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Workplace Stressors and Coping Strategies Among Nurses Working in Public Tertiary Hospitals of Sindh

Original Research

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Abstract

Background:
Workplace stress is a critical challenge within the nursing profession, particularly in resource-limited public healthcare systems where nurses face heavy workloads, emotional strain, and organizational constraints. Despite its prevalence, limited research has explored how nurses in Pakistan experience and cope with these stressors. A qualitative approach is essential to understand the depth and complexity of their lived experiences within their socio-cultural and institutional contexts.

Objective:
This study aimed to explore the workplace stressors and coping strategies among nurses working in public tertiary hospitals of Sindh, Pakistan, through a phenomenological lens.

Methods:
A qualitative phenomenological design was employed. Twenty registered nurses were recruited using purposive sampling from various departments of public tertiary hospitals. Data were collected through in-depth, semi-structured interviews and analyzed thematically using Braun and Clarke's six-step framework. Reflexivity, member checking, and peer debriefing were employed to enhance credibility and trustworthiness.

Results:
Findings revealed multifaceted stressors encompassing heavy workloads, insufficient staffing, lack of managerial support, emotional exhaustion, and moral distress arising from resource limitations. Nurses coped primarily through peer support, personal resilience, spirituality, and self-reflection, though these strategies were often constrained by systemic barriers. Ethical and emotional distress emerged as unexpected yet significant dimensions of workplace stress.

Conclusion:
The study highlights that occupational stress among nurses in Sindh's public hospitals is a systemic issue demanding institutional and policy-level interventions. Strengthening supportive supervision, improving staffing ratios, and providing structured psychosocial support can enhance nurse well-being and healthcare quality. Future research should focus on evaluating intervention models for nurse wellness and retention.

Keywords:
Qualitative Research, Phenomenology, Workplace Stress, Coping Strategies, Nurses, Public Hospitals.

INTRODUCTION:

Work as a nurse in public tertiary hospitals presents a complex range of stressors that significantly affect both caregiver well-being and the quality of patient care. Globally, nursing is recognized as one of the most stressful professions due to long working hours, high workloads, emotional labor, and inadequate institutional support (1). Prolonged exposure to such conditions often leads to burnout, absenteeism, reduced job satisfaction, and impaired professional performance (2). Evidence indicates that stress among nurses not only diminishes personal well-being but also compromises patient safety and healthcare outcomes (3).

In Pakistan and other low- and middle-income countries, the situation is further complicated by staffing shortages, limited resources, and poor organizational structures (4). Studies have shown that nurses working in public hospitals in Sindh frequently encounter excessive workloads, role conflicts, verbal abuse, and lack of recognition, all of which contribute to chronic occupational stress (5). Despite these findings, much of the existing research relies heavily on quantitative, cross-sectional designs that primarily assess stress levels and associated factors, offering limited insight into the personal, lived experiences of nurses (6). Quantitative approaches, while useful for identifying trends, often fail to uncover the emotional, cognitive, and contextual nuances that define how nurses perceive and cope with workplace stress.

To address these limitations, a qualitative phenomenological inquiry offers a suitable framework for exploring the lived experiences of nurses. This approach facilitates a deeper understanding of how individuals interpret stressful events, construct meaning, and develop coping mechanisms in their unique work environments (7). It allows participants to articulate their subjective realities, which may reveal hidden dimensions of stress not captured by structured surveys (8). Phenomenology, in particular, emphasizes lived experience and is thus ideal for uncovering the essence of nursing stress within the complex cultural and institutional context of public tertiary hospitals in Sindh.

Accordingly, this study is guided by the following research question**:** How do nurses working in public tertiary hospitals of Sindh perceive and experience workplace stressors, and which coping strategies do they adopt in response? The specific objectives are: (1) to identify the key workplace stressors encountered by nurses; (2) to explore coping strategies at both individual and organizational levels; and (3) to identify barriers and facilitators influencing coping effectiveness.

