Occupational Stress, Anxiety and Coping Strategies among

Nurses of Public and Private Hospitals.

By

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2018

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The research report submitted in Partial Fulfillment of

The Degree of Master of Science in Psychology

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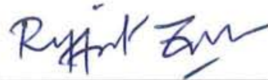

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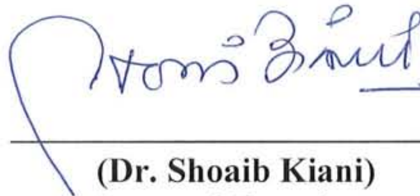

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Ms. Riffat Zahir
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ABSTRACT

The present study aimed to investigate the relationship between occupational stress and anxiety among nurses of public and private sector hospitals of Islamabad and to identify the coping strategies used by them. For this purpose, Extended Nursing Stress Scale (Gray-Toft& Anderson, 1981), Anxiety Sub-scale of Depression Anxiety Stress Scale (Lovibond&Lovibond, 1995) and Brief COPE Inventory (Carver, 1997) were used. The study was divided into two phases: In phase 1, a pilot study was conducted to ensure psychometric screening of the scales, to ensure understandability and appropriateness of items for the scales. Given the satisfactory results of the pilot study, phase 2 (main study) was conducted on a sample of 200 nurses from Islamabad (104 from a public hospital and 96 from a private hospital) with age ranging from 20 to 30 ($M = 2.89$, $SD = .42$). The results showed that the occupational stress and anxiety among nurses are positively correlated. Regression analysis was run on the sub-scale scores of ENSS to identify the work-related predictors for nurses in determining their anxiety and the results showed that problems with co-workers is the significantly strongest predictor of anxiety among nurses. Married nurses scored higher on occupational stress as compared to unmarried nurses, nurses of public hospitalreported higher level of stress and anxiety as compared to the nurses fromprivate hospital. Respondents' scores on study variables were compared on the demographic variable of family system and it was found that nurses from joint family system reported higher levels of occupational stress as compared to nurses from nuclear families on ENSS and higher levels on the coping strategies of self-distraction and denial on Brief Cope. Nurses of both hospital sectorsdid not differ in using coping strategies used to cope up with anxiety and stress except for the sub-scale score on substance use where nurses from the private sector scored significantly higher as compared to nurses from the public sector. Potential implications of this study have also been discussed.

Acknowledgment

In the course of writing this thesis, I found myself thanking Allah Almighty on every turn; for every significant finding, every supported hypothesis, even on rejected hypothesis as it is also providing a direction to new research, on finding any relevant reference a sigh of Alhamdulillah escaped my lips. There is no doubt in my mind that without His help and beyond His countless mercies, I would not have any place to stand on.

I thank my supervisor, one of the best people I know, Ms. RiffatZahir for believing in me and guiding me all along the way. I genuinely believe that without her help, dedication, hard-work (that she did on me) and supervision, I would not be able to perform well in my work.

There are no words that can express my thanks, my love for my family that helped me through my hardest period. Mama, I love you and can never tell you how much you mean to me. You are an energy booster that always boosts me whenever I am in a difficult phase. Papa, thank you so much for always being there and making me forget all my worries. Bhaijaan! I cannot describe how blessed I am to have you in my life, you scolds me whenever I do something irritating but you love me more (I know this), thanks for helping me with the giant (thesis), I would not be able to do this alone. ShahidBhai! I cannot describe the respect in words that I have for you in my heart. You were and are always there whenever I need help regarding anything. Thanks for helping me passing this phase successfully. Your motivation, your lectures, your teachings, your effort to make me laugh when I was not even in the mood to smile really worked as a morale booster and I am able to gain the success.

This acknowledgment would be incomplete without mentioning the ones who supported me both morally and physically and motivated me to work hard and made me realize that I can do this. They stand by me, through thick and thin. Those are called friends but more like gems. Thank you so much Madiha Mushtaq, MairaZahid, Kiran Khan, Rabea Hassan, QandeelSadaf, NoorulainIftikharAbbasi, Misbah Khan, Irum Fatima, Syed Taha, IrumAzhar, NidaHabib, Werdah Ashraf and NosheelaJaved. Thank you so much guys for being there when everyone was busy doing their own stuff. Last but not the least, Punjab Huts kiChae, thanks for keeping me awaken and helping me to get through this whole phase.

SyedaRashke Zahra

Introduction

Chapter I

INTRODUCTION

Work pressures are seen as part of everyday life for health professionals. Stress response is being described as being a mismatch between the perceived demands and the ability of the individual to cope with these demands. Prevalence rates of stress among nursing staff vary across studies with researchers reporting rates of 29–40% (Riding, Richard, & Wheeler, 1995).

Healthcare workers have been recognized as experiencing occupational stress (Wheeler, 1997). Nursing is associated with a range of different demands; these include physical (high workload), emotional (issues to do with death and dying) and social demands (conflict with colleagues) (Gray-Toft, & Anderson, 1981).

Stress

Stress is defined as general acknowledgment of the body to any requirement for development or advancement (Selye, 1973).

Occupational Stress

The word related pressure is the unfriendly, undesirable target and wistful criticism that emerge when the requests of the specific assignment don't meet the fundamentals, capabilities and requests of the worker (Nabirye, Brown, Pryor, & Maples, 2011)

Stress is the bodily response to advancement that desires an objective, subjective or sentimental modification or reaction. It is strongly recognized that the nurses serve in extreme stressful situations and enormous number of research has focused on the elements of this overarching pressure (Munro, Rodwell, & Harding, 1999).

Stress administration makes a difference for the individual in managing psychological and social adjustment midst the stress causing affairs as a balancing component; thus the real response to indirect affair can be as essential as the affair itself. Stress effects the behavior of employee greatly consisting of flexible and maladjusted

reactions proceeding to acute and chronic health conclusions, including drug usage, sleep disorderliness, eating disorders, nervousness and distress (Munro, Rodwell, Harding, 1999).

Stress related research demonstrates that people rehearses distinctive procedures in inclination to just a single, to manage their pressure (Norris, & Uhl, 1993). Word related pressure is an apparent issue in wellbeing looking after workers (Burbeck , Coomber , Robinson & Todd, 2002). Nursing is perceived as profession causing extreme stress (Xianyu & Lambert, 2006).

It was recognized that job related stress has risky or unhealthy effects on nurses' well-being as well as on their capabilities to wrestle with their job requirements. This vigorously distorts the groundwork of affective care and the adequacy of health maintenance conveyance (Ersoy-Kart, 2009). Stress affects the person greatly in premises of well-ness, welfare, and job contentment, as well as the institution in regards of defection and departure, which then in response can affect the essence of patient supervision (Price & Mueller, 1981).

Stress is not genetically adulterous, nonetheless. Each person's mental evaluation, their concepts and apprehensions, provides sense to affairs and regulates if the affairs are seemed as dangerous or affirmative. Natural attributes also affect the stress equalization as what being distressing to one individual may be exciting to other individual (French & Caplan, 1972).

In fact, the occupation distress is mentioned as a compelling subjective issue (Jennings, 1990). Different four causes of nervousness were recognized in the working environments of nurses that are: patient supervision, decision formation, taking authority and advancement (Menzies, 1960). The nursing occupation is recognized as stressful long ago positioned on concrete activity, personal hardships, working durations, crew, and mutual connections that are fundamental to the tasks nurses performs. Since mid-1980's, work related stress in nurses is intensifying because of high usage of electronics, enduring acceleration in health care charges (Jennings, 1994) and disturbance at work settings (Jennings, Scalzi, Rodgers & Keane, 2007).

Numerous individuals can grapple with worry for brief periods however determined pressure causes broadened progressions in the physical condition (Chang, Tugade & Asakawa, 2006). The concerns of job related distress, and fatigue among nurses are of broad interests to all officials and executives in the field of health supervision (Xianyu & Lambert, 2006).These stresses can be altered in an affirmative fashion by using proper stress execution skills.

Stress among nurses is a local issue. It adds to health issues among nurses and declines their abilities. The nursing occupation is perceived as stress causing around the universe and has harmful impacts on the subjective and emotional wellness of person's well-being (Onasoga & Osamudiamen, 2013). Occupational distress is of basic importance to managers due to its recognized harmful or negative impacts on workers achievement, yield, job contentment and well-being as integrity (Moustaka & Constantinidis, 2010).

Stress is recognized as a connection among persons and their surroundings that are perceived as threatening or outstripping their belongings and staking their wellness. WHO has realized that stress is universally contagious as it is currently acclaimed to be related to 90% of appointments to specialists (Moustaka & Constantinidis, 2010).

Research from prior years depicted that symptoms of occupational stress presented to be increasing among nurses that is associated to different aspects varying from decreasing, reconstructing, and consolidating to performance barrier and authority (Berger & Hobbs, 2006). Nursing stress is described as sentimental and subjective response occurring due to connections among nurse and his/her work setting where the job demands outstrip the capacities and belongings (Tzeng, Ketefian, & Redman, 2002).

The work related stress has increased twice in United States since 1985. Almost, 1/3 of all the Americans examined job stress as their huge cause of stress (Krohe, 1999).This is proved by global voting where 82.0% of voters proclaimed that work related tension aimed them to experience stress on daily base and approximately 1/3 of voters experienced stress daily (Krohe, 1999). There is a increased perception of stress faced by nursing crew in hospitals (Moustaka & Constantinidis, 2010).

Stress is second strongest health issue prevailing at work settings. Occupational stress can be described as the negative sentimental position faced when the requirements because of occupational components affects the capability of a worker to locate or regulate the position.

Another essential aspect is the absence of help and affirmative evaluation to the nurses by the official practitioners in the nursing assistances (Ouzouni, 2005). The nurses of clinical settings works under acute stress with restricted freedom in decision formation, as they most of the time work under the protocols constructed by others (Eleni et al., 2010).

Theoretical Approach to Occupational Stress

Several theories are included that are related to occupational stress. These theories highlight the factors and aspects associated to occupational stress. The theories are as under.

Interactional Theories

These theories concentrate on the basic components of individuals connections with their work settings. Two appropriate theories serves as influential among others. These are: the Individual Environment Fit hypothesis (Edwards, Caplan, & Van, 1998) and the Demand– Control hypothesis (Kain, & Jex, 2010). Both of the speculations are free of criticism.

Person-environment fit Theory. Number of researches has recommended that the rightness of fit among individual and their work setting usually endeavor an improved clarification of behavior as compared to person or conditional contrasts. Another theory formed based on the strong idea of PEF. It said that stress prevails and the wellness of individual is influenced when there occurred an inadequacy of fit in one or both regards.

Two complete and fine perceptions are formed in this theory: firstly, among unbiased realism and biased consciousness, and secondly, among coincidental parameter (E) and person parameter (P). According to this simple equation of P x E connection,

loss of fit most probably arise in four unique structures, and every one presents to undermine the representative's wellbeing. There might be both loss of unprejudiced and one-sided P-E fit: these are the specific worry of thought with principle hugeness being appeared in loss of one-sided fit: how a worker sees his/her working environment. This gives a firm connection with other subjective theories related to stress.

