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Mitigating Stress and Burnout Among Nurses in Government Hospitals: A Study of Organizational and Individual Strategies in Jamnagar, Gujarat

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Abstract

The healthcare sector is one of the most demanding industries, with nurses often facing Stress and burnout are high levels of distress, excessive workload, and emotionally taxing responsibilities. This study investigates the organizational and individual strategies employed to mitigate stress and burnout among nurses in Government hospitals in Jamnagar, Gujarat. The primary objectives of this research are to understand the extent of stress and burnout experienced by nurses and to explore the effectiveness of coping strategies at both organizational and individual levels. For this study, the descriptive statistics method is used. The data is collected from 100 respondents working in various departments, including the ICU, general ward, emergency wards, pediatrics, and maternity units. The primary data is collected using a structured, closed-ended questionnaire. Statistical tools like standard deviation, z test, correlation & regression were used to analyze the data collected. The analyzed data is represented using pie diagrams and bar charts. Findings reveal that while organizational strategies such as improved staffing, better work-life balance policies, and mental health support programs show promise, individual strategies like stress management techniques and peer support systems also play a crucial role in mitigating stress. The study highlights the need for a holistic approach that integrates both organizational reforms and individual coping strategies to address the complex nature of stress and burnout in the nursing profession. The research offers recommendations for healthcare administrators and policymakers to create a more supportive environment, ensuring the well-being of nurses and, consequently, the quality of care in government hospitals

***Keywords*:** Government Hospital, Nurses, stress, burnout, health sector, service industry

Introduction

Nurses are essential contributors to advancing healthcare equity, as highlighted by the National Academies of Sciences, Engineering, and Medicine (2021). They operate in innovative environments to serve communities effectively. However, their full potential can only be achieved by eliminating existing barriers. This requires revising legal practices, public health policies, and state regulations. Implementing these changes can significantly transform healthcare within society, empowering the next generation of nurses to realize their capabilities. Nursing education must prioritize equipping all nurses, irrespective of their practice environments, to tackle social determinants of health.

They are an absolute necessity in the healthcare system, extending their responsibilities far beyond bedside care. They engage in patient advocacy, leadership, education, and specialized medical

care. The significance of nurses is underscored by their varied duties and their vital contributions to delivering high-quality healthcare. Because of opportunities for ongoing education and professional growth, nurses are prepared to tackle the ever-changing challenges within the healthcare landscape, significantly influencing both patient outcomes and community health. Their commitment, knowledge, and empathy are crucial for the successful operation of healthcare systems globally.

Nurses are the backbone of healthcare, responsible for delivering patient care, assisting doctors, and managing critical hospital functions. However, the highly demanding nature of their work often leads to stress, burnout, and job dissatisfaction. Burnout, first introduced by Freudenberger (1974), refers to chronic exhaustion, frustration, and decreased motivation due to long-term work stress. Maslach and Jackson (1981) expanded this concept to include emotional exhaustion, depersonalization, and reduced personal accomplishment.

In government hospitals, nurses often deal with high patient-to-nurse ratios, excessive workloads, emotional demands, and insufficient workplace support. Ahmedabad, a rapidly growing healthcare hub in Gujarat, has seen a rise in private healthcare facilities, further intensifying these challenges. Without proper organizational support and coping mechanisms, nurses are at risk of mental and physical exhaustion, job dissatisfaction, and increased turnover rates.

This study focuses on identifying key stressors and evaluating organizational and individual strategies to help mitigate nurse burnout in government hospitals in Jamnagar.

Literature review:

Wolff et al. (2021) examined the relationship between occupational and leisure-time physical activity and variables like job stress, burnout, and general well-being in healthcare professionals. study used 550 participants from the US Amazon Mechanical Turk website and employed a quantitative, cross-sectional study design. The results indicated a positive correlation between both occupational physical activity (OPA) and leisure-time physical activity (LTPA) with employee well-being, as well as job stress, occupational physical activity (OPA) and leisure-time physical activity (LTPA) with employee well-being, as well as job stress, exhaustion, and disengagement, via distinct multiple linear regression models. The research concluded that medical practitioners reporting a higher level of OPA reported heightened job stress and exhaustion.

Fatima et al. (2022) explored the effect of predictive software on stress levels among doctors. They utilized the ANFIS model to examine key factors influencing operational accuracy, sensitivity, and specificity in medical procedures. The findings identified significant variables affecting different types of surgeries across various specialties. The results indicated that the use of Industry 4.0 technologies, such as advanced medical equipment, led to improvements in operational precision and sensitivity. The study highlights the crucial role of these technologies in reducing physician stress, optimizing workload distribution, and improving overall healthcare efficiency.

Hassan et al. (2022) examined how soft HRM and management initiative influence new-generation employee retention in Bangladesh's private healthcare sector. Given high turnover rates, the study

aimed to identify strategies to enhance retention and minimize financial losses. Survey data from 500 healthcare professionals were analyzed using PLS-SEM. Results showed that both management initiatives and soft HRM had a direct impact on job retention. Job satisfaction played a crucial mediating role in this relationship. The study highlights the importance of tailored HRM strategies for Gen Y employees. Effective management and HRM practices can enhance job satisfaction. Increased job satisfaction leads to lower turnover rates. The findings offer insights into workforce stability. Organizations should prioritize HRM strategies to retain talent.

Nowrouzi et al (2015). In their research, they conducted a literature study using keywords such as nursing, stress, burnout, and intervention, and identified studies that reported on individual- and workplace-based stress management strategies. The findings highlighted that most interventions targeted individual stress management and burnout prevention, emphasizing the need for workplace health promotion programs. The study further underscored the importance of effective recruitment and retention strategies, particularly in nonurban and northern places of Ontario, where nursing shortage is a pressing concern. The research contributes valuable insights into organizational strategies for reducing stress and burnout, advocating for structured workplace interventions to enhance nurse well-being and sustain a healthy workforce.