The study includes registered nurses from various departments—such as intensive care units, emergency wards, and general medicine—across public tertiary hospitals in Sindh. These institutions often operate under heavy patient loads, staff shortages, and infrastructural constraints, making them a relevant setting for exploring occupational stress.

The significance of this study lies in its potential to inform nursing management and health policy. By capturing nurses' lived experiences, this research may provide practical insights for designing supportive workplace interventions, staff-wellness programs, and evidence-based policies to mitigate stress and enhance professional resilience (2,5). Moreover, understanding the coping strategies already employed by nurses may help identify adaptive behaviors that can be strengthened through institutional support and training.

In sum, this qualitative phenomenological investigation will contribute to a deeper, contextually grounded understanding of workplace stress and coping strategies among nurses in public tertiary hospitals of Sindh. Such insights are vital for improving both nurse well-being and the overall quality of healthcare delivery in Pakistan.

METHODS:

This study employed a qualitative phenomenological design to explore and describe the lived experiences of nurses working in public tertiary hospitals of Sindh regarding workplace stressors and their coping strategies. The phenomenological approach was deemed appropriate because it allows for deep engagement with participants' subjective realities and focuses on understanding the meanings they ascribe to their experiences (9). This design enabled the researchers to elicit rich, contextualized data about how nurses interpret stressful work situations and develop coping mechanisms in their unique organizational and sociocultural environments (10).

Participant recruitment was conducted using purposive sampling to ensure inclusion of information-rich cases relevant to the study objectives. Participants were registered nurses currently employed in public tertiary-care hospitals across Sindh province. Inclusion criteria required at least one year of continuous service, direct involvement in patient care, and willingness to provide informed consent. Nurses on prolonged leave, administrative-only positions, or unwilling to participate were excluded. Recruitment continued until data saturation was achieved, defined as the point where no new themes or insights emerged from successive interviews (11).

Data were collected through semi-structured, in-depth interviews using an interview guide developed from a review of relevant literature and expert input. Open-ended questions encouraged participants to describe their experiences of workplace stress, perceived stressors, coping behaviors, and organizational support. Interviews were conducted in Urdu or English, depending on participant preference, and lasted approximately 45–60 minutes. All interviews were conducted in private, comfortable spaces within the hospital premises, ensuring confidentiality and minimal disruption to workflow. With consent, interviews were audio-recorded, and field notes

were maintained to capture nonverbal cues and contextual details (12).

All interviews were transcribed verbatim and, where necessary, translated into English by bilingual researchers fluent in both Urdu and English. Data analysis followed Braun and Clarke's six-phase framework for thematic analysis: familiarization with the data, initial coding, searching for themes, reviewing themes, defining and naming themes, and producing the report. Coding was carried out manually and cross-checked by multiple researchers to enhance dependability. The thematic analysis allowed the identification of both explicit and latent meanings within the data, reflecting individual and collective experiences of workplace stress and coping among nurses (13).

Ethical approval for this research was obtained from the institutional ethics review board of the participating hospitals.(Before data collection, participants were provided with detailed information about the study's objectives, voluntary participation, and confidentiality. Written informed consent was obtained from all participants. To preserve anonymity, identifying information such as names, wards, and hospital identifiers were removed from transcripts. Data were stored securely, accessible only to the principal investigator and research team.

To ensure trustworthiness and rigor, several methodological strategies were adopted. Credibility was strengthened through **member checking**, where participants reviewed preliminary interpretations to verify accuracy and authenticity. **Peer debriefing** was used during coding and theme development to minimize researcher bias and enhance confirmability. **Reflexivity** was maintained throughout the study, with researchers keeping reflective journals to examine their assumptions and positionality in relation to the data(14). **Triangulation** was achieved by comparing interview data with field notes and researcher reflections, ensuring a comprehensive and balanced interpretation of findings. An **audit trail** was maintained to document analytic decisions, ensuring transparency and dependability. Collectively, these measures enhanced the rigor, credibility, and authenticity of the findings.