Demand–control Theory. Work attributes may not be directly related to employees' wellness, and that they may associate mutually in regards of wellbeing. This theory was originally exhibited by the help of trivial inquiry of statistics from US and Sweden, outcomes showed that the workers at jobs having low decision making and increased job requirements were more prone to address meager health and low contentment (Kain & Jex, 2010). Later conducted studies came to certify the theory.

Communal help plays an important character in the regulation of stress at work settings. It presents as a cushion across conceivable harmful health influences of increased mental requirements differentiate among four types of less communal help working conditions and four of increased communal help. This theory model was also condemned because of its deficiency to recognize the personal distinctions in perceptivity and coping probability. The connection among the extensions of model and the result quota may bet on employees' personal tendencies. For example, disordered leisure capacity was presented to be a credible prognosticator of elevated sympathetic awaking and postponed improvement of cardiovascular criterions. It showed qualified strength of work and job-regarding fatigue.

Transactional Theories of Stress

Most of these theories concentrate on the subjective techniques and sentimental responses underlying the individual's connection with their surroundings. For instance, effort-reward imbalance quarrels that sense of persistent stress can be described as a discrepancy among more expenditure and less achievement. In simple words, stress at work settings results from increased struggle and low benefits gained (Siegrist, 2016).

Two causes of struggle are differentiated: an acquired cause, the requirement of job, and an innate cause, the inspiration of individual employee in challenging condition.

Three measurements of benefit are essential: economical pleasure, social-sentimental benefit and dignity hold. Harmful health impacts, as heart diseases are most common in professions where conditional pressures refrains employees from declining high expenditure-less achievement situations.

Theories of Appraisal and Coping

Most easily proven wrong figures rose to base on the visionary frameworks instructed in the shared worldview regarding the Michigan school. Kain and Jex (2010), focus on the plausible imbalance amongst prerequisites and capacity or ability. This is the situation in the United States in the United States (1984) and Cox and Mackay in the United Kingdom (1981). As per value-based models, stretch is a negative mental express that influences parts of comprehension and feeling. It manages the condition of worry as an inner portrayal and dangerous exchanges between the individual and their condition.

Appraisal is the assessment procedure that offers significance to these individual condition exchanges (Holroyd & Lazarus, 1982). Consequent refinements of the hypothesis propose both essential and optional parts for the appraisal procedure. The essential evaluation includes constantly checking the individual's exchanges with their condition (regarding necessities, abilities, skills, restrictions, and bolster) and spotlights on the inquiry, "Am I Having a Problem?" The acknowledgment of an issue circumstance is normally joined by repulsive sentiments of general distress. The auxiliary evaluation relies upon the information that an issue exists and incorporates a more nitty gritty examination and the age of conceivable adapting methodologies: "What am I going to do about it?" When the individual sees that it doesn't enough adapts to the requests made on or with dangers to their prosperity are restless or discouraged about it (Cox & Ferguson, 1991).

The topic of "mindfulness" has been brought up in connection to pressure and the appraisal procedure (Cox & Mackay, 1981). Examination is a consider procedure. In the most punctual stages, notwithstanding, changes that are normal for the pressure state can be identified, yet the presence of an issue may not be perceived, or the acknowledgment

is just "indistinct." It was proposed that distinctive levels of mindfulness may exist amid the assessment procedure.

In concurrence with Lazarus and Folkman (1985) and Edwards et al. (1998) stress was depicted as the psychological express that emerged when there was a by and by noteworthy irregularity or befuddle between the view of the individual's needs and their apparent capacity to adapt to these requests. The mental and physiological changes related with the acknowledgment of such a condition of pressure and including adapting speak to the third level of the model.

The experience of worry through work, both physical and psychosocial, and the laborer's acknowledgment that they are adapting to the essential parts of their work circumstance. The experience of pressure is generally joined by endeavors to manage the fundamental issue (adapting) and by changes in cognizance, conduct and physiological capacity. Albeit most likely versatile for the time being, such changes may debilitate wellbeing in the long haul. The experience of pressure and its behavioral and psychophysiological relates intercede, to a limited extent, the impacts of a wide range of kinds of work request on wellbeing. This point has been made by numerous creators in the course of the most recent three decades.

Anxiety

Portrayed by a mind-boggling feeling of concern; the desire that something awful will happen or will happen; Class of mental issue described by unending and incapacitating uneasiness. (Anderson, Jacobs, & Rothbaum, 2004). The showdown with death is a huge human worry that is impacted by individual encounters and socio-social convictions (Nia, Lehto & Stein, 2009; Sharif, Ebadi, Lehto & Peyrovi, 2015), Danger of death, a Negative full of feeling state, which is empowered by mortality remarkable quality, can be experienced by medical attendants and other medicinal services laborers who are presented to malady, injury, viciousness and demise factors that influence the experience and level of mortal dread in medicinal services suppliers Age, self-image uprightness, physical issues, mental conditions, religiosity (Neimeyer, Wittkowski &

Moser, 2004), ethnicity, word related stressors, individual passing encounters and media impacts.

What's more, uneasiness over dread of death is concentrated among attendants who nurture patients in an assortment of settings, including escalated mind units, mental wards, crisis rooms, and inpatient and outpatient settings (Beckstrand, Smith, Heaston & Bond, 2008). Nursing staff has likewise recognized instructive holes in their planning for compelling consideration of passing on patients. (White & Coyne, 2011)

Care is viewed as a calling of the holy messenger of benevolence, yet it is additionally a standout amongst the most upsetting occupations contrasted with different regions of social insurance. Amid their standard work, attendants connect more with youngsters, families and individuals, bringing about unpleasant circumstances.

Medical caretakers should be very much arranged for stressors they can look amid their obligations. There is confirming that medical caretakers working in a placated situation give quality care. This will enhance the models of care offered (Stathopoulou, Karanikola, Panagiotopoulou, & Papathanassoglou, 2011). The versatile reaction to stressors might be compelling for the time being, yet drawn out pressure prompts physical and mental disorders. It has been reported that there is more anxiety among emergency patients compared to other care facilities (Yang & Koh, 2001). This is credited to workload and pressure in basic circumstances (Battles, 2007; Laposa, Alden & Fullerton, 2003). What's more, progressing pressure not just significantly affects the personal satisfaction of parental figures yet can likewise lessen the nature of crisis mind and diminish efficiency. Be that as it may, a set number of studies have inspected the rate of business related feelings of dread among escalated mind medical caretakers. The Ministry of Health in Saudi Arabia depends for the most part on a non-Saudi parental figure.

In addition, Saudi nursing graduates are not enough to meet the demands of growing healthcare. In addition, Saudi health nurses account for less than 30% of all nurses in the kingdom (Gazzaz, 2009). This elucidating study meant to decide the tension and related indications among serious care nurture in state clinics in Albaha.

Since nervousness is included paying little heed to the sort or level, strain and distress, and can influence every individual's ordinary working, the medical caretakers are not resistant (Godin, Kittel, Coppieters & Siegrist, 2005). Every day individuals are frightened. Insecurity of the human culture, upsetting workplace, the want to keep pace with our quick paced innovative age, dread without bounds, work requests, financial retreat and frail connections are continually making dread in us.

Dread is an obnoxious feeling or perspective described by stresses, fears, fears and fears. It is a regular ordeal that everybody has occasionally. In some cases it is classified as feeling or influence, contingent upon whether it is depicted by the individual (feeling) or by an outside onlooker (influence) (Mohr, Petti, & Mohr, 2003).

In the United States, the lifetime commonness of nervousness issue was around 29%. (Kessler et al., 2005). Australian medical caretakers 11.2% had summed up nervousness issue. (Cheok, Snowdon, Mill operator, Vaughan, 1996), the commonness rate of tension issue in the Jordanian populace was 5.7% (Ali & Kareem, 2012).

Theories of Anxiety

Several theories are included related to anxiety. These theories highlight the important factors that contribute to anxiety according to different approaches. These theories are as under.

Psychoanalytical Approach

Dread is at the focal point of the psychoanalytic hypothesis of effects (sentiments), and from the earliest starting point psychoanalytic reasoning has been perceived as key to the comprehension of mental clashes (since awful emotions make clashes felt and known).

In 1926, Freud profoundly updated his thoughts of tension by abrogating the qualification amongst hypochondriac and practical uneasiness and guaranteeing that constraint incited nervousness. In this new hypothesis, Freud recognizes two kinds of tension, a horrendous, reality-arranged "programmed" nervousness in which the framework is overpowered, and an optional, "psychotic" uneasiness in which

suppressions of these circumstances are foreseen and started. "Programmed uneasiness" was a full of feeling reaction to weakness amid a horrible affair. The model for this experience was the newborn child's weakness amid and after birth, when the threat originated from outside, and overflowed a mystic framework that was basically momentary through the (not yet shaped) sense of self.

This better approach for conceptualizing fears was a result of Freud's late amendments of his hypothesis (1923) of auxiliary hypothesis and it's detailing of the intervening part of the inner self, and had the impact of moving the clinical work of dread into the domain of nervousness Ego. The relationship of perilous circumstances with formative stages likewise proposed a symptomatic part of nervousness, with prior sorts of tension showing prior obsessions. In crafted by the later theoreticians, the presence of the most punctual feelings of trepidation in clinical work was viewed as a sign of pre-oedipal formative issue and comparing basic deficiencies in the inner self.

Regardless of his later plans, Freud never unequivocally surrendered his first thought of dread, and the two hypotheses lived awkwardly one next to the other long after Freud's passing in Freudian metapsychology.

Attentional Control Theory

Consideration Control Theory is a way to deal with nervousness and insight that speaks to a noteworthy improvement in the handling productivity hypothesis of Eysenck and Calvo (2007). It is trusted that uneasiness disables the proficient working of the focused on consideration framework and builds the degree to which preparing is influenced by the boost driven consideration framework. Notwithstanding lessening consideration control, uneasiness builds regard for danger related jolts.

Antagonistic impacts of nervousness on the productivity of handling rely upon two focal official capacities identified with consideration control: restraint and uprooting. Notwithstanding, fear can't influence the execution viability (nature of execution) on the off chance that it prompts the utilization of remuneration methodologies (e.g. expanded utilize, expanded utilization of preparing assets).

Drive Theory and Manifest Anxiety

A broad book reference of exploratory investigations utilizing the Manifest Anxiety Scale (Taylor, 1956) has aggregated since its first prologue to inquire about writing. The reason for existing is to basically explore this examination regarding drive hypothesis and the first motivations behind the scale. Tests managing the connections amongst MAS and traditional molding, boost speculation, maze learning and verbal learning are displayed. What's more, the connection amongst uneasiness and stretch and the MAS and clinical estimations of nervousness is analyzed. By and large, the test discoveries bolster the idea of a communication between nervousness level and errand multifaceted nature, yet extra research is expected to decide whether the hypothesis can be effectively stretched out to more perplexing circumstances than initially thought proper (Taylor, 1956).

Coping Strategies

Set of deliberate, intentional endeavors that individuals make to limit the physical, mental or social mischief of an occasion or circumstance (Lazarus & Folkman, 1985).

