CHAPTER I
INTRODUCTION

Background of the study

Health is a relative state of existence, multidimensional and specific for each individual. As per the concept of health propounded by World Health Organization, mental health is an integral part of total health. The issue of women’s health as a separate field of study emerged relatively recently. An international conference on health promotion held in Adelaide (Australia) in 1998 identified “supporting the health of women” as one of the four specific areas of action.¹ A woman’s mental health is just as important as her physical health. However too often in their lives as wives, daughters, employers, volunteers, mothers and general care givers they forget to take care of their own emotional needs. Along with this, women are forced to live more for others than for themselves even in places like home and community.

Since the late 1960s through the 1970s and the 1980s several catchments studies and surveys have been carried out in India, correlating demographic variables, such as marital status, age, education, etc. with the occurrence of mental illness.² Both community based studies and studies of treatment seekers indicate that women are disproportionately affected by mental health problems and that their vulnerability is closely associated with marital status, employment and roles in society. Women’s mental health cannot be considered in isolation from social, political and economic issues. When women’s position in the society is examined, it is clear that there are sufficient causes in current social arrangements to account for the surfeit of depression and anxiety experienced by women.³
Goldberg and Huxley (1992) compute the rate of prevalence for women from the many surveys done in the West, to observe that morbidity is 202 per thousand, on around 20 per cent, whereas, for men it is around 12 per cent. In India Prevalence of mental disorders among men is around 11 percent and among women it is around 15 percent.

Dennerstein (1995) gives a comprehensive review of the long tradition of research in the area of women, work and mental health in the West, where more than fifty per cent of women in the work force are in the lower levels of the service industry rather than in the upper levels. As Dennerstein lists, the work of ‘housewifery’ is not comparable to paid employment, and has mental health costs for many reasons: raising children and running a house is frustrating; the role of a housewife is unstructured, unremunerated, taxing and invisible, expectations from women are unclear and diffuse. The role of motherhood for Dennerstein, is a ‘primary source of stress’ because it is both ‘low in control and high in demand’ and she reviews the research which shows that having more children at home to care for, not having child care and having an uncooperative spouse who does not participate in child care can all be stressful in themselves, whether the woman worked or not. In the urban settings of the West, two classes of women are likely to be stressed with respect to work, unemployed and low educated women; and employed women whose employment causes conflicts in the household.

Santiago, Vazquez, Diez (1993) conducted a study to analyze the relationship between traditional feminine role and mental health among 630 Spanish women aged 17 and above by using general health questionnaire containing 60 items. The rate of probable prevalence of psychiatric disorders among them was 26.4%. In contrast to
previous studies, motherhood and traditional feminine role correlated with the lowest mean scores in general health questionnaire – 60 (GHQ). Occupational status was not related to mental health. Women living with husband, children, parents and / or parents-in-law scored lower on G H Q- 60 than those living with husband and children.\textsuperscript{6}

Quality of life (QOL) is an important dimension of health. It is a subjective term which varies from person to person and depends on each individual’s capacity to cope with a situation. Quality of life can be defined as a person’s sense of well-being, which is based on his/her satisfaction from the areas of life that are important for him/her.\textsuperscript{7} It is an area of study that has attracted a great deal of interest over the past ten years, particularly in the area of health, and social services, but increasingly in medicine and education. Working life comprises a big and important part of the daily life of a person. That is why lack of job satisfaction can adversely affect his/her perception of quality of life. Similarly Quality of life can be affected negatively by one’s poor working life. The study of the quality of life is an examination of the factors that contribute to the goodness and meaning of life as well as people's happiness. It also explores the inter relationship among these factors.

Achat, Kawachi, Levine, Berkey, Coakley, Colditz (1998) examined the importance of social networks and aspects of mental functioning (mental health vitality and role - emotional functioning )and the relationship between social networks and mental functioning in the presence of stressors. Multiple linear and logistic regression models were used to examine the data in 47,912 middle aged and older healthy women. They observed strong associations between levels of social networks
and multivariate adjusted quality of life scores, particularly in potentially high stress situations. Compared to the most socially integrated, women who were socially isolated had reductions in mental health and vitality scores of 6.5 and 7.4 points respectively and a 60% increased risk of limitation in role emotional functioning. Social networks are positively associated with mental functioning in women. This association is strongest for women reporting high level of work stressors.\textsuperscript{8}