Through this systematic and reflexive approach, the study sought to capture the essence of how nurses in Sindh's public tertiary hospitals experience workplace stress and the coping strategies they employ, producing an in-depth understanding that quantitative research cannot adequately achieve.

RESULTS:

The study involved twenty registered nurses working in public tertiary hospitals across Sindh. All participants were female, consistent with the gender composition of the nursing workforce in Pakistan. Their ages ranged from 24 to 52 years, and their professional experience varied between 1 and 25 years. The nurses were drawn from multiple departments, including emergency, intensive care, surgical, obstetrics, and general wards. Each interview lasted between 45 and 60 minutes, generating detailed narratives about workplace stressors, emotional experiences, coping behaviors, and institutional support systems.

The data revealed that nurses experience persistent and multifaceted stressors embedded in their daily work routines. Heavy workloads and inadequate staffing emerged as central challenges. Many nurses described their shifts as physically and mentally exhausting, with one participant explaining that she often cared for thirty to forty patients with only a few colleagues available for support. Others reported frequent overtime and lack of rest periods, resulting in fatigue and declining motivation. Such workload-related pressures were viewed as chronic rather than situational, producing a sense of helplessness and emotional strain consistent with previous findings in similar healthcare settings (15).

Emotional stress also arose from frequent interactions with patients' families. Participants shared experiences of being verbally abused or blamed for outcomes beyond their control. Some expressed that they felt disrespected or undervalued, noting that their professional role was often misunderstood by patients' relatives. These interactions not only intensified emotional exhaustion but also contributed to feelings of frustration and diminished self-worth, echoing findings from global nursing studies reporting that interpersonal conflicts are a major source of workplace distress (16).

Organizational limitations further compounded these stressors. Participants commonly mentioned the lack of institutional support, resource shortages, and ineffective administrative responses to their concerns. Several nurses recalled repeated denials of leave requests or insufficient breaks during long shifts. Others spoke about being compelled to continue working under equipment shortages and high patient inflows. Such institutional constraints reinforced perceptions of neglect and reduced morale, leading many nurses to describe their work environments as "unsympathetic" or "emotionally draining." These organizational inadequacies have also been recognized in other low-resource health systems, where weak management support exacerbates burnout and attrition among nursing professionals (17).

Despite these challenges, nurses demonstrated resilience through various coping strategies. Peer support was the most frequently mentioned mechanism. Many participants described informal sharing, humor, and emotional venting among colleagues as essential to managing stress. They emphasized that mutual understanding among coworkers provided emotional relief and maintained a sense of belonging. Others relied on personal coping mechanisms such as faith, prayer, acceptance, and self-talk to sustain their emotional balance during difficult shifts. Several nurses reported that spiritual coping and self-reflection helped them find meaning in their

profession and strengthen their sense of duty despite the strain (18).

A smaller number of participants described conscious self-care practices, including setting boundaries between work and personal life, resting during off days, and avoiding work-related discussions at home. However, these nurses acknowledged that such practices were often difficult to maintain due to unpredictable schedules and systemic understaffing. Many expressed guilt about taking breaks or days off, fearing that their absence would burden their colleagues. Similar findings have been documented in international research, where nurses' self-care behaviors are often constrained by institutional expectations and workload demands.

Interestingly, an unexpected dimension of the findings was the emergence of moral and ethical distress. Several nurses reported feelings of guilt and professional inadequacy when they were unable to deliver what they considered "proper care" due to time and resource limitations. They expressed sadness and internal conflict over being unable to attend to every patient's needs, describing it as "emotional pain that never leaves." This moral distress went beyond physical exhaustion and reflected the deep emotional commitment nurses hold toward their professional roles, aligning with prior qualitative studies highlighting the moral dimensions of nursing stress (19).