Adapting alludes to an assortment of subjective and behavioral techniques that people use to deal with their pressure (Folkman & Moskowitz, 2000). Folkman and Lazarus (1980, 1985) recognized two noteworthy adapting styles: issue and feeling focused. The previous alludes to the wellspring of the pressure, while the second mirrors the endeavors to manage contemplations and sentiments related with the stressor. To gauge the individual contrasts in these two measurements of adapting, Folkman and Lazarus (1985), created adapting abilities, an agenda of issue and feeling related adapting techniques that can be utilized as a part of different pressure circumstances.

Carver (1989), noticed that these two adapting style measurements were critical; however advance separation was viewed as vital. To assess a more extensive assortment of helpful adapting styles and some less valuable methodologies built up the COPE stock (Carver, 1989).

Carver (1989), considered the individual COPE scale scores and recognized four measurements; the primary factor was firmly identified with issue arranged adapting; A moment factor was for the most part characterized by scales went for assessing feeling centered systems, however the hesitance, initially considered an issue situated methodology, likewise weighed on that factor. A third factor was the scan for social help to look for guidance or express feelings, and a fourth factor was an endeavor to abstain from managing the issue or its related feelings.

In spite of the fact that issue and feeling focused methodologies have not generally characterized isolate factors, past research has over and over distinguished components that separate whether to adapt to or without social help. These outcomes propose that it might be more helpful to recognize "socially bolstered" and "independent" adapting styles than when the systems are intended to handle issues or feelings. Furthermore, it ought to be noticed that the socially upheld factor quite often comprises of scales that survey both issue and feeling focused systems.

Another figure found various investigations includes shirking administration, characterized by scales that portray disregarding or pulling back the stressor or the emotions related with it. Evasion situated adapting can be appeared differently in relation to adapting styles that are more approach-arranged; he concentrated on the treatment of either the issue or related feelings (Roth & Cohen, 1986). Adapting methodologies are related with identity attributes and results that are negative, while approach styles are related with positive characteristics and results (Stowell, Kiecolt-Glaser & Glaser, 2001).

To explore the adapting procedure, Lazarus and his partners built up a measure called "methods for adapting" (Folkman & Lazarus, 1980); this has since been amended (Folkman & Lazarus, 1985). This activity comprises of a progression of predicates, every one of which is an adapting thought or activity that individuals some of the time take part in under pressure. Respondents show whether they have utilized every one of these reactions in a specific unpleasant exchange (or part of such an exchange) with either a yes or no answer or a multi-point scale rating.

Installed in the "Methods for Coping" scale, a qualification is made between two general types of adapting. The main, alluded to as issue arranged adapting, goes for critical thinking or accomplishing a remark the wellspring of the pressure. The second, feeling controlled adapting, means to decrease or deal with the enthusiastic pain related with (or caused by) the circumstance. Albeit most stressors trigger the two kinds of adapting procedures, issue situated adapting is prevalent when individuals feel that something helpful should be possible, while feeling based adapting wins when individuals feel that the stressor is something that needs to persist (Folkman & Lazarus, 1980).

Coping with Stress

Little is known about the coping strategies of veterinarians. A survey at an Australian veterinary school found that students did not consistently use a range of effective coping methodologies to adapt to the stressors they experienced amid their course. Anecdotal is the clinical experience in psychiatry that veterinarians try to solve problems beyond the point where this is possible, and not to properly assess stressful situations. They seem to be using their previous coping strategies without enough thought as to whether they are appropriate or imaginative enough (R. Persuade, Personal Communications.

Coping is the process of thinking and acting that individuals use to deal with the interior and outside necessities of circumstances that they find up setting or overly high. Attempt to cope with, master, tolerate, reduce or minimize the demands of a stressful environment. Over 400 different types of coping have been identified and numerous frameworks for their categorization proposed (Skinner, 2003). Systems are regularly sorted out as indicated by whether they address the issue that causes pressure (issue situated adapting) or diminish the negative feelings related with the issue (feeling focused adapting).

Versatile adapting aptitudes can be learned and enhanced to diminish mental pressure and enhance prosperity. Adapting Effectiveness Training (CET) enhances individuals' capacity to perceive and assess distressing circumstances and to discover and

utilize proper adapting abilities and social help (Chesney & Folkman, 1994). Stressors that are overwhelming are broken down into their constituents, changeable and unchanging aspects are identified and coping strategies adapted accordingly.

Relationship between Occupational Stress and Anxiety

Uneasiness is a feeling portrayed by sentiments of strain and/or stress, and additionally physical changes, for example, expanded pulse. Although anxiety is a normal response to stress, anxiety disorders can develop in cases of excessive occurrence (American Psychiatric Association, 2013). Nervousness issues are a typical psychological maladjustment in Western nations (Kessler et al., 2005)

The pervasiveness of nervousness issue is most elevated in the US with a predominance of 18.2%, in France and the Netherlands with 12.0% and 8.8%, individually. Among Asian nations, this rate was moderately low at 5.3% and 3.2%, individually, in Japan and China (Demyttenaere et al., 2004).

Not with standing depressive issue, tension issue have likewise been portrayed as hazard factors for self-destructive considerations and suicide endeavors (Sareen et al., 2005; Bolton et al., 2008; Kanwar et al., 2013). Considering the way that South Korea has the most astounding suicide rate among all OECD part nations (31.7 for every 100,000 tenants for the aggregate populace, 43.3 for each 100,000 men and 20.1 for every 100,000 ladies), the accompanying increment in nervousness issue could be the most extraordinary clarify high frequency of suicide.

Also, it has been accounted for that uneasiness issue are essentially connected with an expansion in labor nonattendance, weakened work execution, expanded medicinal expenses, and low profitability (Plaisier et al., 2010; Lim, Sanderson & Andrews, 2000). In this way, tension issue can be an issue in regarding laborers' wellbeing and also a financial issue.

As indicated by the National Institute for Occupational Safety and Health, word related pressure is characterized as the pressure that happens when the requirements of the activity are ineffectively coordinated with the abilities of the representative, the assets

accessible and the desires of the business, and this pressure is accepted to cause destructive physical and enthusiastic responses. Past examinations have demonstrated that business related pressure coming about because of variables in the psychosocial workplace, for example, work requests, deficient work control, absence of reward and low social help, are altogether connected with tension manifestations or clutters of specialists (Andrea et al., 2004; Gao et al., 2012).

In South Korea, look into on the connection between specialist tension and occupation stretch has discovered that business related pressure coming about because of the psychosocial workplace is fundamentally identified with the predominance of male office laborer uneasiness side effects (Park, Lee, Park, Min & Lee, 2008). In any case, few examinations have inspected this connection between laborers in assembling and/or ladies specialists. What's more, since ladies experience 1.6 to 1.8 times the frequency of anxiety disorders than men, it is believed that women are prone to anxiety disorders. Therefore, it may be necessary to study the link between the professional stress and anxiety of Korean workers in production.

Literature Review

Greater psychological stress was observed among respondents who worked mainly with palliative care patients. Persons who identified themselves as spiritual showed greater job satisfaction, while a distanced response to professional practice was associated with younger, male, less work experience and membership in the RRRP team. Future initiatives should focus on promoting stress-relieving activities, the need for stress management courses and the overall importance of raising awareness of possible signs and causes of stress at work.

Occupation stretch is a noteworthy test for present day wellbeing and security. It is realized that the crisis division (ED) is a high weight condition; the particular hierarchical stressors influencing ED faculty have not been resolved.

The audit gives a manual for creating mediations that address the reasons for ED push. It recommends that the individuals who diminish necessities and increment specialists' control over work, enhance administration bolster, manufacture better

working connections, and feel more significant to their endeavors might be of advantage to laborers (Basu, Qayyum & Mason, 2016).

Work environment worry in the ED has set up its nonappearance, high staff turnover and early retirement. What's more, those maladaptive ways of life practices? It takes after that work pressure; burnout and goal to take off.

The audit features the significance of various components including work request and choice scope, and in addition administrative help and companion connections in impacting view of work pressure. Significantly, these are authoritative supporters of the improvement of business related psychological instability; burnout; empathy exhaustion; goal to leave the forte and early retirement. This gives a layout from which to plan mediations that objectives the birthplaces of worry inside the ED; which is at present being painted. A survey of sixty-three pressure situated mediations in 2003 found that lone three detailed changes in burnout, with the most spotlight on optional level methodologies, and in addition strength through care and subjective behavioral treatment.

In any case, look into somewhere else has shown the positive and durable impacts of essential level administration intercessions intended to enhance correspondence and human services among social insurance staff, and in addition through the CREW (Civility, Respect and Engagement in the Workplace) programs in 2015, Cochrane survey of pressure mediations in medicinal services staff found that they were intended to enhance or lessen work plans.

The investigations displayed in this audit have various confinements. Most are cross-sectional and causal connections are dubious. Numerous investigations were performed in a solitary area, which restricted the generalizability of discoveries. Barely any examinations utilized a control gathering, either from the all-inclusive community or from a reasonable healing facility unit. This is vital in light of the fact that it is imperative by and by to recognize whether certain stressors in the working environment are particular to the ED, an element of the doctor's facility or illustrative of the whole social insurance segment. The utilization of surveys in all examinations additionally builds the

likelihood of inclination in announcing, and few investigations thought about the part of the basic technique (Greenberg, 1987) in detailing the outcomes.

At last, the survey concentrated on the clinical staff. It is likely that non-clinical staff is experiencing significant job stress, as demonstrated by a study by ED office and administrative staff. (Zautcke, Neylan & Hart, 1996) A holistic, departmental approach to stress management is therefore recommended.

Pakistani Perspective about Occupational Stress and Anxiety

Health professionals deployed in their own communities for essential medicinal services have a few titles; however "Group Health Worker (CHW)" is the most ordinarily utilized term to portray this unit. As indicated by the WHO: "Wellbeing laborers in the group ought to be individuals from the groups where they work, be chosen by the groups, be dependable to the groups for their exercises, be upheld by the wellbeing framework, yet not really part of it and have one Shorter preparing than talented specialists. These specialists assume a key part in enhancing access and scope of wellbeing administrations in remote regions and can add to better wellbeing results.

The "Woman Health Worker" (LHW) of the National Family Planning and Primary Care Program in Pakistan fits in well with the meaning of "group wellbeing laborer" and is a crucial piece of the nation's wellbeing framework. The Lady Health Workers Program (LHWP) is an administration subsidized improvement program that has been working at neighborhood level since 1994. In each of the 135 areas of Pakistan, around 96,000 laborers and their bosses were prepared and sent. They at present cover around 65% of the objective populace (ghettos in rustic and urban territories), and full scope is arranged in the following couple of years (Ministry of Health Pakistan, 2007-2008). Pakistan has high maternal and child mortality rates (UNICEF, 2007), low access of women to health services (Fikree, Khan, Sajan, Rahbar & Kadir, 2001), with less than a third Health benefit centers untrained and less contraceptive use among the rural population (Ahmed, 2015). Therefore, the lady health workers work is a provocation.

The expected set of responsibilities of the LHW has developed after some time. At first, it included wellbeing instruction and essential family arranging avoidance

administrations; Health of child and mother; Improving basic hygiene, nutrition; and sanitary facilities; the children's vaccination. Today likewise incorporates mass inoculations for polio destruction; Newborn care; maternal vaccination with lockjaw toxoid (TT); Referral of qualified cases and wellbeing measures to refresh the administration data framework (MIS) of the program; Community administration of tuberculosis; and Health Education on HIV-AIDS and Hepatitis (Ministry of Health of Pakistan, 2007-2008).