Walters (1993) reported in a study of stratified random sample of 356 Canadian women that stress, anxiety and depression were among the most frequently reported health problems. Women experienced mental health problems differently depending on their socio-economic status, ethnicity, family structure, the quality of family relationship and the nature of their participation in the labor market.\textsuperscript{9}

Nurses make up the largest single group of health care professionals. There are four times as many nurses as there are physicians in the United States. Registered nurses (RNs) work to promote health, prevent disease, and help patients cope with illness. They are advocates and health educators for patients, families, and communities. When providing direct patient care, they observe, assess, and record symptoms, reactions, and progress; assist physicians during treatments and examinations; administer medications; and assist in convalescence and rehabilitation.

Nurses are trained to consider patient’s quality of care and life but seldom their own; they rarely consider that they themselves or others in the profession may need care. Nurses often complain of overwork and underpay. Problems persist with nurse’s job satisfaction, stress, organizational commitment and intent to leave. Quality
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Introduction

of working life is a system of analyzing how people experience work, how the experience relates to job satisfaction, intent to leave, turnover rate, personality and work stress.\textsuperscript{10} It is now almost universally recognized that nursing is, by its very nature, a stressful occupation. Nursing was chosen as one of the occupations on which the International Labour Organization (ILO) has commissioned a manual on stress prevention.\textsuperscript{11} Due to insufficient staffing, nurses experience difficulties in meeting patient needs. They become frustrated about their inability to complete their work to their professional satisfaction and express wishes to leave the nursing profession.\textsuperscript{12}

Evans, Pellizarri, Culbert, Metzen (1993) found that satisfaction with various job characteristics such as type of work, amount of work, supervision, coworker, physical work conditions, financial rewards and career future were related to QOL and that hardiness was an important component of QOL.\textsuperscript{13}

Lerner, Levine, Malspeis, Agostino (1994) indicated that job strain was significantly associated with five of nine components of health related QOL which include physical functioning, role functioning related to physical health, vitality, social functioning and mental health.\textsuperscript{14}

Ergun, Oran (2005) determined the quality of life of nursing staff working in oncology units in Turkey. The study was descriptive and included 89 oncology nurses from 12 different cities in Turkey. Quality of life was assessed with the World Health Organization QOL Scale (WOQOL-BREF). Data were analyzed using descriptive statistics including Student $t$ tests, analysis of variance, and the Scheffe test for post hoc analysis. Mean scores for QOL were 14.52 for the physical health domain, 14.3
for the psychological domain, 13.57 for the social relationships domain, and 11.78 for
the environment domain. It has been concluded that providing care for patients with
cancer has a negative impact on the QOL of oncology nurses. 15

Cimete, Gencalp, Keskin (2003) conducted a study to determine whether there
is a relation between job satisfaction and quality of life of nurses. The study was
based on a sample of 501 nurses. Job satisfaction was measured by means of the Short
Form Minnesota Satisfaction Questionnaire (MSQ) and QOL by means of
WHOQOL-BREF. The results demonstrated a positive correlation between job
satisfaction and QOL. It was also found that job satisfaction and QOL scores of
nurses showed a significant difference according to their age, economic level, marital
status, duration of working life, and position at work.16

Wong, Leung, Christopher, Lam (2001) studied the sources of stress and
mental health of nurses in Hong Kong. It also attempted to explore the functions of
coping strategies in determining the stress and mental health of nurses. Results
showed that more than one-third of the nurses could be considered as having poor
mental health. While supervisory role produced the highest level of stress,
organizational environment also created a substantial amount of stress for nurses. The
most frequently used coping strategies were positive ones, including direct action
coping and positive thinking. This study confirmed the hypotheses that nurses who
adopted more positive and fewer negative coping strategies had better mental health,
but failed to substantiate the moderating effects of coping on stress and mental health
of nurses. 17
Piko (1999) investigated the relationship between levels of stress, and some of the psycho-social and organisational characteristics of the job among 218 female nurses through a cross-sectional survey. The participants were female nurses (n = 218) chosen at random from public hospitals in Csongrad, Hungary. A self-administered questionnaire was used for data collection and it contained various items on psychosomatic symptoms, self-perceived health, sociodemographic data, job satisfaction, health risk behaviours, drug consumption, emotional load and social support from peers. The findings suggest that the frequency of common psychosomatic symptoms (e.g. sleeping problems, tension headache, chronic fatigue or palpitations), regular alcohol drinking, heavy smoking, and frequent use of tranquilisers and sleeping pills can be read as an indicator of nurses’ work-related stress level. Nurses with only primary education had the highest such levels, while those with baccalaureate-level education had the lowest. Furthermore, nurses aged 51-60 years and those on rotating night shift proved to be vulnerable to stress most frequently. However, no significant differences were found between nurses working in-theatre and that non-theatre; nor were job satisfaction found to have a significant impact on the levels of stress experienced. The results suggest that supportive relationships with peers may reduce the occurrence of high stress levels among nurses, leading the author to conclude that social support and the psycho-social work climate should be improved in health care institutions.  