Overall, the findings portray a complex reality in which nurses in Sindh's public tertiary hospitals navigate constant stress shaped by organizational, emotional, and moral pressures. Their coping is primarily self-directed, sustained through interpersonal solidarity and personal resilience rather than institutional mechanisms. While these strategies help maintain functionality, the persistence of structural and emotional burdens underscores the urgent need for systemic interventions that address both the organizational and psychological dimensions of nursing work.

Table 1. *Demographic Characteristics of Participating Nurses (n = 20)*

Variable	Category
Age (years)	24-52 (Mean=36.8)
Gender	All Female (n=20)
Marital Status	Married (n=15), Unmarried (n=5)
Years of Experience	1-25 years (Mean=9.4)
Department	ICU (5), Emergency (5), Surgical (4), General Ward (3), Maternity (3)

Table 2. *Prevalence of Major Workplace Stressors Reported by Nurses (n = 20)*

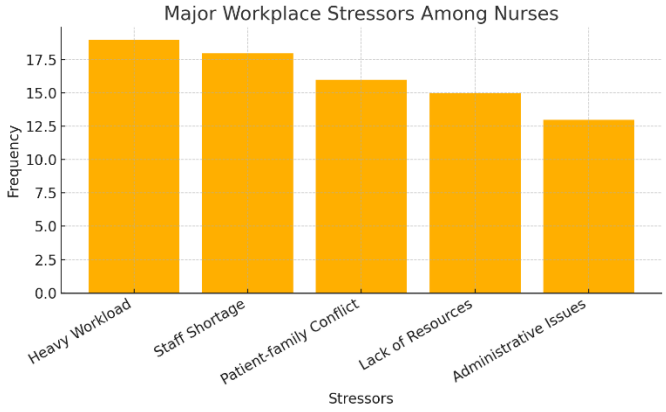
Workplace Stressor	Frequency (n=20)	Percentage (%)
Heavy Workload	19	95
Staff Shortage	18	90
Patient-family Conflict	16	80
Lack of Resources	15	75
Administrative Issues	13	65

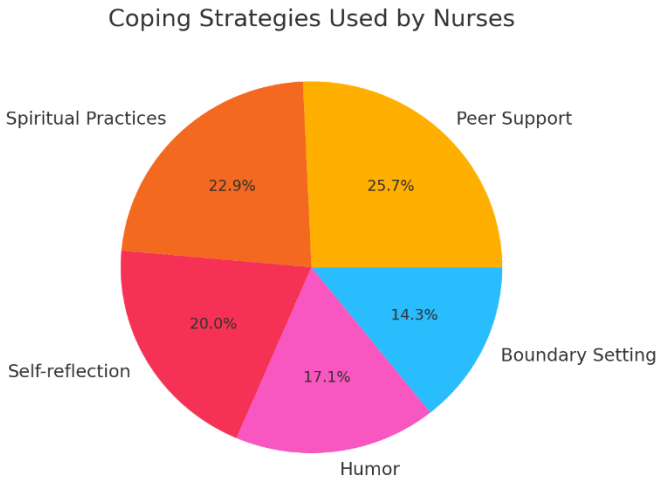
Table 3. *Coping Strategies Employed by Nurses in Response to Workplace Stress (n = 20)*

Coping Strategy	Frequency (n=20)	Percentage (%)
Peer Support	18	90
Spiritual Practices	16	80
Self-reflection	14	70
Humor	12	60
Boundary Setting	10	50

Table 4. *Perceived Availability and Effectiveness of Institutional Support Mechanisms (n = 20)*

Support Type	Perceived Availability (%)	Perceived Effectiveness (%)
Managerial Support	40	50
Counseling Services	25	40
Rest Breaks	35	55
Training Programs	30	60
Shift Flexibility	45	65





DISCUSSION:

The findings of this qualitative inquiry offer deep insight into the lived experiences of nurses working in public tertiary hospitals of Sindh. The study revealed that workplace stress among nurses arises from a combination of excessive workload, organizational shortcomings, emotional strain, and moral distress, with coping largely limited to self-directed and peer-based mechanisms. These findings are significant as they expand understanding beyond conventional burnout frameworks, emphasizing the complex psychosocial realities of nurses operating within resource-limited public health systems. The results are consistent with global evidence showing that high workload and staffing shortages are among the strongest predictors of occupational stress in nursing environments (20). Similar to prior studies conducted in low- and middle-income countries, participants described chronic exhaustion and sustained emotional fatigue, indicating systemic rather than individual origins of stress.

Emotional strain associated with interactions with patients and their families further intensified nurses' stress experiences. Many participants described being subjected to verbal aggression or blamed for negative clinical outcomes, which mirrors findings from other qualitative studies that identified patient-family conflict and disrespect as prominent stressors contributing to burnout and emotional exhaustion. In the context of public hospitals in Sindh, such stress is compounded by a lack of institutional mechanisms for addressing staff grievances or providing counseling support. These findings highlight the need to view workplace stress not merely as an occupational hazard but as an organizational issue rooted in insufficient structural and emotional support systems.

A particularly important and unexpected finding in this study was the emergence of moral and ethical distress. Participants expressed guilt and emotional pain over being unable to deliver the level of care they perceived as adequate due to time, staffing, or resource limitations. This sense of moral burden has been recognized in recent global literature as a distinct form of occupational distress, one that affects nurses' professional integrity and long-term psychological well-being. Moral distress often arises when nurses' ethical standards conflict with systemic barriers that prevent optimal patient care. Studies among Korean and European nurses have similarly reported that moral distress contributes significantly to burnout and turnover intention, especially in understaffed hospitals (21). This convergence of moral responsibility and systemic constraint underscores the importance of institutional ethics support, reflective sessions, and structured debriefing opportunities for nursing staff.

The coping behaviors reported by participants—peer solidarity, self-reflection, acceptance, humor, and spiritual practices—reflect adaptive resilience commonly documented in nursing literature. Peer support emerged as a protective factor that mitigated emotional fatigue and fostered a sense of belonging among nurses, consistent with findings from international studies highlighting social connectedness as a key buffer against burnout(22). Spiritual coping, particularly prayer and faith-based reflection, was also central to stress management, echoing cultural coping patterns observed in other South Asian contexts. However, reliance on individual coping strategies also points to institutional deficiencies; while nurses demonstrated resilience, their coping mechanisms were largely self-reliant and unsupported by structured programs. The absence of formal psychosocial support or wellness initiatives leaves nurses vulnerable to cumulative stress and professional fatigue over time.

Differences in coping effectiveness across participants may reflect variations in experience, personal resilience, and departmental environments. Some nurses described maintaining emotional stability through acceptance and boundary-setting, while others reported exhaustion and hopelessness. These differences may relate to shift patterns, leadership quality, and available social support—factors that have been shown to influence nurses' coping capacity and burnout outcomes. Such variability emphasizes that resilience is not a fixed personal trait but an adaptive process shaped by contextual and institutional factors.

This study is not without limitations. The relatively small and homogenous sample—comprising female nurses from public tertiary hospitals in Sindh—limits generalizability to other settings, such as private or rural hospitals, or to male nursing staff. Moreover, qualitative data derived from self-reported interviews may be subject to recall bias or social desirability effects, where participants underreport distress to maintain a professional image. Additionally, as the study represents a cross-sectional snapshot, it cannot capture temporal fluctuations in stress or coping responses over time(23). Nonetheless, the study's methodological rigor—including triangulation, member checking, and reflexive journaling—enhances its credibility and provides a robust foundation for future research.

