TEXILA AMERICAN UNIVERSITY

OCCUPATIONAL STRESS, SOCIAL RELATIONSHIPS AT THE WORKPLACE, PSYCHOLOGICAL WELLBEING AND COPING STRATEGIES OF NURSES AND MIDWIVES IN THE CATHOLIC HEALTH SERVICE OF THE WESTERN REGION, GHANA

THESIS

SUBMITTED TO TEXILA AMERICAN UNIVERSITY

IN PARTIAL FULFILLMENT FOR THE AWARD OF DEGREE OF DOCTOR OF PHILOSOPHY IN GUIDANCE AND COUNSELLING PSYCHOLOGY

SUBMITTED BY

ERIC KWASI ELLIASON

UNDER THE GUIDANCE OF

DR. ANTHONY KWABENA NKYI

OCTOBER 2021

CERTIFICATE

This is to certify that the thesis entitled "Occupational Stress, Social Relationships at the Work Place, Psychological Wellbeing and Coping Strategies of Nurses and Midwives in the Catholic Health Service of the Western Region, Ghana", submitted to the Texila American University, in partial fulfilment of the requirements for the award of the Degree of Doctor of Philosophy in Guidance and Counselling Psychology, is a record of original research work done by Eric Kwasi Elliason, under my/our supervision and guidance and that the thesis has not formed the basis for the award of any Degree / Diploma / Associateship / Fellowship or other similar titles to any candidate of any University.

…….

Dr Anthony Kwabena Nkyi

Seal:

DECLARATION

I, **Eric Kwasi Elliason**, declare that this thesis entitled, "Occupational Stress, Social Relationships at the Workplace, Psychological Wellbeing and Coping Strategies of Nurses and Midwives in the Catholic Health Service of the Western Region, Ghana", submitted to Texila American University, in partial fulfilment of the Degree of Doctor of Philosophy in Guidance and Counselling Psychology is a record of original work carried out by me under the supervision of Dr Anthony Kwabena Nkyi of the University of Cape Coast, Ghana and has not formed the basis for the award of any other degree or diploma, in this or any other Institution or University. In keeping with the ethical practice in reporting scientific information, due acknowledgements have been made wherever the findings of others have been cited

Candidate's Signature……Date……..

Name: ERIC KWASI ELLIASON

ABSTRACT

This study investigated occupational stress, social relationships at the workplace, psychological wellbeing and coping strategies of nurses and midwives in the Catholic Health Service of the Western Region, Ghana. Positivist research philosophy was employed for the study, and a quantitative research approach was adopted. A descriptive cross-sectional study design was used for the study. A sample of 300 nurses and midwives (nurses= 237; midwives = 63) was selected from four purposely selected Catholic Hospitals in the Catholic Health Service of the Western Region of Ghana. For gathering information from participants, a questionnaire based on Nurses' Occupational Stress Scale was adopted to measure the level of occupational stress; Ryff's Psychological Wellbeing Scale (PWB 18 items) to measure the level of psychological wellbeing, the Coping Strategies Inventory (CSI-SF, 1989) to measure the type of coping strategies adopted and the Worker Relationship Scale developed by Biggs, Swailes and Baker (2016) to measure the level of social relationships at the workplace among nurses and midwives. Statistical tools used to analyse data were one-sample t-test, Pearson Product Moment Correlation coefficients, one-sample Kolmogorov-Smirnov test, regression, t-test and ANOVA. The findings of the study showed that nurses and midwives in the Catholic Health Service in the Western Region experience significantly high levels of stress, positive psychological wellbeing and favourable work-related social relationship. The study also found that occupational stress was moderately and weakly associated with psychological wellbeing and workplace social relationships. The study results also indicated that nurses and midwives adopted both problem-focused and emotion-focused coping strategies but predominantly adopted problem-focused coping strategies in dealing with occupational stress. Also, the study's findings indicated that psychological wellbeing and social relationships at the workplace significantly impact the experiences of occupational stress among nurses and midwives. The study results also showed that occupational stress had a significant influence on the psychological wellbeing of nurses and midwives. It was recommended that the Ministry of Health employ Counselling Psychologists for all health facilities in Ghana to meet the counselling needs of nurses and midwives and, by extension, all health workers. Also, the Ministry of Health and its agencies should post enough nurses and midwives to where they are needed the most and ensure they report to such places. There be workshops and continuous professional development for nurses and midwives on coping strategies, social relationships, and psychological wellbeing.

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DEDICATION

This thesis is dedicated to the sweet memory of my dear mum

Theresah Alleah Kwofie on the occasion of her 15th Death Anniversary

28th March 2006 to 28th March 2021

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CHAPTER 1

INTRODUCTION

For World Health Organization (2015), the most significant health professional group in all countries are nurses and midwives. Nurses and Midwives are critical resources in meeting the public health needs of our various societies, handling the continuity of health care, addressing people's rights, and helping to address the changing health needs of the world (World Health Organization 2013). They are essential to provide safe, high quality and efficient health services across the life-course, especially with increasing service demands and ageing populations. Therefore, nurses and midwives are vital resources towards achieving the goals of Health 2020 (WHO, 2013).

World Health Organization (2020) recognized nurses and midwives as part of a multi-disciplinary solid team towards achieving the commitments made in the 2018 Astana Declaration on Primary Health Care which aimed to ensure patient-centred care close to the community. Birch (2001) asserts that midwives and nurses make up a big part of the health workforce worldwide and cover more than 80% of patient care. The hospital personnel, especially nurses and midwives, are prone to severe or moderate occupational stress (Hashemi et al., 2013). Akbar, Elahi, Mohammadi and Khoshknab (2017) affirms stress in all jobs or careers that deal with human health, but the issue becomes more sensitive and critical.

Vahed et al. (2011) found that 47.2% of nurses had psychological disorders and 50.7% from severe occupational stress, and 46.7% from moderate occupational stress. In a study by Hashemi et al. (2013) situated in Kerman, Iran, 60.7% of midwives suffered from psychological disorders, 81.8% from moderate occupational stress and 17.6% from severe occupational stress.

This study employed a quantitative research method to investigate occupational stress, social relationships at the workplace, psychological wellbeing, and coping strategies of nurses and midwives in Ghana's Catholic Health Service of the Western Region. The researcher recognizes the burden and stress nurses and midwives have to go through in their work. These could have terrible effects on the psychological wellbeing of these nurses and midwives. This study was significant because the results would help policymakers,

especially the Ministry of Health, employ professional counsellors in the various health facilities to take care of the psychological health needs of the different categories of health staff in the health facilities.

1.1 Background to the Study

Nurses and midwives form an essential part of the workforce of the healthcare settings (Beek, McFadden, & Dawson, 2019; Walker, Clendon, & Nelson, 2015). Nursing is defined to be the promotion, protection and optimization of health and abilities. It deals with the prevention of illness and injury, facilitating healing, alleviating suffering through diagnosis and treatment of human response and is also involved in advocacy in the care of individuals, families, groups, communities and populations. (American Nurses Association, 2016). Nurses thus play a crucial role in promoting health, preventing disease, and delivering primary and community care. They are therefore essential in achieving universal health coverage (World Health Organization, 2020). From the perspective of Rudolfsson and Berggren (2012), some qualities of efficient nurses in providing quality health service include being respectful, compassionate, wise, knowledgeable, sensitive, and caring to meet the needs of patients.

According to the American College of Nurse-Midwives (2012), midwifery involves primary care services for women and adolescents even beyond menopause. The services rendered by midwives include but are not limited to the provision of primary care, family planning and gynecologic services, preconception and post-conception care, care during pregnancy, and care of the newborns during the first 28 days of life. (American College of Nurse-Midwives, 2012). Midwives are also involved in promoting health, prevention of diseases, wellness education and counselling for pregnant women and mothers. They perform other vital activities relating to maternal and child health services.

Therefore, nurses and midwives are crucial partners in achieving holistic health and wellness as envisaged by Sustainable Development Goal 3.

Approximately 50% of the global health professionals are nurses and midwives (World Health Organization, 2020). In Ghana, it was estimated that as of 2017, the nurses and midwives ratio was 2.65 per 1000 population (Ghana Health Services, 2018). In 2018,

there was an increase of over 37% in the number of nurses recruited into the health sector of Ghana population (Ghana Health Services, 2019). Irrespective of this milestone, the country still faces challenges in terms of the shortage of nurses in the country. Consistent with this assertion, the WHO in the report indicated a shortage of nurses and midwives globally though they represent over 50% of health professionals. The need for nurses and midwives in the healthcare setting means that their workload will increase substantially, invariably leading to occupational stress.

For Mohajan (2012), occupational stress refers to physiological and psychological reactions when the job demands exceed the abilities, desires, and resources. Colligan and Higgins (2006) define occupational or workplace stress as the change in one's physical or mental state in response to a workplace that poses an appraised challenge or threat to that employee. Many factors contribute to occupational stress. Harshana (2018) indicated that stress from the workplace is a result of mismanagement of the organization, undefined work roles or duties, poor leadership and management, poor working conditions and competitive work cultures. Similarly, Kane (2009) reiterated that occupational stressors among nurses encompass an extended period of work, unpleasant sights and sounds, being extra vigilant in the care of patients, and unexpected changes of work routine. According to Yada et al. (2015), some sources of stress in the health settings include unfavourable working relationships among nurses, doctors and other management, heavy workload, emergency cases, understaffing, lack of feedback from senior members.

Occupational stress is associated with work dissatisfaction, decreased work output, emotional disturbances, physical illness, high staffs' turnover, and absenteeism (Malik and Noreen, 2015). Cramer and Hunter (2019) disclosed that midwives' emotional distress was highly associated with poor working conditions such as high workload, employee shortages, low social support, intentions to leave work, and clinical autonomy. For Leka, Griffiths and Cox (2003), stressed workers are usually unhealthy, poorly motivated, less productive and less safe at work. Mark and Smith (2012) asserted that "occupational stress can have dire consequences for organizational growth, and the psychological wellbeing of employees; Stress causes a lot of psychological trauma, such as anger, anxiety, depression, nervousness,

irritability, aggressiveness, and a decline in workers self-worth, hatred to supervision, lack of concentration, difficulties in decision-making and job dissatisfaction".

Occupational stress exists in all occupations. Every employee experiences some form of stress in one way or another, which happens in a wide variety of job circumstances (Murtaza et al., 2015). However, excessive occupational stress has been considered a "toxic" part of the job environment and is often associated with psychological and physical health (Wang, Liu, Yu, Wu, Chang & Wang, 2017). Against this backdrop, the International Labour Organization (2016) asserted that long-term excessive stress could lead to psychological problems like depression and anxiety. A couple of studies have shown that occupational stress significantly predicts pressure (Mark & Smith, 2011; DiGiacomo & Adamson, 2001; Mensah and Amponsah-Tawiah, 2016). Furthermore, occupational stress inversely correlates with psychological wellbeing (Suleman, Hussain, Shehzad, Syed & Raja, 2018) and is positively associated with depressive symptoms (Wang et al., 2017; Banerjee, 2012). Nakao (2010) recognized that occupational stress is a meaningful cause for mental health worldwide.

Stress in healthcare settings adversely affects the wellbeing of health professionals (Koinis, Giannou, Drantaki, Angelaina, Stratou, & Saridi, 2015). Omori (2015) asserted that the wellbeing of nurses is affected due to the tedious nature of their work and the highly stressful environment they find themselves in. Onasoga, Osamudiamen, and Ojo (2013) pointed out that stress is a serious concern among nurses and is associated with physical and mental health disorders and often leads to a declined work performance. Consistent exposure to stress will affect nurses' coping strength. The high levels of occupational stress invariably affect their psychological wellbeing.

Levi (1987), as cited in Madhuchandra and Srimathi (2016), defined psychological wellbeing as a state characterized by a reasonable amount of harmony between an individual's abilities, needs and expectations, environmental demands, and opportunities. Psychological wellbeing is how people evaluate their lives (Diener et al., 1999). Wellbeing includes subjective, social, and psychological dimensions and health-related behaviours (Ryff, 1989). The idea of psychological or emotional wellbeing was initially construed as a challenge in overcoming the hedonistic concept of wellbeing in psychology (Madhuchandra

& Srimathi, 2016). Psychological wellbeing is affected in many ways by the occupational stress of nurses and midwives.

"Social connectedness is critical for good health" (Saeri et al., 2018). It is generally agreed that people with limited social relationships have poorer mental and physical health, including increased depression (Cruwys et al., 2014). The literature shows that having strong social relationships protects and promotes mental health (Kawachi and Berkman, 2001; Perkins et al., 2021). For Kawachi and Berkman (2001), it is generally agreed that social ties play a beneficial role in maintaining psychological wellbeing. Thus, an excellent organizational relationship among employees is likely to promote and advance their psychological and general wellbeing. Although not set in healthcare settings, studies on social relationships have shown that social connectedness could positively impact psychological wellbeing. Chipeta et al. (2016) noted that positive relationships among health professionals serve as a source of motivation and higher job performance. Hellenbuyck (2021) of Mental Health America asserted that favourable and favourable relationships among employees enhance a better work environment and foster higher job satisfaction and productivity levels. Inversely, harmful or toxic relationships in the workplace can increase stress levels among employees, as well as feelings of isolation" (Hellenbuyck, 2021). Some studies have endorsed the essential role of positive working relationships on nurses' job performance, nurses and patients' satisfaction, employee retention, and organizational commitment (Adam & Bond, 2000; Force, 2005).

An efficient way to deal with occupational stress is knowledge about the sources of stress and the measures devised by health professionals to deal with such circumstances. In other words, positive coping methods are needed by nurses and midwives to mitigate the effects of occupational stress. Coping strategies are the measures used by an individual to overcome threatening situations. According to Skinner and Zimmer-Gembeck (2016), coping is an integral part of humans' survival and show the degree to which individual handle misfortunes in life. It encompasses both cognitive and behavioural efforts to reduce the impact of life demands which exceeds one's coping resources (Lazarus & Folkman, 1984). Adzakpah, Laar, and Fiadjoe (2016) indicated that the coping strategies used by nurses to combat the effects of occupational stress include engagement in hobbies,

avoidance of stressful work, proper time management, using adequate means to talk about their ordeals, and adapting to work ethics. Among midwives, Bánovčinová (2017) found that both problem-focused and emotion-focused strategies are adopted in dealing with stressful situations.

Rapid transformations are occurring in the healthcare settings, and there is more significant than ever pressures on the health organizations and workers to cope with these changes. A hard-working and well-established employee can feel a sense of satisfaction and achievement from his workplace. Nevertheless, sometimes the demanding nature of the work itself and the work environment can put a great deal of pressure on the employee. The burden of work stress affects the employees and the organization in which they work (Malik and Noreen 2015). The adverse effects of occupational stress on nurses, patients, and organizational life make it imperative to ensure concrete interventions are put in place to deal with occupational stress in health settings. In this context, this study is conducted to investigate occupational stress, social relationships at the workplace, psychological wellbeing, and coping strategies of nurses and midwives in the Catholic Health Service of the Western Region, Ghana.

1.2 Statement of Research Problem

Stress from healthcare settings has adverse health implications for nurses (Sarafis et al., 2016). Globally, its prevalence among nurses varies widely between 9.2% and 68.0% (Dagget, Molla and Belachew 2016). The higher emotional demands at work and lower opportunities for development associated with nurses and midwives make them suffer significantly from occupational stress (Peter, Hahn, Schols and Halfens, 2020). The health care settings are flooded with excessive workload, difficult working conditions, dealing with complex patients, uncertainty concerning treatment of patients and numerous occupational health and safety hazards is essentially a stressful profession (Mosadeghrad, 2013). These challenges significantly impact nurses and midwives. Evidence from a couple of studies done in different contexts indicates that workers experience various forms of psychological issues due to occupational stress (Buhrmaster, 2006, Mangwani, 2012).

Staff records at hospitals and clinics within the Catholic Health Service in the Western Region indicate high absenteeism due to ill health and other related issues such as domestic problems (2019). This confirms that nursing-related stress also contributes to absenteeism and high turnover rates in the profession (Sveinsdóttir, Biering, and Ramel, 2006). Nurses and midwives especially would have to combine tight work schedules with domestic chores and marital commitments. In Ghana, "the average nurse or midwife in the hospital is expected to work a maximum of seven hours for daily duties and twelve (12) hours for night shifts. Depending on the working unit and the overall staff strength, night shifts run for four (4) to seven (7) days followed by three (3) to five (5) days off duty" (Kaburi et al. 2019).

Positive psychological functioning is critical to ensure active employees for the good of the organization. Onasoga, Osamudiamen, and Ojo (2013) pointed out that stress is a serious concern among nurses and is associated with physical and mental health disorders and often leads to a declined work performance. The same could be said of midwives. Occupational stress affects nurses and midwives in various ways, especially concerning their psychological wellbeing. Studies on occupational stress and psychological wellbeing have either concentrated on nurses alone or midwives alone. There seems to be no single study that has combined both midwives and nurses concerning occupational stress and psychological wellbeing.

Literature confirms the importance of workplace social relationships in helping reduce the effects of occupational stress (Adam & Bond, 2000; Force, 2005). Coping strategies are also crucial in helping reduce the impact of occupational stress on nurses and midwives. According to Skinner and Zimmer-Gembeck (2016), coping is an integral part of humans' survival and shows how individuals handle misfortunes in life. Thus, social relationships at the workplace and coping strategies adopted by nurses and midwives are vital in managing the adverse effects of occupational stress, thereby ensuring positive psychological wellbeing. Despite this, there seems to be no single study that has combined the four variables – occupational stress, social relationships at the workplace, psychological wellbeing and coping strategies – among nurses and midwives.

Consequently, evidence on the association of these variables among nurses and midwives is scarce in Ghana. Thus, works on occupational stress, social relationships, psychological wellbeing and coping strategies among nurses and midwives in Ghana are mainly underexplored. Against this backdrop, the researcher investigates occupational stress, social relationships at the workplace, psychological wellbeing, and coping strategies of nurses and midwives in the Catholic Health Service of the Western Region of Ghana.

1.3 Research Objectives

The main objective of this study was to investigate occupational stress, social relationships at the workplace, psychological wellbeing and coping strategies of nurses and midwives in the Catholic Health Service of the Western Region, Ghana.

The Specific Objectives of the study were to:

1. Identify the level of occupational stress, social relationships and psychological wellbeing among nurses and midwives in the Catholic Health Service in the Western of Ghana.
2. Examine the relationship among occupational stress, social relationships and psychological wellbeing among nurses and midwives in the Catholic Health Service in the Western Region, Ghana.
3. Determine the type of coping strategies adopted by nurses and midwives to mitigate the impact of occupational stress in the Catholic Health Service of the Western Region.
4. Examine the influence of psychological wellbeing and social relationship at the workplace on the experiences of occupational stress between nurses and midwives in the Catholic Health Service of the Western Region.
5. Determine the influence of occupational stress on the psychological wellbeing of nurses and midwives in the Catholic Health Service in the Western Region of Ghana.

6. Examine the impact of social relationships on the psychological wellbeing of nurses and midwives in the Catholic Health Service of the Western Region of Ghana.
7. Establish the relationship between occupational stress and coping strategies between nurses and midwives in the Catholic Health Service of the Western Region of Ghana.
8. Determine the difference in occupational stress between nurses and midwives in the Catholic Health Service of the Western Region regarding age.
9. Determine the experience of occupational stress between nurses and midwives in the Catholic Health Service of the Western Region regarding the duration of service.
10. Examine the experience of occupational stress between nurses and midwives in the Catholic Health Service of the Western Region regarding the category of health professionals.

1.4 Research Questions

The following research questions were proposed to guide this study:

1. What is the level of occupational stress, social relationship and psychological wellbeing of nurses and midwives in the Catholic Health Service in the Western Region of Ghana?
2. Is there any relationship between occupational stress, social connection and psychological wellbeing of nurses and midwives in the Catholic Health Service of the Western Region of Ghana?
3. What type of coping strategies are adopted by nurses and midwives to mitigate the impact of occupational stress in the Catholic Health Service of the Western Region?

1.5 Research Hypotheses

1. Ho: There is no statistically significant influence of psychological wellbeing and social relationship at the workplace on the experiences of occupational stress between nurses and midwives in the Catholic Health Service of the Western Region of Ghana.

   H_1: There is a statistically significant influence of psychological wellbeing and social relationship at the workplace on the experiences of occupational stress among nurses and midwives
2. Ho: Occupational stress has no significant negative influence on the psychological wellbeing of nurses and midwives.

   H_1: Occupational stress has a significant negative influence on the psychological wellbeing of nurses and midwives.

3. Ho: Social relationships will have no significant positive influence on the psychological wellbeing of nurses and midwives.

   H_1: Social relationships will have a significant positive influence on the psychological wellbeing of nurses and midwives.
4. H_O: There will be no significant positive relationship between occupational stress and coping strategies

   H_1: There will be a significant positive relationship between occupational stress and coping strategies
5. H_O: There will be no significant age differences regarding experiences of occupational stress among nurses and midwives.

   H_1: There are significant age differences with regards to experiences of occupational stress among nurses and midwives.
6. H_O: There will be no significant differences in experiences of occupational stress of nurses and midwives concerning duration of service

   H_1: There is a significant difference in the experiences of occupational stress among nurses and midwives concerning duration of service.
7. H_O: There will be no significant difference in the experiences of occupational stress concerning the category of health professionals.

H_1: There is a significant difference in the experiences of occupational stress concerning the category of health professionals.

1.6 Significance of the Study

The study will help the Ministry of Health in Ghana, the Christian Health Association of Ghana, the Ghana Health Service and other agencies under the Ministry of Health to identify the effects of occupational stress in the health sector and make policies to improve the psychological health of nurses and midwives in Ghana. The study will also help these agencies to know the factors that affect the psychological wellbeing of nurses and midwives, thereby finding appropriate ways of addressing them. The study will also look at very crucial variables that impinge on the psychological wellbeing of nurses and midwives. The results will thus be used to improve the psychological health of nurses and midwives to help them give off their best in the execution of their duties.