Al-Aameri (2003) conducted a study to assess the different sources of job stress for nurses and to find out the most and least perceived sources of stress, and the effect of demographic factors on nurses perception of these sources in a number of public hospitals in Riyadh city, Kingdom of Saudi Arabia. Four-hundred and twenty-
four nurses working in a number of public hospitals in Riyadh city were the samples. A questionnaire was used as method of data collection. The findings revealed six possible sources of job stress for nurses in public hospitals. These included organizational structure and climate, job itself, managerial role, interpersonal relationships, career and achievement and homework interface. The major sources of stress were the first three factors, but they had mixed views on the last three. Homework interface was not seen as a source of stress for nurses, which may refer to the fact that most of them are expatriate and may have little familial obligations. On the other hand, it was found that the effects of demographic factors on nurses’ perception of these sources are little. The exception was between age and marital status regarding homework interface factor. It was found that old and unmarried nurses did not see this factor as a stressor contrary to young and married ones.¹⁹

Albion, Fogarty, Machin (2005) conducted a study with 1097 employees (866 females, 217 males, 14 did not indicate gender) in a regional Health Service District who completed the Queensland Public Agency Staff Survey in 2002. Nurses’ results on measures of organizational climate and psychological outcomes were compared with those of other employees in the Health Service District. Nurses reported less favourable outcomes on all but one of the organizational climate scales, and also were found to have more distress (strain), and lower levels of morale, job satisfaction and Quality of work life than others. Results were generally less favourable for nurses working in the large regional hospital and in mental health than for nurses in other facilities.²⁰
Healy, McKay (2000) examined relationships between nursing work-related stressors and coping strategies, and their impact upon nurses' levels of job satisfaction and mood disturbance among a sample of 129 Australian nurses. It was proposed that higher levels of perceived work stress and use of avoidance coping would increase mood disturbance, while problem-focused coping would be associated with less mood disturbance. The study also aimed to explore the possible 'buffering effects' of using humour in coping with stress, and the effect of job satisfaction on the stress-mood relationship. Questionnaires included were the Nursing Stress Scale, Ways of Coping Questionnaire, the Coping Humour Scale, Job Satisfaction Scale of the Nurse Stress Index, and the shortened version of the Profile of Mood States. Results revealed a significant positive relationship between nursing stress and mood disturbance, and a significant negative relationship between nursing stress and job satisfaction. The use of avoidance coping and the perception of work overload were found to be significant predictors of mood disturbance. No evidence was found to indicate that the use of humour had a moderating effect on the stress-mood relationship but there was support for the influence of job satisfaction upon this relationship. These results provided some support for a transactional model of stress since situational factors were found to influence the nurses' coping and perceptions of stress.21

Sveinsdottir, Biering, Ramel (2005) conducted a study to explore what factors contribute to work-related stress among Icelandic nurses working within and outside the hospital environment. The study used a cross-sectional survey design and the study population composed of all working nurses registered at the Icelandic Nurses' Association. Questionnaires were posted to 522 (23.4%) randomly selected participants. The response rate was 42% (N=219), representing 9.8% of the population. Data were analyzed from 206 nurses; 35% worked outside the hospital
setting and 65% were hospital based. Data were gathered on demographic information and indicators of working conditions, occupational stress, workload, and job satisfaction. A stepwise, multiple linear regression model was employed to calculate significant predictors of occupational stress. The findings suggested that the strenuous conditions of Icelandic nurses are felt more severely among hospital nurses than among nurses working outside hospital settings. The study identified which sources of occupational stress are specific to each of the two groups.22