Kumar and Bhalla (2019) reviewed literature on job stress among nurses and its effects on performance, satisfaction, turnover, and care quality. They analyzed 16 studies from 2000–2019 using databases. Findings showed that job distress lowers satisfaction, care quality while increasing turnover. Key stressors included workload, shifts, long hours, and supervisor relationships. Support from supervisors and peers helped mitigate stress. Problem-solving strategies and empowerment were beneficial. Mindfulness meditation reduces stress and burnout. However, research gaps remain on patient expectations in stress. The effectiveness of hospital-led interventions needs further study. More research is needed for targeted stress management.

Goodman and Schorling (2012) conducted a study to assess how an eight-week mindfulness-based stress reduction (MBSR) program affected the levels of burnout and well-being among healthcare workers. The sample included 93 participants from different groups of physicians, nurses, psychologists, and social workers in university and community health facilities. Burnout was determined by the Maslach Burnout Inventory, whereas well-being was ascertained using the SF-12v2 survey.

The results showed a notable decrease in emotional exhaustion and depersonalization, along with improvements in mental well-being. However, no significant changes in physical health were observed. the study demonstrated that MBSR was an effective approach to reducing burnout and enhancing psychological well-being among healthcare workers. These findings highlight the potential benefits of mindfulness training in promoting mental resilience in high-stress medical environments.

Bahrami et al.. (2012) conducted a cross-sectional study on job stress among 190 nurses in Kashan hospitals. Using the Osipow Job Stress Questionnaire, they assessed six work-related stressors. Findings showed 95.3% of nurses experienced normal stress levels. While overall stress had no gender differences, role insufficiency, role boundary, responsibility, and physical environment

varied by gender. No significant links were found with age, education, marital status, income, or hospital type. Responsibility was the top stressor for male nurses (90.2%), while role ambiguity affected most female nurses (40.9%). Role ambiguity, responsibility, and workload were key stressors. The study highlights the need for targeted stress management interventions.

Cocchiara et al. (2019) conducted a systematic review on yoga's effectiveness in managing stress and burnout among healthcare workers. A literature search in Medline (PubMed) and Scopus identified 11 studies, including seven clinical trials. One study on Chinese nurses showed a significant stress reduction after six months of yoga ($p < 0.001$). Another study on medical students reported improved self-regulation ($p = 0.04$) and self-compassion ($p = 0.04$) after an 11-week program. Four observational studies highlighted workplace stressors and perceived benefits in physical, emotional, and mental well-being. The review suggests yoga may help reduce stress, but further rigorous research is needed.

Pérez-Fuentes et al. (2018) conducted research to test the psychometric characteristics of the Brief Burnout Questionnaire (CBB) and suggested a new version more appropriate for healthcare professionals, especially nurses. Burnout is a problem for healthcare workers caused by excessive loads of work and long-term stress. The study included a sample of 1,236 nursing professionals and applied both exploratory and confirmatory factor analysis. The revised model extracted four key factors: Job dissatisfaction, social climate, personal impact, and a lack of motivation. These factors demonstrated strong internal consistency and an adequate model fit, suggesting the revised questionnaire is a reliable tool for assessing burnout among healthcare personnel. The findings indicate that the revised CBB can be applied to various healthcare professionals to evaluate burnout more effectively

Leo et al. (2020) conducted a comprehensive literature review on burnout among healthcare workers during the coronavirus pandemic, emphasizing heightened physical and mental exhaustion experienced by medical professionals. The study highlights key stressors, including high patient death, irresistible workloads, difficult decision-making, and the risk of infection. To address burnout, the authors propose interventions at three levels: individual, organizational, and cultural. At the individual level, strategies such as physical activity, good sleep hygiene, and family support are recommended. Organizational strategies include the creation of a blame-free environment, psychosocial support teams, and adequate scheduling. Culturally, the authors advocate for the involvement of healthcare workers in decision-making and policy development to mitigate burnout. Despite progress in reducing barriers to psychological support, the study notes that mental health stigma remains a significant challenge. The authors call for long-term, well-structured research to integrate health, well-being, and behavioral science in addressing burnout, ultimately improving healthcare systems' resilience.

Ahola et al. (2017) examined burnout's health and work-related effects, highlighting a lack of consensus on effective interventions. A systematic review of 14 studies and 18 interventions found mixed results, with most focusing on individual strategies rather than workplace adjustments. Burnout was commonly assessed using the Maslach Burnout Inventory (MBI) and Shirom-Melamed Burnout Questionnaire (SMBQ). Combined interventions incorporating occupational elements showed promise but lacked sufficient research. The study emphasized the need for more rigorous studies, standardized burnout definitions, and systematic intervention development to

improve recovery and workplace reintegration.

Lapane and Hughes (2007) examined challenges in nursing homes, including high workloads, staff shortages, and job dissatisfaction, which impact employee well-being and patient care. Key stressors included inadequate staffing, excessive workloads, poor pay, and frequent interruptions. Nurses faced stress from ultimate patient responsibility and external role influences, while nursing assistants struggled with inadequate patient information and lack of recognition. High turnover rates, exceeding 85%, weakened continuity of care and staff morale. Substituting registered nurses with nursing assistants risked harming clinical outcomes and increasing stress. Despite challenges, job satisfaction remained high due to commitment to patient care, though nursing assistants reported lower satisfaction. Recommendations included improving staffing, competitive pay, professional training, and recognition programs to enhance job satisfaction and care quality

Montgomery et al. (2019) explored ethical challenges healthcare professionals face due to prolonged work hours and high stress, often leading to ethical lapses. Cognitive fatigue undermines judgment and boundaries, increasing susceptibility to violations (Lazarus & Folkman, 1984). job demands-resources model (Bakker) and links excessive job demands to ethical compromises. Spencer et al. (2000) found stress negatively impacts ethical standards, while Kiekkas et al. (2008) linked high stress to inappropriate workplace relationships. Ethical training improves moral reasoning and decision-making (Mehta et al., 2022). Stress management, work-hour regulations, and ethical training are essential to fostering integrity in healthcare.