The results of this study will benefit the employers, management, researchers and employees of the Catholic Health Service in the Western Region to know the effects of occupational stress on the psychological wellbeing of nurses and midwives. The results of this study will also help nurses and midwives, and other healthcare workers to identify the sources of their stress, what coping strategies they could adopt in dealing with them and what to do to improve their psychological wellbeing.

1.7 Scope of the Study

This study investigated occupational stress, social relationships at the workplace, psychological wellbeing and coping strategies among nurses and midwives in the Catholic Health Service of the Western Region of Ghana. The emphasis of the study was on the psychological wellbeing of nurses and midwives and how it is impacted by occupational stress, social relationships at the workplace and coping strategies. There are other components to wellbeing such as social wellbeing, economic wellbeing, physical wellbeing, but the focus of this research was on psychological wellbeing. This is because psychological

wellbeing receives little or no attention in Ghana, especially among health workers. The study thus did not dwell on the totality of wellbeing but psychological wellbeing among nurses and midwives. The time limit did not permit the study to be conducted in all health facilities in the Western Region. The researcher chose Catholic Health facilities for easy access to data and convenience, considering that the researcher is also an employee of the Catholic Health Service of the Western Region.

1.8 Operational definition of Key Terms

1. **Occupational Stress:** The experiences of stress by an employee due to interaction with their working environment and conditions.
2. **Psychological Wellbeing:** A state of optimum psychological functioning and experiences of positive emotions and feelings of happiness.
3. **Coping Strategies:** The efforts or measures adopted by people to adapt to or decrease the effects of stressful events.
4. **Workplace Social Relationship:** The interaction and connections among workers in an organization.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

The study looked at occupational stress, social relationships at the workplace, psychological wellbeing, and Coping strategies of nurses and midwives in the Catholic Health Service of the Western Region of Ghana. The goal of the research was to: Identify the level of occupational stress, social relationships and psychological wellbeing among nurses and midwives in the Catholic Health Service in the Western of Ghana; Examine the relationship among occupational stress, social relationships and psychological wellbeing among nurses and midwives within the Catholic Health Service in the Western Region, Ghana; Determine the type of coping strategies adopted by nurses and midwives to mitigate the impact of occupational stress in the Catholic Health Service of the Western Region; Examine the influence of psychological wellbeing and social relationship at the workplace on the experiences of occupational stress among nurses and midwives in the Catholic Health Service of the Western Region; Determine the influence of occupational stress on the psychological wellbeing of nurses and midwives within the Catholic Health Service in the Western Region of Ghana; Determine the difference in occupational stress between nurses and midwives in the Catholic Health Service of the Western Region regarding age; Determine the experience of occupational stress between nurses and midwives in the Catholic Health Service of the Western Region regarding the duration of service; Examine the experience of occupational stress between nurses and midwives in the Catholic Health Service of the Western Region regarding the category of health professionals

Stemming from this, chapter two of this study reviews literature related to the study, looking at the theories that underpin the study, the conceptualization of the variables in the research, and an empirical review of all existing studies related to the current research.

2.1.1 Theoretical Review

The Diathesis Stress Model (Zuckerman, 1999), the PERMA Model (Seligman (2011), the Transactional Stress and Coping Theory (Lazarus & Folkman, 1980), the Social Exchange Theory (George Homans, 1984), the Spillover effect and the Role theory were reviewed for the study.

2.1.2 The Diathesis Stress Model

The Diathesis-stress model of psychopathology is a framework that helps to understand that psychopathology results from an interaction between biological factors and environmental stress (Broerman, 2020). According to the general model, each individual has an inherent level of predisposing factors (Diathesis) for developing a mental health disorder. Zuckerman (1999), the putative founder of the Diathesis-stress model of psychopathology, opines that the pathological states begin from combining a predisposition with stressful events. According to the Diathesis-stress model, an individual can develop mental health disorder. This rests heavily on the interaction between an individual's vulnerability and the extent of a life situation that an individual deems stressful (Munroe and Hadjiyannakis, 2002). Salomon and Jin (2013) asserted that several models stipulate that neither stress nor a predisposing factor (Diathesis) alone is enough to develop a disorder; however, stress triggers the Diathesis, leading to stress to the disease. More broadly, an individual's vulnerabilities may heighten the likelihood that having a stressful experience can start the individual's mental disorder.

The Diathesis-stress model can be said to be the risk factor for stress-related diseases. Ingram and Luxton (2005) conceptualized Diathesis as a set of characteristics or predisposition factors that make an individual prone to psychopathology. These predispositions factors can either be psychological (cognitive and interpersonal) or biological (genetic) (Ingram and Luxton, 2005). Ingram and Luxton (2005) believed that psychological vulnerability is subject to change because it starts from dysfunctional learning experiences, and these experiences can be corrected. On the other hand, genetic vulnerability was perceived by Ingram and Luxton (2005) as an enduring trait that cannot be fixed easily.

Though the Diathesis-stress model proves how an individual's vulnerability makes them susceptible to disorders, scholars such as Ford (2015) maintains that protective factors such as social support and self-esteem can provide a buffer against the effects of significant stressors an individual faces, and this will provide the individual with an adaptive mechanism to deal with stress.

In summary, the diathesis-stress model elucidates that an individual's psychological vulnerabilities or genetic vulnerabilities to a particular mental disorder can be triggered by stressful life events. However, any resilient individual with a quality social support system might adapt to such stressors or take a high level of stress to activate the disorder. Nurses and midwives in the various health facilities might be prone to these stressors in the course of work. According to the tenets of this theory, the vulnerability to such stressors may trigger psychological disorders among these nurses and midwives. Still, support systems such as a good relationship between leaders of these healthcare facilities and nurses might serve as a buffer against these stressors.

2.1.3 The PERMA Model

The pursuit of psychological wellbeing is one that individuals have been working toward since the beginning of time. In various workplaces, individuals undertake activities to gear towards achieving general wellbeing. The PERMA theory developed through the works of Seligman (2011) proposed five ways through which individuals can achieve general wellbeing. According to Seligman (2011), the five (5) measurable elements that make up an individual's wellbeing are Positive Emotion, Engagement, Relationships, Meaning and Accomplishment. These five pathways form the acronym PERMA hence the PERMA model of general wellbeing.

2.1.3.1Positive emotion

The first measurable element, the pleasant life, concerns the maximization of positive emotions. D'raven and Pasha-Zaidi (2016) posit that positive emotions are crucial to performance and growth. Fredrickson (2001) believes that positive emotion is a significant indicator for change, and these emotions can be learned to help improve one's

general wellbeing. Tugade and Fredrickson (2004) also asserted that individuals who cultivate positive emotions strengthen their thinking, promoting resilience. A study by Fredrickson (2001) on broaden-and-build theory reveals that the experience of positive emotions enables individuals' thoughts and actions. Individuals living in individualistic societies opt for high arousal positive emotions (excitement), whiles persons living within collective communities appear to choose low arousal emotions (contentment) (Tkach and Lyubomirsky, 2006; Tsai et al., 2006; D'raven and Pasha-Zaidi, 2016).

In sum, The PERMA Model believes that one of the five pathways to improve an individual's wellbeing is through positive emotions. Increasing positive emotions among nurses and midwives will help them build intellectual, physical, social and psychological resources that will lead to resilience and improve an individual's general wellbeing.

2.1.3.2 Engagement

The second pathway to an individual's general wellbeing is engagement. Engagement deals with an individual giving much attention to work or life. The engagement pathway aligns with Csikszentmihalyi's (1990) concept of "flow." Flow at the workplace is when an individual or an employee understands their role and effortlessly undertakes the activity assigned. Here, the employee focuses on the present task. In such circumstances, a person provides the right attitude for the work, and they can handle the job without any form of limitation. D'raven and Pasha-Zaidi (2016) posit that the tenets of engagements as part of the five pathways for the PERMA model for general wellbeing can be explained through the lenses of intrinsic motivation created by Deci and Ryan (2008). According to Deci and Ryan (2008), intrinsic motivation occurs when individuals see themselves as responsible for their outcomes and are motivated by internal rewards such as interest, pleasure, and the sense of achievement in undertaking a task. The individual with this quality can perform a task with or without supervision. Developing such a character helps an individual to be more productive at the workplace.

Nurses and midwives would benefit significantly from engagement if they focus on their work and derive pleasure from it other than seeing it as a duty or some form of punishment that may lead to discontentment. They should be internally motivated to work and derive joy and happiness from the helping relationship that results from their work.

2.1.3.3 Relationships

A relationship entails all the various interactions individuals have with colleagues, family members and the community (Bagnall, South, Martino, Mitchell, Pilkington & Newton, 2017). Farooqi (2014) believes that human relationships form the essence of an individual's personality, contributing mainly to a person's wellbeing. As part of the PERMA model, relationships refer to the feeling of being loved, supported and valued by members of a social group. Humans are inherently social creatures (Seligman, 2012), and as such, the quality of their social relationship have a toll on their wellbeing. The quality of relationships hinges on how positively or negatively a person feels about their relationships (Morry, Reich and Kito, 2010; Farooqi, 2014). An individual's social environment and social relationship have been known in the literature to play a massive role in building strong social networks that shape one's health and also prevent a cognitive decline (Umberson & Montez, 2010). Lincoln (2000), on the other hand, pointed out that several research works have delved into the relationship between social support and the psychological wellbeing of an individual; however, few pieces of research show the negative side of social interactions. According to Lincoln (2000), empirical reports of evidence suggest that negative interactions can potentially be more harmful to an individual than social support is helpful.

Within the various hospitals, support systems seek to genuinely support nurses and midwives in cases such as a nurse or midwife who unintentionally causes damage to an individual or unknowingly take actions that will lead to a patient's demise. At this stage, the healthcare worker goes through a second victim experience. The second victim experience of the nurse/midwife might lead her into depressive moods; however, the presence of a quality support system will help calm the nurse/midwife and nurture them through such periods.

2.1.3.4 Meaning

The fourth pathway of psychological wellbeing explained by the PERMA Model is meaning. Seligman (2011) defined meaning as the need for an individual to have a sense of worth and value. It is achieved when an individual belongs or serves something much more extraordinary in life. Having a purpose in life helps an individual to focus on life. Meaning

based on the PERMA model encompasses using strengths and skills not for oneself but towards fulfilling a goal worthy such as developing meaningful relationships at the workplace and promoting healthy lifestyles (Seligman, 2002). An individual having a meaning in life is an intrinsic human quality, enabling an individual's wellbeing. Purpose or meaning among individuals, even at a workplace, varies from one other. Some individuals find meaning in life by pursuing a particular profession or through volunteering. A comparative study by Kleftaras and Psarra (2012) on the meaning in life, psychological wellbeing and depressive symptomatology revealed that individuals with the higher meaning of life possess better psychological health than those with lower meaning in life. Again, Kleftaras and Psarra (2012) study showed that meaningful romantic relationships, marriage, and social activities are some of the proven sources of meaning.

2.1.4 Achievements/Accomplishments

Achievement refers to the successes individuals attain by using their skills and efforts towards their goals. As pointed out by the PERMA Model, an achievement that is the last pathway of an individual's wellbeing is mastery, accomplishments, or competence. A sense of accomplishment contributes primarily to one's overall wellbeing (Seligman, 2012). Achievements improve one's wellbeing because an individual feels proud. Seligman (2013) opines that individuals attaining intrinsic goals such as connections and growth can lead to high general wellbeing than external goals such as fame. Wang, Li, Sun, Cheng and Zhang (2017) found that an individual's achievement goals were positively related to life satisfaction. In defining achievement goal, Wang et al. (2017) defined achievement goal as *"a future-focused cognitive representation that guides behaviour to a competence-related end state that the individual is committed to either approach or avoid"*. D'raven and Pasha-Zaidi (2016) asserted that pursuing mastery, achieving and winning are means to happiness. At the workplace, individuals have to separate their goals. The tendency for an individual to utilize their skills in meeting their set targets or goals will help improve their psychological and general wellbeing.

In sum, Seligman (2011) hypothesized that PERMA (Positive Emotion, Engagement, Relationships, Meaning, and Accomplishment) contributes mainly to the wellbeing of individuals. Concerning this study, the theory suggests that nurses and midwives with Positive Emotions, Engagement, Relationships, Meaning, and feeling of accomplishment will improve their psychological and general wellbeing.

One major criticism levelled against the PERMA model is that the PERMA model sees the attainment of happiness and wellbeing as an individualistic effort rather than the collective satisfaction of individuals found in other cultures. However, the PERMA model was selected as part of the theoretical underpin of the study because it provides pathways that can help understand the sources of happiness and psychological wellbeing of nurses and midwives.

2.1.5 Transactional Stress and Coping Theory

The Transactional Stress Theory has been widely used, especially in research on stress, burden and coping. The Transactional Stress Theory posits that there is an interaction between an individual and the environment. The Transactional stress model emphasizes that stress occurs when an individual is faced with environmental demands. It also suggests that the individual's ability to cope with these demands largely rests on their cognitive appraisal (Kim, 2017). Here, stress occurs when the interaction between an individual and the environment threatens their coping resources and burdens physical and psychological wellbeing.

Velichkovsky (2009) also opines that the central tenets of the transactional model are that stress goes through a series of phases. Velichkovsky (2009) identified that the first stage is the "antecedents of the stress process": they involve the individual's personality, the environmental factors, and the stressors. The second phase is the cognitive appraisal phase, and when the condition at hand and the individual's ability to cope with the stressor are appraised, the third phase starts. At this phase, several managing processes are employed, which encompasses the actual response to the stressor. The fourth phase is the stress outcomes. When faced with a stressor, an individual interprets the demands of the condition

at hand. If these interpretations exceed an individual's ability to cope with the demands, the individual will then give a stress response. When a threat lurks, an individual will have both primary and secondary appraisals of the perceived threat. The transactional model of stress posits three forms of cognitive appraisal: primary appraisal, secondary appraisal, and re-appraisal (Lazarus & Folkman, 1984: Kim, 2017).

Primary appraisal occurs when the individual appraises the stressor and sees it as harmful, a threat, or a challenge (Lazarus & Folkman, 1984). According to Velichkovsky (2009), a primary appraisal assesses how dreadful a stressor is. Primary appraisal is one assessment of an event that poses a threat. At the primary appraisal level, the person focuses mainly on the gravity of the stressor (Matthieu and Ivanoff, 2006). On the other hand, a second appraisal is the individuals' evaluation and judgement on whether or not they can control the stressor (Matthieu and Ivanoff, 2006). According to Matthieu and Ivanoff (2006), this judgement is subjective, which means it solely lies on the individual's decision on the resources at hand to control the stressor. The individual makes a cognitive assessment of the resources available to cope with the stressor. In turn, the individual copes with the stress by engaging in cognitive and behavioural efforts to control the physical and emotional demands beyond the individual's ability to handle the stressful event (Lazarus & Folkman, 1984). The more dreadful a person perceives the stressor, the more unfavourable the response. According to Lazarus and Folkman (1984), as cited by Kim (2017), previous experiences play a significant role in the appraisal process, and as such, these appraisal processes are not conscious. Re-appraisal can be done if the individual facing a threat is exposed to new information based on an outcome of 'initial cognitive appraisal. A threat appraisal can be reappraised as irrelevant or reappraised as a challenge (Kim, 2017).

The transactional model of stress is pivotal in explaining focus among second victims. This is because second victims go through several appraisals to cope with the situation they find themselves in. The transactional model reveals that second victims will first evaluate the problem at hand, known as the primary appraisal. Secondly, second victims will assess all the resources at hand that are needed in managing the stressor, and this phase is known as the secondary appraisal. The transaction model further postulates that after all the assessments made by a second victim, a third phase known as the re-appraisal is

undertaken to classify these stressors as relevant or irrelevant, which is likely to cause depression and other health problems.

One of the critical parts of the Transactional Model of Stress is an individual's coping mechanisms in dealing with a stressor. According to Folkman and Lazarus (1980), coping is *the cognitive and behavioural efforts made towards mastering, tolerating, or reducing external and internal demands and conflicts. Krohne (2002) opines that coping is intimately linked to the concept of cognitive appraisal.* As stated earlier*,* psychological stress occurs when the individual encounters specific situations demanding beyond the individual's resources, thereby creating a risk to the person's physical, mental, or emotional wellbeing. Thus, in the face of every stressful event, the theory posits that there are specific processes of cognitive appraisal to assess whether *a person believes they possess the required resources to deal adequately with the challenges posed by a stressor.*

This theory considers two types of coping: problem-focused and emotion-focused (Folkman & Lazarus, 1980; Lazarus & Folkman, 1984).

2.1.6 Problem-Focused Method of Coping

The problem-focused coping method occurs when an individual adopts strategies to solve or tackle any stressful situation at hand. Here, the individual undertakes a conscious effort to change the stressful situation by adopting practical solutions to tackle the problem (Lazarus and Folkman, 1984: Orzechowska, Zajączkowska, Talarowska and Gałecki, 2013). In an article published by Saul McLeod on stress management, the writer pointed out that problem-focused strategies are directed to either reduce or remove the source of the problem. Some of these strategies include solving the problem, time management and accessing social support. The problem-focused approach does not work in every situation, especially in cases where the individual facing the problem cannot completely solve the primary source of the stress. Instead, the problem-focused method works best when the individual has control over the source of the stress. With the problem-focused method of coping, nurses and midwives in the face of stressors at the workplace find ways to cope with the problem at hand by adopting strategies to lessen or deal with the stress they face.

2.1.7 Emotion-focused Method of Copying

The emotion-focused coping method is either positive or negative. Emotion-focused coping deals with managing emotional distress linked with the situation (Lazarus& Folkman, 1984: Orzechowska et al., 2013). Here, an individual tries to lessen the negative emotional responses related to stress. Such negative effects include fear, depression, embarrassment, loss of self-confidence. This type of coping mechanism is only effective when the source of stress is beyond an individual's control. Examples of a positive emotion-focused approach to coping are writing or talking about an individual's emotions, which can be done through therapies, meditation, and others.

A negative emotion-focused system isn't helpful in the long run. According to Esia-Donkoh et al. (2011), the problem-focused coping approach dominates when a person believes that he can take practical actions to curb the solution at hand. On the other hand, the negative emotion-focused approach includes avoidance, drug use, and alcohol use to avoid the emotion. Still, the emotion-focused approach dominates when individuals feel they can do nothing and the only alternative left is to endure.

Most people can only cope with short time stress, and the effectiveness of any copying mechanisms mainly used rests on the situations they are used to. Individuals differ in how they encounter stressors at the workplace.

2.1.8 Social Exchange Theory

The workplace has been known as one of the areas individuals experience stress. Stress at the workplace over a period can lead to several adverse effects for individuals and firms. Such adverse effects include low turnover, burnout, absenteeism, low work performance (Mirela and Mădălina-Adriana, 2011). A socially supportive and positive communication system is critical to help employees cope with stress (Sias, 2009). One

theory that offers helpful insight into how social relationships at the workplace can help mitigate stress is the Social Exchange Theory (SET).

Sociologist George Homans developed the Social Exchange Theory. According to the social exchange theory, social behaviour is the result of an exchange process. The main crux of this exchange is to minimize cost whiles at the same maximizing profit. The social exchange theory further posits that individuals assess the potential risk and benefit of social relationships. In situations where the risk outweighs the reward, individuals will terminate the relationship. The social exchange theory postulates that more relationships involve give-and-take, but this does not in any way suggest that the exchanges here are always equal. Evaluating the costs and benefits of each of the relationships shows whether an individual will choose to continue with a social association or not. According to the Social Exchange Theory, Costs entail all activities within a relationship that an individual perceives as unfavourable. At the workplace, lack of opportunity for growth and a supportive system are examples of costs to employees. Benefits, on the other hand, encompass all activities an individual perceives as positive and worthy. At the workplace, allowances and opportunities for growth are part of the rewards. According to most social exchange theorists, social changes between individuals are deep-rooted in self-interest and are characterized by mutual dependency (Huston & Burgess, 1979 cited by Cole, Schaninger and Harris, 2002).

Generally, the social exchange theory at the workplace has three central tenets: Rationality, Rewards and workplace relationships. According to the idea, rationality entails the choices employees make in their relationships at the workplace, based on rational decision making. Here, the individual employee assesses their decision on different employees and chooses what they believe will make a huge difference. Rewards based on the theory is a peculiar way of reinforcing positive relationships at the workplace. People can achieve this by providing awards and other incentives to employees for work done. Proponents of the social exchange theory believe that individuals will form a relationship based on their rewards. Here, their investment into the relationship must be directly proportional to what the individual perceives to get out of the relationship. Lastly, another tenet as espoused by the theory is workplace relationship. The theory theorizes on the need for friendly relationships at the workplace to enable a positive working environment. Any

feeling of displeasure or hostility an employee feels will be a disincentive to the willingness to seek out a relationship at the workplace. Employee satisfaction hinges hugely on the relationships employees form at the workplace (Morgeson & Humprey, 2007).

Redmond (2015) reveals that one of the main critiques that can be levelled against the social exchange theory is when individuals remain in a relationship even when they are inequitable. In such situations, the Social Exchange Theory posits that an individual will leave such relationships. However, there are periods where individuals will stay in a relationship without the expectation of future returns.

2.1.9 The Spill-over Effect Theory

One of the best theories that explains the relationship between work and family is the Spillover theory. AlHazemi and Ali (2016) contend that several scholarly writers describe the spillover effects to mean situations where an employee carries the attitudes, behaviours, skills, and emotions developed into their family lives. Sometimes, the learnt attitudes, behaviours, and actions developed at home are carried to the workplace. Akinyele, Peters and Akinyele (2016) asserted that the Spillover effect can be positive or negative. The positive Spillover effect refers to situations where achievement, fulfilment and satisfaction in one domain bring along happiness and accomplishment in the other domain.