A study was conducted by De Martino, Misko (2004) to analyze the nurses’ psychological variables taken from Engelmann's List of Emotional States and based on the questionnaire answered by the subjects at the beginning and end of each shift in different units of Hospital. The results revealed that the nurses' emotional parameters have alterations during the shift which can be related to the burnout and stress of the care delivery activity. Tiredness was a strong variable at the end of the shifts in all units. The results obtained at the beginning and end of the shifts were statistically compared using the Kruskal-Wallis method and the group profiles demonstrated a variety of feelings and intensities that were statistically significant.23

Ernst, Mesmer, Franco, Gonzalez (2004) identified a set of factors that describes nursing satisfaction in the pediatric setting. An exploratory descriptive design was used. Questionnaires were distributed to all nurses employed at a children's hospital in the Southeast. The survey included nursing satisfaction, organizational work satisfaction, job stress, and nurse recognition scales. Two hundred and forty-nine out of 534 pediatric nurses (46%) responded. Data were analyzed using factor analysis and correlation. The results demonstrated that several
factors predict pediatric nurses' job satisfaction and organizational work satisfaction. These factors included pay, time to do the nursing care, confidence in one's ability, and task requirements. A relationship among nurses' job satisfaction, organizational work satisfaction, job stress, and recognition in the pediatric setting was also found. Nurses with more years of experience and longevity on the unit and at the hospital had more confidence, showed less concern about time demands, and were less concerned about pay and task requirements than younger nurses. Job stress correlated significantly and inversely with age, years as a nurse, and years in the organization. Older nurses were more satisfied with recognition they received than their younger counterparts. 24

Lambert, Lambert, Itano, Inouye, Kim, Kuniviktikul et al (2004) examined work stressors, ways of coping and demographic characteristics as predictors of physical and mental health among 1554 hospital nurses from Japan, South Korea, Thailand and USA. Subjects were administered four self-report questionnaires: Demographic Questionnaire, Nursing Stress Scale, Ways of Coping Questionnaire and SF-36 Health Survey. Findings suggested that nurses indicated similar workplace stressors, ways of coping, and levels of physical and mental health. While subjects, across countries, demonstrated a variety of predictors of physical and mental health, several predictors were found to be the same. Cross-culturally the role of nurses may vary; however, certain factors are predictive of the status of hospital nurses' physical health and mental health.25

Carson, Fagin, Bromn, Leary, Bartlett (1997) identified the relationship between self-esteem and stress, coping and burnout in 568 mental health nurses. The
A modified Rosenberg Self-Esteem Scale was administered to nurses in both hospital and community, along with a range of other standardized measures. While there were no significant differences in self-esteem between the two groups of mental health nurses, smokers and drinkers in the sample were found to have significantly lower levels of self-esteem. Equally, nurses who felt happy with their life were physically fit and who had job security, had higher self-esteem scores. Self-esteem correlated highest with measures of stress. Multiple regression analyses showed that happiness was one of the best predictors of self-esteem. Evidence is also presented on the discriminative validity of the concept of self-esteem. Enhancing nurses’ levels of self-esteem may help reduce staff stress levels.  

Bradley, Cartwright (2004) explored the relationship between perceived social support, job stress, health, and job satisfaction among nurses from four organizations in northwest England. A total of 350 usable questionnaires measuring stressors, perceived support, health, and job satisfaction, were obtained from a sample of 1,162 nurses drawn from four healthcare organizations. A follow-up study was conducted after six months. Results indicate that perceived organizational support is related to nurses’ health and job satisfaction. Current interventions to increase support, which typically operate at individual or group level, may be limited in their effectiveness unless nurses’ perceptions of organizational support are taken into account.

According to World Health Organisation quality of life is defined as an individual’s perception of his or her position in life in the context of the cultural and value system in which he or she lives and in relation to his or her goals, expectations, standards and concerns. Quality of life is a subjective satisfaction expressed by an
individual in his physical, mental, social and spiritual situation. It is a term which varies from person to person and depends on each individual’s capacity to cope with a situation. Considering the WHO concept of health as a state of physical, mental, and social wellbeing, the improvement in the quality of life of nurses becomes a very important since they have to play multiple roles in their lives. With this back ground and the researcher’s personal experience of working as a clinical nurse and nurse educator and the experience of working with nurses motivated the researcher to take up a study on nurses’ quality of life and its associated psycho-social variables.