The implications of these findings are far-reaching. Addressing workplace stress among nurses in Sindh's public hospitals requires systemic, multi-level strategies. At the institutional level, reforms should focus on adequate staffing, equitable workload distribution, structured peer-support systems, and access to mental health services. Leadership engagement and supportive supervision have been identified as effective interventions to reduce nurse burnout and improve retention. Policymakers should prioritize occupational well-being as a component of healthcare quality, incorporating stress management and resilience training into ongoing professional development programs.

Future research should explore longitudinal trajectories of stress and coping to understand how nurses' emotional and professional resilience evolves over time. Mixed-methods studies could link qualitative narratives with quantitative outcomes such as absenteeism, turnover, and quality-of-care indicators, helping to inform data-driven workforce policies. Comparative studies between public and private institutions or across provinces could further elucidate the contextual drivers of occupational stress within Pakistan's healthcare system.

In summary, this study underscores that nursing stress in Sindh's public tertiary hospitals is not solely an individual burden but a structural and ethical concern rooted in systemic inadequacies. While nurses exhibit remarkable resilience and moral commitment, their coping mechanisms are constrained by institutional barriers. Sustainable improvements in nurse well-being and patient care quality will require a shift from individual-centered to system-centered interventions that recognize and address the organizational roots of occupational stress.

REFLEXIVITY AND RESEARCHER POSITIONALITY:

The researcher engaged with this project not as a detached observer but as a health-systems researcher familiar with the context of public hospitals in Sindh. Prior experiences—such as working or training in similar healthcare settings, awareness of institutional constraints, and understanding of cultural norms around nursing and hierarchy—inevitably shaped the lens through which participants' narratives were interpreted. This positionality may have influenced the framing of interview questions, attention to certain stressors (e.g., staffing shortages, resource constraints), and sensitivity to expressions of moral distress or institutional neglect. At the same time, this familiarity offered advantages: insight into contextual realities, ability to communicate empathetically with participants, and culturally appropriate probing of sensitive topics.

To limit undue influence of personal beliefs or assumptions, the researcher adopted reflexivity as a continuous, structured process throughout the study. A reflexivity journal was maintained to note thoughts, emotional responses, and potential preconceptions arising at various stages—during interview scheduling, data collection, transcription, translation, coding, and analysis. This practice of reflexive memoing helped to make explicit how the researcher's identity, prior assumptions, and contextual knowledge might shape interpretive choices (24). In addition, peer debriefing sessions were held with colleagues experienced in qualitative health research. In these sessions, emerging codes and tentative interpretations were discussed and challenged; alternative perspectives were considered, and decisions documented. Such peer debriefing helps mitigate individual bias and enhances confirmability of findings.Where possible, direct participant quotations were used to ground interpretations, minimizing the risk of over-imposing researcher meaning onto participants' voices.

The researcher also recognized methodological and contextual challenges. Given the cultural and hierarchical dynamics within public hospitals in Sindh, nurse participants might have been hesitant to share candidly about institutional failures, coping difficulties, or emotional distress. The researcher attempted to create a trusting, non-judgmental interview environment, emphasizing confidentiality and voluntary participation. Nevertheless, the power differential inherent between researcher and participant — as one interpreting and reporting experiences — may have constrained full disclosure. Moreover, translation of interviews (from Urdu to English) posed a challenge: subtle nuances, emotion-laden expressions, or culturally embedded meanings may not always carry over accurately, which could affect interpretation.

Despite these limitations, reflexivity was leveraged not as a barrier to validity but as a methodological strength. By reflexively acknowledging the researcher's positionality, documenting decision-making processes, and engaging peers in debriefing, the study aimed to uphold credibility, dependability, and confirmability — key pillars of qualitative trustworthiness (25). The researcher's dual role as both an "insider" (familiar with the setting) and a reflective "outsider" (analytic observer) enabled a balance: sensitivity to context and critical distance for interpretation.