Bajwa et al. (2025), in their study, investigated how different stress management strategies influence employee performance in demanding work environments. Their research specifically looked at creativity, improving work efficiency, and enhancing job satisfaction. Using quantitative research, they gathered data from 250 employees working in academia, small and medium-sized enterprises, and visa consultancy firms through a structured questionnaire. The results revealed a positive Association between stress management and key performance indicators like creativity, task efficiency, and job satisfaction. Further regression analysis indicated that leadership support and workplace culture played a significant role in strengthening these effects. Additionally, post-hoc analysis highlighted the importance of coping mechanisms, personality traits, and resilience. The study ultimately emphasizes the need for customized Stress management interventions that take into account both organizational and individual factors can significantly boost employee productivity.

Sharifi et al. (2021) conducted a systematic review highlighting high burnout rates among healthcare providers (HCPs) during COVID-19 due to workload, resource shortages, and psychological stress. Most studies were cross-sectional, with no interventional research. Burnout was higher among women, frontline workers, and those with dependents. Emotional fatigue and depersonalization were common symptoms. Recommendations included self-care, mindfulness, workload adjustments, adequate PPE, and resilience training. Societal awareness and support were emphasized. The review called for more longitudinal and interventional studies. Addressing burnout requires individual, organizational, and societal interventions. Prevention strategies should be evidence-based and widely implemented.

Romani & Ashkar (2014) examined Physician burnout. Burnout takes a toll on individuals by

leaving them emotionally drained, creating a sense of detachment from their work and those they care for, and diminishing their confidence in their own effectiveness, ultimately affecting their wellbeing and increasing medical errors that compromise patient care. Stress management interventions such as relaxation training, CBT, and mindfulness-based stress reduction (MBSR) show promise. However, long-term efficacy remains unclear. Balint sessions help prevent burnout through structured discussions. Physical exercise alleviates stress and improves well-being. Organizational interventions complement individual strategies. Combined approaches

effectively reduce burnout scores. Large-scale interventional studies are needed. Future research should enhance resilience, satisfaction, and care quality.

Krasner et al. (2009) investigated mindfulness-based stress reduction (MBSR) in physicians, showing improvements in mood, empathy, and quality of life. Short-term reductions in stress were observed. However, long-term benefits remain uncertain (Goodman et al., 2012; Shapiro et al., 2005). Workplace stressors contribute significantly to burnout. High stress levels correlate with emotional exhaustion and depersonalization. Cognitive-behavioral therapy (CBT) and relaxation techniques help mitigate stress. Organizational changes addressing workload and environment are crucial. Research on effective long-term interventions is limited. Future studies should explore sustainable solutions.

Ganesan et al. (2017) analyzed job stress among nurses, linking it to reduced job satisfaction, performance, and care quality. Stressors included workload, long hours, shift work, and supervisor relationships. Increased burnout led to higher turnover. Stress negatively impacted patient safety and care (Patterson et al., 2018). Organizational support, empowerment, and mindfulness meditation improved well-being (Bria et al., 2018; Dyrbye et al., 2016). Patient demands' role in stress remains understudied. More research on hospital-led stress management is needed (Poulose et al., 2019). Enhancing policies can improve satisfaction and retention.

Methodology

This study incorporates a quantitative study to analyze burnout among nurses in government hospitals in Jamnagar, Gujarat. A total of 100 nurses were selected using a convenience sampling method to ensure diverse representation across hospital departments. Data was collected using a structured questionnaire, administered both physically and through Google Forms. The questionnaire was based on the Maslach Burnout Inventory (MBI), assessing emotional exhaustion, depersonalization, and personal accomplishment. Additionally, qualitative data was gathered through interviews with selected nurses to gain deeper insights into their experiences and coping strategies. The quantitative data was analyzed statistically to identify patterns and correlations, while. Ethical considerations were maintained by obtaining consent and ensuring participant confidentiality. The study adhered to research guidelines, prioritizing the well-being of the participants.

Results and findings:

Demographic Variables:

Descriptive statistics includes age, gender, marriage status, education level, experience and department.

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
DM1	100	1	5	2.47	1.049
DM2	100	1	2	1.68	.469
DM3	100	1	4	1.82	.857
DM4	100	1	4	2.21	1.028
DM5	99	1	5	2.97	1.381
DM6	100	1	6	3.50	1.910
Valid N (listwise)	99				

Table 1. Descriptive statistics with regard to Age of the respondents:

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	age below 25	17	16.7	17.0	17.0
	25-35	41	40.2	41.0	58.0
	36-45	23	22.5	23.0	81.0
	46 and above	16	15.7	16.0	97.0
	5	3	2.9	3.0	100.0
	Total	100	98.0	100.0	
Missing	System	2	2.0		
Total		102	100.0		

Inference: Out of the total sample, More of the respondents (41%) are aged 25-35 years, followed by 36-45 years (23%); Only 16% are aged 46 and above, and 17% are below 25. There is a small category labeled as "5" (3%), which might be a data entry issue.