**Need for the study**

In the world of work, we find employment may bring self-esteem and independence; however, low paid or unpaid labor may contribute to oppression rather than independence. Many women work a double day maintaining households, raising children, carrying out economically productive activities in marketing and agriculture and in household-based industries. Numerous studies document that women work more hours than do their husbands given their widely diverse economic and household responsibilities. Being a working woman may not necessarily increase her social support system, because having friends and sustaining relationship is not as easy for Indian women, as it is for the men. The social aspects of modern friendships, including meeting in the evening, having dinner together etc. are often denied to the women because of a need to attend to the pending responsibilities of care at home. The working environments for women are also fundamentally disempowering, whether the setting is traditional or modern. In both the settings, women end up having little choice about their career options or about the benefits of these options, usually the demand of her career are added on to the household responsibilities.
Nursing is widely acknowledged to be a stressful occupation. In an extensive review of literature, Moore, Simendinger (1989) suggested that factors contributing to occupational stress can be divided into sources related to the workplace and sources focusing on stress at the personal level. Eight major workplace sources of stress have been identified within nursing: death and dying, conflict with doctors, lack of support, inadequate preparation, and conflict with other nurses, work load, shift work and uncertainty over treatment. In addition to job characteristics, individual characteristics such as personality hardiness, social support and ways of coping are related to burnout.\textsuperscript{29}

Yang, Shung, Yang (2004) conducted a study among 907 registered nurses via stratified random sampling from hospitals in Kaohsiung, Taiwan. Each participant was requested to answer a structured questionnaire anonymously and a 98.1% response rate was achieved. The Job Strain Questionnaire was used to measure job strain. The minor psychiatric disorder was measured by the Chinese Health Questionnaire, and a cut-off score of four or more was used to identify the subjects who had minor psychiatric disorder. Results indicated that 24.5% of the nurses were in the high strain group and that those who were unmarried, had a lack of social support, and those with shift work were the most susceptible to high job strain. A total of 443 (48.8%) respondents were identified as having minor psychiatric disorder. Multiple logistic regressions revealed that high job strain, poor social support, and poor self-perceived health were the significant factors for nurses to have minor psychiatric disorder.\textsuperscript{30}
Sources of job stress and levels of job satisfaction are extensively investigated abroad. However, studies addressing issues of nurses’ QOL are scarce. Quality of life is a person’s sense of well-being, which is based on his or her satisfaction with areas of life that are important for him or her. Work life comprises a significant and important part of the daily life of a person and stress at work is a very important factor that affects one’s QOL. Quality of life is very subjective and can be understood from an individual perspective that is individuals are the only proper judge of their well-being. The researcher could not identify any researches conducted in India on quality of life of nurses.

The immense shortage in nursing personnel is a significant impediment in achieving Indian public healthcare objectives. India has only eight nurses per ten thousand populations in comparison to Sri Lanka which has 14, Indonesia which has 13, Thailand at 37 and Maldives at 33. We have a nurse to population ratio of 1:1100 as compared to developed country averages of 1:150. It is also estimated that of the 10.35 lakh registered nurses, active nurses pursuing the profession in the country are only around four lakhs. It is also anomalous that there are more doctors than nurses in the country and for every 3 doctors there are 2 nurses. In comparison, in most developed countries, there are three nurses per doctor. The total number of active nurses by 2012 in India is expected to be 6.85 lakh. With 2,000 nursing diploma schools, 1,200 nursing degree schools and 281 MSc nursing colleges in the country, the annual production of nurses is around 60,000, but the majority prefers private sector than public due to which there is a gap of 3.5 lakh nurses. The officials point out the basic reason for the acute shortage to the migration of large number of qualified nurses to countries like Europe for better prospects. According to an official,
"India will require 10.43 lakh nurses by the end of the 11th plan (2007-2012). But keeping in mind the existing infrastructure, the figure stands at just 6.84 lakh, falling short by 3.59 lakh nurses. India has the ability to train 79,850 diploma nurses, 41,650 graduate nurses and 1,940 postgraduate nurses per year but the numbers collapse as over 20% of this number every year head to foreign shores. There has to be one nurse for every 500 persons. According chief nursing officer at the Ministry of Health and director of the Indian Nursing Council (INC), 2.4 million nurses will be needed by 2012 to provide a nurse-patient ratio of one nurse per 500 patients. According to the official statistics available with the health ministry, the total number of registered allopathic doctors in the country is 5.5 lakh. The doctor-population ratio works out to 1:2000 approximately. There are around 3.72 lakh nurses in the country and the nurses-population ratio comes to 1:2950.
Table I. State wise number of registered nurses in India