On the other hand, the negative spillover effect refers to the situations where stress, strain and difficulties in one domain bring the same negative emotions on the different domain (AlHazemi & Ali, 2016). Edwards and Rothbard (2000) postulated that for spillover effects to occur, there should be the presence of solid connections between work and family, and these strong connections must be observable. Negative emotions and moods such as anger and fatigue carried by an individual from one social structure (e.g. family) to the other (e.g. work) create work-family conflict, signalling incompatibility (Radó, Nagy and Kiraly, 2015).

In summary, the spillover effect theory helps understand how an individual can carry a mood, behaviour, or attitude from one domain to another. The strong connections between family with the role of an individual as a family member and an employee mean any occurrence in one part of the life of individuals may create a spillover effect on the other

domain. Here, when not resolved, an imbalance between work and family tends to create work-family conflict. This theory was selected as one of the main theoretical underpinnings of the topic under study because it sheds light on the connection between work and family and how one domain impacts the other domain. Although this study did not consider work-life balance, the researcher still feels family issues can play out at work and lead to occupational stress, causing negative psychological wellbeing among nurses and midwives.

2.1.10 The Role Theory

The role theory posits that opposing expectations related to different roles harm the general wellbeing of an individual. Poelmans (2001) defined roles as a set of behaviours linked with a particular status or a position. However, the main focus of the position this study seeks to study is that of work and family. These two social structures or positions can be seen as the two most critical institutions in the lives of many individuals. The role theory generally predicts that engagement in multiple duties leads to role stress. Expectations from work and that of the family can spark psychological and physical stress. For instance, the opposing demands from one's role can lead to intra-role conflict or sometimes the expectations can lead to an inter-role conflict when the demand in a particular role intrudes in the pressure of the other role. Lastly, the accretion of expectations from varied roles can lead to the burden of overload in one of the two main roles. The role theory concerns a vital social life and its roles. Roles are constantly changed to achieve effectiveness. According to Turner (2001), the role theory posits that "Individual behaviour within social contexts is organized and acquires meaning in terms of roles. Work responsibilities in organizations are organized into roles, as is participation in groups and society".

In summary, roles are a set of behaviours and attitudes associated with a particular position. Therefore, the role theory claims that multiple duties create role stress, which tends to cause depression, and the expectation towards family and work duties can lead to psychological and physical strain. Critiques of the role theory suggest that multiple roles are not detrimental rather salutary. However, this study selected the role theory as part of its theoretical underpinnings since nurses and midwives take on different roles at work leading to stress and negative psychological wellbeing.

CONCEPTUAL ISSUES

2.2.0 Concept and Meaning of Stress

Stress is a multidimensional concept and occurs when our physical and psychological strength cannot handle environmental threats (Kakunje, 2011). Quick and Henderson (2016) defined stress as the *"rubric for the causes (demands or stressors), consequences (distress and eustress), and modifiers of the psychophysiological phenomenon known as the stress response"*. According to Selye (1973), stress refers to "*the bodily processes that result from circumstances that place physical or psychological demands on an individual"*. In its basic terms, stress refers to the body's reaction to change that needs response. The body, in the face of any adjustment, reacts with emotional, physical and mental responses. Ismail, Yao, Yeo et al. (2010) established that stress might be divided into positive (good stress or eustress) and negative stress (distress). Whiles eustress aid in higher performance of activity, distress decreases the motivation to engage in quality work and is associated with health problems (Nakao, 2010). According to Seiler, Fagundes and Chrsitian (2020), research over the past three decades proves beyond doubt that psychological stress has a significant impact on clinically crucial immune system outcomes. These, according to the scholars, include inflammatory processes, vaccination, and wound healing, among others. It is evident that stress is needed to a certain point which helps boost one's performance; however, excessive stress is harmful. Lastly, it is essential to note that stress is a state and should not be classified as an illness (Moustaka & Constantinidis, 2010).

A look into existing literature reveals the numerous types of stress pointed out by scholars. For instance, according to Bhowmik, Durai Vel, Rajalakshi and Sampath Kumar (2014), there are three types of stress. They are routine stress, stress brought about by change, and traumatic stress. According to the researcher, routine stresses are the types of stress which are usually connected to the daily pressures and demands of work. These types of stress are brought about through our daily responsibilities. According to Bhowmik et al.

(2014), the second type of stress is the type of stress that occurs due to a sudden negative change in an individual's life. Example of such negative changes includes losing one's job, illness or sickness and divorce. The last type of stress revealed by the researchers is traumatic stress. According to them, traumatic stress occurs when an individual is in danger of being hurt or killed. War, fatal accidents, natural disasters and assaults are events that lead to traumatic stress. Traumatic stress tends to cause post-traumatic stress disorder (PTSD).

On the other hand, Agarwal and Malhotra (2019), in their quest to research the stress within the workplace, pointed out three types of stress: Acute Stress, Episodic Acute Stress, and Chronic Stress.

2.2.1. Acute stress

According to the researchers, acute stresses are brief. They are the type of stress that is usually common and frequent in the lives of individuals. This type of stress is generally caused by reactive thinking. This type of stress usually calls for an immediate response from the body to a new challenge. Acute stress can be caused by negative thoughts that occur in a particular situation. Usually, overthinking and worry lead to such stress. Some effects of acute stress are; depression, neck pain, muscular tensions, sweaty palms, sleep problems, cold hands and feet. Acute stress is not always negative.

2.2.2. Episodic Acute Stress

The experience of acute stress over and over again leads to episodic acute stress. It's a repetitive form of acute stress, which can result from facing several stressful challenges. Individuals with episodic acute stress usually live a life full of tension. They are constantly under pressure to act. Individuals experiencing episodic stress disorder typically have a negative outlook on every sphere of their lives, and they tend to worry over petty issues. Victims of episodic acute stress embrace stress as part of their lifestyle, and they find it hard to change it. Some effects of episodic stress disorder are anxiety, compromised attention, high blood pressure and heart palpitation.

2.2.3. Chronic stress

Prolonged acute stress leads to chronic stress. Chronic stress does not quickly go. Chronic stress encompasses heavy pressures and demands with no hope of any solution to

the problem. This kind of stress harms the lives of people. Individuals suffering from chronic stress are predisposed to heart attacks and other mental and physical health issues.

Besides, Wallace (2005) on types of stress added three types of stress that are also common in the lives of individuals. They are:

2.2.4. Psychological stress

This type of stress deals with both emotional and cognitive stress. According to Wallace, psychological stress usually triggers panic attacks, anxiety, self-criticism, jealousy, sadness, anger, attachments, sadness, fear and frustration.

2.2.5. Psychosocial stress

This is stress experienced by individuals facing challenges and turmoil in relationships with others, especially marriage problems. The forms of relationship that can cause such stress are relationships with family members, spouse, employer and employee. Psychosocial stress can lead to isolation. The loss of employment, loss of a loved one and lack of social support can lead to stress.

2.2.6. Physical stress

Physical stress can occur from significant harm to the body. Individuals who experience trauma due to injury are said to be facing this type of stress.

Moreover, with regards to the types of stress, Colligan and Higgins Distress and Eustress. As revealed earlier, individuals, especially at the workplace, need some form of stress to boost their performance, and this type of stress is known as eustress. Distress is known as negative or lousy stress, whiles eustress is perceived as positive or good stress. On the other hand, any form of stress that brings adverse or harmful reactions and sometimes leads to depression is known as distress.

Stress at any moment can affect individuals at all levels of life. Stress can affect individuals physically, emotionally, socially, spiritually and cognitively. Usually, individuals experience some form of headaches as signs of stress. Through stress, individuals may find their memories being affected, which sometimes translates into the concentration of the

individual. The feeling of hopelessness, having disturbing memories, dizziness, numbness and nervousness are all adverse effects of stress when not properly managed. Stress can occur in every aspect of human life; however, this study looks into occupational stress.

2.3. Occupational stress

Kushal, Kumar, Mehta and Singh (2018) opine that the modern corporate environment has become so competitive that employees are experiencing several forms of stress at the workplace. The uncontrollable demands and pressure at the workplace, coupled with other factors, create stress for employees. Occupational stress received much importance to the extent that the United Nations declared it as the disease of the 20th Century, and the World Health Organization declared it as a global epidemic (Tangri, 2003, cited in Moghadam et al., 2016).

In the occupational stress literature, the concept has been defined in several ways. Occupational stress is all harmful emotional and physical responses that occur in job requirements that exceed or do not match the employees' resources, needs, or capabilities (Landsbergis, Dobson, LaMontagne, Choi, Schnall & Baker, 2017). Colligan and Higgins (2006) also defined occupational stress as the change in an employee's physical or mental state in response to the workplace stress that poses a threat or an appraised challenge to that employee. Shinn et al. (1984), cited in Yu et al. (1989), defined occupational "stress as a negative feature of the work environment that impinges on the individual". For Shinn et al. (1984 as cited in Yu et al., 1989), job stress also occurs when a job poses demands the worker cannot meet or fails to provide sufficient supplies with the worker needs.

According to Arrman and Björk (2017), stress at the workplace is inevitable and also a certain level of stress is needed to motivate and help individuals grow and develop. However, stress beyond a particular level can affect an employee's physiological and psychological well-being, which can hurt the employee's performance.

2.3.1.Sources of Occupational Stress

The interaction between a worker and the environment in which they work leads to stress. In the performance of their duties at the workplace, several factors such as gender, location, environment, among others, contribute largely to stress. In general, a mismatch between perceived employee effort and reward and the loss of control with job demands leads to stress. It is imperative to stress that stress is a state and not an illness. Exposure to several work demands can contribute to occupational stress, which may toll the employee's health (Moustaka & Constantinidis, 2010). Murtaza, Illzam, Muniandy, Hashmi, Sharifa and Nang (2015) asserted that working conditions, workload, position in the workplace, extended working hours, financial factors and Sexual harassment are some of the causes of stress at the workplace.

Arrman and Björk (2017) classified the sources of occupational stress under four main umbrellas: Individual stressors, Group stressors, Organizational stressors, Extra organizational stressors.

2.3.1.1.Individual Stressors

Arrman and Björk (2017) posited that many individual stressors seek to impede one's personal and organizational life. According to Arrman and Björk (2017), individual stressors depend on an individual's constraints of change and personality traits. Some of the individual stressors include:

Personality type: Zamir, Hina and Zamir (2014) defined personality as an organized and dynamic set of characteristics possessed by an individual, and these set of characteristics influence the individuals' motivations, behaviours and motivation in various situations. Generally, an individual's personality is considered unique characteristics of one's behaviour. An individual's personality type can be a significant source of an occupational stressor. An employee with a very high work ethic may suffer from burnout due to the constant movement at the workplace and undertaking several tasks (Arrman & Björk, 2017). Individual personality differences are manifests in their stress processes: exposure, evaluation, coping, short-term response and long-term effects (Kovacs, Găman, Călămar, Pupăzan & Nicolescu, 2019). A study by Törnroos (2015) on personality and work stress affirmed that an individual's personality significantly bears occupational stress.

Role characteristics: One of the primary sources of occupational stress stems from one's role characteristics. Arrman and Björk (2017) pronounced that role stress may occur due to role ambiguity or role conflict. Role conflict occurs when job expectations accepted by an employee conflict with another set of expectations (Soltani, Hajatpour, Khorram & Nejati, 2013). Thus, the incompatibility of two or more roles creates role conflict. This in itself can create occupational stress. Fisher (2001) also asserted that role ambiguity occurs when an employee does not have helpful information that permits them to perform their duties effectively. Role conflict and role ambiguity are all examples of role characteristics that tend to lead to occupational stress.

Life and career changes: Changes in an individual's life and career have been a source of occupational stress. According to Arrman and Björk (2017), several scholarly writings have proven that stress is more prevalent in higher education categories.

2.3.1.2. Group stressors

Group stressors have been known to be a significant source of occupational stress. The dynamics within employees at the workplace and their relationship has a bearing on occupational stressors.

Conflict: Conflicts that arise at the workplace can lead to stress for all group members. Murtaza et al. (2015) stated that interpersonal conflicts among employees at the workplace had been proven to be one of the significant sources of stressors for employees. Aside from conflicts, Murtaza et al. (2015) further opine that bullying at the workplace is also a significant contributor to stress among employees, and it usually occurs in five ways:

i. Threat to professional status
ii. Threat to personal status
iii. Isolation
iv. Excess work and
v. Destabilization (lack of credit for work, meaningless tasks, among others)

These forms of bullying can create an unfriendly working environment for all employees which can lead to stress.

Lack of social support: According to Cobb (1976), social support is a perception that the individual is loved, esteemed, and belongs to a network of mutual obligation. Individuals who receive social support from other group members usually feel better because they feel that they can share their problems without any fear of malice (Arrman & Björk, 2017). Therefore, in the absence of social support, employees do not have any better medium to share their concerns, leading to stress.

2.3.1.3.Organizational stressors

According to Soltani et al. (2013), organizational stressors include human resource development, participation, minimum implementation of resources, and organizational structure. Here, both individual and group stressors come to play. The following are some of the sources of organizational stressors:

Organization structure: Bowditch, Buono and Stewart (2007) defined Organizational structure as means through which a firm divide and control its work, coordinates the manner of its decision-making procedures and links the firms' objectives and strategies to employee's behaviour. The organizational structure provides formal relationships among the employees within a firm. Any weakness within a corporate structure tends to cause stress among employees, which can be attributed to inadequate relationships among employees at the workplace.

Organizational Policies: Organizational policies are guidelines for action. The adoption and implementation of bad policies at the workplace may lead to stress among employees. Vague or poor job description, inequality, higher workloads, inflexible rules and schedules at the workplace, among others, are all part of organizational policies that can lead to stress among employees.

Physical conditions: The physical conditions at the workplace can be a significant source of stress for employees. Individuals seek comfort from their environment. Physical comfort encompasses all basic human needs such as hygiene, accessibility and safety, and without which a building is uninhabitable. It is against this backdrop that Vischer (2007)

stated that several research works have delved into assessing how the physical environment meets users' needs.

Organizational processes: The existence of flawed Organization processes can create poor communication processes, poor information flow, among others, and this can lead to stress among employees within a firm.

2.3.1.4. External Organizational Stressors

Several occurrences outside the workplace domain have a bearing on an individual's life and the Organization, leading to stress among employees. For instance, Areekkuzhiyil (2014) argued that work-family interaction, if not correctly handled, can be a significant source of stress. This shows that work stress is not limited to only events occurring within, but other external factors such as financial, family and economic conditions can also lead to occupational stress.

2.3.2. Effect of Stress on Health

The World Health Organization in 1948 defined health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity". Huber (2011) affirmed that this definition by WHO in 1948 was 'groundbreaking' because it defined health as a more profound understanding since health was viewed as just the mere 'absence of diseases. Several factors affect our lives daily, and as individuals, we try as much as possible to fight against elements that inhibit our wellbeing. One of the threatening factors to our health is life stress.

According to Holt-Lunstad, Smith and Layton. (2010), as cited by Toussaint et al. (2016), the implication of stress on an individual's wellbeing even exceeds other known factors such as excessive alcohol intake and the use of tobacco. Sharma (2018) posits that stress impacts both the mental and physical well-being of a person and pointed out that such impacts usually differ from one person to another. Sharma (2018) further stated some effects of stress on the wellbeing of individuals. They include the following:

Weakening of the Immune System: The activation of the Hypothalamic Pituitary Adrenal (HPA) axis when stressed damages the immune system, making the body prone to

diseases. Researches have proven that individuals under chronic stress are more prone to viral infections and other infectious diseases (Cohen et al., 1997 cited by Sharma, 2018).

Problems in the digestive system: Diarrhea, constipation, change in eating habits are signs of a stressed person (Sharma, 2018).

Effect on Circulatory problems: cardiovascular diseases are the notable effect of chronic stress. The presence of high adrenaline secreted during stress causes high blood pressure due to the force with which the heart pumps blood in such a situation. Cardiac failure and other heart-related diseases are sometimes the results of chronic stress experienced by an individual.

Effect on the Reproductive System: Chronic stress is known to affect the reproductive system of both men and women. Chronic stress lowers the level of testosterone in men, which can create erectile dysfunction. Chronic stress among women can generally affect their menstrual cycle.

O'Donovan, Doody and Lyon (2013) opine that the health of individuals can have psychological or physiological responses that can significantly affect the health of such individuals. By extension, nurses' face a lot of stressors and their reaction towards these stressors generally affect their health (emotional, mental and psychological health).

2.3.4. Coping with Occupational Stress

Lazarus and Folkman (1984) defined coping as the cognitive and problem-solving behaviours individuals adopt to tolerate, minimize, or eliminate stress. Coping is a complex interaction between behaviours and thoughts. Coping permits individuals to regulate their actions to a stressful event. The modes through which an individual cope with a stressor have a bearing on the impact outcome. Coping deals with the efforts and does not apply to the quality of the coping outcome. It can successfully avoid, control or prevent individual distress, or it can also be ineffective. Teixeira et al. (2016) asserted that individuals develop varied ways of coping with a stressful situation, and these differences can be linked to situational demands, personality, and available resources. Coping resources are those reserves an individual possess to manage a stressful situation. Harris (2013) revealed that when coping resources equal the stress event at hand, there will be a successful control

outcome no matter the type of the resources. However, if the stressor at hand exceeds the available resources available to the individual, stress will manifest.

Lazarus and Folkman (1987) identified two main dimensions of coping strategies: problem-focused and emotion-focused coping strategies, which have been discussed above. In situations where employees can take the necessary actions to change the source of the stressors, it is advisable to adopt the problem-focused coping strategy. On the other hand, in situations where employees cannot completely deal with the source of stress, it is advisable to adopt an emotion-focused coping strategy that helps respond better to the emotional distress an individual faces (Lazarus & Folkman, 1984). Besides adopting problem-focused and emotion-focused coping, other scholars have brought to bear some other forms of coping strategies. Examples of such coping strategies include acceptance, seeking instrumental support, active coping, and suppressing competing activities, seeking religious help, emotional ventilation, seeking social support, planning, positive framing, behavioural or mental disengagement and denial (Amirkhan, 1990; Carver, Weintraub and Scheier, 1989).

Nursing and midwifery are high-risk professions laden with work-related stress. Stemming from this, healthcare centres should aid their workers in coping with some of these daily stressors, which can be achieved by assisting nurses and midwives to gain knowledge in stress management strategies.

2.3.5. Stress management strategies

According to Kenny (2007), one of the leading causes of morbidity and mortality is emotional stress. It will be prudent to provide nurses and midwives with stress management strategies to help curtail the menace. Stress management encompasses several techniques geared towards controlling one's stress, specifically chronic stress. Stress management aims at guiding an individual to maintain their harmful stress level (chronic stress) and not eustress, which is known to be helpful. Michie and Abraham (2004) posited that stress management could be classified into two groups based on approach: "self-change and environmental-change". The self-change approach refers to an individual's effective coping with stressors by possessing positive attitudes and taking the necessary actions. The environmental change approach refers to when individuals change the environment to adapt

or cope with stressors. Occupational stress, when not curtailed, might aggravate chronic stress. As noted earlier, chronic stress can cost an individual's health; therefore, it behoves stakeholders to manage stress within the various healthcare facilities. Moreover, a quality social support system and an excellent social relationship at the workplace can serve as buffers to occupational stress.

2.3.5.1. Social support

Social support is a multidimensional concept that was proposed by Cobb (1976). Several researchers have used the term to refer to various phenomena that characterize the social environment or the people in an individual's network (Feeney & Collins, 2015; Helgeson, 2003). According to Cobb (1976), social support is a perception that they are loved, esteemed and belong to a network of mutual obligation. Thus, be it from partner, family, friends, co-workers or organizations, this support which is a form of resource, offers emotional support. The concept is studied across various disciplines such as public health, psychology, sociology, medicine, nursing and social work. Social support in society is crucial in the lives of people. Highly engaged employees with manifold duties try to meet numerous expectations by seeking support from individuals in their social networks. Considering the increasing number of dual-career families, it is not surprising that the level of conflict of domains has also intensified. However, in collectivistic societies, soliciting assistance from family and friends is the expected approach for dealing with these conflicting roles (Ayman & Antani, 2008). Bolger and Amarel (2007) believed that even though enormous positive effects on mental and physical health have been attributed to social support, it is not constantly advantageous.

It is essential to note that different people have preferences for a particular type or a combination of a few kinds of support. In providing support, the matching hypotheses indicate that the support given must be per the individual's desired support. Undoubtedly, offering the wrong type of support at any point to an individual in a situation can be detrimental (Brock & Lawrence, 2009).

2.3.5.1.0 Categories of Social Support

There are several ways by which social support can be categorized. One of such is by taking into consideration the functions of the support provided. Social support's four common functions are emotional, appraisal, instrumental and informational support (Trepte, Dienlin and Reinecke, 2015).

2.3.5.1.1.Emotional support

This has to do with the provision of empathy, affection, encouragement, concern, love, trust, acceptance, and intimacy (Hobfoll, 2009). It depicts the nurturance and warmth offered by people in one's social network. This is also called 'companionship support'. Behaviours that express sympathy and care for others are part of emotional support (Ayman & Antani, 2008).

2.3.5.1.2.Appraisal support

This is also called esteem support. The expression of confidence and encouragement fall under this type of support. Here, the recipient of the support is reminded and also made to believe in his capabilities and strengths that can be used to handle any given situation (Feeney & Collins, 2015). Providing this type of support is essential because it can assure the individual of how valuable they are.

2.3.5.1.3.Instrumental support

McInnis, McQuaid, Matheson and Anisman (2017) opined that offering material goods and services or financial assistance are included in instrumental support. This form of support can also be referred to as 'tangible support'. It incorporates concrete and direct ways people assist other individuals.

2.3.5.1.4. Informational support

This comes in the form of counsel, guidance or valuable information to other people. Recipients can solve a specific problem when they access this type of information (Siedlecki, Salthouse, Shigehiro, & Jeswani, 2014).