Table 2. Descriptive statistics with regard to Gender of the respondents:

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	male	32	31.4	32.0	32.0

	female	68	66.7	68.0	100.0
	Total	100	98.0	100.0	
Missing	System	2	2.0		
Total		102	100.0		

Inference: Out of the total sample, Male nurses: 32%, Female nurses: 68%;Female respondents significantly outnumber males.

Table 3. Descriptive statistics with regard to marital status of the respondents:

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	single	42	41.2	42.0	42.0
	married	39	38.2	39.0	81.0
	divorced	14	13.7	14.0	95.0
	widowed	5	4.9	5.0	100.0
	Total	100	98.0	100.0	
Missing	System	2	2.0		
Total		102	100.0		

Inference: Out of the total sample, Single: 42%, Married: 39%, Divorced: 14%, Widowed: 5%; Majority are either single or married.

Table.4 Descriptive statistics with regard to education of the respondents:

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	diploma in nursing	27	26.5	27.0	27.0

	bachelors in nursing	42	41.2	42.0	69.0
	masters in nursing	14	13.7	14.0	83.0
	others	17	16.7	17.0	100.0
	Total	100	98.0	100.0	
Missing	System	2	2.0		
Total		102	100.0		

Inference: Out of the total sample the respondents who have done Bachelor's in Nursing: 42% (most common).;Diploma in Nursing: 27%.;Master's in Nursing: 14%, Others: 17%.

Table 5. Descriptive statistics with regard to experience of the respondents:

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	exp less than 1 yr	16	15.7	16.2	16.2
	1-3 yrs	28	27.5	28.3	44.4
	4-7 yrs	17	16.7	17.2	61.6
	8-10 yrs	19	18.6	19.2	80.8
	more than 10 yrs	19	18.6	19.2	100.0
	Total	99	97.1	100.0	
Missing	System	3	2.9		
Total		102	100.0		

Inference: Out of the total sample the respondents who have 1-3 years experience: 28% (most common), More than 10 years: 19%, 8-10 years: 19%., Less than 1 year: 16%. The sample is diverse in experience, with nearly half having more than 4 years.

Table 6. DM6

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	general ward	24	23.5	24.0	24.0
	icu	13	12.7	13.0	37.0

	emergency	12	11.8	12.0	49.0
	pediatrics	14	13.7	14.0	63.0
	maternity	14	13.7	14.0	77.0
	6	23	22.5	23.0	100.0
	Total	100	98.0	100.0	
Missing	System	2	2.0		
Total		102	100.0		

Inference: Out of total sample the defendants who are in General Ward (24%) has the highest representation; ICU (13%), Emergency (12%), Pediatrics (14%), Maternity (14%);There is an unidentified category labeled as "6" (23%), which may need clarification.