In sum, while researcher background, beliefs, and context undeniably shaped aspects of this study—from question framing to interpretation of data—these influences were managed transparently through ongoing reflexive practices, peer collaboration, and reliance on participants' own words. This reflexive posture enhances the trustworthiness of the findings and acknowledges that in qualitative research, the researcher is not a neutral vessel — but a conscious actor whose lens must be examined as part of the research process.

IMPLICATIONS FOR PRACTICE, POLICY, AND FUTURE RESEARCH:

The findings from this study carry important implications for clinical practice. Nurses' sustained exposure to heavy workload, staffing shortages, emotional strain, and moral distress undermines both their well-being and their capacity to deliver safe, compassionate, high-quality care. Given prior

evidence that nurse burnout and stress are associated with lower patient safety, increased errors, and reduced quality of care, institutional recognition of nurse stress becomes a patient-safety priority rather than just a staff-welfare issue (26). In practice, hospitals should invest in structured support mechanisms — for example, regular peer-support or debriefing sessions, accessible psychological support (counseling), and schedule reforms to prevent excessive overtime or unrelieved shifts. Encouraging self-care behaviors (adequate rest, nutrition, physical activity) and creating a culture where nurses feel supported and valued may help maintain their resilience and improve care delivery (27).

At the policy level, public health authorities and hospital administrations should prioritize nurse well-being as an essential component of health-system strengthening. Policy measures might include establishing staffing norms to ensure safe nurse-to-patient ratios, mandating rest breaks, and enforcing limits on consecutive shifts or overtime to mitigate chronic overload — conditions associated with burnout and adverse care outcomes (28). Additionally, health policy should integrate mental health and occupational well-being into institutional accreditation and quality assurance frameworks, making support for nursing staff part of standard hospital policy. Implementation of organizational-level interventions — such as structured stress-reduction programs (mindfulness, supervision, wellness activities), institutional peer-support networks, and formal recognition of nursing contributions — can help buffer stress, sustain workforce retention, and ultimately benefit patient care (29).

For future research, several directions emerge. Longitudinal qualitative and mixed-methods studies could examine how stress, coping strategies, and moral distress evolve over time, particularly under changing institutional or policy contexts. Evaluative studies testing the effectiveness of organizational interventions (e.g., wellness programs, staffing reforms, structured peer-support, shift-restructuring) in reducing stress, improving nurse retention, and enhancing patient safety and quality of care are warranted (30). Comparative research across different hospital types (public vs private), regions (urban vs rural), and cultural contexts could shed light on context-specific stressors and coping needs. Moreover, quantitative studies linking qualitative experiences to measurable outcomes (burnout incidence, turnover, patient safety incidents, satisfaction) would strengthen the evidence base for systemic changes.

In sum, recognizing and addressing the structural, organizational, and emotional dimensions of nursing stress in public tertiary hospitals offers a pathway to enhance nurse welfare, improve care quality, and strengthen health-system resilience.

CONCLUSION:

This qualitative phenomenological inquiry illuminated the complex realities of workplace stress and coping among nurses working in public tertiary hospitals of Sindh. The study revealed that nurses experience persistent structural and emotional pressures — including chronic understaffing, excessive workloads, interpersonal conflicts, and moral distress — that collectively erode their well-being and professional satisfaction. Despite these challenges, nurses demonstrated remarkable resilience, relying on peer solidarity, personal reflection, and faith-based coping to sustain their capacity for compassionate care. These findings underscore that occupational stress in nursing is not merely an individual issue but a systemic one rooted in organizational and policy deficiencies. The study highlights the urgent need for healthcare leaders to establish supportive institutional environments, equitable staffing policies, and accessible mental health resources to preserve nurse well-being and ensure safe, high-quality patient care. Ultimately, by addressing workplace stressors through evidence-informed reforms and fostering a culture of empathy, recognition, and support, Pakistan's public health system can strengthen both its nursing workforce and the quality of care it provides.

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