<table>
<thead>
<tr>
<th>States</th>
<th>Number of registered nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andhra Pradesh</td>
<td>101103</td>
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<tr>
<td>Assam</td>
<td>13351</td>
</tr>
<tr>
<td>Bihar</td>
<td>8883</td>
</tr>
<tr>
<td>Chhattisgarh</td>
<td>1807</td>
</tr>
<tr>
<td>Delhi</td>
<td>17679</td>
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<tr>
<td>Gujarat</td>
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<td>Haryana</td>
<td>17821</td>
</tr>
<tr>
<td>Himachal Pradesh</td>
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</tr>
<tr>
<td>Jharkhand</td>
<td>1998</td>
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<tr>
<td>Karnataka</td>
<td>84550</td>
</tr>
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<td>Kerala</td>
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<td>Madhya Pradesh</td>
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<td>Meghalaya</td>
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<td>Rajasthan</td>
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<td>Tripura</td>
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<tr>
<td>Uttar Pradesh</td>
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</tr>
<tr>
<td>Uttarakhand</td>
<td>92</td>
</tr>
<tr>
<td>West Bengal</td>
<td>47844</td>
</tr>
<tr>
<td>Total</td>
<td>993256</td>
</tr>
</tbody>
</table>

(Indian Nursing Council).\(^{35}\)

Nurse-per-bed ratio in India is 0.87 vis-à-vis the world average of 1.2 nurses per bed, which has been arrived at based on data from the World Health Organisation (WHO). The nurse-to-bed ratio was 1.4 in 2006. This ratio may fall to 1.29 in 2011.
and ultimately to 1.15 in 2016. According to the planning commission, India faces a shortage of about one million nurses.  

In order to prevent this shortage it is important to retain the nurses who are active in India. Due to the shortage, active nurses experience lot of problems, and no extensive studies have been conducted in India to identify their problems. Heavy workload can have a devastating effect and threaten the life and security of patients as the study by Tarnow, Warden, Shearer et al (2000) found that inadequate nursing staffing in an Intensive Care Unit increased patients’ mortality rate. Furthermore occupational stress has been found to be one of the major work related health problems. In addition to these serious consequences, a high level of occupational stress has been found to reduce nursing quality.  

To cope with the challenges in the health care delivery system and to guarantee the quality of care rendered and client satisfaction on the care received, it is important to know how satisfied nurses are with their QOL and jobs and what characteristics influence their quality of life. Increased workload among nurses, growing occupational stress and inability to cope with it, lack of social or family support and declining job satisfaction are major concerns in nursing. Numerous studies have shown that nursing is strenuous work and hence the occupational stress is prevalent among nurses.

Considering this background it would be useful to study the factors contributing to the quality of life of nurses who have the dual responsibilities of being the bread winners and the home makers. Having this information will direct and guide nursing and hospital administrators to focus on ways to maintain or improve QOL, job
satisfaction, self-esteem, social support and also to reduce the stress experienced by them, so that psychiatric morbidity among the nurses also may be reduced. This may in turn increase their job performance and quality of nursing care provided.

**Statement of the problem**

A co-relational study on quality of life and psycho-social variables of nurses working in selected hospitals of Udupi and Mangalore (South Canara) districts.

**Purpose**

The purpose of the study was to determine the QOL of nurses and to correlate QOL with psycho-social variables: stress, coping, psychiatric morbidity, self-esteem, family support and job satisfaction. The study further aimed to find the relationship among the psycho-social variables. The findings of the study would help the administrators to identify the factors affecting QOL of nurses and to initiate appropriate strategies to improve the quality of life of nurses.

**Objectives**

The objectives of the study were to:

1. determine the Quality of Life of nurses as measured by WHO Quality of Life questionnaire.
2. determine the psycho-social variables of nurses: stress, coping, psychiatric morbidity, self-esteem, social support, and job satisfaction.
3. find out the determinants of Quality of life of nurses with regard to:
3.1 Demographic variables such as age, professional qualification, marital status, married status, number of children, type of family, and monthly income.