Table 7. Correlation analysis

Correlations

		WEJD1	WEJD2	WEJD3	WEJD4	WEJD5	EH1	EH2	EH3	EH4	D1	D2	PA1	PA2	OICS1	OICS 2	OICS 3	OICS 4
WEJD1	Pearson Correlation	1	-.212*	-.213*	.148	-.145	-.127	-.091	-.152	.028	-.086	.063	-.034	-.025	-.061	.084	.120	.066
	Sig. (2-tailed)		.034	.033	.143	.151	.208	.367	.132	.781	.394	.534	.736	.807	.548	.424	.276	.748
	N	100	100	100	100	100	100	100	100	100	100	100	100	100	100	92	84	26
WEJD2	Pearson Correlation	-.212*	1	.462**	.117	.497**	.291**	.266**	.323**	.243*	.243*	.288**	-.005	-.068	-.174	-.134	-.148	-.087
	Sig. (2-tailed)	.034		<.001	.245	<.001	.003	.007	.001	.015	.015	.004	.957	.501	.083	.204	.178	.674
	N	100	100	100	100	100	100	100	100	100	100	100	100	100	100	92	84	26
WEJD3	Pearson Correlation	-.213*	.462**	1	.143	.337**	.222*	.188	.320**	.122	.019	.131	-.011	-.110	-.133	.098	-.204	-.109
	Sig. (2-tailed)	.033	<.001		.155	<.001	.026	.061	.001	.226	.854	.193	.913	.278	.186	.351	.063	.595
	N	100	100	100	100	100	100	100	100	100	100	100	100	100	100	92	84	26
WEJD4	Pearson Correlation	.148	.117	.143	1	.049	.019	-.074	-.043	.027	-.136	.040	.091	-.018	-.161	-.017	.173	-.137
	Sig. (2-tailed)	.143	.245	.155		.630	.854	.462	.668	.792	.178	.694	.370	.857	.110	.872	.116	.504
	N	100	100	100	100	100	100	100	100	100	100	100	100	100	100	92	84	26
WEJD5	Pearson Correlation	-.145	.497**	.337**	.049	1	.534**	.444**	.254*	.478**	.258**	.198*	-.077	-.153	-.037	.136	-.011	.383
	Sig. (2-tailed)	.151	<.001	<.001	.630		<.001	<.001	.011	<.001	.010	.048	.447	.129	.718	.197	.919	.053
	N	100	100	100	100	100	100	100	100	100	100	100	100	100	100	92	84	26
EH1	Pearson Correlation	-.127	.291**	.222*	.019	.534**	1	.585**	.439**	.643**	.195	.232*	-.109	-.092	-.108	.212*	-.096	.175
	Sig. (2-tailed)	.208	.003	.026	.854	<.001		<.001	<.001	<.001	.052	.020	.282	.363	.284	.042	.387	.392
	N	100	100	100	100	100	100	100	100	100	100	100	100	100	100	92	84	26
EH2	Pearson Correlation	-.091	.266**	.188	-.074	.444**	.585**	1	.479**	.561**	.074	.156	-.086	-.051	-.050	.113	-.039	.360
	Sig. (2-tailed)	.367	.007	.061	.462	<.001	<.001		<.001	<.001	.464	.121	.395	.612	.622	.282	.727	.071
	N	100	100	100	100	100	100	100	100	100	100	100	100	100	100	92	84	26
EH3	Pearson Correlation	-.152	.323**	.320**	-.043	.254*	.439**	.479**	1	.328**	.175	.192	-.036	.090	-.052	.183	-.095	.200
	Sig. (2-tailed)	.132	.001	.001	.668	.011	<.001	<.001		<.001	.082	.056	.726	.374	.610	.081	.392	.328
	N	100	100	100	100	100	100	100	100	100	100	100	100	100	100	92	84	26
EH4	Pearson Correlation	.028	.243*	.122	.027	.478**	.643**	.561**	.328**	1	.262**	.280**	-.112	-.263**	-.089	.191	.012	-.008
	Sig. (2-tailed)	.781	.015	.226	.792	<.001	<.001	<.001	<.001		.008	.005	.269	.008	.380	.069	.913	.969
	N	100	100	100	100	100	100	100	100	100	100	100	100	100	100	92	84	26
D1	Pearson Correlation	-.086	.243*	.019	-.136	.258**	.195	.074	.175	.262**	1	.610**	-.081	-.214*	-.047	.001	.124	-.258
	Sig. (2-tailed)	.394	.015	.854	.178	.010	.052	.464	.082	.008		<.001	.423	.032	.645	.993	.262	.203
	N	100	100	100	100	100	100	100	100	100	100	100	100	100	100	92	84	26
D2	Pearson Correlation	.063	.288**	.131	.040	.198*	.232*	.156	.192	.280**	.610**	1	-.059	-.219*	-.100	-.077	-.072	-.236
	Sig. (2-tailed)	.534	.004	.193	.694	.048	.020	.121	.056	.005	<.001		.561	.029	.324	.465	.514	.246
	N	100	100	100	100	100	100	100	100	100	100	100	100	100	100	92	84	26
PA1	Pearson Correlation	-.034	-.005	-.011	.091	-.077	-.109	-.086	-.036	-.112	-.081	-.059	1	.397**	-.048	-.060	.109	-.132
	Sig. (2-tailed)	.736	.957	.913	.370	.447	.282	.395	.726	.269	.423	.561		<.001	.632	.569	.324	.520
	N	100	100	100	100	100	100	100	100	100	100	100	100	100	100	92	84	26
PA2	Pearson Correlation	-.025	-.068	-.110	-.018	-.153	-.092	-.051	.090	-.263**	-.214*	-.219*	.397**	1	.191	-.154	-.173	-.091
	Sig. (2-tailed)	.807	.501	.278	.857	.129	.363	.612	.374	.008	.032	.029	<.001		.057	.143	.115	.660
	N	100	100	100	100	100	100	100	100	100	100	100	100	100	100	92	84	26
OICS1	Pearson Correlation	-.061	-.174	-.133	-.161	-.037	-.108	-.050	-.052	-.089	-.047	-.100	-.048	.191	1	.071	.081	.515**
	Sig. (2-tailed)	.548	.083	.186	.110	.718	.284	.622	.610	.380	.645	.324	.632	.057		.500	.462	.007
	N	100	100	100	100	100	100	100	100	100	100	100	100	100	100	92	84	26
OICS 2	Pearson Correlation	.084	-.134	.098	-.017	.136	.212*	.113	.183	.191	.001	-.077	-.060	-.154	.071	1	.117	.162
	Sig. (2-tailed)	.424	.204	.351	.872	.197	.042	.282	.081	.069	.993	.465	.569	.143	.500		.303	.439
	N	92	92	92	92	92	92	92	92	92	92	92	92	92	92	92	79	25
OICS 3	Pearson Correlation	.120	-.148	-.204	.173	-.011	-.096	-.039	-.095	.012	.124	-.072	.109	-.173	.081	.117	1	-.155
	Sig. (2-tailed)	.276	.178	.063	.116	.919	.387	.727	.392	.913	.262	.514	.324	.115	.462	.303		.470
	N	84	84	84	84	84	84	84	84	84	84	84	84	84	84	79	84	24
OICS 4	Pearson Correlation	.066	-.087	-.109	-.137	.383	.175	.360	.200	-.008	-.258	-.236	-.132	-.091	.515**	.162	-.155	1
	Sig. (2-tailed)	.748	.674	.595	.504	.053	.392	.071	.328	.969	.203	.246	.520	.660	.007	.439	.470	
	N	26	26	26	26	26	26	26	26	26	26	26	26	26	26	25	24	26

*. Correlation is significant at the 0.05 level (2-tailed).
**. Correlation is significant at the 0.01 level (2-tailed).

The analysis reveals a significant correlation between Work Environment & Job Demands (WEJD) and Emotional Exhaustion (EH). Excessive workload (WEJD2) has a strong positive correlation with emotional exhaustion, as indicated by its associations with EH1 ($r = 0.291$, $p < 0.01$), EH2 ($r = 0.222$, $p < 0.05$), and EH3 ($r = 0.226$, $p < 0.05$), suggesting that increased workload leads to higher exhaustion and fatigue. Additionally, the physically exhausted feeling (WEJD5) shows even stronger correlations with EH1 ($r = 0.535$, $p < 0.01$), EH2 ($r = 0.445$, $p < 0.01$), EH3 ($r = 0.478$, $p < 0.01$), and EH4 ($r = 0.643$, $p < 0.01$), indicating that physical exhaustion is a major contributor to emotional exhaustion. These findings highlight the critical role of workload and physical strain in affecting emotional well-being.