This social support system can be provided to an individual through family members, a religious body or head, the workplace or a counselling unit that professionally handles

such matters. A balanced work-family relationship brings happiness and job satisfaction, and therefore the presence of these supporting institutions is vital to help boost psychological wellbeing among nurses and midwives.

2.3.5.2. Social Relationships at the workplace

Scholars such as Aristotle and Charles Darwin believed in the importance of social relationships. Aristotle (384-322 B.C) opined that man is social animal and depends on each other. Darwin and Kebler (1859) also asserted through his natural selection theory that humans are social species par excellence and stated that the survival of the fittest does not only happen between individuals. It also occurs among groups. Charles Darwin saw the need for a strong relationship among group members to provide a unified and robust group to survive.

Moreover, Csikszentmihalyi (1990) believed that humans are "biologically programmed to find other human beings the most important objects in the world". Stemming from these assertions made by these scholars, one can argue that quality social relationships at the workplace are essential for the growth of an organization. According to Chadsey and Beyer (2001), close relationships among individuals have a positive outcome, and therefore, organizations should endeavour to promote quality social relationships among their employees. A social relationship can thus be explained as to how employees relate to themselves in the workplace.

Umberson and Montez (2010) also opined that psychologists have long pointed out that one of the basic human needs is the desire to feel belonged through interpersonal relationships. This has a significant impact on the physical health, mortality risk and mental health of individuals. Venkataramani, Labianca and Grosser (2013) opined that the quality of interpersonal relationships among employees shapes their overall attachment with the organization. Rosales (2015) believes that employees are a company's greatest asset and as such increasing social relationships and coordination among them can propel a company to tremendous success. Rosales (2015) elaborated that the success of an organization largely depends on the quality of social connections among its employees. Positive social interaction leads to effectiveness, cooperation, improves organizational learning, and ensure employee loyalty. High-quality social connections are noted to empower employees to give

their all for the success of an organization. It is not surprising that Seligman (2011) pointed out that a healthy positive relationship is one of the five pillars of an individual's wellbeing.

A relationship involves various interactions individuals have with colleagues, family members and the community (Bagnall, South, Martino, Mitchell, Pilkington & Newton, 2017). Farooqi (2014) believes that human relationships form the essence of an individual's personality, contributing mainly to a person's wellbeing. Humans are inherently social creatures (Seligman, 2012), and as such, the quality of their social relationship has a bearing on their wellbeing. The quality of relationships hinges on how positively or negatively a person feels about their relationships (Morry, Reich & Kito, 2010; Farooqi, 2014). Roffey (2017) outline the following as some of the benefit for the promotion of positive relationships at the workplace (Enhancing individual flourishing, Promoting mental health and wellbeing, Physical wellbeing, attendance and retention of staff, the promotion of effective collaboration and teamwork, Reducing conflict, Motivation, Creativity and innovation).

2.4. Concept and Meaning of Psychological Wellbeing

Psychological wellbeing is key to living meaning and fulfilled life. This is so much rooted in the World Health Organization's (1946) definition of health as a "state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity". Flowing from this, Trudel-Fitzgerald et al. (2019) opine that psychological wellbeing reflects more than the mere absence of psychological distress, such as anxiety or depressive symptoms. Definition of psychological wellbeing flows from the concept of wellbeing. There is no consensus around a single definition of wellbeing. Still, there is general agreement that at minimum, wellbeing includes the presence of positive emotions and moods (e.g., contentment, happiness), the absence of negative emotions (e.g., depression, anxiety), satisfaction with life, fulfilment and positive functioning (Frey & Stutzer, 2002). Wellbeing is a complex and multifactorial construct. While specific psychological wellbeing dimensions such as life satisfaction are often embedded in "quality of life" measures, this latter multidimensional construct is much broader. It includes other mental and physical

health aspects like perceived stress, functioning/disability status, and physical symptoms. (Centers for Disease Control and Prevention, 2018; Salvador-Carulla, Lucas-Carrasco, Ayuso-Moses and Miret, 2014).

Psychological wellbeing refers to positive mental health (Edwards, 2005 cited in Ismail and Deshmukh, 2012). Research has shown that psychological wellbeing is a diverse multidimensional concept (MacLeod & Moore, 2000; Ryff, 1989; Wissing & Van Eeden, 2002) which develops through a combination of emotional regulation, personality characteristics, identity and life experience (Helson and Srivastava, 2001). According to Wissing and Van Eeden (1998), psychological wellbeing has undergone extensive empirical Review and theoretical evaluation. This makes it extremely difficult to have a single conceptual understanding of psychological wellbeing. Preliminary research was mainly concerned with the experiences of positive and negative affect, subjective wellbeing and life satisfaction formed around the Greek word 'eudemonia', which was translated as 'happiness' (Ryff, 1989b). Experts have indicated that psychological wellbeing is a diverse multidimensional concept despite extensive evaluation and assessments, with exact components still unknown (MacLeod & Moore, 2000; Ryff, 1989b; Wissing & Van Eeden, 2002).

2.4.1. Components of Psychological Wellbeing

Ryff's (1989) research on psychological wellbeing resulted in developing an objective scale of psychological wellbeing regarded as the best objective measure of positive mental health. In her model, Ryff (1989) distinguished six core dimensions of psychological wellbeing and developed an instrument widely used by researchers interested in wellbeing (Dierendonck et al., 2008). Ryff drew her model from points of convergence in prior theories of life course development, clinical accounts of positive functioning, and mental health conceptions. The model includes six distinct components of psychological wellness. Ryff (1989), as cited in Gao and Mcllenan (2018), proposed a theoretical model of psychological wellbeing, which comprises six different aspects of positive functioning, namely autonomy, environmental mastery, personal growth, purpose in life, positive relations with others and self-acceptance. This model was developed based on a thorough study of human functioning (Ryff, 1989, cited in Gao & Mcllenan, 2018).

2.4.1.1.Autonomy

Autonomy regulates one's behaviour through an internal locus of control (Ryff, 1989; Ryff & Keyes, 1995). A fully-functioning person has a high level of internal evaluation, assessing the self on personal standards and achievements while not relying on the standards of others. They do not strive for endorsement from other individuals (Ryff, 1989); they are focused on their own beliefs and are less swayed by other people's ideas. A high level of autonomy suggests independence, with a low level suggesting concern over and self-perception. Internal locus of control is an essential component of motivation (Weinberg and Gould, 2007), with athletes' generally requiring autonomy, personal insight, and objectivity to sustain self-confidence and belief. Increased control over the work environment motivates workers to try and master new tasks and provide citizenship behaviours consistent with work design research that has demonstrated the motivational benefits of autonomy (Fried & Ferris 1987; Morgeson & Campion, 2003). This suggests that workers are likely to integrate more organizational citizenship behaviour in organizations where they find themselves when given autonomy. This is truer for nurses and midwives working in health facilities.

2.4.1.2. Environmental Mastery

For Ryff (1989) and Ryff and Keyes (1995), environmental mastery is understood as choosing and controlling the surrounding and imagined environment through physical and mental actions. Ryff (1989) asserts that a high level of environmental mastery reflects control over one's context, but a low level is related to the inability to control one's environment successfully. Weinberg and Gould (2007) opined that a mature individual could generally interact and relate to various people in diverse situations and adapt to multiple contexts upon demand. Environmental mastery means controlling complex environmental and life situations (Ryff, 1989b) and seizing opportunities that present themselves. It often requires the ability to step out of one's 'comfort zone' when striving for optimal sporting performance.

2.4.1.3. Personal Growth

Personal growth is the ability to develop and expand the self, become a fully functioning person, and self-actualize and accomplish goals (Ryff, 1989b; Ryff & Keyes, 1995). Ryff (1989b) believes that to achieve peak psychological functioning, one must continue to develop the self through growth in various facets of life. For Weinberg and Gould (2007), a growth mindset is critical in achieving personal growth. A growth mindset requires openness to a variety of new and diverse experiences. Personal growth is potentially the psychological wellbeing dimension closest to eudemonia (Ryff, 1989b).

2.4.1.4. Purpose in Life

Purpose in life refers to the perceived significance of one's existence. It involves setting and reaching goals, which contribute to the appreciation of life (Ryff, 1989b; Ryff & Keyes, 1995). Ryff (1989b) asserts mental health includes awareness that one has a greater goal and purpose in life. Maturity involves having a clear sense of intentionality (Ryff, 1989b). Purpose in life has more to do with goals in life. Weinberg & Gould (2007) assert that when athletes sustain focus, attention and concentration, set realistic goals and aim to be more holistic, they seek a greater goal for themselves and assist others.

2.4.1.5. Positive Relation with Others

Ryff (1989b) asserts that while good relations result in understanding others, poor relations can cause frustration. In this sense, having positive relations with others is essential in developing trusting and lasting relationships and belonging to a network of communication and support (Ryff, 1989b; Ryff and Keyes, 1995).

2.4.1.6. Self-Acceptance

Positive levels of self-acceptance create a positive attitude and improved satisfaction with life (Ryff, 1989b). For Weinberg and Gould (2007), moderate confidence levels lead to more extraordinary achievement and acceptance.

2.5 Empirical Review

The sources of occupational stress among nurses and midwives

Gholamzadeh, Sharif and Rad (2011) sought to ascertain the primary sources of occupational stress for nurses working in an Accident and emergency department. A descriptive survey study was undertaken, and a sample of ninety (90) emergency ward nurses from three large teaching hospitals in Shiraz was selected for the study. Out of the chosen sample, 86.7% of women were between the ages of 23 years to 50 years old with less than five years of experience (56.7%). With the help of a self-administered questionnaire and Lazarus standard questionnaires, data were gathered for the study. The findings from the survey revealed the following as the primary sources of stressors - the absence of the designated physician in the emergency room, lack of equipment, lack of support by, being exposed to health and safety hazards, workload and problems related to the physical environment.

Adzakpah, Laar and Fiadjoe (2016) contended that the increasing rate of job stress among nurses is an endemic problem. Stemming from this background, Adzakpah et al. (2016) examined the prevalence of occupational stress experienced by nurses. The researchers adopted Weiman Occupational Stress Scale to determine the most common occupational stressors and the major coping strategies employed by nurses seventy-three (73) nurses from the nursing and midwifery department from the Akwatia St Dominic Hospital in Ghana were selected through purposive sampling. A self–administered questionnaire was used to solicit data from the chosen sample. The research used descriptive statistics to analyze the data collected. Findings from the study indicated that most nurses' experience above-average levels of occupational stress, and the most common stressors were inadequate resources, workload and conflicting demands.

Banovcinova and Baskova (2014), through a cross-sectional study, investigated the sources of occupational stress and their association with burnout in midwives. A sample of 100 midwives (mean age 54.62; SD=11.94) staff in gynecologic and obstetric clinics in Slovak hospitals were selected for the study. Banovcinova and Baskova (2014) employed the Maslach Burnout Inventory and Expanded Nursing Stress Scale to solicit data from the chosen sample. The findings from the study indicated that doctors, supervisors and other midwives, work overload and emotional exhaustion were all sources of occupational stress.

Gautam and Farzanmehr (2016) examined the occupational stress among nurses working in a surgical care setting and elderly care setting through a qualitative study. Gautam, Gautam and Farzanmehr (20126) adopted the Job Demands–Control (JDC) work design model and salutogenic paradigm as the theoretical underpinning of the study. The findings from their work indicated that lack of knowledge and lack of cooperation among health professions, high demand for labour and shortage of staff were the primary sources of stress at the healthcare facilities. Gautam et al. (2016) recommended that coping mechanisms and organization policies be tailor-made to help curtail the prevalence of occupational stress among nurses.

Similarly, Mosadeghrad (2013) adopted a cross-sectional research design to ascertain the prevalence of occupational stress among a sample of hospital employees in Iran and examine the effects of these stresses on the wellbeing of healthcare personnel. Mosadeghrad (2013), through a validated questionnaire, solicited data for the study. The findings from the study indicated that interpersonal factors, working environment, job-related factors, and organizational factors are related to job stress. The study revealed that the significant sources of stress to the respondents included inequality at work, inadequate pay, work overload, poor recognition at the workplace, job insecurity and time pressure.

Faremi, Olatubi, Adeniyi and Salau (2019) examined the frequency of stressful events among nurses. A descriptive study design was employed for the study. With the help of a simple random sampling technique, a sample of one hundred and eighty (180) nurses were selected from two hospitals. Faremi et al. (2019) adopted the Nursing Stress Scale to help solicit data from the chosen sample. Descriptive and inferential statistics were adopted to analyze the data collected. The findings from the study indicated that performing procedures that patients experience as painful, overall workload, lack of drugs and equipment required for nursing care, death of patients, inadequate staff to cover ward workload are the primary sources of stressors.

In sum, though nurses and midwives are trained to give help, they must also be equipped to deal with the prevalence of occupational stress among nurses and midwives. In their line of duty, nurses become susceptible to occupational stress, which can be attributed

mainly to their intense daily activities at the workplace. Findings from Gholamzadeh et al. (2011), Adzakpah et al. (2016), Banovcinova and Baskova (2014), Faremi et al. (2019) and Gautam, Gautam and Farzanmehr (2016) reveals that several areas in the healthcare setting trigger stress among nurses and midwives. Knowing these sources of stress at the workplace is crucial in providing solutions to curb these menaces. A look through the above empirical evidence (Gholamzadeh et al., 2011; Adzakpah et al., 2016; Banovcinova & Baskova, 2014; Faremi et al., 2019; Gautam, Gautam & Farzanmehr, 2016) help to identify the sources of stress among nurses and midwives and help them deal with these sources.

2.6. Impact of occupational stress on the psychological wellbeing of nurses and midwives

Theme, Costa and Guilam (2013), through a cross-sectional study, researched the association between job stress and self-rated health among nurses in public hospital emergency units. A sample of one hundred and thirty-four (134) health professionals was selected for the study. The brief version of the Job Stress Scale was employed to help gather data from the sample chosen. In analyzing the data collected, the researcher used descriptive and multivariate analysis through unconditional logistic regression. The findings from the study indicated that health professionals with high demand and low control experienced poor self-rated health. From this study, Theme, Costa and Guilam (2013) affirmed that occupational stress has a toll on the overall wellbeing of employees. Adegoke (2014) adopted a descriptive survey to analyze the impact of occupational stress specifically on the psychological wellbeing of police employees. A sample of two hundred and fifty (250) police employees were selected from five local government areas of Ibadan Metropolis, Nigeria. Data gathered from the respondents were analyzed with the help of a one-way analysis of variance (ANOVA) statistical method. The findings from the study indicated that there is a significant impact of work stress on the psychological wellbeing of the respondents. Stemming from this, Adegoke (2014) recommended that the government find ways to control the work stress of its employees.

Suleman, Hussain, Shehzad, Syed and Raja (2018), on their part through multistage sampling technique, selected four hundred and two (402) secondary school heads to help

assess the relationship between perceived occupational stress and psychological wellbeing. Headteachers of Secondary schools within Khyber Pakhtunkhwa formed the population for the study. The researchers employed a descriptive, quantitative and correlative research design for the study. Ryff's Psychological Wellbeing Scale and the Occupational Stress Index measure psychological wellbeing and perceived occupational stress. Pearson's product-moment correlation and multiple regression, mean and standard deviation were used in analyzing the data. The findings from the study pointed out a strong negative correlation between perceived occupational stress and psychological wellbeing.

Again, Saka, Kamal and Alabi (2018) examined the influence of perceived occupational stress on the psychological wellbeing of road safety personnel with Osun state as the case study. Primary data were gathered from two hundred and sixty-eight (268) personnel selected from all the seven commands within Osun state in Nigeria. The Job Stress Scale (JSS) by Theorell and the psychological wellbeing scale by Ryff was employed in assessing data on occupational stress and psychological wellbeing, respectively. Multiple linear regression and t-test independent samples were used in analyzing the data collected from the respondents. The findings from the study indicated that perceived job stress had a statistically significant impact on the psychological wellbeing of personnel.

Similarly, Mosadeghrad (2013) adopted a cross-sectional research design to ascertain the prevalence of occupational stress among a sample of hospital employees in Iran and examine the effect of these stresses on the wellbeing of these healthcare personnel. Mosadeghrad (2013), through a validated questionnaire, solicited data for the study. The findings from the study indicated that interpersonal factors, working environment, Job-related factors, and organizational factors are related to job stress. The study found that the significant sources of stress to the respondents included inequality at work, inadequate pay, work overload, poor recognition at the workplace, job insecurity, and time pressure. The study results also indicated that job stress among the respondents leads to depression and increases in negative personal behaviours such as anxiety, anger and irritability. These increase risk of cardiovascular diseases among employees.

Again, Basińska (2008) examined the effects of job stress factors on the psychological wellbeing of firefighters. The researcher selected one hundred and twenty-one

(121) firefighters who were staff of the rescue-firefighting units within the Pomeranian Region. Basińska (2008) adopted Goldberg's General Health Questionnaire (GHQ-12) for wellbeing evaluation and the Perceived Job Stress Questionnaire (PJSQ) to solicit data on the psychological wellbeing and occupational stress among the respondents. The findings from the study indicated that 90% of the respondents faced an increased risk of mental disorders. Based on the data collected, it was observed that individuals with high work-related stress experience lower psychological well-being. Basińska (2008) recommended that reducing work overload will be vital in reducing occupational stress among the respondents, which is crucial in maintaining healthy psychological wellbeing. It is noteworthy to reveal that this study was carried out among firefighters. The findings from this study are vital in assessing the impact of occupational stress on the psychological wellbeing of individuals.

2.7. Coping Methods Used By Nurses And Midwives To Resolve The Impacts Of Occupational Stress At The Workplace

Gholamzadeh, Sharif and Rad (2011) researched the main coping strategies used by nurses working in an Accident and emergency department. A descriptive survey study was undertaken, and a sample of ninety (90) emergency ward nurses from three large teaching hospitals in Shiraz was selected for the study. Out of the chosen sample, 86.7% of women were between the ages of 23 years to 50 years old with less than five years of experience (56.7%). With the help of a self-administered questionnaire and Lazarus standard questionnaires, data were gathered for the study. The findings from the study revealed the following as the primary sources of stressors: absence of the corresponding physician in the emergency room and lack of equipment, lack of support by nursing administrators, being exposed to health and safety hazards, workload and problems related to the physical environment. Moreover, Gholamzadeh, Sharif and Rad (2011) found out that nurses' most common coping strategies were self-controlling and Positive re-appraisal. The least common strategy was accepting responsibility. The findings from the study indicated that most of the nurses preferred an emotion-focused coping strategy to Problem-focused approaches in coping with occupational stressors at the hospital.

Adzakpah, Laar and Fiadjoe (2016) also contended that the increasing rate of job stress among nurses is an endemic problem. Stemming from this background, Adzakpah et al. (2016) examined the prevalence of occupational stress experienced by nurses. The researchers adopted Weiman Occupational Stress Scale to determine the most common occupational stressors and the major coping strategies employed by nurses. Seventy-three (73) nurses from the nursing and midwifery department from the Akwatia St Dominic Hospital in Ghana were selected through purposive sampling. A self–administered questionnaire was used to solicit data from these samples selected. Descriptive statistics were also used to analyze the data collected. Findings from the study indicated that most nurses experience above-average levels of occupational stress, and the most common stressors were inadequate resources, workload and conflicting demands. In coping with the occupational stressors, the study found out that identifying the source of stress and avoiding unnecessary stress, adjusting to standards and attitudes, engaging in hobbies and expressing their feelings instead of bottling them up were some of the copings strategies adopted by these nurses in coping with the occupational stressors.

Bánovčinová (2017), through a quantitative cross-sectional study, analyzed coping strategies frequently used among Slovak midwives. A sample of one hundred midwives was selected for the study. Bánovčinová (2017) adopted the Brief COPE questionnaire to measure the coping strategies adopted by the respondents. Again, the Expanded Nursing Stress Scale was also employed by the researcher. In analyzing the data, Bánovčinová (2017) used Kruskal-Wallis Test, Descriptive statistics, Pearson's Correlation Analysis and Student's t-test. The findings from the study showed that conflicts with doctors, workload and the death of patience were the primary source of stressors for the respondents. In coping with these stressors, it was observed that acceptance, active coping and instrumental support mainly was used. In sum, the findings proved that midwives adopted both problem-focused and emotion-focused strategies. Bánovčinová (2017) recommended that intervention strategies and education programs should be provided to these midwives to help them cope better with stress at the workplace.

Akbar, Elahi, Mohammadi and Khoshknab (2016) claimed that nursing staff encounter numerous psychological, physical and social stressors in their line of duty. Akbar

et al. (2016) further opined that these stressors harm midwives' health and even affect the quality of healthcare they provide. Stemming from this, Akbar et al. (2016) sought to examine the stressors faced by nurses and how they cope with these stressors. The researchers adopted a qualitative study content analysis approach for the study. The purposive sampling technique was adopted in selecting eighteen (18) nurses working in three hospitals. Through face to face, an unstructured interview was used in collecting data for the study. In analyzing the data, six main themes emerged about the coping strategies. They are preventive monitoring of the situation, situational control of conditions, self-controlling, seeking help, avoidance and escape and spiritual coping. These key strategies, they observed, top the primary coping strategy employed by nurses in dealing with the various occupational stressors.

Ramezanli, Koshkaki, Talebizadeh, Jahromi, and Jahromi (2015) admitted that nursing is a highly stressful job to the extent that stress experienced by nurses can force them to leave their jobs. Ramezanli et al. (2015) also asserted that how individuals react to stress depends on their coping strategies. In light of this, the main focus of their study was to investigate the coping strategies used by nurses working in intensive care units of hospitals affiliated with Jahrom University of Medical Sciences. The cross-sectional descriptive study was adopted to achieve this goal. Ramezanli et al. (2015), through a simple random technique, selected one hundred and seven (107) nurses from the intensive care units of hospitals affiliated to Jahrom University of Medical Sciences. The Jallowice Standard Coping Questionnaire was used in collecting data from the sample selected. Descriptive statistics were also employed in analyzing the data gathered. The study indicated that 43% of the respondents were poor, 40.2% were moderate, and 16.8% were satisfactory in the application of the problem-focused coping strategies. Again, 33.6% of the respondents were poor, 25.2% were mild, and 41% were acceptable in applying an emotion-focused coping strategy. Ramezanli et al. (2015) called on authorities to take measures in helping nurses by equipping them with effective coping strategies.