3.2 Work place variables such as area of work, daily working hours, experience in current area of work and total years of experience.

4. find out the determinants of psycho-social variables with regard to demographic and work place variables.

5. find the relationship between quality of life and psycho-social variables.

6. find the relationship among the psycho-social variables.

7. compare the quality of life of nurses working in private and government hospitals.

8. compare the psycho-social variables of nurses working in private and government hospitals.

9. determine the predictors of quality of life.

Hypotheses

H_1. There will be significant association between Quality of life and

H_{1.1} Demographic variables: age, professional qualification, marital status, married status, number of children, type of family, and monthly income.

H_{1.2} Work place variables: area of work, daily working hours, experience in current area of work, and total years of experience.

H_2. There will be significant association between stress of nurses and

H_{2.1} Demographic variables: age, professional qualification, marital status, married status, number of children, type of family, and monthly income.

H_{2.2} Work place variables: area of work, daily working hours, experience in current area of work, and total years of experience.

H_3. There will be significant association between coping of nurses and
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H₃.₁ Demographic variables: age, professional qualification, marital status, married status, number of children, type of family, and monthly income.

H₃.₂ Work place variables: area of work, daily working hours, experience in current area of work, and total years of experience.

H₄. There will be significant association between psychiatric morbidity of nurses and

H₄.₁ Demographic variables: age, professional qualification, marital status, married status, number of children, type of family, and monthly income.

H₄.₂ Work place variables: area of work, daily working hours, experience in current area of work, and total years of experience.

H₅. There will be significant association between self-esteem of nurses and

H₅.₁ Demographic variables: age, professional qualification, marital status, married status, number of children, type of family, and monthly income.

H₅.₂ Work place variables: area of work, daily working hours, experience in current area of work, and total years of experience.

H₆. There will be significant association between social support of nurses and

H₆.₁ Demographic variables: age, professional qualification, marital status, married status, number of children, type of family, and monthly income.

H₆.₂ Work place variables: area of work, daily working hours, experience in current area of work, and total years of experience.

H₇. There will be significant association between job satisfaction of nurses and

H₇.₁ Demographic variables: age, professional qualification, marital status, married status, number of children, type of family, and monthly income.

H₇.₂ Work place variables: area of work, daily working hours, experience in current area of work, and total years of experience.
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H₈. There will be significant relationship between Quality of Life and psycho-social variables of nurses.

H₉. There will be significant relationship among psycho-social variables of nurses.

H₁₀. There will be significant difference between the quality of life of nurses working in private and government hospitals.

H₁₁. There will be significant difference between:

H₁₁.₁ stress score of nurses working in private and government hospitals.

H₁₁.₂ job satisfaction score of nurses working in private and government hospitals.

H₁₁.₃ psychiatric morbidity score of nurses working in private and government hospitals.

H₁₁.₄ score self-esteem of nurses working in private and government hospitals.

H₁₁.₅ social support score of nurses working in private and government hospitals.

H₁₁.₆ coping score of nurses working in private and government hospitals.

Assumptions

1. Nursing is a helping profession requiring a high degree of commitment and involvement.

2. Quality of life is subjective and can be measured.

3. Quality of life influences the performance of nurses.

4. Nurses’ health and well-being are greatly influenced by the psycho-social and physical environment at workplace.

5. Stress is a natural phenomenon that everyone experiences in their lifetime.

6. Coping responses are influenced by the source of stress, individual’s appraisal and situation in the workplace.
7. Self-esteem is one of the most important moderating variables in determining the effects of stress on individuals.

8. Job satisfaction is an important aspect of quality service delivery.

9. Social support contributes to a person's physical and mental well-being generally and/or as a buffer for someone under stress.

10. Subjects will feel free to answer the questions in the questionnaires.

Variables

Primary outcome variable
Quality of life.

Psycho-social variables
Stress, Coping, Psychiatric morbidity, Self-esteem, Social support, and Job satisfaction

Demographic variables
Age, professional qualification, marital status, married status, number of children, type of family, monthly income.

Work place variables
Area of work, daily working hours, experience in current area of work and total years of experience
Chapter I

Introduction

Operational definition of terms

Quality of life

WHO defines Quality of Life as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment. 28

In this study it refers to the subject’s response to the items given in the WHO Quality of life questionnaire (WHO QOL-BREF) which includes the domains on physical health, psychological health, social relationship and environment.

