforce. *Nurs Manag (Harrow)*. 2020;27(3):22-27. doi:10.7748/nm.2020.e1933
36. Cervera-Gasch A, González-Chordá VM, Mena-Tudela D. COVID-19: are Spanish medicine and nursing students prepared? *Nurse Educ Today*. 2020;92:104473. doi:10.1016/j.nedt.2020.104473
37. Hendel T, Fish M, Aboudi S. Strategies used by hospital nurses to cope with a national crisis: a manager's perspective. *Int Nurs Rev*. 2000;47(4):224-231. doi:10.1046/j.1466-7657.2000.00046.x

TEACHING TIP

Cocreating Assessment Criteria With Nursing Students

A challenge for nursing teachers and students is the successful implementation of assessment for learning strategies that promote self-regulation and commitment. Nurse educators should share assessment criteria with students and use them to engage the students with their learning goals. In a healthcare management course that we teach in Chile, the teachers and clinical nurses shared assessment criteria based on the expected learning outcomes with their students using a rubric. In the classroom, we explained the criteria and rubric to the students organized in small groups. Each group discussed the clarity and purpose of each criterion. Then, the teachers organized the students' comments and modified the rubric. During the next class, the updated rubric was presented to the students. Later, during simulations, students were assessed in a formative way and received feedback based on the rubric's criteria. This strategy enabled the early identification and support of students with difficulties before going to clinical practice. Finally, the student groups attended 2 weeks of clinical practice in hospitals and decentralized health centers with the supervision of the clinical nurses who evaluated them with the same rubric, giving them plenty of time for self-assessment. Closing the process, a survey was conducted among the students, and results showed that they positively valued the experience, highlighting the importance of working with clear assessment criteria shared by their teachers and clinical nurses and recognizing the usefulness of the rubric for their self-regulation and better performance.

By **Maura Amaranti Pesce**, PhD, Education at the Universidad de la Frontera; and Pontificia Universidad Católica de Valparaíso, Chile, maura.amaranti@pucv.cl, and **Patricia Fernández Díaz**, MPH, RN, Nursing Faculty, Universidad del Desarrollo, Santiago, Chile, pfernadi@uc.cl.
DOI: 10.1097/NNE.0000000000000917