Jannati et al. (2011) believed the various coping strategies employed by nurses in dealing with job-related stress involves cognitive, affective, and behavioural coping strategies. Lastly, Jannati, Mohammadi and Seyedfatemi (2011) believed that job stress is

inevitable in healthcare facilities, and as such, nurses have several ways to cope with these stressors. To examine the coping strategies employed by the Iranian clinical nurses, the study adopted qualitative research using Straus and Corbin's grounded theory approach. This approach focused mainly on the process of coping with occupational stress. The findings from the study revealed that self-control, work management, cognitive, emotional and spiritual coping strategies are the forms of coping strategies employed by Iranian clinical nurses.

2.8. Influence of social relationships and support at the workplace on the psychological wellbeing of nurses and midwives

Tumen and Zeydanli (2016) revealed that existing literature asserts that job satisfaction positively correlates with worker performance and productivity. The researchers adopted the Workplace Employment Relations Survey (WERS) at the workplace level and the British Household Panel Survey (BHPS) at the local labour market level. Their findings revealed a significant impact of social interactions at the workplace. Their results also proved the importance of quality social relationships and their role in shaping the job satisfaction level of employees. Social interactions should be at the centre of these policies in the quest to examine the effectiveness of policies designed to improve job satisfaction among employees.

Tran, Nguyen, Dang, and Ton (2018) explored the Social support on employees' development and welfare within the nursing community. Tran et al. (2015) developed an integrated model that focused on the impact of high-quality workplace relationships on the working attitudes of the staff. The study adopted a questionnaire and solicited data from three hundred and there (303) hospital nurses. A structural equation modelling technique was employed to analyze the data collected. The findings from the study proved that high-quality workplace relationships have a positive impact on factors such as occupational stress among nurses. The study's conclusions were consistent with other research works that have long proven that quality social relationships have a positive impact on employees' overall wellbeing of employees (Tran et al., 2015).

Lastly, Mahmoudi, Hosseini, Joonbakhsh and Ajoodanian (2020) explored the effects of social support on nursing and midwifery. The researchers conducted this study by adopting a systematic review of the study of texts and the usage of the author's experiences and the opinions of experts in nursing. The researchers selected articles within 2008 and 2018 using keywords midwifery, nursing support, nursing, medical support from various databases. In all, 160 papers were reviewed, and 18 of them were selected for the study. The findings from the study proved that the presence of a social support group within the nursing profession provides nurses with the needed support.

Social relationships and social support at the workplace, through the lens of Tumen and Zeydanli (2016), Tran et al. (2015) and Mahmoudi et al. (2020), are essential to the overall wellbeing of employees. It was observed that few existing pieces of literature have holistically examined the influence of social relationships and social support on the psychological wellbeing of nurses and midwives, which is one of the gaps this research seeks to fill.

2.9.Age Differences and Occupational Stress

Osei-Mireku, Wang, Lartey and Sarpong (2020) indicated that experiences come with age. Some studies reveal that older or more experienced employees record lower levels of stress than younger and less experienced ones (Osei-Mireku, Wang, Lartey and Sarpong, 2020). People's ability to deal with occupational stress increases with age (Ang et al., 2016; Shukla & Srivastava, 2016, all cited in Osei-Mireku et al., 2020). According to Faraji et al. (2019), employees who are less than 40 years old experience the highest stress levels. Duarte and Pinto-Gouveia (2019) explained that more senior employees had reached a stage where career development is no longer their primary concern. Hence, several job characteristics which may cause stress to younger staff, who have their career ahead of them, do not cause stress to older staff. In this regard, Mauno, Rulkolainen and Kinnunen (2013) asserted that more senior and more experienced workers are more resilient than younger ones against work-family conflicts for academic employees, and older workers are more capable of buffering workload stress and life satisfaction in service sectors. However, Hui-Chuan (2018) posited that workers in age face more barriers and stressors at work, such

as physical strength limitations and health concerns, gaps related to using new technology, and engagement in work.

From the Review above, it is established that age difference has a lot to do with how workers respond to occupational stress. It was discovered that age is associated with work experience. This helps older workers respond much better to stress than younger workers who may not have adequate internal resources to deal with stress.

2.10. Factors that Influence Psychological Wellbeing of Health Workers

Human as they are, nurses and midwives will have a lot of factors that would influence their psychological wellbeing. This session looks at the factors that influence or are likely to influence the psychological wellbeing of nurses and midwives or health workers in general. A Thematic Review by Philip and Cherian (2020) examined factors affecting the psychological wellbeing of healthcare workers during an epidemic identified thirteen factors that were grouped under the broad categories of socio-demographic variables, individual characteristics, social characteristics, and psychological constructs. The factors affecting the psychological wellbeing of healthcare workers are primarily poor social support, stressful work environments, more excellent patient contact, inadequate training, quarantine, history of physical or mental health issues, poor coping mechanisms, high perceived risk, stigma, social isolation, and a lack of resilience (Philip and Cherian, 2020). Although this work is not assessing such factors in an epidemic, the researcher thinks some of these factors also affect healthcare workers in their everyday work environment.

A cross-sectional study by Meng et al. (2015) on the Nurses' Well-Being Index and Factors Influencing this Index among Nurses in Central China shows that the nurses' overall happiness level was moderate based on their index score. The dimensions of the happiness index are listed in descending order of their contribution to the nurses' comprehensive happiness levels: health concerns, friendly relationships, self-worth, altruism, vitality, positive emotions, personality development, life satisfaction and negative emotions. Four variables (positive emotion, life satisfaction, negative emotions, and friendly relationships) jointly explained 47.80% of the total variance of the happiness index; positive emotions had

the most significant impact on the happiness index. From this study, it could be deduced that factors such as health, friendly relationships, self-worth, altruism, vitality, positive emotions, personality development, life satisfaction and negative emotions influence the psychological wellbeing of nurses to a more significant effect. This could be extended to midwives and, to a more substantial extent, health care workers.

2.11. Conceptual Framework

The model below shows the proposed conceptual framework of the study. The study population is nurses and midwives of the Catholic Health Service in the Western Region of Ghana. The figure shows the expected relationships among the variables used in the study. First, it is expected that occupational stress and psychological wellbeing will impact each other. It is assumed that there will be a bilateral relationship between occupational stress and coping strategies. In other words, occupational stress and coping strategies will impact each other. Thus, occupational stress among participants will affect the coping strategies used; the different coping strategies can also determine the level of occupational stress. Again, it is expected that social relationships at the workplace will influence nurses' psychological well-being and occupational stress.

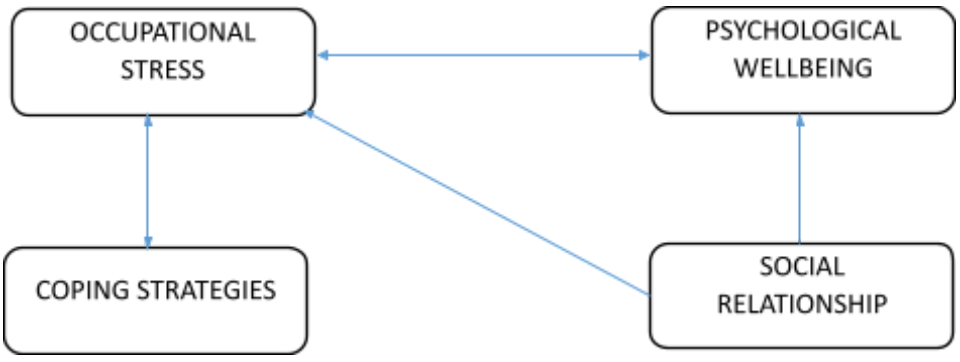

Figure 1:*Hypothetical model showing the expected relationships among occupational stress, psychological wellbeing, coping strategies, and social relationships.*

2.12. Rationale/Justification of the study

The review of relevant literature indicates that earlier studies (Adzakpah, Laar and Fiadjoe 2016; Bánovčinová, 2017; Akbar et al.,2016; Ramezanli et al., 2015) focused on only occupational stress among nurses. There seems to be none that focused on both nurses and midwives. Besides, all these works were either on occupational stress or strategies to help nurses cope. There seems to be a shortage of study on the simultaneous consideration of the four variables that form the focus of this study: occupational stress, social relationships at the workplace, psychological wellbeing and coping strategies. Therefore, the thrust of this study was to bridge the gap and investigate occupational stress, social relationships at the workplace, psychological well-being, and coping strategies of nurses and midwives in the Catholic Health Service of the Western Region of Ghana. Furthermore, there seems to be no study on the experience of occupational stress among nurses and midwives concerning age, duration of service and category of health professionals. This study intended to fill the knowledge gap by investigating how age, duration of service and type of health professional impinge on the experience of occupational stress of nurses and midwives in the Catholic Health Service of the Western Region of Ghana.

2.13. Chapter Summary

Psychological wellbeing, and Coping strategies among nurses and midwives. The Chapter Two of this study sought to examine Occupational Stress, social relationships at the workplace. This chapter discussed the theories that underpin this study, the conceptualization of the variables in the research and the empirical Review of the study. It also presented the conceptual framework of the work showing the expected relationship among the variables.

CHAPTER 3

MATERIALS AND METHODS

3.0 Introduction

The study investigated occupational stress, social relationships at the workplace, psychological wellbeing and coping strategies of nurses and midwives in the Catholic Health Service of the Western Region of Ghana. This chapter presented the scientific procedures adopted in conducting the study. Specific areas of consideration of the study included the study area, the research philosophy, the research design, population, sample and sampling procedure, data collection instrument, data collection procedure, and data processing and analyses.

3.1. Study Area

The study was conducted in four (4) Catholic health facilities located in the Western Region of Ghana. The Western Region is one of the 16 Administrative Regions in Ghana. The region is situated in the southwestern part of Ghana. It shares common borders with La Cote d'Ivoire on the west, the Central Region in the East, the Western North Region in the North and the Gulf of Guinea (Atlantic Ocean) in the South (Ghana Statistical Service, 2013). The Western Region covers a land area of 13,847 kilometres square with a total population of 1,664 586 (Ghana Statistical Service, 2013) and 2 214,660 (2020 projection). The region has 13 districts/municipal assemblies. These include Ahanta West Municipal, Sekondi Takoradi Metropolitan Assembly, Effia-Kwesimintsim Municipal, Ellembelle District, Jomorro Municipal, Mpohor District, Nzema East Municipal, Prestea-Huni Valley Municipal, Tarkwa-Nsuaem Municipal, Shama District, Wassa Amenfi Central District, Wassa Amenfi West Municipality and Wassa Amenfi East District There are 9 Catholic Health facilities in the Western Region.

The four (4) Catholic health facilities chosen for the study were Holy Child Catholic Hospital, Fijai, located in the Sekondi-Takoradi Metropolitan Assembly, Jubilee Catholic Children Hospital located in the Ahanta West Municipal, St. Martin de Porres Hospital,

Eikwe, situated in the Ellembelle District, and the Father Thomas Alan Rooney Memorial Hospital, Asankrangwa, located in the Wassa Amenfi West District.

3.1.1. Holy Child Catholic Hospital, Fijai

The Holy Child Catholic Hospital was started as a maternity home and upgraded officially into a health centre and inaugurated on 6th January 1979 at Fijai as Holy Child Health Centre, under the National Catholic Health Service (NCHS) of the Christian Health Association of Ghana. (CHAG). The facility is situated at Fijai, in the Sekondi-Takoradi Metropolitan Assembly. The Holy Child Catholic Hospital is located off Fijai -Ntakonful road in the Sekondi-Takoradi Metropolis. The facility is off the Takoradi-Accra major road and is approximately 5 km from Takoradi. The facility was chosen as part of this study because of the high number of patient attendance and the fact that it is one of the Catholic Health Facilities within the Western Region.

3.1.2. Jubilee Catholic Children Hospital, Apowa

Jubilee Catholic Children Hospital, Apowa, was established on 16th October 2019 as one of the Golden Jubilee Anniversary Projects of the Catholic Diocese of Sekondi-Takoradi. The Catholic Diocese of Sekondi-Takoradi owns the facility. The facility is located in the Ahanta West Municipal, situated in the southernmost point of the Republic of Ghana, with its capital as Agona Nkwanta (also called Agona Ahanta). The hospital was intended to be a purely Children Hospital motivated by providing quality healthcare for children in the Western Region and beyond. This was to fill the gap in child health in Western Region. Whilst maintaining the pediatric- orientation, the facility offers general services to adults to meet the growing healthcare needs in the Ahanta West Municipality and other districts. Jubilee Catholic Children Hospital is a member of the National Catholic Health Service and the Christian Health Association of Ghana. The human resource strength of the facility stands at 95 in the various categories.

The facility was included in this study because it runs the 24hr service and the shift system, which puts burden and pressure on nurses and midwives. Besides, most of the nurses and midwives, who work in the facility, commute from the Sekondi-Takoradi Metropolis. This can also be potentially stressful looking at the perennial traffic situation on the road. Hence, the inclusion of this facility in the study.

3.1.3. Father Thomas Alan Rooney Memorial Hospital. Asankrangwa

Father Thomas Alan Rooney Memorial Hospital (FTARMH) was established and officially inaugurated as a hospital on 3rd October 1954 at Asankrangwa under the National Catholic Health Service (NCHS) of the Christian Health Association of Ghana (CHAG). FTARMH is a faith-based Hospital with a long reputation for providing quality healthcare service to an expanding area. It is a full service and not for profit hospital located at Asankrangwa, the Municipality capital of Amenfi West Municipality in the Northern part of the Western Region of Ghana and share a border with the Western North Region Ghana.

This facility has been included in the study because of its location and the dynamic nature of services rendered in the facility. Most of the nurses and midwives working in this facility are from distant places posted to work at Asankrangwa. Most of these find it very difficult to accept postings to the facility, but the system of postings would place them there because they are needed to render services to the people in the area. This alone can have a psychological impact on these nurses and midwives as they have to leave their families and spouses to travel to this distant place on a horrible road network. Most staff working in this facility ask for transfer or release barely after working there for two years to join their spouses or other domestic reasons.

3.1.4.St. Martin de Porres Hospital, Eikwe

St. Martin de Porres Hospital is a facility owned by the Catholic Diocese of Sekondi-Takoradi. The facility was established in 1959. It is situated at Eikwe, in the Ellembelle District. St. Martin de Porres Hospital, Eikwe, is primarily a rural-based Catholic health facility. The hospital has a wide catchment area with an average Out Patient Attendance and Admissions of over 90,000 and 14,000, respectively.

Because of its location, the hospital serves a population spread across three districts. It serves as a referral centre for about 20 satellite health facilities in three geographical districts with more than 400,000. These include two government district hospitals from where several patients are received on referral.

The hospital specialises in providing obstetrics and gynaecological care for women in rural areas. It also provides general health and medical services as well as surgical

services. Strategically, the hospital is bracing itself for the inclusion of mental health services.

The Eikwe Sub District has a projected population of about *12,500* settled in *seven communities*. It forms part of the *Ellembelle District*, which has a population of 101,200 [*Projected Pop. of 2010*]. The district has an estimated *Growth Rate* of *2.8%* and a *Total Fertility Rate* of *4.0.* The population density of the *Ellembelle District* is uneven and higher in the southern sector. The catchment occupation is farming and fishing.

3.2. Research Philosophy

Research philosophy refers to beliefs and assumptions about developing knowledge (Saunders, Lewis and Thornhill, 2015). It is all about how data about a phenomenon should be collected, analysed and used. For Saunders, Lewis and Thornhill (2007), philosophical assumptions look at questions of a particular view of the relationship between the development of knowledge and the nature of that knowledge.

The focus of this study, which was to look at occupational stress, social relationships, psychological wellbeing and coping strategies among nurses and midwives working in the healthcare environment, warranted the use of a positivist research philosophy. Positivism is based on the belief that knowledge obtained from scientific processes is considered accurate and reliable. In this regard, research founded on this principle entails data collection, interpretation, and findings are either quantifiable or observable. In sum, positivism connotes quantifiable researcher observations that can be analyzed statistically.

According to Collins (2010), positivism describes the elements of the world as observable and discrete and that come together in an observable, regular, and determined manner. In this research approach, the deductive method of knowledge or understanding is used. Additionally, researchers who use the positivism approach must concentrate on facts compared to phenomenology, which allows for human interest (Gray, 2009). The positivist approach was appropriate for this study because it sought to gather objective data from nurses and midwives on occupational stress, social relationships at the workplace and coping strategies. The study thus focused on facts as they emerged from the research and not an opinion from the researcher.

3.3. Research Design

A quantitative approach was used for the study. Specifically, a cross-sectional descriptive survey design was adopted to look at occupational stress, social relationships, psychological wellbeing and coping strategies among nurses and midwives in the Catholic Health Service of the Western Region.

According to Coughlan and Brydon-Miller (2014), the quantitative methodology is the dominant research framework in the social sciences. It refers to strategies, techniques and assumptions used to study psychological, social and economic processes by exploring numeric patterns. For Coughlan and Brydon-Miller (2014), the collection of quantitative information allows researchers to conduct simple to highly sophisticated statistical analyses that aggregate the data, show relationships, or compare across aggregated data. Quantitative research includes methodologies such as questionnaires, structured observations or experiments and stands in contrast to qualitative research, which involves collecting and analysing narratives and/or open-ended observations through interviews, focus groups or ethnographies (Coughlan and Brydon-Miller, 2014). Allen (2017) explains the purpose of using quantitative research design. The purpose of quantitative research is to generate knowledge and create an understanding of the social world. Quantitative research is used by social scientists, including communication researchers, to observe phenomena or occurrences affecting individuals. Social scientists are concerned with the study of people. Quantitative research is a way to learn about a particular group of people, known as a sample population. Quantitative research relies on observed or measured data to examine questions about the sample population (Allen, 2017).

The quantitative method helped the researcher gather numerical data to deal with the research problem. The study required the determination of how one variable influenced the other variable. In this study, the researcher described how occupational stress, social relationships and coping strategies influenced the psychological wellbeing of nurses and midwives by soliciting responses from individual nurses and midwives. This made the use of the quantitative design more appropriate.

In using the quantitative method, a descriptive cross-sectional survey was employed for the study. A cross-sectional study is a type of research design in which data is collected from many different individuals at a single point in time. In cross-sectional research, variables are observed without influencing them (Thomas, 2020). This study employed a cross-sectional survey because data were collected from the research participants at a particular time. Also, the study sought to observe, describe and document aspects of the phenomenon as they naturally occur (Creswell, 2002). Besides, it was concerned with determining the nature of prevailing conditions, practices and attitudes, and opinions that are held and the process going on or trends that are developed (Gravetter and Forzano, 2009). This design provided an opportunity for respondents to provide responses that aided in describing how occupational stress, social relationships and coping strategies influenced the psychological wellbeing of nurses and midwives by soliciting answers from individual nurses and midwives. The aptness of the design lies in its ability to assist us in knowing the current status of the phenomenon and how people feel or think about it. In this case, it helped me understand how occupational stress, social relationships and coping strategies influence the psychological wellbeing of nurses and midwives. Also, this design typically uses the method of randomisation that makes it possible to estimate error when population characteristics are inferred from observation of samples. These notwithstanding, the measuring tool associated with the use of this design could be susceptible to nonresponse bias and respond set bias (Asamoah-Gyimah & Anane, n.d). These biases were addressed in this study with the repetition of some items.

3.4. Population.

The study's population included nurses and midwives from the four selected Catholic health facilities in the Western Region, Ghana. According to data from the four selected health facilities, a total of 501 nurses and midwives (398 nurses, 79% and 103 midwives, 21%) were available for the study. The number of nurses and midwives from each health facility is presented in Table 1.

Table 1*: Population of Nurses and Midwives.*

HEALTH FACILITY	NUMBER OF NURSES	NUMBER OF MIDWIVES	OVERALL TOTAL
Holy Child Catholic Hospital	112	32	144
Jubilee Catholic Children Hospital	50	13	63
St. Martin de Porres Hospital	112	29	141
Father Thomas Alan Rooney Memorial Hospital	124	29	153
TOTAL	**398**	**103**	**501**

Source: Sekondi-Takoradi Catholic Health Directorate (2021)

3.5. Sample and Sampling Procedure

3.5.1. Sample Size

The sample size for the study was 300. The overall sample was determined using the Gill, Johnson, and Clark (2010) sample size estimation table. The assumption of this sample size estimation table includes a 95% confidence level, 55 margins of error, and a population variance of 50%. According to this sampling formulae, given a population of 500, a sample of not less than 217 was used for the study. However, to increase the power of generalizability and decrease statistical errors, a sample of 300 was used. The calculation of representation of health professionals in each health facility was calculated based on the 300 samples.

First, the proportionate sampling technique was used to determine the total percentages of nurses and midwives. This method calculated the percentage of nurses and midwives in terms of the sample size (300). A total of 237 nurses and 63 midwives was determined.

Further, the proportion of nurses and midwives was calculated in terms of the contribution of each facility to the total sample. This was calculated by dividing the number of nurses/ midwives from each facility by the overall total of nurses/ midwives multiplied by the sample of nurses/midwives. This is expressed mathematically as:

Number of nurses/midwives from a health facility × sample of nurse/ midwives

The overall number of nurse/ midwives

Lastly, the simple random sampling technique selected the number of estimated nurses and midwives from each health facility. By this technique, all population members had an equal chance of being selected as a participant for the study.

The obtained figures represent the number of health professionals from each facility presented in Table 2.