Lady Health Workers are rarely advised to change their job description. These become bigger and bigger workloads of the LHW, in which they have too little stress. This Bedding by definition can be found in the documents of the consideration of a effectiveness (Brédart et al., 1998).

Since the start of the LHWP in Pakistan, a progression of program orders has been completed. Most far reaching was the examination directed in 2000-2001 (Oxford Policy Management, 2002). There was proof that the program has enhanced the take-up of key wellbeing administrations in the zones sought after by LHW.

In the meantime, it suggested that the nature of work must be progressed. Nonetheless, there was no data about LHW's own particular perspectives on their expected set of responsibilities and their level of occupation push. These elements would be essential for enhancing the nature of administration conveyance and execution/usage of existing LHWs. The territory is by and large under-inquired about and precise surveys have featured information holes in territories, for example, work fulfillment/disappointment and occupation maintenance (Rowe, Savigny & Lanata, 2005).

A roused workforce has been depicted as key to any medicinal services framework. The change of HR administration in the wellbeing part has been prescribed to meet the Millennium Development Goals (MDGs) (Hongoro & McPake, 2004). The evaluation of the LHW program by third parties also featured the need to enhance the nature of work through enhanced administration of the workforce. To accomplish this present, LHW's own sentiment on the elements adding to their activity

fulfillment/disappointment should be explored. The subjective character of our examination has permitted us a few bits of knowledge around there. In the meantime, this subjective examination directed in a sub district has clear restrictions and is suggestive, best case scenario.

The potential part of CHWs in enhancing general wellbeing has been perceived, particularly in asset poor nations. It has been depicted this in light of the converse relationship of thickness of wellbeing laborers (specialists, medical attendants, birthing specialists) with maternal, baby and under 5 mortality; Combined with the high expenses of preparing specialists and medical attendants and the low utilization of administrations in social insurance offices in numerous zones, there is the possibility to accomplish huge medical advantages through the arrangement of wellbeing laborers in the group. The Task Force on Training of Health Professionals (Crisp, Gawanas & Sharp, 2008) prescribed enhancing their preparation through quality confirmation projects and encouraging universal activity to build the creation of profoundly gifted wellbeing specialists.

Different investigations have likewise detailed regions for enhancing the structure and execution of CHW programs, including the LHWP Pakistan. The low compensation and the absence of vocation way were accounted for as a purpose behind the disappointment of the LHW representatives. Mumtaz, Salway, Waseem, & Umer, (2003) detailed an oppressive various leveled authority structure, slight for male associates, absence of affectability to sexual orientation particular social limitations, clashes amongst home and work obligations, and poor infrastructural bolster as critical issues looked by female people on call from their investigation in 1998, when the program initially started was four years of age. Our investigation recommends that carelessness for male partners and the contention amongst home and work duties have enhanced, while different variables have continued as before.

Douthwaite and Ward (2005) noticed that the LHWP has prevailing with regards to expanding the utilization of current contraceptives by ladies in country regions. In this manner, ladies looked after by LHW were fundamentally more prone to have the capacity to utilize a cutting edge reversible technique than ladies in groups who were not

administered to by LHW in the wake of having controlled different individual and residential attributes. They supported the continuation of the arrangement of way to-entryway benefits by neighborhood laborers to accomplish general access to safe family arranging strategies. Our investigation proposes that family arranging correspondence is as yet seen as a troublesome region by these laborers, and in spite of the fact that the program should proceed with, a few measures to reinforce relational correspondence are expected to additionally enhance execution and results.

Fluctuated mediations (e.g., preparing in addition to supervision) that address numerous determinants of execution have been suggested (Rowe, Savigny, Lanata & Vivtora, 2005) to enhance CHW execution. We add this change to the compensation; A reasonable profession way and enhanced administration are additionally required. Moreover, the fortifying of correspondence procedures ought to be incorporated into the preparation and progressing checking forms to enhance the adequacy of wellbeing experts in the group.

Stress is frequently alluded to as a sentiment over-burden. It is "the unspecific response of the body to any request (Seyle, 1973). It can be characterized from two viewpoints: dialect and association. "More grounded", ward (Cartwright & Cooper, 1997). As far as association implies worry in the work environment or worry in the work environment. Worry at work is the second most essential compatible utilize. Work pressure is of two kinds: mental pressure and physiological pressure. Mental pressure implies a passionate response, for example, tension, estrangement, nervousness, dissatisfaction, misery, and so on. Physiological pressure is alluded to as a physiological reaction of the body, for example, stomach torment, chest torment, palpitations, neediness, headache, back agony, and so on. (Beehr, Glaser, Canali, & Wallwey, 2001).

The dedication of representatives to their association is fundamental to the achievement of the association, as undiscovered representatives can't adapt to their work and perform close to nothing. An investigation by Luchak and Gellatly (2007) has demonstrated a high level of authoritative duty in a high workload and superior. In the association to high non-appearance (Paré & Tremblay, 2007) and a high worker turnover increment (Allen & Meyer, 1996), which in the end lead to actual sales? In addition, high

sales are very cheap for any organization. Because organizational engagement is very important, this study is being organized to allow a systematic study of national and multinational pharmaceutical companies Factors, the organizational commitment of employees of pharmaceutical companies.

The motivation behind this examination was to inspect the connection between work pressure and hierarchical engagement. Information was gathered from three hundred and thirty-four (334) therapeutic data officers (otherwise called restorative delegates) from national and multinational pharmaceutical organizations working in KPK, Pakistan. Physiological Stress Scale, Psychological Stress Scale and Organizational Obligation Questionnaire were utilized to gauge physiological pressure, mental pressure and authoritative duty, individually. The consequences of the connection demonstrated that both physiological and mental pressure had a noteworthy opposite relationship to the association's inclusion. Numerous relapse likewise demonstrated that both autonomous factors, which are physiological pressure and mental pressure, represented 56% change in authoritative engagement.

The administration of pharmaceutical organizations working in KPK, Pakistan, is asked for to focus on expanding hierarchical engagement and diminishing word related worry with a specific end goal to enhance the execution of therapeutic delegates.

Rationale

Stress is anything that presents a challenge or a threat to our well-being. It has been defined as a process whereby environmental requirements exceed the adaptive capacity of an organism, leading to psychological and biological changes that can expose individuals to disease risk. Uneasiness is a mental and physiological condition

portrayed by subjective, physical, passionate and behavioral segments. These parts make an awkward inclination that is commonly connected with inconvenience, tension or stress. Nervousness is a general mind-set that happens without an identifiable activating jolt. It is critical to distinguish the pervasiveness and hazard variables of worry among guardians that influence their wellbeing as well as their execution at work. In addition, patient care is associated with mental stress on physicians such as poor communication, decreased quality of care, and medical errors associated with physical stress.

Workload, administration style, proficient clashes and enthusiastic expenses of care have been the primary driver of pain for parental figures for a long time, yet there is difference about their effect. The absence of reward and move work would now be able to likewise move a portion of alternate issues in the positioning. Authoritative measures target most, yet not all, of these sources, and their adequacy is probably going to be restricted, in any event in the short to medium term. People require better help, however this is obstructed by an absence of comprehension of how the wellsprings of worry in the diverse regions of training differ, the absence of prescient energy of appraisal devices, and an absence of comprehension of how individual and expert variables communicate. (McVicar A., 2003)

Stress is a physiological and mental response to any occasion. It is vital to find out about word related pressure since it influences wellbeing and decreases the nature of attendants' work. Healing facility based diagnostic cross-sectional examination was led from January to November 2015 out of two Karachi tertiary educating doctor's facilities. The examination was led on 265 medical caretakers who had a substantial permit from the Pakistan Nursing Council. An advantageous non-likelihood technique was utilized to get to subjects. After endorsement, a semi-organized and pre-tried word related presentation poll was utilized to get the information. Information was entered and investigated in SPSS form 21.

The examination comes about demonstrated that the dominant part of medical caretakers were 125 (47.2%) in the vicinity of 25 and 30 years of age. The greatest proportion of medical caretakers was 160 ladies (60.4%) and of them 148 (55.8%) were hitched. Two hundred and one (75.8%) were graduate medical attendants, while just 2

(0.8%) had graduate degrees in nursing. Study members revealed word related pressure; light load 2.0%, direct load 36.5% and substantial 61.5% (Badil, Shah, Rehman, Ali, Siddiqui, 2016).

Stress recognition is profoundly subjective, thus the many-sided quality of nursing practice can prompt errors between parental figures in distinguishing wellsprings of stress, particularly as the employments and parts of guardians' change, as is as of now the case in UK social insurance. This could have suggestions for the acquaintance of measures with address pressure issues in mind.

Stress and anxiety greatly affects the working of individuals and hence affect their health. Different factors contribute to stress and anxiety e.g. sleeplessness, domestic issues, financial issues etc. the current study focuses on the stress and anxiety faced by nurses at work and different coping strategies used by them to lessen the stress and anxiety to work efficiently.

- The profession of nursing has been assessed as being competitive and stressful. Number of researches is being conducted in this sector
- However, in Pakistan, this research segment is not focused as in other countries
- Keeping in sight this issue, the present study is carried out to provide awareness about stress and anxiety faced by female nurses and different coping strategies they use to reduce stress and anxiety levels. The present study included female nurses in their twenties with at least two years of work experience to have as much homogeneity in the sample as possible. Nurses below age 20 and above age 30 were not included in the sample. Our study also not included the nurses above 30 as we had to measure the stress and anxiety and the coping styles among young nurses working at hospitals.

Method

Chapter II

METHOD

The method consists of the objectives about study and the hypotheses that were to be tested in the research study. It further contains the information about the research design and measures that were used.

Objectives

- To identify the occupational stress faced by nurses at their work place
- To identify the coping strategies used by Pakistani female nurses at work
- To identify the levels of anxiety faced by female nurses at work

Hypotheses

- There is positive relationship between nurses' occupational stress and anxiety
- Married nurses will score higher on occupational stress than unmarried nurses
- Married nurses will score higher on anxiety than unmarried nurses
- Nurses working in public hospitals will face higher level of occupational stress than nurses in private hospitals
- Nurses serving in public hospitals will face higher level of anxiety than nurses in private hospitals

Research Design

The present study used survey research design to fulfill the research objectives of the study.

Participants

For selection of sample, convenience sampling technique was used. A sample of two hundred female nurses (*N*=200) was selected. Participants' age ranged between 20 and 30 years. The sample was drawn from the private (Al-Shifa International Hospital) and public (Polyclinic) sectors of Islamabad.

Table 1

Frequencies and Percentages of Sample along Demographic Variables (N = 200)

Variable	*f*	%
Gender (Women)	200	100.0%
Marital Status		
Single	113	56.5%
Married	87	43.5%
Hospitals		
Public	104	52%
Private	96	48%
Family system		
Joint	37	18.5%
Nuclear	163	81.5%

Inclusion/Exclusion Criteria

The present study included female nurses in their twenties with at least two years of work experience to have as much homogeneity in the sample as possible. Nurses below age 20 and above age 30 were not included in the sample. We did not included the nurses below age 20 as they would not be professional and would be practicing ones whereas our study focused on the occupational stress, anxiety and coping strategies of professional nurses. Our study also not included the nurses above 30 as we had to measure the stress and anxiety and the coping styles among young nurses working at hospitals.