Age

Refers to the length of time that an organism has lived. 38 In this study age is considered as the number of years of life, the subject has completed and is categorized as 21- 30, 31- 40, 41- 50 and 51- 56 years.

Type of family

In this study it is classified as nuclear and joint

Marital status

The marital status is the civil status of each individual in relation to the marriage laws or customs of the country. 39 In the present study it was classified as Single, Married: If married (married status) - Staying with spouse, Staying away from spouse due to job related reasons, Divorced/Separated or Widowed.
Area of current work

Refers to the area/ward where the subjects were working at the time of data collection.

Experience in current area of work

Refers to the total duration spent by the subjects at present area of work in months or years.

Total years of experience

Refers to the total duration of working as a nurse in years after passing the qualifying examination.

Psycho-social variables

Refer to stress, coping, psychiatric morbidity, self-esteem, job satisfaction and family and social support of the subjects.

Stress

Is defined as a person’s adaptive response to a stimulus that places excessive psychological or physical demands on that person.\(^{40}\)

In this study it refers to the expressed problems encountered by the nurses which are measured by a standardized scale on nursing stress.

Coping

Is defined as the specific cognitive and behavior methods used to deal with stressors.\(^{41}\)

In the present study it refers to confrontive coping, distancing, self-controlling, seeking social support, accepting responsibility, escape/avoidance, planful problem solving and positive reappraisal as measured by Lazarus and Folkman’s Ways of Coping Questionnaire.
• **Confrontive Coping**: describes aggressive efforts to alter the situation and suggests some degree of hostility and risk-taking.

• **Distancing**: describes cognitive efforts to detach oneself and to minimize the significance of the situation.

• **Self-Controlling**: describes efforts to regulate one's feelings and actions.

• **Seeking Social Support**: describes efforts to seek informational support, tangible support, and emotional support.

• **Accepting Responsibility**: acknowledges one's own role in the problem with a concomitant theme of trying to put things right.

• **Escape/Avoidance**: describes wishful thinking and behavioral efforts to escape or avoid the problem. Items on this scale contrast with those on the Distancing scale, which suggests detachment.

• **Planful Problem Solving**: describes deliberate problem-focused efforts to alter the situation, coupled with an analytic approach to solving the problem.

• **Positive Reappraisal**: describes efforts to create positive meaning by focusing on personal growth. It also has a religious dimension.

**Nurses**

Refer to individuals who have graduated from a formal programme of nursing education (Diploma /Degree), licensed by a state authority and working as registered nurses in government /private hospitals.

**Social support**

Social support is defined as a set of perceived general or specific supportive behaviors that contribute to a person's physical and mental well-being generally
and/or as a buffer for someone under stress. A popular model of social support proposed by Tardy (1985) describes several elements of social support. First, social support comes from people in one's social network. Additionally, social support can take many forms such as emotional or caring support (listening), instrumental support (providing time or resources), informational support (providing needed information), and appraisal support (providing feedback). Social support can be given to someone or received, and can be perceived to be available and/or actually used. Finally, when asked about social support, one can provide a description of that support (e.g., frequency) or provide an evaluation (e.g., importance) of the support they perceive or receive.

In this study it refers to the support available to the nurses from the family members, friends and significant others as measured by a social support scale developed by the investigator.

**Job satisfaction**

It is defined as the feelings a worker has about his or her experiences in relation to her previous experiences, current expectations or available alternatives.

In the present study it refers to the subject’s feelings regarding the nature of job as measured by the Minnesota Satisfaction Questionnaire.

**Self-esteem**

Refers to an individual's sense of his or her value or worth, or the extent to which a person values, approves of, appreciates, prizes, or likes him or herself.

In this study it is the nurse’s subjective appraisal of herself as intrinsically positive or negative to some degree as measured by Rosenberg’s self-esteem scale.
Chapter 1  

Introduction

Conceptual Framework

A conceptual framework consists of concepts that are placed in logical, sequential design. The conceptual framework was developed by the researcher by relating all the concepts under the study. The researcher could not locate any appropriate model which includes all the variables under the study, as a base for the conceptual framework for the present study. The schematic representation of the conceptual framework is given in figure 1.