Table 2: ***Sample Size of Nurse and Midwives.***

HEALTH FACILITY	NUMBER OF NURSES	NUMBER OF MIDWIVES	OVERALL TOTAL
Holy Child Catholic Hospital	67	20	87
Jubilee Catholic Children Hospital	30	8	38
St. Martin de Porres Hospital	67	17	84
Father Thomas Alan Rooney Memorial Hospital	73	18	91
TOTAL	**237**	**63**	**300**

Source: Field survey (2021)

3.5.2. Sampling Procedure

The multistage sampling technique, comprising purposive sampling and stratified sampling, was used to select the sample for the study. First, purposive sampling, a non-probability sampling technique, was used to determine the health facilities to be included in the study. This technique was used because there are only Eight (8) health facilities within the Catholic Health Service in the Western Region and purposive sampling helped select the facilities

with the characteristics that advanced the course of this research. Thus, four (4) hospitals were purposively selected for the study based on geographical location, work characteristics, and the extent to which they impact the psychological wellbeing of nurses and midwives.

In selecting nurses and midwives for the study, stratified sampling was used to put nurses and midwives into two (2) strata. The list of nurses from all the four selected hospitals was collected. The list of midwives in the four facilities was also compiled. All midwives in all the facilities were put together to get the population of midwives for the study. The list of nurses was also put together to get the population of the nurses for the study. Stratified sampling was used because the study population consisted of two sub-groups – nurses and midwives, with different characteristics and work schedules. The strata are thus formed based on common characteristics among the study population.

A simple random sampling method was used to select samples from among nurses and midwives to give members in each stratum equal opportunity to participate in the study. A simple random sampling method was used for the selection of samples from each stratum. A sampling frame was used for this purpose. The list of all nurses and midwives in a facility were collected, and numbers were randomly generated for each name on the lists. Every 5th member on the list was sampled for the study. Each This helped in selecting an unbiased representation of the population under investigation.

Table 3 presents the stages, sampling techniques and purposes for their use.

Table 3*:Stages for sample selection*

Stage	**Sampling Technique**	**Purpose**
1	Purposive sampling	To deliberately select health facilities with nurses and midwives that can provide relevant and information-rich data

2	Stratified sampling	To put the population into two strata of nurses and midwives
3	Simple random sampling	To finally, select participants for the study, giving each equal and valuable chance to be selected.

Source: Field survey (2021)

3.6. Variables

The variables identified in this study are occupational stress, psychological wellbeing, coping strategies, and social relationships at the workplace. Other variables that could be identified in this work include the following: demographic variables (age, duration of service, Category of Health professional, and location of facility).

3.7. Data Collection Instrument

The study used a questionnaire as the main instrument for data gathering. Several standardized scales were used to measure the variables in this study. The questionnaire constituted five parts (Section A, B, C, D, and E). The first section gathered information on participants' demographic characteristics. Section B solicited information on the experiences of occupational stress among nurses and midwives. The Nurses' Occupational Stress Scale (Shiao et al. 2020) was used to fulfil this objective. Section C examined the psychological wellbeing of participants using Ryff's Psychological Wellbeing Scale (PWB, 1995). Section D considered the coping strategies used by nurses to mitigate the effects of occupational stress. The Coping Strategies Inventory (CSI-SF, 1989) was adopted for this assessment. Section E explored the social relationship of nurses and midwives in the workplace. The Social Relationship Scale (Biggs, Swailes & Baker, 2016) was adopted.

3.7.1. Section A: Demographic Characteristics of Participants

This part of the questionnaire used self-designed items to collect data on respondents' demographic characteristics such as age, duration of service, and category of health professionals.

3.7.2. Section B: Nurses' Occupational Stress Scale

Occupational stress experiences among nurses and midwives were assessed (Shiao et al., 2020). The scale was designed to evaluate sources of stressors in the health settings experienced by nurses and to predict personal burnout, nurses' job satisfaction, and their intentions to leave the profession. The scale comprises 21 items grouped under nine (9) subscales, namely *"work demands, work-family conflict, insufficient support from co-workers or caregivers, workplace violence and bullying, organisational issues, occupational hazards, difficulty taking leave, powerlessness, and unmet basic physiological needs".* All items are rated on a 4-Likert scale ranging from 1 to 4, representing Strongly Disagree to Strongly Agree, respectively. The internal consistency of the 21-item NOSS as a whole was 0.91.

3.7.3. Section C: Ryff's Psychological Wellbeing Scale (PWB 18 items)

The study's psychological wellbeing of nurses and midwives was measured using Ryff's Psychological Wellbeing Scale developed by Ryff and Keyes (1995). The 18-item scale is ranked on a 7 Likert scale ranging from 1 (Strongly Agree) to 7 (Strongly Disagree). The scale is made up of 6 subscales, namely Autonomy (questions 15, 17, and 18), Environmental Mastery (questions, 4, 8, and 9), Personal Growth (questions 11, 12, and 14), Positive Relationship with others (questions 6, 13, and 16), Purpose in Life (questions 3, 7, and 10), and Self-Acceptance (questions 1, 2, and 5).

Item 1, 2, 3, 8, 9, 11, 12, 13, 17, and 18 are revised scores before they are added to the scores of the other items for an overall psychological wellbeing score. Scores for each subscale is obtained by summing the scores of the respondent(s). The higher the scores, the higher the level of psychological wellbeing. Les, Sun, and Chiang (2019) reported that the scale has a Cronbach's alpha of 0.88, and internal consistency for the subscales ranges from 0.72-0.88. Only the autonomy subscale had a score of 0.57 for the Cronbach's Alpha.

3.7.4. Section D: Coping Strategies Inventory (CSI-SF)

The fourth section assessed participants coping styles using the *Coping Strategies Inventory* developed by Tobin, Holroyd, Reynolds, and Wigal (1989). This scale was adopted to determine the management practices used by nurses and midwives to cope with the experiences of occupational stress. The scale consists of 16 items comprising four (4) subscales (Problem-focused Engagement, Problem-Focused Disengagement, Emotion-focused Engagement, and Emotion-focused Disengagement). The items are measured on a 4-Likert scale ranging from 1(Never) to 4 (Almost Always). According to Addison et al. (2007), the CSI has reliability coefficients ranging from 0.58 – 0.72. The scale yielded a good reliability coefficient during pilot testing (Cronbach's Alpha=0.82).

3.7.5. Section E: Worker Relations Scale

The workplace relationship among nurses and midwives was measured using the Worker Relationship Scale developed by Biggs, Swailes and Baker (2016). The 9-item scale was proposed to assess employees' relationships at the workplace in three dimensions: co-workers, supervisors, and organisation relations. It is rated on a 5-point Likert scale, namely 1= Strongly Disagree, 2= Disagree, 3=Uncertain, 4=Agree, and 5=Strongly Agree. Internal consistency reliability (alpha) of the three subscales was; Individual 0.74, Supervisor 0.79, and Organisation 0.72. Overall, the scale demonstrated an internal consistency of 0.76 from pilot testing in this study.

3.8. Pilot Testing

Pilot testing is a critical step that occurs early in the survey development process. It is used to identify and correct the flaws in the instruments under development. Proper pilot testing requires a clear understanding of each survey question and hypotheses purpose. Pilot testing encourages the researcher to clarify the survey's goals, which guide the entire research process. Oppenhem's (1992) indicated that pilot testing aid researchers to identify possible weaknesses, ambiguity and problems with an instrument and correct the flaws before actual data collection.

The instrument for the study was pilot tested among nurses and midwives at the Esikado Government Hospital located in the Sekondi-Takoradi Metropolis. This validation process ensured that the selected scales were reliable and accurately assessed the intended objectives. Approximately 10% (30) of the sample size was involved in the pilot testing. The validity and reliability of the scales were established by computing the Cronbach's Alpha Formula. In Cronbach's Alpha model, when a tested scale yields consistent results, the scale or inventory is reliable. Cook and Beckman (2006) revealed that a reliability coefficient equal to or above 0.7 is appropriate for a study.

3.9. Ethical Clearance and Considerations

Since the study involved human participation, ethical clearance was necessary. According to Yip, Han, and Sng (2016), ethical consideration is essential to the conduct of research because researchers are required to ensure that their study conforms to all the laws and rules that regulates. This ensures the safety of participants and guides researchers to adopt safe and accurate practices during the conduct of a study.

As a demand, permission was first sought from the Diocesan Directorate of Health of the Catholic Health Service in the Western Region. Ethical Clearance was sought from the Institutional Review Board (IRB) of Texila American University. The Review Board certified that the study conformed to all the necessary research ethical issues and was harmless to participants.

Before the collection of the data, informed consent was sought from participants. A discussion was held with participants to explain the purpose of the study. All other

participants' concerns were also dealt with. These enabled participants to understand the research and why their participation was of great benefit to the study**.** The voluntary nature of the study was strictly followed. Participants were not coerced to complete their responses to the questionnaire.

Another critical issue that was considered was the anonymity of participants. This describes the process by which the identity of participants is concealed in research so that no individual, including the researcher, can trace participants of the study. All personally identifying information of participants such as names, addresses, e-mail addresses, phone numbers, and other data were not collected. Indexes and numbers were assigned to the responded questionnaire during data entry.

Lastly, the confidentiality of participants' information was highly considered. All nurses and midwives who volunteered to participate in the study were required to sign a consent form to indicate their willingness to participate. Data from participants were stored using proper data management and security practices. The information was used strictly for academic purposes and was not disclosed to any third party. All printed questionnaires were kept in a locked cabinet, and only the researcher had access to them. Likewise, a password was used to protect electronic data. Data concerning the study will be appropriately discarded after two years of submitting the final work of the research and in fulfilling all other requirements of the study.

3.10. Data Collection Procedure

A structured questionnaire was used as the data collection tool for the study. The questionnaire was structured based on specific objectives and consisted of close-ended questions. The questionnaires were administered at the four (4) hospitals selected for the study. An informed consent form was attached to each participant’s questionnaire. Each participant was asked to sign the form after all their concerns related to the questionnaire had been addressed. Also, each participant was assured of utmost confidentiality. Five research assistants were employed and trained to assist in the administration of the questionnaire. Each was assigned to the facilities where data was gathered to guide respondents who had difficulty completing the questionnaire. The questionnaire was

distributed to participants on the 1st and 2nd of April 2021. They had four days to complete the questionnaire. Each participant used about 50 minutes to complete the questionnaire.

3.11. Data Processing and Analysis

A total of 300 participants were sampled for this study. However, a total of 287 responses were received, constituting a response rate of 96%. Data were entered and analyzed using SPSS version 23 and Microsoft Excel 2016 after data were assessed for accuracy and completeness. Descriptive statistics such as frequencies, percentages, means, and standard deviations were used to present the sociodemographic information of the study participants.

For research question one, a One-sample t-test was used to assess the level of occupational stress, social relationship and psychological wellbeing among nurses and midwives against the hypothesized mean of the three-item domain.

Further, Pearson's Product Moment Correlation (r) was used to ascertain any linear relationship and strength of association between occupational stress, social relationships at the workplace and psychological wellbeing scores among the nurses and midwives after assessing the assumption of independence linearity and normality.

The One-Sample Kolmogorov-Smirnov test to test if the items used in assessing the coping strategies of the nurses and midwives were normally distributed.

In testing hypothesis one, a Multiple Linear Regression Model was developed to predict occupational stress from nurses and midwives' psychological wellbeing and social relationship. The assumption of normality, linearity, homoscedasticity, no extreme value (outliers), multicollinearity and singularity were checked and followed. Also, the coefficient of predictability/determination was conducted to determine variations in each variable in terms of their influence.

Simple Linear Regression was used to test hypothesis two. In this method, we have only two variables, independent and dependent variables. It tests the extent to which the independent variable predicts the dependent variable. The hypothesis sought to test if occupational stress (independent variable) significantly influences nurses and midwives' psychological

wellbeing (dependent variable). All assumptions surrounding simple linear regression were checked and followed.

Hypothesis Three was tested with regression analysis. The extent to which the independent variable (Social Relationship) predicts the dependent variable (Psychological Wellbeing) was tested. All assumptions surrounding simple linear regression were checked and adhered to.

Hypothesis Four was tested with the use of Correlation (Pearson Product Moment Correlation). Pearson Product-Moment Correlation (r) is a statistical technique that helps to describe the linear relationship between two continuous variables. It helps to determine the direction and strength of the relationship. Hypothesis Four sought to test if there was a positive relationship between occupational stress and coping strategies. The use of r statistics was suitable because the variables (occupational stress and coping strategies) were continuous and could be measured on the interval scale. Also, the coefficient of determination was determined to explain the variance between the variables of occupational stress and coping strategies.

Hypothesis Five was tested using Analysis of Variance (ANOVA). It was tested at a 0.05 level of significance. ANOVA is a technique for comparing three or more population means. In this study, age of respondents has four levels (18 – 29; 30 – 39; 40 – 49; 51 – 60). Therefore, the use of one-way ANOVA was more apt. Underlying assumptions such as normality, homogeneity of variance (homoscedasticity), and independence of observations were checked and followed.

Hypothesis Six was tested with the use of One-Way ANOVA. ANOVA helps to make a comparison among three or more population means. It further allows us to deal with two or more independent variables simultaneously, asking about their personal effects separately and about their interacting effects (Howell, 2007). The hypothesis sought to test whether there were significant differences in service duration concerning occupational stress experiences. Duration of service has four (4) categories (Less than a year; 1 – 3 years; 4 – 6 years; More than six years). The use of ANOVA was appropriate since it helped us to determine whether the population means of the groups of the duration of service were equal

or not. The significance of the difference was determined by conducting a post-hoc analysis (Bonferroni's test), having taken into consideration Type I and Type II errors.

Hypothesis Seven was tested by employing a t-test (independent sample t-test). The hypothesis was tested at a 0.05 significant level. Independent sample t-test is a statistical technique that helps to compare the mean score of two different groups. Hypothesis Seven tested if there was a significant difference in occupational stress concerning the category of the health professional. This technique was apt since it helped test whether the variation of scores for the two groups (nurses and midwives) were the same. The assumptions undergirding the use of the t-test were checked and followed. These assumptions included normality, homogeneity of variance and independence of observation. Finally, the effect size was calculated using the eta squared. This helped to know whether the difference was statistically significant or not.

3.12. Limitations of the study

The researcher would have wished to apply the study to all healthcare workers within the Western Region of Ghana, but this is not possible because of time and financial constraints. Therefore, the study is limited to only selected nurses and midwives within the Catholic Health Service of the Western Region of Ghana.

3.13.Summary of the Chapter

This chapter provided a detailed description of the materials and methods used to conduct the study. The research design, study area, samples, instrumentation, procedures and measures, and techniques for analysis were described. Efforts were made to ensure that clarity in description, validity, reliability and ethical considerations was followed.

CHAPTER 4

RESULTS AND DISCUSSION

4.0. Introduction

This chapter focused on the analyses of data and the discussions and interpretation of the findings. The study's main objective was to investigate experiences of occupational stress, social relationships, psychological wellbeing, and coping strategies of nurses and midwives in the Catholic Health Service of the Western Region, Ghana.

The study further examined the relationship among occupational stress, social relationships and psychological wellbeing of nurses and midwives. Similarly, the impact of psychological wellbeing, social relationships at the workplace, and occupational stress on each other was explored. Age differences, duration of service and category of a health professional in terms of occupational stress and psychological wellbeing were also investigated. The analyses are made up of three main parts, namely, preliminary analysis, analyses of research questions, and hypotheses testing. Preliminary analysis, which is the first part, deals with summaries of the demographic characteristics of respondents. Thus, "descriptive analyses are presented in preliminary analyses followed by statistical analysis and tests of the research questions and hypotheses. The chapter is concluded with a discussion of the results from the analysis.

4.1. Demographic Information on Participants (n=287)

Demographic data about participants were collected and analysed in this section. This data looked at the age of participants, Duration of Service of participants, and Category of health profession of participants.

From table 4, 119 (41.5) participants were between 18-29 years, were the majority. One hundred and forty 143 (49.5) was between 30-39 years. Twenty-two 22 (7.7) were between 40-49 years, and the least of the study participants, 3 (1.00), were between 50-60 years. 86 (30.0%) of the respondents have been in the service for 1-3years, 77 (26.8%) has been in the

service for four years. 66 (23.0%) of the participants have been in the service for less than a year, and 58 (20.2 %) have been there for more than six years. Most 194 (67.6%) of the study participants were nurses, followed by 93 (32.4%) midwives.

Table 4: ***Sociodemographic Characteristics of the participants***

Variables	Frequencies	Percentage (%)
Age Group		
18-29	119	41.5
30-39	143	49.5
40-49	22	7.7
50-60	3	1.0
Duration of Service		
Less than a year	66	23.0
1 – 3 years	86	30.0
4 – years	77	26.8
More than six years	58	20.2
Category of health professional		
Nurse	194	67.6
Midwife	93	32.4

Source; Field Survey, (2021)

4.2. ANALYSES OF RESEARCH QUESTIONS

4.2.1. Research Question One

What is the level of occupational stress, social relationship and psychological wellbeing of nurses and midwives within the Catholic Health Service in the Western Region?

Research objective one sought to determine the overall level of occupational stress, psychological wellbeing, and workplace social relationship among nurses and midwives. A One-sample t-test was used to analyze the research question. By this method, a hypothesized

mean was determined from the overall total items by multiplying their respective test value with the number of items in scale (Occupational Stress: 2.5 X 21 = 52.5; Psychological Wellbeing: 4.0 X 18 = 72; Workplace Social Relationships: 3.0 X 9 = 27). The hypothesized values are the criterion measures against which the obtained mean of participants will be compared. Regarding occupational stress, a score above the hypothesized mean indicated significantly high levels of work-related stress; in terms of psychological wellbeing and workplace social relationship, a score above the hypothesized mean showed that participants have a positive level of psychological wellbeing and favourable workplace social relationships. The results of the analyses are presented in Table 5.

As indicated in Table 5, nurses and midwives within the Catholic Health Service in the Western Region experience significantly high levels of stress, positive psychological wellbeing, and favourable work-related social relationship. This is because each variable's obtained means are substantially higher than their hypothesized or obtained mean.

Table 5: ***One-Sample t-test for Occupational Stress, Psychological Wellbeing, and Workplace Social Relationship among Nurses and Midwives***

Items	N	Mean	SD	t	df	p
Occupational Stress	287	56.91	9.10	-5.76	286	.000
Psychological Wellbeing	287	87.16	4.19	18.06	286	.000
Workplace Social Relationship	287	34.66	5.73	19.68	377	.000

Source: Field Survey, (2021) Significant $p < 0.05$

4.2.2. Research Question Two

Is there any relationship between occupational stress, social relationships at the workplace and psychological wellbeing of nurses and midwives in the Catholic Health Service of the Western Region of Ghana?

Objective two sought to determine the association among occupational stress, workplace social relationship, and psychological wellbeing of nurses and midwives. Analysis was done

using the Pearson Moment Correlation coefficients. The result of the analysis is presented in Table 6.

Pearson Correlation among Occupational Stress, Psychological Wellbeing, and workplace social relationship (n = 287)

From the correlation matrix below, the correlation coefficient among the variables is worth noting. It is revealed that occupational stress was moderately and weakly associated with psychological wellbeing (r =0.426**, p<0.01) and workplace social relationships, respectively (r =0.236**, p<0.01). The relationship among the variables was positive. The positive association between occupational and psychological wellbeing suggests that occupational stress increases with lower psychological wellbeing. Similarly, the positive relationship between occupational stress and workplace social relationships connotes a higher level of occupational stress is linked with a lower social relationship between nurses and midwives in the work environment. It was further found that psychological wellbeing was positively correlated with workplace social relationships (r =0.511, p<0.01) such that lower psychological wellbeing was associated with lower workplace social relationships or with a higher level of psychological wellbeing is linked with better workplace social relationship. The relationship between these two variables was significantly moderate.

***Table 6*:Pearson Correlation among Occupational Stress, Psychological Wellbeing, and workplace social relationship**

No.	Variables	**1**	**2**	**3**
1.	Occupational Stress	–	.426**	.236**
2.	Psychological wellbeing		–	.511**
3.	Workplace social Relationship	.		–

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

4.2.3. Research Question Three

What type of coping strategies are adopted by nurses and midwives to mitigate the impact of occupational stress in the Catholic Health Service of the Western Region?

Research question three examined the coping strategies used by nurses in midwives in the face of occupational-related stress. First, the one-sample Kolmogorov-Smirnov test was conducted to estimate if the items of coping strategies are normally distributed. The result indicated that the items are normally distributed. The result is presented in Table 7

Table 7: ***One Sample t Kolmogorov-Smirnov Test (n = 287)***

Items		
Normal Parameters [a, b]	Mean	51.92
	SD	7.408
Most Extreme Differences	Absolute	.090
	Positive	.090
	Negative	– .079
Test Statistic		.090
Asymp. Sig. (2 - Tailed)		.000

a. Test distribution id normal

b. Calculated from data.

Means and Standard deviation were used to analyze the coping strategies of nurses and midwives. By this analytical Procedure, a hypothesized value (known mean) was determined to serve as the criterion against which the means of the coping strategies will compare to. The hypothesized mean was calculated by multiplying a test value of 3.0 to the number of items in each sub-dimension (*problem-focused engagement, problem-focused disengagement, emotional-focused engagement,* and *emotional focused engagement*) of the coping strategies (4-items). This gave a value of 12. Judging from the response set, (1= never, 2= seldom, 3= sometimes, 4= often, 5= almost always), and obtained score above the criterion mean suggests that nurses and midwives adopt the more of the coping strategy

which a score below the criterion mean shows that means of coping is not overly patronised or used by participants.