Variables

This study focused on the following three main variables with reference to the nursing profession:

- Occupational Stressors
- Anxiety
- Coping Strategies

Additionally, demographic variables included information about participant's marital status, hospitals and family system.

Operational Definitions

The operational definition provides the specification of how the constructs are being measured.

Stress. I have used Extended Nursing Stress Scale (ENSS) to measure Occupational Stress among nurses of public and private sector hospitals. According to the measure used, Stress can be defined as an inward prompt in the physical, social, or mental condition that undermines the balance of a person (Gray-Toft & Anderson, 1981).

Anxiety. I have used Anxiety sub-scale of Depression Anxiety Stress Scale (DASS) to measure Anxiety among nurses of public and private sector hospitals. According to the measure used, anxiety can be defined as a physiological arousal, perceived panic and fear (Lovibond, 1995).

Coping Strategies. I have used Brief COPE that is utilized to recognize distinctive adapting techniques that are used to measure the occupational stress caused by number of stressors. The Brief COPE is a 28-thing measure of situational and dispositional adapting styles and incorporates 14 two thing scales. According to the measure used, coping strategies can be defined as natural or learned way of responding to a changing environment or specific problem or situation (Carver , 1989).

Instruments

Extended Nursing Stress Scale (ENSS). The Nursing Stress Scale (NSS) was initially developed by Gray-Toft & Anderson (1981), and later on extended by French, Walters, Lenton, and Eyles (2000), with 57-item version which was used in the present study to measure the extent of stress among nurses. The old version of ENSS is used in the current study as no new version is being developed.

The ENSS (57-item scale) was developed according to the three objectives: (a) identification of stressful situations not present in NSS (b) included more diverse settings for nurses (c) reliability and validity of the scale (examination of psychometric properties of the ENSS). In the present study 57-item scale was used. For this scale, participants rate the items on a scale that ranged from 1 to 5 (5=does not apply, 4=extremely stressful, 3=frequently stressful, 2=occasionally stressful, 1=never stressful). It has 9 sub-scales (a) death and dying, items 1 to 7, (b) conflict with a physician, items 8 to 12, (c) inadequate emotional preparation, items 13 to 15, (d) problems with co-workers, items 16 to 21, (e) patients and their families, items 22 to 29, (f) uncertainty concerning treatment, items 30 to 38, (g) problems with nurse managers, items 39 to 45, (h) workload, items 46 to 54, (i) discrimination, items 55 to 57 (French et al., 2000).

AbuRuz (2014) depicted the mean scores of ENSS sub-scale: demise and biting the dust (*M*=15.52, score run 7 to 28), strife with doctors (*M*=11.71, score go 5-20), lacking arrangement (*M*=6.31, score run 3-12), issues with peers (*M*=11.44, score go 7-28), issues with chiefs (*M*=17.21, score extend 6-24), workload (*M*=23.62, score run 9-36), vulnerability concerning treatment (*M*=20.23, score go 10-40), patients and their families(*M*=4.88, score range 3-12), and discrimination (*M*=4.88, score range 3-12). Total ENSS score ranges from 57-228 and *M*=131.22.

The high score on ENSS scale shows the higher level of stress among nurses whereas low score shows low level of stress. In the present study, overall ENSS computed alpha was .94, while its sub-scales also have satisfactory alpha value such as death and dying (α =.51), conflict with physician (α =.75), inadequate emotional preparation (α=.57), problem with co-workers (α=.65), patients and their families (α=.62), uncertain treatment (α=.63), problem with nurse manager (α=.73), workload (α=.70), and discrimination (α=.71).

Depression Anxiety Stress Scale (DASS). The scale was created to quantify the builds of misery, nervousness and stress (Lovibond & Lovibond, 1995). The first DASS has 42 things estimating three measurements of negative passionate states, specifically gloom (DASS-D), nervousness (DASS-An) and stretch/strain (DASS-S). Sorrow alludes to low levels of positive effect, e.g., dysphoria, sadness, absence of vitality and adhedonia, while tension alludes to a blend of general pain, for example, peevishness, tumult, trouble unwinding and eagerness. A third factor rose amid the factor investigation. This factor was named "Stress".

Afterward, a shorter variant of the DASS, the DASS-21, was produced by Lovibond and Lovibond (1995) to decrease organization time and has been utilized generally in clinical examples to screen for indications at various levels of despondency, nervousness and stress (Lovibond & Lovibond, 1995). DASS-21 is frequently directed by analysts or clinicians through pencil-and-paper surveys or organized clinical meetings (Antony, Bieling, Cox, Enns & Swinson, 1998). Since its production in 1995, the DASS-21 has been utilized as a part of different research, e.g., early life stress and grown-up

passionate encounters bring down back torment patients, issue betting, work responsibility, and spinal line damage (Raylu & Oei, 2004).

The measure was intended to gauge enthusiastic misery in three sub classifications (Lovibond & Lovibond, 1995) of wretchedness (e.g. loss of confidence/motivations and discouraged state of mind), nervousness (e.g. dread and reckoning of negative occasions) and stress (e.g. relentless condition of over excitement and low disappointment resistance). It was a self-revealing poll with 21 things (seven things for every classification) in light of a four-point rating scale. Things included, "I thought that it was difficult to slow down", "I knew about dryness of my month" and "I couldn't appear to encounter any positive inclination whatsoever". Members were solicited to rate what number of from every one of the things (as explanations) connected to them over the previous week, with "0 = did not make a difference to me by any stretch of the imagination" to "3 = connected to me in particular, or more often than not". The higher the score on the scale, the more extreme the enthusiastic trouble was. The scoring of the scales is also divided in three parts as the scores on stress are added and checked whether they lie within the score range to measure the extent of stress and the other two dimensions are also measured in same manner. There is a total score available for DASS that shows the extent of overall distress

There are different ranges of three sub-scales that provide the information about the normality, mildness or severity of the dimensions prevailing in an individual.

We used DASS in the current study for measuring anxiety among nurses of public and private hospitals. As we are more concerned with simple anxiety rather than trait or state anxiety, so this measure is more suitable for my study.

Brief cope. In the present study, Brief COPE was used to identify different coping strategies used by nurses to cope up with occupational stress and anxiety at work (Carver, 1997). It is the shorter version of COPE Inventory (Carver, 1989). It has 4-point rating scale ranges from 1 to 4 (4-I've been doing this a lot, 3=I've been doing this a medium amount, 2=I've been doing this a little bit,1=I haven't been doing this at all). The Brief COPE is scale having 28-items based upon circumstantial and natural coping

strategies including 14, two item scales. The fourteen sub-scales are self-diversion (things 1 and 19), dynamic adapting (things 2 and 7), dissent (things 3 and 8), substance utilize (things 4 and 11), utilization of enthusiastic help (things 5 and 15), utilization of instrumental help (things 10 and 23), behavioral withdrawal (things 6 and 16), venting (things 9 and 21), positive reframing (things 12 and 17), arranging (things 14 and 25), humor (things 18 and 28), acknowledgment (things 20 and 24), religion (things 22 and 27), and self-fault (things 13 and 26).

The measure has attractive reliabilities i.e. over .50. its creator announced that the shorter thing set halfway in light of the fact that prior examples ended up restless at reacting to the full instrument, both due to the length and repetition of the full instrument and due to the general time weight of the evaluation convention. In this way, just two itemsper scale was developed (Carver, 1997). It has been used in samples of medical students, nursing students, communities affected by natural disasters, caregivers, and patients. The Brief COPE is available in Spanish, French, English, Greek, and Korean. It is an adaptable apparatus, as the directions and thing dialect might be acclimated to fit the specialists' needs, and scientists may pick those scales most fitting for their work. Some sub-scales of the Brief COPE have less support than others (Valvano & Stapleman 2013). Brief COPE's scores range from 2 to 8. The mean and standard deviation are: self-distraction (*M*=4.51, *SD*=1.32), active cope (*M*=4.59, *SD*=1.57), denial (*M*=4.54, *SD*=1.22), substance use (*M*=4.42, *SD*=1.29), emotional support (*M*=5.35, *SD*=1.64), instrumental support (*M*=4.73, *SD*=1.52), behavioral engagement (*M*=4.96, *SD*=1.28), venting (*M*=4.89, *SD*=1.17), positive reframing (*M*=4.96, *SD*=1.17), planning (*M*=5.07, *SD*=1.18), humor (*M*=4.90, *SD*=1.24), acceptance (*M*=4.89, *SD*=1.20), religion (*M*=4.57, *SD*=1.29), and self-blame (*M*=4.37, SD=1.12).

The score on a sub-scale shows the more use of that particular coping style to cope up with anxiety and occupational stress and low score on sub-scale shows the less use of that coping style to cope up with anxiety and occupational stress.

In the present study, computed alpha values of Brief COPE were found as: self-distraction (α =.60), active cope (α =.89), denial (α =.55), substance use (α =.65), emotional support (α =.53), instrumental support (α =.85), behavioral engagement (α

=.53), venting (α =.64), positive reframing (α =.60), planning (α =.51), humor (α =.52), acceptance (α =.55), religion (α =.59), and self-blame (α =.66). The overall coping alpha was found as .86. Therefore, this measure has satisfactory reliabilities.

Procedure

The present research was conducted to measure occupational stress and to identify coping strategies in young female nurses.

Firstly, Head of Department of Psychology, Quaid-i-Azam University, Islamabad was requested to issue a command letter for data collection, from hospital nurses. The letter was shown to the Head of the Al-Shifa International Hospital and Polyclinic Islamabad. The consent of participants was taken during data collection.

The participants of the study were given a booklet of questionnaires that consisted of consent form, demographic sheet, ENSS, DASS, and Brief COPE. The guidelines were given to the members for topping off the surveys. All surveys were filled independently. The motivation behind the investigation was cleared up to the members and any inquiries from the members were replied. The members were guaranteed of their protection and the privacy of their data. The need of moral concerns was additionally kept up amid explore work. Creator's authorization for scales was taken and command letters were signed from particular departments. Information privacy was guaranteed and any critical requirement for encourage investigation of data was confined for the exploration reason. Members' rights were clarified and any inquiries from them were replied. It has been additionally guaranteed that the directions were conveyed to the members previously gathering reactions.

Results

Chapter III

RESULTS

In this chapter, pilot testing and main study results are presented. Pilot testing consisted of sample and the procedure that was followed to carry out the study. It also consisted of tables that showed the results of study.

Pilot Testing

Pilot testing was carried out to ensure psychometric screening of the scales, to ensure understandability and appropriateness of items for the scales.

A sample of 28 young nurses from Al-Shifa and Polyclinic Hospital was selected from the city of Islamabad. Their age ranged between 20 to 30 years, and convenient sampling strategy was used (M= 2.89, SD = .42). The participants for the pilot study were approached personally at their work place, and briefed about the purpose of their response. The measures were distributed among the respondents with their will and respondents filled them up at the spot. Respondents were asked to take their time in filling up the questionnaires and it took 10-15 minutes to complete it.