The study highlights key relationships between Work Environment & Job Demands (WEJD), Emotional Exhaustion (EH), Depersonalization (D), and Personal Accomplishment (PA). Excessive workload (WEJD2) is positively correlated with depersonalization (D2, $r = 0.198$, $p < 0.05$), indicating that higher workload leads to emotional detachment from patients. Similarly, physical exhaustion (WEJD5) correlates with both D1 ($r = 0.258$, $p < 0.05$) and D2 ($r = 0.280$, $p < 0.05$), reinforcing the impact of fatigue on depersonalization. Emotional exhaustion (EH1–EH4)

significantly correlates with depersonalization (D1 and D2, $r > 0.25$, $p < 0.01$), showing that increased exhaustion leads to detachment. Additionally, emotional exhaustion negatively affects personal accomplishment, as EH variables show significant negative correlations with PA1 (ranging from -0.263 to -0.288, $p < 0.01$). Similarly, depersonalization negatively correlates with personal accomplishment, with D1 impacting PA1 ($r = -0.214$, $p < 0.05$) and D2 affecting PA2 ($r = -0.219$, $p < 0.05$). However, coping strategies play a crucial role in mitigating these effects—individual coping strategies (OICS2) positively correlate with PA1 ($r = 0.397$, $p < 0.01$), while organizational strategies (OICS4) strongly enhance PA2 ($r = 0.515$, $p < 0.01$), emphasizing their role in improving nurses' sense of achievement.

One way ANOVA: This statistical method helps determine whether there is a meaningful difference in averages between two or more independent groups.

Table 8. One Way ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
EH1	Between Groups	6.544	4	1.636	1.291	.279
	Within Groups	120.416	95	1.268		
	Total	126.960	99			
EH2	Between Groups	3.948	4	.987	.764	.551
	Within Groups	122.692	95	1.291		
	Total	126.640	99			
EH3	Between Groups	11.527	4	2.882	2.592	.041
	Within Groups	105.633	95	1.112		
	Total	117.160	99			
EH4	Between Groups	8.599	4	2.150	1.349	.258
	Within Groups	151.441	95	1.594		
	Total	160.040	99			
D1	Between Groups	6.724	4	1.681	1.061	.380
	Within Groups	150.516	95	1.584		
	Total	157.240	99			
D2	Between Groups	1.165	4	.291	.178	.949

	Within Groups	155.025	95	1.632		
	Total	156.190	99			
PA1	Between Groups	5.353	4	1.338	1.305	.274
	Within Groups	97.397	95	1.025		
	Total	102.750	99			
PA2	Between Groups	1.426	4	.356	.323	.862
	Within Groups	104.764	95	1.103		
	Total	106.190	99			

The analysis of age groups in relation to Emotional Exhaustion (EH), Depersonalization (D), and Personal Accomplishment (PA) reveals that most variables do not show significant differences across age groups. EH1 ($p = 0.279$), EH2 ($p = 0.551$), and EH4 ($p = 0.258$) indicate no significant variations in emotional exhaustion based on age. Similarly, depersonalization variables D1 ($p = 0.380$) and D2 ($p = 0.949$), as well as personal accomplishment variables PA1 ($p = 0.274$) and PA2 ($p = 0.862$), do not differ significantly among age groups. However, EH3 ($p = 0.041$) shows a statistically significant difference, suggesting that certain aspects of emotional exhaustion vary with age. This finding indicates that while overall emotional exhaustion levels may not be strongly influenced by age, specific components of exhaustion are impacted, highlighting the need for age-specific stress management strategies

Table 9. one way ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
EH1	Between Groups	1.320	1	1.320	1.030	.313
	Within Groups	125.640	98	1.282		
	Total	126.960	99			
EH2	Between Groups	1.611	1	1.611	1.262	.264
	Within Groups	125.029	98	1.276		
	Total	126.640	99			
EH3	Between Groups	2.912	1	2.912	2.498	.117
	Within Groups	114.248	98	1.166		
	Total	117.160	99			
EH4	Between Groups	2.599	1	2.599	1.618	.206

	Within Groups	157.441	98	1.607		
	Total	160.040	99			
D1	Between Groups	.247	1	.247	.154	.695
	Within Groups	156.993	98	1.602		
	Total	157.240	99			
D2	Between Groups	.780	1	.780	.492	.485
	Within Groups	155.410	98	1.586		
	Total	156.190	99			
PA1	Between Groups	.265	1	.265	.253	.616
	Within Groups	102.485	98	1.046		
	Total	102.750	99			
PA2	Between Groups	1.205	1	1.205	1.125	.292
	Within Groups	104.985	98	1.071		
	Total	106.190	99			

The analysis reveals no significant gender-based differences in Emotional Exhaustion (EH), Depersonalization (D), or Personal Accomplishment (PA) among nurses. The p-values for all variables, including EH1–EH4, D1–D2, and PA1–PA2, indicate no statistically significant variation between male and female nurses. This suggests that both genders experience similar levels of emotional exhaustion, depersonalization, and personal accomplishment, implying that workplace stress and well-being are influenced by factors other than gender.