Further, the analysis of the four sub-scales of the Coping Strategies Inventory (CSI) was classified into two: Total Problem-Focused and Total Emotional-Focused. This was to assess whether participants used a lot of problem-focused or emotional-focused coping strategies to minimise the effects of occupational stress. Like the four subscales, a hypothesised mean of 24.0 was determined by multiplying the number of items in each classification (8) by the test value (3.0). The result of the analysis is presented in Table 8

Table 8: ***Means and Standard Deviation for Coping Strategies of Nurses and Midwives (n=287)***

Items	M	SD
1. Problem-Focused Engagement	13.02	2.58
2. Problem-Focused Disengagement	14.18	2.61
3. Emotional-Focused Engagement	12.71	2.71
4. Emotional-Focused Disengagement	12.02	2.34
5. Total Problem-Focused	**27.72**	**4.36**
6. Total Emotional-Focused	**24.73**	**4.19**

Source: Field Survey, (2021)

According to the analysis results in Table 8, participants significantly used all four coping strategies compared with the hypothesized value. This is evident because the means of the sub-scales are significantly above the hypothesized value (12.0). Comparing the means of the subscales indicated that the leading coping strategy used by nurses and midwives is the Problem-Focused Disengagement (M = 14.18, SD = 2.61), followed by Problem-Focused Engagement (m = 13.02, SD = 2.58). According to the analysis, the least used coping method is Emotional-Focused disengagement.

Further, the results showed that usually nurses and midwives adopted Problem-Focused coping (M = 27.72, SD = 4.36), than Emotional-Focused Coping (M = 24.73, SD = 4.19).

This is because the mean score of Problem-Focused Coping is significantly greater than Emotional-Focused Coping.

4.3. HYPOTHESES TESTING

4.3.1. Research Hypothesis One:

$H_0$1: There is no statistically significant influence of psychological wellbeing and social relationship at the workplace on the experiences of occupational stress among nurses and midwives

H_A1 There is a statistically significant influence of psychological wellbeing and social relationship at the workplace on the experiences of occupational stress among nurses and midwives

Hypothesis one examined the influence of psychological wellbeing and workplace social relationships on occupational stress among nurses and midwives. A Multiple regression analysis was run to predict the influence of independent variables (psychological wellbeing and workplace social relationship) on occupational stress. The result of the analysis is presented in Tables 9 and 10.

Table 9*:Multiple Regression Analysis for Occupational Stress, Workplace Social Relationship, and Psychological Wellbeing*

Variables	***df***	**SS**	**MS**	***F***	**Sig.**	***R***	R^2
Regression	2	4301.006	2150.503	31.540	.000	.427	.182
Residual	284	19295.711	68.183				
Total	**286**	**23596.717**					

Source: Field Survey, (2021) Significant $p < 0.05$

Table 10*:Coefficients results of Influence of Psychological Wellbeing and Workplace Relationship on Occupational Stress*

Model	Standardised Coefficient	Unstandardised Coefficient		t	Sig.
	Beta	B	Std. Err		
(Constant)		32.113	3.476	9.240	.000
Psychological Wellbeing	.407	.261	.040	6.513	.000
Workplace Social Relationship	.036	.058	.100	.577	.564

Source: Field Survey, (2021)**.** Dependent Variable = Occupational Stress

As shown in Tables 9 and 10, psychological wellbeing and social relationship at the workplace significantly influenced the occupational stress of nurses and midwives. This is evident from the results, which indicated that psychological wellbeing and workplace social relationship explained 18.2% variance in occupational stress (R^2 =. 182, F(2, 284)=31.540, P=.000). It was also shown from the multiple regression analysis that whiles psychological distress significantly predicted variances in occupational stress (β = .407, p < 0.05), workplace social relationship was not a significant predictor of occupational stresses (β = .038, p = .564).

4.3.2. Research Hypothesis Two

Ho2: Occupational stress has no significant negative influence on the psychological wellbeing of nurses and midwives.

H_A2: Occupational stress has a significant negative influence on the psychological wellbeing of nurses and midwives.

Hypothesis Two determined the influence of occupational stress on psychological wellbeing. It was assumed that the impact of occupational stress on psychological wellbeing was negative. Linear regression analysis was used to test if occupational stress significantly predicts respondents' psychological wellbeing. The regression analysis results indicated that occupational stress explained 18.1% psychological wellbeing variances (R^2 =.181, F(1, 285)=62.895, P=.000). It was also found that occupational stress predicted psychological wellbeing among nurses and midwives in the Catholic Health Service of the Western Region (β = .426, p<0.05). Hence, the alternative hypothesis, which states, *"Occupational stress has a significant negative influence on the psychological wellbeing of nurses and midwives"*, is accepted against the null hypothesis. The results of the analysis are presented in Tables 11 and 12.

***Table 11*:Regression Analysis for Occupational Stress and Psychological Wellbeing**

Variables	***df***	**Sum of Squares**	**Mean square**	***F***	**Sig.**	***R***	***R²***
Regression	1	10406.735	10406.735	62.895	.000	.462	.181
Residual	285	46991.184	165.462				
Total	**286**	**57397.920**					

Source: Field Survey, (2021) Significant p < 0.05

***Table 12:* Coefficients results of Influence of Occupational Stress on Psychological Wellbeing**

Model	**Standardized Coefficients**	**Unstandardized Coefficients**		**t**	**Sig.**
	Beta	**B**	**Std. Err**		
(Constant)		49.385	4.823	10.239	.000
Occupational Stress	.426	.664	.084	7.931	.000

Source: Field Survey, (2021)**.** Dependent variable = Psychological Wellbeing

4.3.3. Research Hypothesis Three

Ho3: Social relationships will have no significant positive influence on the psychological wellbeing of nurses and midwives.

H_A3: Social relationships will have a significant positive influence on the psychological wellbeing of nurses and midwives.

The objective of the hypothesis was to determine the extent of the impact that social relationship at the workplace has on the psychological wellbeing of nurses and midwives. To test this hypothesis, linear regression analysis was conducted. The results are presented in Tables 13 and 14.

Table 13:*Regression Analysis for Workplace Social Relationship and Psychological Wellbeing*

Variables	***df***	**Sum of Squares**	**Mean Square**	***F***	**Sig.**	***R***	R^2
Regression	1	14999.633	14999.633	100.473	.000	.511	.261
Residual	285	42398.287	149.290				
Total	**286**	**57397.920**					

Source: Field Survey, (2021) Significant $p < 0.05$

Table 14: *Coefficients results of Influence of Workplace Social Relationship on Psychological Wellbeing*

Model	**Standardized Coefficients**	**Unstandardized Coefficients**		**t**	**Sig.**
	Beta	**B**	**Std. Err**		
(Constant)		42.981	4.466	9.624	.000
Workplace Social Relationship	.511	1.273	.127	10.024	.000

Source: Field Survey, (2021)**.** Dependent variable = Psychological Wellbeing

As shown in Table 13 and 14, the regression analysis results indicated that Workplace social relationships explained 26.1% significant psychological wellbeing variances (R^2 =.261, F(1, 285)=100.473, P=.000). Further, it was noted that workplace social relationship is a significant predictor of psychological wellbeing among nurses and midwives of Catholic Health Service in the Western Region (β = .511, $p<0.05$). The results indicate that social interaction and experiences among health professionals (nurses and midwives) at the workplace significantly determine their psychological wellbeing. It could be asserted that a favourable positive relationship at the workplace will promote better psychological wellbeing, while toxic social relations will breed negative psychological wellbeing.

4.3.4. Research Hypothesis Four

H_O4: There will be no significant positive relationship between occupational stress and coping strategies

H_A4: There will be a significant positive relationship between occupational stress and coping strategies

This hypothesis tested the association between occupational stress and coping strategies adopted by nurses and midwives. To test this hypothesis, the Pearson Moment Correlation Coefficients was run. The result of the analysis is presented in Table 15.

Table 15*: Pearson Correlation among Occupational Stress and Coping Strategies*

No.	Variables	1	2
1.	Occupational Stress	–	.176**
2.	Coping Strategies		–

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

From Table 15, the results revealed that occupational stress has a weak positive significant relationship with coping strategies. The results imply that a significant increase in occupational stress is linked with the adoption of various coping responses. In contrast,

lower work-related stress experiences are associated with less adoption of coping strategies. In other words, nurses and midwives are likely to adopt several coping strategies in the face of heightened stress levels. However, lesser stress experiences among these health professionals are related to the use of few coping methods.

4.3.5. Research Hypothesis Five

H_O5: There will be no significant age differences regarding experiences of occupational stress among nurses and midwives.

H_A5: There are significant age differences with regards to experiences of occupational stress among nurses and midwives.

The purpose of hypothesis 5 was to find if a significant difference exists among age categories of nurses and midwives in terms of experiences of occupational stress. A one-way analysis of variances (*ANOVA*) was used to test this hypothesis. Two (2) basic assumptions were checked to warrant the use of *ANOVA*. They are tests of *normality* and *homogeneity of* variables (age categories and occupational stress). The analysis is presented in Tables 16 and 17.

Table 16: ***Test of Normality of Variances for Age and Occupational Stress among Nurses and Midwives***

	Age	**Shapiro-Wilk**		
		Statistic	***df***	***Sig.***
Occupational Stress	18 – 29 years	.988	119	.377
	30 – 39 years	.955	143	.312
	40 – 49 years	.952	22	.340
	50 – 60 years	.964	3	.637

Source: Field Survey, (2021) Significant $p > 0.05$

From Table 16, all categories of age groups were normally distributed. This is because of the Sig. value of the Shapiro-Wilk Test is greater than 0.05.

A test of Homogeneity of Variances was conducted to confirm the assumption that justifies the statistical tool *ANOVA*.

Table 17:*ANOVA Test of Homogeneity of Variances for Age and Occupational Stress among Nurses and Midwives*

Levane Statistic	df1	df2	Sig.
.868	3	283	.458

Source: Field Survey, (2021) Significant $p > 0.05$

From Table 17, the sig. value is greater than 0.05. Therefore, variances are assumed to be equal. An ANOVA was used to find the difference among the ages.

Table 18: ***ANOVA Test for Ages of Nurses and Midwives in Terms of Occupational Stress***

Group	Sum of Squares	*df*	Mean Square	F	Sig.
Between Groups	1709.413	3	569.804	7.345	.000
Within Groups	21953.047	283	77.573		
Total	**20903.38**	**377**			

Source: Field Survey, (2021) Significant $p < 0.05$

From the one-way analysis of variance (ANOVA) in Table 18, the sig value is less than 0.05 (F (3, 283) = 7.35, p = .000), indicating that there is a significant difference within the ages group of nurses and midwives in terms of their experiences of occupational stress. Hence, a post hoc test was conducted to determine which pairs of ages means are statistically different. Table 19 presents the post hoc test result of the ages of respondents regarding occupational stress.

Table 19*:Multiple Comparisons of Ages Categories in terms of occupational stress*

	(I) Age (Years)	(J) Age (Years)	Mean Difference (I-J)	Std. Error	Sig.
Tukey HSD	18 – 29	30 – 39	–4. 51*	1.09	.000
		40 – 49	–6.85*	2.04	.005
		50 – 60	–2.56	5.15	.960
	30 - 39	18 – 29	4.51*	1.09	.000
		40 – 49	–2.34	2.02	.653
		50 – 60	1.95	5.14	.981
	40 – 49	18 – 29	6.85*	2.04	.005
		30 – 39	2.34	2.02	.653
		50 – 60	4.29	5.42	.858
	50 – 60	18 – 29	2.56	5.15	.960
		30 – 39	–1.95	5.14	.981
		40 – 50	–4.29	5.42	.858

Source: Field Survey, (2021). Significant $p < 0.05$

*The mean difference is significant at the 0.05 level

The results indicate that there is a significant difference between the "*18 – 29 years*" age category and "30 – 39 years" as well as "*40 – 49 years*" because of their respective sig. values (.000 and .005) is less than 0.05. The results connote that participants within the age category "*30 – 39 years*" and "*40 – 49 years*" experience significantly higher levels of occupational stress than nurses and midwives with the age category "*18 – 29 years*". It could be observed from the Table that there were no significant differences among the other age

categories because of the sig. values were greater than 0.05. Due to the presence of differences among some of the age categories, the Alternative hypothesis (H_A), which states, *"There is a significant age difference with regards to experiences of occupational stress among nurses and midwives", is* accepted against the Null hypothesis (H_0).

4.3.6. Research Hypothesis Six

H_O6: There will be no significant differences in duration of service with regards to experiences of occupational stress among nurses and midwives.

H_A6: There is a significant category in the duration of service with regards to experiences of occupational stress among nurses and midwives.

Similar to hypothesis 5, 2 basic assumptions were checked to warrant using *a parametric or non-parametric inferential statistical tool*. They are a test *of normality* and *homogeneity of variables* among the variables (age categories and occupational stress). The analysis is presented in Tables 20 and 21.

Table 20: ***Test of Normality of Variances for Duration of Service and Occupational Stress among Nurses and Midwives***

	Age (Years)	**Shapiro-Wilk**		
		Statistic	***df***	***Sig.***
Occupational Stress	Less than a year	.965	66	.031
	1 – 3	.971	86	.047
	4 – 6	.947	77	.003
	More than 6 years	.971	58	.018

Source: Field Survey, (2021) Significant p > 0.05

From Table 20, the data regarding the duration of services is not normally distributed. This is because of the Sig. value of the Shapiro-Wilk Test of all categories is lesser than 0.05. A test of Homogeneity of Variances was run.

Table 21:*ANOVA Test of Homogeneity of Variances for Duration of Services and Occupational Stress among Nurses and Midwives*

Levene Statistic	df1	df2	Sig.
2.8790	3	283	.041

Source: Field Survey, (2021) Significant $p > 0.05$

From Table 21, the sig. value is lesser than 0.05. Therefore equal variances are not assumed among the group. Therefore, the non-parametric version of an ANOVA, thus Kruskal-Wallis test was conducted to test for differences among the group.

Table 22: *Kruskal-Wallis Test for Duration of services of Nurses and Midwives in Terms of Occupational Stress*

	Duration of Service	*n*	Mean Rank	*df*	Chi-square	Sig.
Occupational Stress	Less than a year	66	106.67	3	31.907	.000
	1 – 3 years	86	134.23			
	4 – 6 years	77	183.08			
	More than six years	58	149.09			

Source: Field Survey, (2021) Significant $p < 0.05$

The results of the Kruskal Wallis test showed a statistically significant difference in the categories of duration of services of nurses and midwives regarding experiences of occupational stress (X^2 (3) = 31.907, p = 0.000).

The post hoc test was conducted to estimate the differences among the categories of duration of services. The results are presented in Table 23.

Table 23*:Multiple Comparisons of Ages Categories in terms of occupational stress*

Sample 1 – Sample 2	Test Statistic (TS)	Std. Error	Std. Test Statistic	Adj. Sig.
Less than a year vs 1 – 3 years	–27.55	13.57	–2.03	.253
Less than a year vs 4 – 6 years	–42.21	14.92	–2.84	.027
Less than a year vs. More than 6 years	–76.40	13.91	–5.60	.000
1 – 3 years vs more than 6 years	–14.86	14.09	–1.06	1.000
1 – 3 years vs 4 – 6 years	–48.85	13.01	–3.76	.001
More than 6 years vs 4 – 6 year	33.99	14.41	2.36	.110

Source: Field Survey, (2021). Significant $p \leq 0.05$

NB: *Significance values have been adjusted by the Bonferroni correction for multiple tests.*

The finding from Table 23 indicated a significant difference in the duration of service experiences with occupational stress. The results showed that a significant difference exists between "*Less than a year*" and "*more than 6 years*" (p = .027) as well as "*Less than a year*" and "*4 – 6 years*" (p = .000) with regards to experiences of occupational stress. Similarly, participants have statistically significant differences with "1 – 3 years " duration of service experience and 4 – 6 years (p = .001).

4.3.7. Research Hypothesis Seven

H_O7: There will be no significant difference in the experiences of occupational stress concerning the category of health professionals.

H_A8: There is a significant difference in the experiences of occupational stress concerning the category of health professionals.

To determine whether a significant difference exists between nurses and midwives in terms of their experiences with occupational stress, an independent samples t-test was used as the statistical tool. The result is presented in Table 24.

Table 24:*Independent Samples t-test for Nurses and Midwives in terms of their Occupational Stress*

Occupational Stress	N	Mean	SD	*t*	*df*	*Sig.*
Nurses	194	56.88	9.35	- .080	285	.985
Midwives	94	56.97	8.59			

Source: Field Survey, (2021) Significant, $p < 0.05$

As shown in Table 24, there is no difference between the experiences of nurses and midwives in terms of occupational stress. This is noted from the fact that the sig. value which shows the differences is greater than 0.05 (t (285) = -. 985, p = .985). The results imply that nurses and midwives in the Catholic Health Service of the Western Region of Ghana experiences did not differ significantly on levels of occupational stress. The results may be because these workers' job or work experiences are similar and that they meet the same clients and situation that predisposes them to stress.

Therefore, the null hypothesis (Ho), which states that significant difference in the experiences of occupational stress concerning the category of health professionals, is accepted in favour of the alternative hypothesis.

4.4. DISCUSSIONS

4.4.1. Level of Occupational Stress, Social Relationship and Psychological Wellbeing among nurses and midwives in the Catholic Health Service of the Western Region of Ghana.

The first research question sought to ascertain the level of occupational stress, social relationship at the workplace and psychological wellbeing among nurses and midwives in the Catholic Health Service of the Western Region of Ghana. The study results indicated that nurses and midwives within the Catholic Health Service of the Western Region experience significantly high levels of stress, a high level of psychological wellbeing and a high level of work-related social relationship. The analysis indicated significantly high levels of occupational stress among the nurses and midwives in the Catholic Health Service of the Western Region of Ghana. This is evident in that occupational stress scored above the hypothesized mean, indicating a significantly high level. Regarding the level of social relationship and psychological wellbeing among nurses and midwives, the scores were also above the hypothesized mean showing a positive social relationship and positive psychological wellbeing among the nurses and midwives in the Catholic Health Service of the Catholic Health Service the Western Region of Ghana.

The results of the study that nurses and midwives experience significantly high levels of occupational stress affirm the work of Vahid et al. (2011) and Hashemi et al. (2013) that the

hospital personnel especially nurses and midwives are exposed to severe or moderate occupational stress. The study is in line with the report of the World Health Organization (2020) and Ministry of Health (2018), where it is recorded that in Ghana, the nurses-population ratio suggests that the nurses will have excessive workloads, long working hours leading to burnout and high levels of occupational stress. This, in turn, is consistent with the Ghana Health Service (2018) statistics that as of 2017, the nurses and midwives ratio was 2.65 per 1000 population. The result of the study also confirms the study by Adzakpa, Laar and Fiadjoe (2016) conducted at the St. Dominic Hospital, Akwatia in Ghana that nurses of the hospital were found to experience above-average levels of occupational stress with the mean score and individual average score of 37.01 and 2.47 indicating a 10% higher than the established Weiman Occupational Stress Scale mean score of 33.75 and individual average of 2.25. The study result also agrees with the findings that nursing is a stressful occupation with high levels of stress (Xianyu and Lambert, 2006; Marshall, 1980; Bailey, 1985).

About the level of social relationships at the workplace among nurses and midwives in the Catholic Health Service of the Western Region of Ghana, the study revealed a high level of social relationship among them. This is positive as it enhances total employee wellbeing. The result agrees with Persson et al. (2018) that relationships are essential to the psychosocial work environment and maybe resources for the employees' wellbeing. Dutton and Ragins (2007) affirms that positive relationships at work may be a resource that can help individuals and organizations to develop and flourish.

The study results also revealed positive psychological wellbeing among the nurses and midwives in the Catholic Health Service of the Western Region of Ghana. Waters (2021) opines that positive mental health is essential because it allows us to cope with challenges, even good ones, and setbacks in our lives, both at work and at home. Waters (2021) further affirms that positive mental health at work helps us cope with changing roles and responsibilities. It helps us flourish in our roles, manage stress, and boost our resilience. Ultimately, it allows us to reach our highest potential. Thus, as revealed in the study, positive psychological wellbeing among the nurses and midwives will help them deal with challenges at work and home and reach one's highest potential in life.

4.4.2. Relationship among occupational stress, social relationship and psychological wellbeing among nurses and midwives in the Catholic Health Service of the Western Region of Ghana.

The second research question was intended to determine the relationship among occupational stress, social relationships at the workplace and psychological wellbeing among nurses and midwives in the Catholic Health Service of the Western Region of Ghana. The study results revealed that occupational stress was moderately and weakly associated with psychological wellbeing and social relationships. The study showed that the relationship among the three variables was positive. The positive association between occupational stress and psychological wellbeing indicates that occupational stress increases with lower psychological wellbeing. This simply implies that where there is lower psychological wellbeing, there is an increase in occupational stress. Thus, occupational stress decreases psychological wellbeing. The study also discovered a positive relationship between occupational stress and social relationships at the workplace, indicating that a higher level of occupational stress is linked with lower social relationships between nurses and midwives in the work environment. The study's findings further showed that social relationship at the workplace was positively correlated with psychological wellbeing. This suggests that lower psychological wellbeing is indicative of lower social relationships at the workplace. Conversely, higher psychological wellbeing is also indicative of higher social relationships at the workplace.

The findings align with Themes, Costa and Guilam (2013) study that uncovered that health professionals with high demand and low control experience poor self-related health. The study affirmed that occupational stress has a toll on the overall wellbeing of employees. The findings are further substantiated by a descriptive survey of Adegoke (2014), who analysed the impact of occupational stress on the psychological wellbeing of police. He found that there is a significant impact of work stress on the psychological wellbeing of police. These earlier works agree with the research work of Suleman, Hussain, Shehzad, Syed and Raja (2018), where it was revealed that there is a strong negative correlation between perceived occupational stress and psychological wellbeing. The results of their study imply that as occupational stress increases, psychological wellbeing reduces and vice versa.

The results cohere with the Transactional Stress Theory, which posits an interaction between an individual and the environment. The Transactional model of stress emphasizes that stress occurs when an individual is faced with environmental demands. It also suggests that the individual's ability to cope with these demands largely rests on their cognitive appraisal (Kim, 2017). Here, stress occurs when the interaction between an individual and the environment threatens their coping resources and burdens physical and psychological wellbeing.