The purpose of pilot testing was to see the psychometric soundness of the scales. It was found that all the scales, ENSS (a= .90), Brief COPE (a= .84) and DASS (a= .94) had satisfactory reliability on the pilot study's sample and it was an indication to proceed further on.

Main Study

Table 1 shows the demographic information for the respondents of the current sample, and it can be observed from the results that majority of the nurses were single (56.5%) while 43.5% were married. Additionally the 52% nurses were from apublic hospital (Polyclinic) whereas 48% were from a private hospital (Al-Shifa).

Table 2

Means, Standard Deviations and the Alpha Reliability Coefficients for Total and Subscales Scores on Extended Nursing Stress Scale (N=200)

Measures	Item	α	*M*	*SD*	Range		Skewness	Kurtosis
					Potential	Actual		
Total ENSS	57	.92	196.39	21.29	5-285	101-216	-2.41	2.80
Death and dying	7	.64	25.06	2.28	7-35	10-30	-2.58	2.18
Conflict with a physician	5	.44	16.77	1.98	5-25	9-20	-1.75	1.14
Inadequate emotional preparation	3	.68	9.97	1.58	3-15	3-15	-.92	2.46
Problems with co-workers	6	.74	20.71	2.95	6-30	7-27	-2.21	2.90
Patients and their families	8	.86	28.26	3.80	8-40	12-32	-2.28	2.50
Uncertainty concerning treatments	9	.41	30.66	4.62	9-45	16-61	1.51	1.07
Problems with nurse managers	7	.35	24.31	3.94	7-35	12-66	.36	1.79
Workload items	9	.83	30.48	4.22	9-45	13-36	-2.54	2.52
Discrimination	3	.23	10.15	1.26	3-15	6-13	-.90	1.37

Note. M=mean. *SD*= Standard Deviation. α= alpha reliability coefficient

As it is evident from table 2, the respondents of the present study obtained highest mean score on the occupational stressor of uncertainty concerning treatment (30.66) and workload (30.48) thus identifying it the most stressful feature of their occupation. Workload and uncertainty concerning treatments were closely followed by patients and

families (28.26) and death and dying (25.06) respectively, thus making them next strongest occupational stressors. On the opposite end, inadequate emotional preparation (9.97) and discrimination (10.15) appeared as weakest stressors. The remaining stressors obtained mid-range mean values. It was found that most of the subscales were quite reliable, where some had less reliability. It was also noted that the reliability coefficient for ENSS and its subscales ranged from .92.

Table 3

Means, Standard Deviations and the Alpha reliability coefficients for the Total and Subscales Scores on Depression Anxiety Stress Scale (N=200)

					Range			
Measures	Items	*α*	*M*	*SD*	Potential	Actual	Skewness	Kurtosis
Total DASS	21	.89	50.42	7.27	4-84	16-63	-1.45	1.69
Stress	7	.75	16.92	2.71	7-21	6-21	-2.21	1.76
Anxiety	7	.67	16.68	2.48	7-21	4-21	-1.86	2.74
Depression	7	.74	16.81	2.77	7-21	6-21	-1.90	1.32

Note. M=mean. *SD*= Standard Deviation. *α*= alpha reliability coefficient

As it is evident from table 3, the respondents of the present study obtained highest mean score on the Stress (16.92) and it was closely followed by both the other subscales, Depression (16.81) and Anxiety (16.68). The scores on the scale depicted a close relationship between the three sub-scales as the mean values varied slightly, stills showing high on Stress. It was found that all the subscales are quite reliable. It was also noted that the reliability coefficient for DASS and its subscales ranged from .89 to .67. We used DASS to measure the level of anxiety among nurses at workplace.

Table 4

Means, Standard Deviations and the Alpha Reliability Coefficients on Subscales Scores of Brief COPE Inventory (N=200)

Measures	Items	α	*M*	*SD*	Potential Range	Actual Range	Skewness	Kurtosis
Brief COPE								
Self-distraction	2	.30	6.77	.781	2-8	4-8	-1.16	2.01
Active coping	2	.54	6.77	1.05	2-8	2-8	-1.10	2.17
Denial	2	.52	6.65	1.09	2-8	3-8	-1.03	1.44
Substance use	2	.71	3.25	1.67	2-8	2-8	1.29	.60
Use of emotional support	2	.50	6.40	.972	2-8	2-8	-1.05	2.60
Behavioral disengagement	2	.44	6.57	1.05	2-8	3-38	-.99	1.87
Venting	2	.60	6.75	1.11	2-8	2-8	-.92	.69
Use of instrumental support	2	.12	6.64	2.42	2-8	3-8	10.96	2.91
Positive reframing	2	.46	6.35	.95	2-8	2-8	-.83	2.80
Self-blame	2	.42	6.68	1.03	2-8	3-8	-.95	1.31
Planning	2	.55	6.89	1.08	2-8	2-8	.99	-.23
Humor	2	.73	3.50	1.86	2-8	3-8	-1.00	.72
Acceptance	2	.65	6.74	1.07	2-8	4-8	-.66	.50
Religion	2	.41	6.80	.95	2-8	3-8	-.58	.10

As it is evident from table 4, the respondents of the present study obtained highest mean score on the coping strategy of planning (6.89) thus identifying it as the most frequently used coping strategy used by nurses in response to occupational stress.

However, it is important to mention here that the remaining coping strategies did not lag far behind; the mean scores for other coping strategies ranged between 6.80 (religion) and 6.35 (positive reframing) whereas substance use (3.35) and humor (3.50) are the weakest coping strategies being used. These figures suggest that young nurses use a variety of coping strategies to deal with occupational stress. These coping strategies include desirable coping strategies (e.g. planning, positive reframing, and religion) and non-desirable coping strategies (e.g. self-blaming, substance use, denial). It was found from the table that most of the subscales and total Brief COPE were quite reliable with their reliability ranging from .75 to .41 whereas two subscales had less reliability (e.g. self-distraction .30 and use of instrumental support .12).

Table 5

Correlation between Occupational Stress and DASS's Anxiety Sub-scale Score

Variables	1	2
ENSS	-	.67**
Anxiety	-	-

Note. **p> .01, *p> .05

The table shows that there is a positive correlation between Occupational Stress and Anxiety among nurses at workplace (.67**) at significant level greater than .01.

Table 6

Inter-correlations among Scores on ENSS and its Sub-scales Scores (N=200)

	1	2	3	4	5	6	7	8	9	10
ENSS		.78**	.75**	.66**	.87**	.92**	.79**	.57**	.92**	.64**
Death and dying			.60**	.59**	.67**	.72**	.48**	.45**	.66**	.41**
Conflict with physician			-	.38**	.64**	.69**	.49**	.39**	.63**	.48**
Inadequate emotional preparation				-	.53**	.58**	.41**	.36**	.62**	.33**
Problems with co-workers					-	.76**	.61**	.50**	.82**	.55**
Patients and families						-	.65**	.49**	.85**	.56**
Uncertainty concerning treatment							-	.42**	.65**	.48**
Problems with supervisors								-	.55**	.30**
Workload									-	.56**
Discrimination										-

Note. **p> .01, *p> .05

The subscales of ENSS are significantly correlated with each-other at level greater than .01. The subscales are significantly positively correlated with each-other.

Table 7

Inter-correlations among scores on Brief COPE (N=200)

	2	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*
Self-distraction	.38**	.50**	-.18**	.44**	.16*	.31**	.38**	.44**	.49**	-.20**	.47**	.16**	.40**
Active coping		.39**	-.14*	.42**	.18**	.38**	.29**	.50**	.50**	-.12	.36**	.17*	.34**
Denial			-.16*	.46**	.13	.37**	.49**	.46**	.51**	-.18**	.36*	.14*	.35*
Substance use				-.08*	-.03	.01	-.17*	-.09	-.20**	.48**	-.03*	-.12	-.11
Emotional – support					.15*	.47**	.36**	.26**	.49**	-.22**	.52**	.12	.15*
Instrumental – support						.21**	.08	.30**	.10	-.02	.14*	.08	.18*
Behavioral engagement							.33**	.44**	.39**	.05**	.48**	.00**	.35**
Venting								.36**	.62**	-.19**	.37**	.17**	.43**
Positive-reframing									.32**	-.10	.31**	.29**	.41**
Planning										-.22**	.49**	.09**	.42**
Humor											-.07	.01	-.02
Acceptance												-.11	.29**
Religion													.15*
Self-blame													1

The subscales of Brief COPE are correlated at significant level greater than .01. The self-distraction subscale of coping strategies is negatively correlated with substance use (-.182*) and humor (-.209**), active coping is negatively correlated with substance use (-.141*) and humor (-.120), denial is negatively correlated with substance use (-.166*) and humor (-.184**), substance use is negatively correlated with emotional support (-.084*), instrumental support (-.031), venting (-.170*), positive reframing (-.090), planning (-.200**), acceptance (-.031*), religion (-.120) and self-blame (-.117), emotional support is negatively correlated with humor (-.224*), instrumental support is negatively correlated with humor (-.028), positive reframing is negatively correlated with humor (-.194**), planning is negatively correlated with humor (-.104).

Table 8

Regression for ENSS total and sub-scale scores with Anxiety Sub-scale of DASS

					95% confidence interval	
Variables	B	SE	β	*p*	*LL*	*UL*
Constant	.82	1.56	-	.59	3.92	2.26
Death and dying	.18	.08	.16	.04*	.00	.35
Conflicts with physician	.14	.09	.11	.11	-.03	.33
Inadequate emotional preparation	.18	.10	.11	.09	.03	.39
Problems with co-workers	.32	.08	.39	.00**	.16	.49
Patients and families	.05	.07	.08	.43	-.20	.08
Uncertainty concerning treatment	.04	.03	.07	.27	.03	.11
Problems with supervision	.08	.03	.13	.02*	.01	.16
Workloads	.04	.07	.08	.49	.18	.09
Discrimination	.16	.12	.08	.19	.08	.41
R^2	.51					
ΔR^2	.49					
F	22.32					

Linear regression analysis is computed with sub-scale scores of Extended Nursing Stress Scale (ENSS) as a predictor variable, and Anxiety sub-scale of Depression Anxiety Stress Scale (DASS) as an outcome variable. The ΔR^2value of 0.49 specifies that 49% of variance in the dependent variable can be considered for, by the predictor (F=22.32). The results also specify that ENSS sub-scales; death and dying (.04**), problems with co-workers(.00**) and problems with supervisor (.02**) have a significant positive effect on anxiety.