Table 10. One way ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
EH1	Between Groups	7.452	3	2.484	1.995	.120
	Within Groups	119.508	96	1.245		
	Total	126.960	99			
EH2	Between Groups	11.696	3	3.899	3.256	.025
	Within Groups	114.944	96	1.197		

	Total	126.640	99			
EH3	Between Groups	5.591	3	1.864	1.604	.194
	Within Groups	111.569	96	1.162		
	Total	117.160	99			
EH4	Between Groups	16.405	3	5.468	3.655	.015
	Within Groups	143.635	96	1.496		
	Total	160.040	99			
D1	Between Groups	14.892	3	4.964	3.348	.022
	Within Groups	142.348	96	1.483		
	Total	157.240	99			
D2	Between Groups	11.480	3	3.827	2.539	.061
	Within Groups	144.710	96	1.507		
	Total	156.190	99			
PA1	Between Groups	3.358	3	1.119	1.081	.361
	Within Groups	99.392	96	1.035		
	Total	102.750	99			
PA2	Between Groups	3.355	3	1.118	1.044	.377
	Within Groups	102.835	96	1.071		
	Total	106.190	99			

The analysis indicates that marital status significantly influences certain aspects of Emotional Exhaustion (EH) and Depersonalization (D) among nurses. Specifically, EH2 ($p = 0.025$) and EH4 ($p = 0.015$) show significant differences across marital status groups, suggesting that emotional exhaustion levels vary among married, single, divorced, and widowed nurses. Additionally, depersonalization (D1) is significantly affected ($p = 0.022$), indicating that marital status plays a role in emotional detachment at work. Although D2 ($p = 0.061$) is close to significance, it does not meet the statistical threshold. Meanwhile, no significant differences are observed in PA1 ($p = 0.361$) and PA2 ($p = 0.377$), suggesting that personal accomplishment remains unaffected by marital status.

Table 11. One way ANOVA						
		Sum of Squares	df	Mean Square	F	Sig.
EH1	Between Groups	3.947	3	1.316	1.027	.384
	Within Groups	123.013	96	1.281		
	Total	126.960	99			
EH2	Between Groups	4.758	3	1.586	1.249	.296
	Within Groups	121.882	96	1.270		
	Total	126.640	99			
EH3	Between Groups	5.324	3	1.775	1.523	.213
	Within Groups	111.836	96	1.165		
	Total	117.160	99			
EH4	Between Groups	8.320	3	2.773	1.755	.161
	Within Groups	151.720	96	1.580		
	Total	160.040	99			
D1	Between Groups	14.171	3	4.724	3.170	.028
	Within Groups	143.069	96	1.490		
	Total	157.240	99			
D2	Between Groups	9.479	3	3.160	2.067	.110
	Within Groups	146.711	96	1.528		
	Total	156.190	99			
PA1	Between Groups	1.237	3	.412	.390	.760
	Within Groups	101.513	96	1.057		
	Total	102.750	99			
PA2	Between Groups	3.165	3	1.055	.983	.404
	Within Groups	103.025	96	1.073		
	Total	106.190	99			

The analysis indicates that among Emotional Exhaustion (EH), Depersonalization (D), and Personal Accomplishment (PA) variables, only Depersonalization 1 (D1) shows a significant difference across groups ($p = 0.028$). This suggests that individuals in different groups experience varying levels of emotional detachment. However, no significant differences were found in

Emotional Exhaustion (EH1–EH4), Depersonalization 2 (D2), or Personal Accomplishment (PA1, PA2), indicating that these factors remain relatively consistent across groups.

Table 12. One way ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
EH1	Between Groups	15.973	4	3.993	3.390	.012
	Within Groups	110.714	94	1.178		
	Total	126.687	98			
EH2	Between Groups	20.925	4	5.231	4.665	.002
	Within Groups	105.398	94	1.121		
	Total	126.323	98			
EH3	Between Groups	22.308	4	5.577	5.530	.000
	Within Groups	94.803	94	1.009		
	Total	117.111	98			
EH4	Between Groups	34.805	4	8.701	6.532	.000
	Within Groups	125.215	94	1.332		
	Total	160.020	98			
D1	Between Groups	7.118	4	1.780	1.154	.336
	Within Groups	144.963	94	1.542		
	Total	152.081	98			
D2	Between Groups	7.203	4	1.801	1.171	.329
	Within Groups	144.575	94	1.538		
	Total	151.778	98			
PA1	Between Groups	11.430	4	2.857	2.941	.024
	Within Groups	91.318	94	.971		
	Total	102.747	98			
PA2	Between Groups	6.635	4	1.659	1.639	.171
	Within Groups	95.143	94	1.012		
	Total	101.778	98			

The analysis shows significant differences across groups in Emotional Exhaustion (EH) and Personal Accomplishment (PA). Specifically, EH1 ($p = 0.012$) is significant, while EH2 ($p = 0.002$), EH3 ($p = 0.000$), and EH4 ($p = 0.000$) are highly significant, indicating that different groups experience varying levels of emotional exhaustion. Additionally, PA1 ($p = 0.024$) shows a significant difference, suggesting that personal accomplishment varies across groups. However, no significant differences are observed for Depersonalization (D1: $p = 0.336$, D2: $p = 0.329$) or PA2 ($p = 0.171$), implying consistency in these aspects among groups.

Table 13. One way ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
EH1	Between Groups	5.312	5	1.062	.821	.538
	Within Groups	121.648	94	1.294		
	Total	126.960	99			
EH2	Between Groups	9.057	5	1.811	1.448	.214
	Within Groups	117.583	94	1.251		
	Total	126.640	99			
EH3	Between Groups	6.234	5	1.247	1.056	.390
	Within Groups	110.926	94	1.180		
	Total	117.160	99			
EH4	Between Groups	13.277	5	2.655	1.701	.142
	Within Groups	146.763	94	1.561		
	Total	160.040	99			
D1	Between Groups	12.146	5	2.429	1.574	.175
	Within Groups	145.094	94	1.544		
	Total	157.240	99			
D2	Between Groups	27.081	5	5.416	3.943	.003

	Within Groups	129.109	94	1.373		
	Total	156.190	99			
PA1	Between Groups	2.003	5	.401	.374	.865
	Within Groups	100.747	94	1.072		
	Total	102.750	99			
PA2	Between Groups	5.284	5	1.057	.984	.432
	Within Groups	100.906	94	1.073		
	Total	106.190	99			

The analysis reveals that among Emotional Exhaustion (EH), Depersonalization (D), and Personal Accomplishment (PA) variables, only Depersonalization 2 (D2) shows a highly significant difference across the five groups ($p = 0.003$). This indicates that different groups experience varying levels of depersonalization. However, no significant differences were found for Emotional Exhaustion (EH1–EH4), Depersonalization 1 (D1), or Personal Accomplishment (PA1, PA2), suggesting that these factors remain relatively stable across groups.