Table 9

t-test for Marital Status on ENSS, Brief COPE and Anxiety sub-scale of DASS

	Married N = 87		Unmarried N = 113				95% confidence interval		
Variables	*M*	*SD*	*M*	*SD*	*t*	*P*	*LL*	*UL*	Cohen' *d*
ENSS	186.44	11.41	179.10	23.48	2.68	.00	1.93	12.73	0.39
Brief COPE									
Self-distraction	6.91	.60	6.66	.88	2.21	.00	.02	.46	0.33
Active cope	6.99	.93	6.61	1.12	2.53	.04	.08	.67	0.36
Denial	6.80	.86	6.54	1.23	1.70	.00	-.04	.57	0.24
Substance use	3.47	1.70	3.08	1.64	1.64	.23	-.07	.86	0.23
Emotional support	6.53	.81	6.31	1.07	1.58	.13	-.05	.49	0.23
Instrumental support	6.63	.82	6.65	3.14	-.06	.18	-.70	.66	0.00
Behavioral disengagement	6.62	1.00	6.53	1.09	.59	.24	-.20	.38	0.08
Venting	6.87	.97	6.65	1.21	1.37	.03	-.09	.53	0.20
Positive reframing	6.52	.88	6.23	.99	2.12	.99	.02	.55	0.30

Planning	7.07	.83	6.75	1.23	2.05	.00	.01	.62	0.30
Humor	3.76	2.05	3.31	1.69	1.69	.01	-.07	.97	0.23
Acceptance	6.84	.96	6.67	1.14	1.09	.33	-.13	.46	0.16
Religion	6.91	.91	6.72	.97	1.41	.69	-.07	.45	0.20
Self-blame	6.93	.74	6.50	1.17	3.02	.00	.15	.71	0.43
Anxiety	17.07	1.62	16.39	2.95	1.93	.00	-.01	1.37	0.28

Table 6 shows the means and standard deviations for married and unmarried nurses on ENSS, Brief COPE and Anxiety sub-scale of DASS. As it is evident from the results that married nurses scored high on ENSS and Anxiety sub-scale as compared to unmarried nurses. Whereas married nurses have higher levels on the coping strategies of self-distraction, active cope, denial, venting, planning, humor and self-blame.

Table 10

t-test for Family System on ENSS, Anxiety Sub-scale of DASS and Brief COPE Inventory (N = 200)

Variables	Nuclear $n = 163$		Joint $n = 37$				95 % confidence interval		
	M	*SD*	*M*	*SD*	*T*	*P*	*LL*	*UL*	Cohen' *d*
ENSS	180.99	21.12	188.03	7.18	-1.99	.00	-13.98	-.09	0.44
Brief COPE									
Self-distraction	6.73	.802	6.95	.66	-1.52	.00	-.49	.06	0.29
Active cope	6.66	1.06	7.27	.90	-3.22	.29	-.97	-.23	0.62
Denial	6.56	1.15	7.05	.66	-2.48	.00	-.87	-.10	0.52
Substance use	3.28	1.71	3.14	1.49	.46	.24	-.46	.74	0.08
Emotional support	6.39	1.03	6.49	.65	-.56	.02	-.45	.25	0.11
Instrumental support	6.63	2.65	6.70	.77	-.16	.43	-.94	.80	0.03
Behavioral disengagement	6.57	1.11	6.57	.76	.01	.06	-.37	.38	0.95
Venting	6.71	1.15	6.95	.94	-1.18	.12	-.64	.16	0.22
Positive reframing	6.20	.91	7.05	.81	-5.24	.88	-1.18	-.53	0.98
Planning	6.87	1.13	7.00	.88	-.68	.23	-.52	.25	0.12

Humor	3.61	1.96	3.05	1.29	1.63	.00	-.11	1.22	0.33
Acceptance	6.75	1.11	6.70	.84	.26	.09	-.33	.43	0.05
Religion	6.72	.94	7.16	.92	-2.60	.67	-.78	-.10	0.47
Self-blame	6.65	1.04	6.84	.98	-1.00	.35	-.55	.18	0.18
Anxiety	2.64	1.54	16.58	17.14	-1.22	.04	-1.44	.33	0.25

Note. M= mean. *SD*= standard deviation. *p*= significance level

Table 7 shows the comparison between nuclear family system and joint family system on Extended Nursing Stress Scale, Anxiety sub-scale of Depression Anxiety Stress Scale and Brief COPE Inventory. Results reveal that differences are significant on all the variables. Nurses in joint family system are high on occupational stress and anxiety as compared to nuclear family system. The mean and standard deviation for family systems on ENSS, Brief COPE and DASS showed that the nurses from joint family system experienced more stress and anxiety as compared to nurses from nuclear family system.

Table 11

t-test for Hospitals on Brief COPE Inventory (N = 200)

Variables	Public $n = 104$		Private $n = 96$				95 % confidence interval		
	M	*SD*	*M*	*SD*	*t*	*P*	*LL*	*UL*	Cohen' *d*
Brief COPE									
Self-distraction	6.79	.78	6.75	.78	.34	.38	-.18	.25	0.05
Active cope	6.96	.95	6.57	1.13	2.63	.06	.09	.68	0.37
Denial	6.90	1.02	6.39	1.10	3.43	.20	.22	.81	0.48
Substance use	2.93	1.53	3.59	1.76	-2.83	.01	-1.12	-.20	0.40
Emotional support	6.58	.79	6.22	1.10	2.64	.06	.09	.62	0.37
Instrumental support	6.65	.89	6.64	3.37	.05	.22	-.65	.69	0.00
Behavioral disengagement	6.70	.99	6.43	1.10	1.85	.33	-.01	.56	0.25
Venting	6.85	1.00	6.65	1.23	1.26	..00	-.11	.51	0.17
Positive reframing	6.43	.89	6.27	1.02	1.19	.78	-.10	.42	0.16
Planning	7.02	1.00	6.75	1.16	1.75	.06	-.03	.57	0.24

Humor	3.16	1.66	3.88	2.00	-2.73	.02	-1.22	-.19	0.39
Acceptance	6.83	.99	6.66	1.15	1.12	.16	-.12	.46	0.15
Religion	6.85	.95	6.75	.95	.71	.37	-.17	.36	0.10
Self-blame	6.66	1.02	6.71	1.04	-.30	.63	-.33	.24	0.04

Table 8shows the comparison between public hospitals and private hospitals on Brief COPE Inventory. Results reveal that differences are significant on all the variables showing the means of coping strategies used by nurses working at public hospitals and private hospitals. Planning (7.02) is the most frequently used coping strategy by nurses working at public hospitals whereas self-distraction (6.75), planning (6.75) and religion are the most frequently used coping strategies by nurses at private hospitals.

Table 12

t-test for Hospitals on ENSS, Anxiety Sub-scale of DASS and Brief COPE Inventory (N = 200)

Variables	Public n=104		Private n=96				95% confidence interval		
	M	*SD*	*M*	*SD*	*t*	*p*	*LL*	*UL*	Cohen' *d*
ENSS	185.27	14.59	179.06	23.34	2.27	.00	.82	11.59	0.31
Brief COPE									
Self-distraction	6.79	7.84	6.75	7.81	.34	.38	-.18	.25	0.05
Active cope	6.96	.95	6.57	1.13	2.63	.68	.09	.68	0.37
Denial	6.90	1.02	6.39	1.10	3.43	.20	.22	.81	0.48
Substance use	2.93	1.53	3.59	1.76	-2.83	.01	-1.12	-.20	0.40
Emotional support	6.58	.79	6.22	1.10	2.61	.06	.09	.62	0.37
Instrumental support	6.65	.89	6.64	3.37	.05	.22	-.65	.69	0.00

Behavioral disengagement	6.70	.99	6.43	1.10	1.85	.33	-.01	.56	0.25
Venting	6.85	1.00	6.65	1.23	1.26	.00	-.11	.51	0.17
Positive reframing	6.43	.89	6.27	1.02	1.19	.78	-.10	.42	0.16
Planning	7.02	1.00	6.75	1.16	1.75	.06	-.03	.57	0.24
Humor	3.16	1.66	3.88	2.00	-2.73	.02	-1.22	-.19	0.39
Acceptance	6.83	.99	6.66	1.15	1.12	.16	-.12	.46	0.15
Religion	6.85	.95	6.75	.95	.71	.37	-.170	.36	0.10
Self-blame	6.66	1.02	6.71	1.04	-.30	.63	-.33	.24	0.04
Anxiety	17.10	2.28	16.24	2.61	2.46	.43	.17	1.54	0.35

Note. M= mean. *SD*= standard deviation. *p*= significance level.

Table 9 shows the comparison between public hospitals and private hospitals on Extended Nursing Stress Scale, Anxiety sub-scale of Depression Anxiety Stress Scale and Brief COPE Inventory. Results reveal that differences are significant on all the variables. Nurses in public hospitals are high on using coping strategies to cope up with occupational stress as compared to private hospitals.

Discussion

Chapter IV

DISCUSSION

The present study was conducted to identify the occupational stressors in the nursing profession and coping strategies used by young female nurses to deal with them. It also aimed at exploring the role of occupational stressors in determining anxiety in the respondents. It was also intended to compare the main study variables for nurses on demographics: marital status, hospital type (public/private) and family system (nuclear/joint).

The current study hypothesized that there would be a positive relationship between occupational stress and anxiety. The results found that occupational stress and anxiety in nurses are positively correlated (see table 2). McGrath (1976), found the similar results in his study on abnormal state of pressure leading to tension, anxiety and outrage. These mental states in work circumstances prompt bringing down of confidence. Beehr and Newman (1978) also found that hatred of supervision and inattentiveness leads to uneasiness and disappointment. Word related pressure from psychosocial workplace; inadequate occupational control, an absence of any reward, and low social help were essentially connected with workers anxiety. Similar findings were reported by Andrea et al., 2004; Gao et al., 2012. Our first hypothesis is accepted as the previous researches approved to our findings.

Predictive role of various occupational stressors in determining anxiety showed that the married nurses would score high on occupational stress than unmarried nurses (see table 6). Problems with co-workers, problems with supervision and death and dying are the significant predictors of occupational stress among nurses. The results revealed that there is a higher level of occupational stress in married nurses as compared to unmarried nurses. The previous research by Shiji (2016), on a sample of 300 married and unmarried nurses to measure the stress among them found that majority of the married nurses had moderate stress (75%) whereas few (24%) had mild stress as compared to unmarried. According to the outcomes, our hypothesis is accepted as the prior research approved to it.

Along with the identification of occupational stressors, anxiety was also measured in young female nurses and it was shown from the results that the nurses of public hospitals experienced more anxiety as compared to the nurses of private hospitals.

It was hypothesized that the married nurses would score higher on anxiety than unmarried nurses (see table 6). The results showed that there was an increase in anxiety among married nurses as compared to unmarried nurses. Cheung and Yip (2015), found similar results in their study on anxiety among married and unmarried nurses, using a sample of 1,128 nurses and stated that married respondents were 0.7 times more likely than singles to report anxiety symptoms. According to the findings, our hypothesis is accepted as it is approved and supported by previous researches.

Nurses of public and private hospitals respectively would differ in their levels of occupational stress (see table 9). The results showed that the nurses of public hospitals faced more occupational stress than nurses of private hospitals. Tyson and Pongruengphant (2004), found the similar results in their study on occupational stress among nurses of public and private hospitals on a sample of 1161 nurses and stated that nurses working in public hospitals generally reported more stress than private hospitals. According to the findings, our hypothesis is accepted as it is supported by prior research.

The current study hypothesized that the nurses working at private and public hospitals respectively would experience different levels of anxiety at workplace (see table 9). The results revealed that there is a greater amount of anxiety among nurses of public hospitals than nurses of private hospitals. Previous research by Kayalha, Yazdi, Rastak & Dizaniha (2013) on anxiety among public and private hospitals with a sample of 1807 nurses found that nurses working at public hospitals face more anxiety as compared to nurses of private hospitals.