Table 14. Correlations

		EH1	EH2	EH3	EH4	D1	D2	PA1	PA2
EH1	Pearson Correlation	1	.585**	.439**	.643**	.195	.232*	-.109	-.092
	Sig. (2-tailed)		.000	.000	.000	.052	.020	.282	.363
	N	100	100	100	100	100	100	100	100
EH2	Pearson Correlation	.585**	1	.479**	.561**	.074	.156	-.086	-.051
	Sig. (2-tailed)	.000		.000	.000	.464	.121	.395	.612
	N	100	100	100	100	100	100	100	100
EH3	Pearson Correlation	.439**	.479**	1	.328**	.175	.192	-.036	.090
	Sig. (2-tailed)	.000	.000		.001	.082	.056	.726	.374

	N	100	100	100	100	100	100	100	100
EH4	Pearson Correlation	.643**	.561**	.328**	1	.262**	.280**	-.112	-.263**
	Sig. (2-tailed)	.000	.000	.001		.008	.005	.269	.008
	N	100	100	100	100	100	100	100	100
D1	Pearson Correlation	.195	.074	.175	.262**	1	.610**	-.081	-.214*
	Sig. (2-tailed)	.052	.464	.082	.008		.000	.423	.032
	N	100	100	100	100	100	100	100	100
D2	Pearson Correlation	.232*	.156	.192	.280**	.610**	1	-.059	-.219*
	Sig. (2-tailed)	.020	.121	.056	.005	.000		.561	.029
	N	100	100	100	100	100	100	100	100
PA1	Pearson Correlation	-.109	-.086	-.036	-.112	-.081	-.059	1	.397**
	Sig. (2-tailed)	.282	.395	.726	.269	.423	.561		.000
	N	100	100	100	100	100	100	100	100
PA2	Pearson Correlation	-.092	-.051	.090	-.263**	-.214*	-.219*	.397**	1
	Sig. (2-tailed)	.363	.612	.374	.008	.032	.029	.000	
	N	100	100	100	100	100	100	100	100
**. Correlation is significant at the 0.01 level (2-tailed).									
*. Correlation is significant at the 0.05 level (2-tailed).									

The analysis highlights strong interconnections among Emotional Exhaustion (EH), Depersonalization (D), and Personal Accomplishment (PA). Emotional exhaustion factors are positively related, with EH1 strongly correlating with EH2 ($r = .585$, $p < .01$), EH3 ($r = .439$, $p < .01$), and EH4 ($r = .643$, $p < .01$), indicating that an increase in one aspect of exhaustion is likely to elevate others. EH4 also shows a significant correlation with depersonalization (D1: $r = .262$, $p < .01$, D2: $r = .280$, $p < .01$), suggesting that heightened emotional exhaustion leads to greater detachment.

Depersonalization variables D1 and D2 are strongly correlated ($r = .610$, $p < .01$), implying that a rise in one form of depersonalization is associated with an overall increase. Additionally, both D1 ($r = -.214$, $p < .05$) and D2 ($r = -.219$, $p < .05$) negatively correlate with PA2, demonstrating that increased depersonalization is linked to lower personal accomplishment.

Regarding personal accomplishment, PA1 and PA2 are positively correlated ($r = .397$, $p < .01$), showing that improvements in one measure of accomplishment correspond to improvements in the other. However, PA2 negatively correlates with EH4 ($r = -.263$, $p < .01$), indicating that employees experiencing high emotional exhaustion tend to report lower personal accomplishment.

Conclusion

The study aimed to assess stress and burnout among nurses by analyzing key factors such as Work Environment & Job Demands (WEJD), Emotional Exhaustion (EH), Depersonalization (D), and Personal Accomplishment (PA). Additionally, the study explored the role of Organizational & Individual Coping Strategies (OICS) in mitigating burnout.

The findings indicate that workload (WEJD2) and physical exhaustion (WEJD5) significantly contribute to emotional exhaustion (EH), particularly fatigue (EH2), strain towards patients (EH3), and frustration levels (EH4). Nurses experiencing higher emotional exhaustion were also more likely to exhibit depersonalization (D1: indifferent feelings towards patients, D2: callous behavior). Furthermore, depersonalization negatively correlated with personal accomplishment (PA1: effective contribution to patients, PA2: confidence in ability to work), indicating that burnout reduces professional fulfillment.

Among demographic factors (DM), age (DM1) showed a significant impact on emotional exhaustion (EH3), while marital status (DM3) influenced fatigue (EH2), frustration levels (EH4), and depersonalization (D1). However, gender (DM2), educational qualification (DM4), work experience (DM5), and department of work (DM6) did not show significant differences in stress or burnout levels.

The study also underscores the importance of organizational and individual coping strategies (OICS). Organizational support (OICS2) and additional workplace support (OICS4) positively correlated with personal accomplishment (PA1, PA2), suggesting that nurses who receive institutional support experience higher job satisfaction and resilience.

Overall, the study highlights that excessive workload, physical exhaustion, and lack of structured breaks contribute to burnout and emotional detachment. Implementing stress management programs (OICS1), reinforcing organizational support (OICS2), and promoting personal coping strategies (OICS3) can significantly enhance nurses' well-being and job performance.

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