The young nurses of this study identified uncertainty concerning treatment as the most stressful and workload as second most feature of their occupation (see table 10). This finding supported the results of several previous studied conducted (Gray-Toft & Anderson, 1981; Lambert, Lambert, & Misae, 2004). The findings of the current study suggest that nurses regardless of their culture and country have to go through similar

challenges with reference to uncertainty concerning treatment which they perceive most stressful than any other occupational stressors. Patients and families and death and dying respectively were third and fourth strongest occupational stressors in the current sample of Pakistani nurses. Inadequate emotional preparation appeared as least stressful closely preceded by discrimination. The remaining stressors obtained mid-range values. It was interesting to find that death and dying did not emerge as one of the strongest occupational stressors thus suggesting that nurses as thorough professionals were not extremely stressed by people dying around them and take it as an expected feature in their work setting.

The respondents of present study obtained highest mean score on coping strategy of planning thus identifying it as the most frequently used coping strategy used by them in response to occupational stress (see table 12). This finding was consistent with a study by Li and Lambert (2008). However it is important to mention here that the remaining coping strategies did not lag not lag far behind; the mean scores for other coping strategies ranged between 6.80 (religion) and 6.35 (positive reframing) whereas substance use (3.35) and humor (3.50) are the weakest coping strategies being used. These figures suggest that young nurses use a variety of coping strategies to deal with occupational stress. These coping strategies include desirable coping strategies (e.g. planning, positive reframing, and religion) and non-desirable coping strategies (e.g. self-blaming, substance use, denial).

Conclusion

The present study has added valuable content to the pool of available literature on occupational stressors, anxiety and coping strategies in the nursing profession. The present study provided a positive relationship between occupational stress and anxiety among nurses.

The study measured occupational stress and anxiety among nurses of public and private hospitals along-with their marital status (married and unmarried). The results showed high level of occupational stress and anxiety among married nurses as compared to unmarried nurses and there is high level of occupational stress and anxiety among

nurses of public hospitals as compared to nurses of private hospitals. The research also focused on occupational stress and anxiety among nurses living in nuclear and joint family system.it is evident from the results that nurses living in joint family system face more occupational stress and anxiety as compared to nurses living in nuclear family system.

The present study's respondents perceived uncertainty concerning treatment as most stressful and inadequate emotional preparation as least stressful among all the possible occupational stressors they have to deal with. The regression analysis showed the predictive role of various occupational stressors in determining anxiety among nurses and it showed problems with co-workers as the most significant predictor for anxiety.

The respondents identified the coping strategy of planning as the most frequently used coping strategies used by them in response to occupational stress with the remaining coping strategies not lagging far behind.

Limitations and Recommendations

The first limitation of the study is regarding its generalizability of the findings, because its sample only included nurses from Al-Shifa and Polycinic Hospital, Islamabad. In future studies including more hospitals from different cities could help to increase the generalizability of the findings.As more diverse sample can help in identifying different stress and anxiety causing factors in the nurses working in Pakistani scenario.

The age range for nurses was between 20 to 30 years, and therefore these findings could not be generalized to other age groups of nurses. As the main focus of study was on young nurses, so the results cannot be implicated on nurses from older age groups.

It is recommended that future studies relevant to this topic should include nurses with lesser and greater work experiences. This would help in identifying the stressors for nurses working for different time periods.

It is also recommended that future studies relevant to this topic should include nurses from different hospitals from different cities so that the findings could be

generalized. Different hospitals have different working conditions that give rise to different stressors that cause stress and anxiety and lessen the motivation of workers.

Implications

The present study has provided useful information for all those working in hospital settings e.g. nurses and their supervisors, doctors, hospital administrators and managers with reference to occupational stressors in the nursing profession, anxiety faced by them and coping strategies used by nurses. All those concerned can seek benefit from the current study's findings to identify and lessen the intensity of the occupational stressors in the nursing profession. Furthermore, all those concerned can help nurses to develop and maintain functional coping strategies and minimize dysfunctional ones.

The results of the study warrant an immediate investigation and intervention from hospital administrators. Improving social and working environment, promoting education, enhancing healthy lifestyles and providing counseling can leads to reduction in occupational stress and anxiety and enhance the morale and motivation of individuals.

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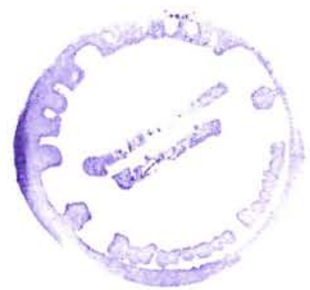

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Appendices

Appendix A

Informed Consent

I, Syeda Rashke Zahra, student of M.Sc at the National Institute of Psychology, Quaid-i-Azam University, Islamabad. I am conducting the research to see the relationship between occupational stress and anxiety among nurses serving in public and private sector hospitals and to find out which coping strategies are being used by nurses to deal with them.

I assure you that all the information given by you will be kept confidential and will only be used for the purpose of research.

Your participation in this research is voluntary, and you have right to quit while filling the questionnaire.

If you are agreeing to fill out the questionnaire, please provide your signature below.

____

Signature

Thank you for your participation in the research!

National Institute of Psychology

Quaid-i-Azam University, Islamabad.

Appendix B

Demographic Sheet

Name	Optional		
Age			
Education	MA/M.SC	BA/B.SC	FA/F.SC
Hospital	Public		Private
Marital Status	Married		Unmarried
Experience			
Family System	Nuclear		Joint
Socio-economic Status	Low	Middle	Upper

Appendix C

Extended Nursing Stress Scale

Instructions

Read each of the statements below carefully. For each statement, select the answer that fits you best.

Response Options:

1 = Never Stressful

2 = Occasionally Stressful

3 = Frequently Stressful

4 = Extremely Stressful

5 = Does not Apply

Sr	Statements	1	2	3	4	5
1	Performing procedures that patients experience as painful					
2	Feeling helpless in the case of a patient who fails to improve					
3	Listening or talking to a patient about his/her approaching death					
4	The death of the patient					
5	The death of a patient with whom you developed a close relationship					
6	Physicians not being present when a patient dies					
7	Watching a patient suffer					
8	Criticism by physician					
9	Conflict with physician					
10	Disagreement concerning the treatment of a patient					

11	Making a decision concerning a patient when physician is unavailable					
12	Having to organize doctor's work					
13	Feeling inadequately prepared to help with the emotional needs of a patient's family					
14	Being asked a question by a patient for which I do not have satisfactory answer					
15	Feeling inadequately prepared to help with the emotional needs of a patient					
16	Lack of opportunity to talk openly with other personnel about problems in the work setting					
17	Lack of opportunity to express to other personnel on the unit my negative feelings towards patients					
18	Difficulty in work setting with the particular nurse (or nurses) in my immediate work setting					
19	Difficulty in work setting with the particular nurse (or nurses) outside my immediate work setting					
20	Difficulty in working with nurses of the opposite sex					
21	Patients making unreasonable demands					
22	Having to deal with violent patients					
23	Patient's families making unreasonable demands					
24	Being blamed for anything that goes wrong					

25	Being the one that has to deal with the patients' families					
26	Having to deal with abusive patients					
27	Having to deal with abuse from patients' families					
28	Not knowing whether patients' families will report you for inadequate care					
29	Inadequate information from physician regarding the medical condition of a patient					
30	A physician ordering what appears to be inappropriate treatment for a patient					
31	Fear of making a mistake in treating a patient					
32	A physician not being present in a medical emergency					
33	Feeling inadequately trained for what I have to do					
34	Not knowing what a patient or a patient's family ought to be told about patient's condition and its treatment					
35	Being exposed to health and safety hazards					
36	Being in charge with inadequate experience					
37	Uncertainty regarding the operation and functioning of specialize equipment					
38	Conflict with a supervisor					
39	Lack of support of my immediate supervisor					

40	Criticism by supervisor					
41	Lack of support by nursing administration					
42	Being held accountable for things over which I have no control					
43	Lack of support from other health care administrators					
44	Criticism from nursing administration					
45	Unpredictable staffing and scheduling					
46	Not enough time to provide emotional support to the patient					
47	Not enough time to complete all of my nursing tasks					
48	Too many non-nursing tasks required, such as clerical work					
49	Not enough staff to adequately cover the unit					
50	Not enough time to respond to the needs of patients families					
51	Demands of patients classification system					
52	Having to work through breaks					
53	Having to make decisions under pressure					
54	Being sexually harassed					
55	Experiencing discrimination on the basis of sex					
56	Experiencing discrimination on the basis of race or ethnicity					
57	Problems with co-workers					

Appendix D

Brief Cope Inventory

Instructions

The items of the scale tell about different coping styles individual uses to cope up with daily challenges. Mark the statements according to your own self.

	I haven't been doing this at all 1	I've been doing this a little bit 2	I've been doing this a medium amount 3	I've been doing this a lot 4
I've been turning to work or other activities to take my mind off things				
I've been concentrating my efforts on doing something about the situation I'm in				
I've been saying to myself "this isn't real"				
I've been using alcohol or other drugs to make myself feel better				
I've been getting emotional support from others				
I've been giving up trying to deal with it				
I've been taking action to try to make this situation better				
I've been refusing to believe that it has happened				
I've been saying things to let my unpleasant feelings escape				
I've been getting help and advice from other people				
I've been using alcohol or other drugs to help me get through it				
I've been trying to see it in a different light, to make it seem more positive				
I've been criticizing myself				
I've been trying to come up with a strategy about what to do				
I've been getting comfort and understanding from someone				
I've been giving up the attempt to cope				
I've been looking for something good				

in what is happening				
I've been making jokes about it				
I've been doing something to think about it less				
I've been accepting the reality of the fact that it has happened				
I've been expressing my negative feelings				
I've been trying to find comfort in my religion or spiritual belief				
I've been trying to get advice or help from other people about what steps to take				
I've been thinking hard about what steps to take				
I've been blaming myself for things that happened				
I've been praying or meditating				
I've been making fun of the situation				
I've been learning to live with it				

Appendix E

Depression Anxiety Stress Scale

Instructions

Please read each statement and circle the number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week.

Rating is as followed:

0 = Never

1 = Sometimes

2 = Often

3 = Almost always

Statements	Never	Sometimes	Often	Almost always
I found it hard to wind down				
I was aware of dryness of my mouth				
I couldn't seem to experience any positive feeling at all				
I experienced breathing difficulty				
I found it difficult to work up the initiative to do things				
I tended to over-react to situations				
I experienced trembling				
I felt that I was using a lot of nervous energy				
I was worried about situations in which I might panic and make a fool of myself				
I felt that I had nothing to look forward to				
I found myself getting agitated				

I found it difficult to relax				
I felt down-hearted and blue				
I was intolerant of anything that kept me from getting on with what I was doing				
I felt I was close to panic				
I was unable to become enthusiastic about anything				
I felt I wasn't worth much as a person				
I felt that I was rather touchy				
I was aware of the action of my heart in the absence of physical exertion				
I felt scared without any good reason				
I felt that life was meaningless				