4.4.3. Coping strategies adopted by nurses and midwives in the Catholic Health Service of the Western Region of Ghana to mitigate the impact of occupational stress.

The third research question was meant to examine the coping strategies adopted by nurses and midwives in the Catholic Health Service of the Western Region to mitigate the effects of occupational stress. The study's findings showed that regarding coping strategies to reduce occupational stress, nurses and midwives employed all four coping strategies – Problem-Focused Engagement, Problem-Focused Disengagement, Emotional-Focused Engagement, and Emotional-Focused Disengagement- in varying degrees. The study showed that the highest coping strategy employed by nurses and midwives was Problem-Focused Disengagement. The second highest strategy used was Problem-Focused Engagement. The least coping strategy employed by the nurses and midwives was Emotional-Focused Disengagement. The study revealed that nurses and midwives adopted the Problem-Focused coping strategy more than the Emotional-Focused coping strategy.

The results of the study that nurses and midwives in the Catholic Health Service of the Western Region predominantly adopted Problem-Focused coping strategy contradicts the study by Gholamzadeh, Sharif and Rad (2011) that most of the nurses in the study they conducted preferred emotional-focused coping strategies to Problem-focused approaches in coping with occupational stressors at the hospital. The result also contradicts the work of Adzakpah et al. (2016), who also concluded that in dealing with occupational stressors, identifying the source of stress and avoiding unnecessary stress, adjusting to standards and attitudes, engaging in hobbies and expressing their feelings instead of bottling them up were some of the copings strategies adopted by these nurses in coping with the occupational

stressors and these are all emotional-focused. The results of the study that with regards to coping strategies to mitigate the effects of occupational stress, nurses and midwives employed all four coping strategies – Problem-Focused Engagement, Problem-Focused Disengagement, Emotional-Focused Engagement, and Emotional-Focused Disengagement- in varying degrees, confirms the study by Bánovčinová (2017) that in dealing with an occupational stressor, midwives adopted acceptance, active coping and instrumental support which are both problem-focused and emotion-focused strategies as espoused by the Transactional Theory of Stress and Coping by Lazarus and Folkman. A study by Akbar et al. (2016) also reveals that midwives adopted preventive monitoring of the situation, situational control of conditions, self-controlling, seeking help, avoidance and escape and spiritual coping as coping strategies adopted by midwives in dealing with occupational stress. These strategies are both problem-focused and emotional-focused, confirming the study results that nurses and midwives adopted all four coping strategies in varying degrees. This also supports the work of Jannati et al. (2011) that nurses adopted self-control, work management, cognitive, emotional and spiritual coping strategies as primary forms of coping strategies which also indicate a combination of problem-focused and emotional-focused strategies but in varying degrees. This study, therefore, agrees that nurses and midwives in the Catholic Health Service of the Western of Ghana adopted both problem-focused and emotional-focused coping strategies but predominantly employed problem-focused coping strategies in mitigating the effects of occupational stress.

4.4.4. Influence of psychological wellbeing and social relationship at the workplace on the experiences of occupational stress among nurses and midwives in the Catholic Health Service of the Western Region of Ghana

The first research hypothesis sought to examine the influence of psychological wellbeing and workplace social relationships on the experiences of occupational stress among nurses and midwives in the Catholic Health Service of the Western Region of Ghana. The study found that psychological wellbeing and social relationships at the workplace have a significant impact on the experiences of occupational stress among nurses and midwives. The results further showed that psychological wellbeing was a substantial predictor of experiences of occupational stress. However, social relationships at the workplace were

found not to be a significant predictor of experiences of occupational stress among nurses and midwives.

Thus the null hypothesis was rejected, and the alternative hypothesis was upheld.

This finding implies that psychological wellbeing is negatively affected by experiences of occupational stress. This means that as psychological wellbeing increases, occupational stress reduces and as occupational stress increases, psychological wellbeing reduces.

The findings confirm the PERMA model proposed by Seligman (2011). Seligman's explanation that positive emotions, engagement, relationship, meaning and accomplishment reduce stress and ensure ultimate satisfaction in life finds support in the findings of this study. The results also substantiate the work of Suleman, Hussain, Shehzad, Syed and Raja (2018) that pointed out a strong negative correlation between perceived occupational stress and psychological wellbeing.

According to the social exchange theory, socially supportive and positive communication systems are key to mitigating stress at the workplace (Sias, 2009). The findings are, however, contrary to what the social exchange theory posits. This is in line with Tumen and Zeydanli (2016) work, who revealed that job satisfaction is positively correlated with worker performance and productivity. Their findings further revealed that there is a significant impact of social interactions at the workplace. Their results explained the importance of quality social relationships and their role in shaping the job satisfaction level of employees.

The study again finds support in Tran, Nguyen, Dang, and Ton (2018) work, which explored the Social support on employees' development and welfare within the nursing community. Tran et al. found that high-quality workplace relationships positively impact factors such as occupational stress among nurses. The findings from the study were consistent with other research works that have long proven that quality social relationships positively impact the overall wellbeing of employees (Mahmoudi, Hosseini, Joonbakhsh & Ajoodanian, 2020; Zeydanli, 2016; Tran et al., 2015). The findings from the study revealed that the presence of a social support group within the nursing and midwifery profession provides nurses with the needed support for their psychological wellbeing. This, logically, reduces the experience of stress at the workplace.

4.4.5. Influence of occupational stress on the psychological wellbeing of nurses and midwives in the Catholic Health Service of the Western Region of Ghana

The second research hypothesis was meant to determine the influence of occupational stress on the psychological wellbeing of nurses and midwives in the Catholic Health Service of the Western Region of Ghana. The study results indicated that occupational stress had a significant negative impact on the psychological wellbeing of nurses and midwives in the Catholic Health Service of the Western Region of Ghana. This means that occupational stress was a significant predictor of psychological wellbeing among the nurses and midwives.

The result of the study confirms the study by Mensah (2021) that job stress had a direct negative effect on mental wellbeing among workers in Europe. The study also agrees with Costa and Guilam (2013) that occupational stress has a toll on the overall wellbeing of employees. That occupational stress has a significant negative impact on the psychological wellbeing of nurses and midwives is supported by the work of Mark (2017) that occupational stress can have dire consequences for organisational growth and the psychological wellbeing of employees; Stress causes a lot of psychological trauma, such as anger, anxiety, depression, nervousness, irritability, aggressiveness, and a decline in workers self-worth, hatred to supervision, lack of concentration, difficulties in decision-making and job dissatisfaction. Wang et al. (2017) also agree that occupational stress is a significant risk factor for mental health among the occupational population. Murtaza et al. (2015) agree that excessive occupational stress has been considered "toxic" parts of the job environment and is often associated with psychological and physical health. Empirical studies demonstrated that occupational stress is a significant predictor of anxiety (Mark & Smith, 2012; DiGiacomo & Adamson, 2001; Mensah & Amponsah-Tawiah, 2018).

Nakao (2010) recognised that occupational stress is a meaningful cause for mental health worldwide. Furthermore, occupational stress inversely correlates with psychological wellbeing (Suleman, Hussain, Shehzad, Syed & Raja, 2018) and is positively associated with depressive symptoms (Wang et al., 2017; Banerjee, 2012). These confirm the findings of this research study and give it credence.

4.4.6. Influence of social relationships on the psychological wellbeing of nurses and midwives in the Catholic Health Service of the Western Region of Ghana.

The third research hypothesis sought to determine the extent of the impact that social relationship at the workplace has on the psychological wellbeing of nurses and midwives in the Catholic Health Service of the Western Region of Ghana. The study results indicated that workplace social relationships are a significant predictor of psychological wellbeing levels among nurses and midwives of Catholic Health Service in the Western Region. The study thus showed that social interaction and experiences among health professionals (nurses and midwives) at the workplace are a significant determinant of their psychological wellbeing. Therefore, a favourable positive relationship at the workplace will promote better psychological wellbeing, while toxic social relations will breed negative psychological wellbeing.

The results of the study that positive workplace relationship is a significant predictor of psychological wellbeing among nurses and midwives are corroborated by the research findings that endorsed the essential role of positive working relationship on nurses' job performance, nurses and patients' satisfaction, employee retention, and organisational commitment (Adam & Bond, 2000; Force, 2005). This also affirms the study of Tumen and Zeydanli (2016) that proved the importance of quality social relationships and their role in shaping the job satisfaction level of employees.

The result of the study is also consistent with the findings from the study of Tran et al. (2015) that affirmed that high-quality workplace relationships have a positive impact on factors such as occupational stress among nurses. For Tran et al. (2015), their findings were consistent with other research works, which have long proven that quality social relationships have a positive impact on the overall wellbeing of employees, and that is also consistent with the results of this study. The study by Mahmoudi et al. (2020) that the presence of a social support group within the nursing profession provides nurses with the needed support confirms the result of this study. Rosales (2015) also agrees that Positive social interaction leads to effectiveness, cooperation, improves organizational learning, and ensure employee loyalty. High-quality social connections are noted to empower employees to give their all for the success of an organization. These are consistent with the assertion of

Seligman (2011) that a healthy positive relationship is one of the five pillars of an individual's wellbeing.

4.4.7. Relationship between coping strategies and occupational stress among nurses and midwives in the Catholic Health Service of the Western Region of Ghana.

The fourth research hypothesis was meant to test the association between occupational stress and coping strategies adopted by nurses and midwives in the Catholic Health Service of the Western Region of Ghana. The results of the study revealed that occupational stress has a weak positive significant relationship with coping strategies. This indicates that nurses and midwives are likely to adopt several coping strategies in the face of heightened stress levels. This revealed that a significant increase in occupational stress is linked with the adoption of various coping responses. In contrast, a lower experience of work-related stress is associated with less adoption of coping strategies. There is thus a somewhat positive relationship between coping strategies and occupational stress among nurses and midwives in the Catholic Health Service of the Western Region of Ghana.

The result of the study affirms the assertion of Teixeira et al. (2016) that individuals develop varied ways of coping with a stressful situation, and these differences can be linked to situational demands, personality and the resources available. This is true in light of Skinner and Zimmer-Gembeck (2016) assertion that coping is an integral part of humans' survival and shows the degree to which individuals handle misfortunes in life.

The findings are consistent with the Transactional Theory of Stress and Coping that stress occurs when an individual is faced with environmental demands. It also suggests that the individual's ability to cope with these demands largely rests on their cognitive appraisal (Kim, 2017). The result of the study is also consistent with the findings of Harris (2013), which revealed that when coping resources adequately equal the stress event at hand, no matter the type of the resources, there will be a successful control outcome. This also ties in nicely with Millikan et al. (2007) findings that if the stressor at hand exceeds the available resources available to the individual, stress will manifest. Stress, therefore, occurs when the interaction between an individual and the environment threatens the individuals' coping resources and burdens their physical and psychological wellbeing.

4.4.8. Age differences regarding experiences of occupational stress among nurses and midwives in the Catholic Health Service of the Western Region of Ghana.

The fifth research hypothesis was meant to find out if a significant difference exists among age categories of nurses and midwives in the Catholic Health Service of the Western Region of Ghana in terms of experiences of occupational stress. The study found out that there is a significant difference within the age group of nurses and midwives in terms of their experiences of occupational stress. It was revealed in the study that participants within the age category "*30 – 39 years*" and "*40 – 49 years*" experience significantly higher levels of occupational stress than nurses and midwives with the age category "*18 – 29 years*".

The result of the study contradicts the study by Osei-Mireku et al. (2020), which found out that older or more experienced employees record lower levels of stress than younger and less experienced ones. The results of this study instead revealed that nurses and midwives within the age category of "18-29 years" instead experienced lower stress levels. The result of the study also contradicts the findings from Faraji et al. (2019) that employees who are less than 40 years old experience the highest levels of stress. The study revealed that employees less than 30 years rather experience lower levels of stress at the workplace. In supporting why older employees record low levels of stress, as opined by Osei-Mireku et al. (2020) and Faraji et al. (2019), Duarte and Pinto-Gouveia (2019) explained that older employees have reached a stage where career development is no longer their primary concern, and hence several job characteristics which may cause stress to younger staff, who have their career ahead of them, do not cause stress to older staff. Mauno, Rulkolainen and Kinnunen (2013) also asserted that older workers are more resilient than younger ones against work-family conflicts for academic employees. Older workers are more capable of buffering workload stress and life satisfaction in service sectors. This viewpoint is, however, rejected by Hui-Chuan (2018). They instead think that older workers can face more barriers and stressors at work, such as physical strength limitations and health concerns, gaps related to using new technology, and engagement in work and are prone to higher levels of occupational stress. The results of this study, therefore, confirm the viewpoint of Hui-Chuan (2018) and still conclude that nurses and midwives within the age category "*30 – 39 years*" and "*40 – 49 years*" experience significantly higher levels of occupational stress than nurses and midwives with age category "*18 – 29 years*".

4.4.9. Differences in duration of service with regards to experiences of occupational stress among nurses and midwives in the Catholic Health Service of the Western Region of Ghana.

The sixth research hypothesis sought to determine if there were differences in duration of service among nurses and midwives in the catholic Health Service of the Western Region regarding experiences of occupational stress. The study results revealed there was a significant difference among the duration of service in terms of experiences with occupational stress. The study results showed that a significant difference exists between "*Less than a year*" and "*more than 6 years*" as well as "*Less than a year*" and "*4 – 6 years*" with regards to experiences of occupational stress. It was also revealed statistically significant differences between participants with a "1 – 3 years" duration of service experience and 4 – 6 years.

The result of the study confirms the study of Elahi and Apoorva (2012) that there are differences with regards to the duration of service in the experience of occupational stress among employees. In their study, Elahi and Apoorva found that occupational stress was minimal in the extended tenure group and medium in the medium. Still, it is minutely observed that it is maximum in a short tenure period. In explaining their findings, Elahi and Apoorva (2012) asserted that such a finding is logical because the longest tenure is usually associated with substantial experiential learning, making individuals better equipped for managing their problems.

4.4.10. Differences in the experiences of occupational stress concerning the category of health professionals among nurses and midwives in the Catholic Health Service of the Western Region of Ghana.

The seventh research hypothesis was meant to determine the differences in the experiences of occupational stress concerning the category of health professionals among nurses and midwives in the Catholic Health Service of the Western Region of Ghana. The study found out that there were no significant differences between the experiences of nurses and midwives in terms of occupational stress. The results showed that nurses and midwives in the Catholic Health Service of the Western Region of Ghana experiences did not differ significantly on levels of occupational stress.

Finding literature on the experiences of occupational stress concerning the category of health professionals was difficult. The research, therefore, did not find literature on the subject. The discussion of these results was consequently based on logic and analogy. The researchers assumed that results might be because nurses and midwives' job or work experiences are similar in the analysis. This may be true to some extent. It is true that nurses and midwives are all shift workers and are predisposed to similar conditions at the facility. They meet the same clients and situation that predisposes them to stress.

Literature, however, reveals the significant differences between nurses and midwives in terms of work performance. The American Nursing Association (2013) listed some nursing activities as protecting, promoting, improving health abilities, prevention of illness/injuries, alleviation of suffering, diagnosis, treatment, and advocacy for the care of patients, families and communities. Lesley and Rona (2006) asserted that midwives influence family health by providing quality services related to maternal health conditions. Their job typically covers supporting mothers and their babies during pregnancies and delivery issues (Bahadoran, Alizadeh, & Valiani, 2009; Beek et al., 2019). The literature shows that although nurses and midwives may have similar characteristics, they differ in job performance. Their job is different, and this may have a lot to do with their experience of stress.

To conclude, the researcher posits that although the research findings favoured and accepted the null hypothesis (Ho), which states that there will be no significant difference in the experiences of occupational stress concerning the category of the health professional, logical analysis favours the alternative hypothesis that there is a considerable difference in the experiences of occupational stress concerning the category of health professionals. The researcher thinks there is a significant difference among nurses and midwives in the Catholic Health Service of the Western Region of Ghana. This conclusion is reached based on the different work schedules of nurses and midwives.

CHAPTER 5

SUMMARY

5.0 Introduction

This chapter summarizes the research process and the findings on occupational stress, social relationship at the workplace, psychological wellbeing and coping strategies among nurses and midwives in the Catholic Health Service of the Western Region, Ghana. The chapter has been divided into two sections. The first section summarizes the research process, and the second section summarizes the study's key findings.

5.1 Summary of the Research Process

The descriptive cross-sectional design was employed to investigate occupational stress, social relationship at the workplace, psychological wellbeing and coping strategies among nurses and midwives in the Catholic Health Service of the Western Region, Ghana. The

research utilized the positivist research philosophy and the quantitative approach. The questions and hypothesis for the study were categorized into ten main groups as follows:

1. What is the level of occupational stress, social relationship and psychological wellbeing among nurses and midwives within the Catholic Health Service in the Western Region?
2. Is there any relationship among occupational stress, social relationships at the workplace and psychological wellbeing among nurses and midwives in the Catholic Health Service of the Western Region of Ghana?
3. What coping strategies are adopted by nurses and midwives to mitigate the impact of occupational stress in the Catholic Health Service of the Western Region?
4. There is no statistically significant influence of psychological wellbeing and social relationship at the workplace on the experiences of occupational stress among nurses and midwives.
5. Occupational stress has no significant negative influence on the psychological wellbeing of nurses and midwives.
6. Social relationships at the workplace will have no significant positive influence on the psychological wellbeing of nurses and midwives.
7. There will be no significant positive relationship between occupational stress and coping strategies.
8. There will be no significant age differences with regards to experiences of occupational stress among nurses and midwives.
9. There will be no significant differences in duration of service with regards to experiences of occupational stress among nurses and midwives.
10. There will be no significant difference in the experiences of occupational stress concerning the category of health professionals.

The study employed a questionnaire as the main instrument for the data collection using a descriptive cross-section approach as the research design. Purposive sampling was used to select the facilities for the study. Stratified sampling was used to group nurses and midwives into two strata, whilst random sampling was used in the distribution of the questionnaire. In all, the instrument was administered to 237 nurses and 63 midwives. In all, the instrument was administered to 300 participants. Out of this number, 280 was duly filled and returned.

As a result, 280 nurses and midwives who completed and returned the questionnaires were included in the study. Frequencies and percentages were used to analyze the demographic characteristics of the respondents – age, duration of service, category of health profession and location of health facility. Data on Research Question One were analyzed using One-Sample t-test to determine the overall level of occupational stress, psychological wellbeing, and workplace social relationship among nurses and midwives. For Research Question Two, data were analyzed using correlation (Pearson's Product-Moment Correlation(r)) to determine the association among occupational stress, workplace social relationship, and psychological wellbeing of nurses and midwives. Research Question Three sought to examine the coping strategies used by nurses and midwives in the face of occupational-related stress. First, the one-sample Kolmogorov-Smirnov test was conducted to estimate if the items of coping strategies are typically distributed. Means and Standard deviation were then used to analyze the coping strategies of nurses and midwives. For Hypothesis One, a Multiple regression analysis was run to predict the influence of independent variables (psychological wellbeing and workplace social relationship) on occupational stress. In Hypothesis Two, Linear regression analysis was used to test if occupational stress significantly predicts respondents' psychological wellbeing. For Hypothesis Three, Linear regression analysis was also conducted to determine the extent of the impact that social relationship at the workplace has on the psychological wellbeing of nurses and midwives. The Pearson Moment Correlation Coefficients was run to determine the association between occupational stress and coping strategies adopted by nurses and midwives in Hypothesis Four. To analyze Hypothesis Five, a one-way analysis of variances (*ANOVA*) was used to determine if a significant difference existed among age categories of nurses and midwives in terms of experiences of occupational stress. The non-parametric version of an ANOVA, thus Kruskal-Wallis test was conducted to analyze Hypothesis Six. An independent samples t-test was used to analyze Hypothesis Seven to determine whether a significant difference exists between nurses and midwives in terms of their experiences with occupational stress.

5.2 Summary of Key Findings

The study came out with interesting findings. The following presents the key findings that emerged from the study.

1. The study results indicated that nurses and midwives within the Catholic Health Service in the Western Region experience significantly high levels of stress, positive psychological wellbeing and favourable work-related social relationship.
2. The study found out that occupational stress was moderately and weakly associated with psychological wellbeing (r =0.426**, p<0.01) and workplace social relationships, respectively (r =0.236**, p<0.01). The positive association between occupational and psychological wellbeing suggests that occupational stress increases with lower psychological wellbeing. Similarly, the positive relationship between occupational stress and workplace social relationship connotes that a higher level of occupational stress is linked with a lower social relationship between nurses and midwives in the work environment. It was further established that psychological wellbeing was positively correlated with workplace social relationships (r =0.511, p<0.01). Lower psychological wellbeing was associated with lower workplace social relationships or higher levels of psychological wellbeing linked with better workplace social relationships.
3. The study's findings showed that with regards to coping strategies to mitigate the effects of occupational stress, nurses and midwives employed all four coping strategies – Problem-Focused Engagement, Problem-Focused Disengagement, Emotional-Focused Engagement, and Emotional-Focused Disengagement- in varying degrees. The results, however, revealed that the leading coping strategy used by nurses and midwives is Problem-Focused Disengagement (M = 14.18, SD = 2.61); this was followed by Problem-Focused Engagement (m = 13.02, SD = 2.58). According to the analysis, the least used coping method is Emotional-Focused Disengagement. Further analysis revealed that nurses and midwives usually adopted Problem-Focused coping (M = 27.72, SD = 4.36), than Emotional-Focused Coping (M = 24.73, SD = 4.19).
4. The study found out that psychological wellbeing and social relationships at the workplace significantly impact the experience of occupational stress among nurses and midwives. The study revealed that psychological wellbeing and workplace social

relationships explained an 18.2% variance in occupational stress (R^2 =. 182, F(2, 284)=31.540, P=.000). The multiple regression analysis showed that whiles psychological distress significantly predicted variances in occupational stress (β = .407, p < 0.05), workplace social relationship was not a significant predictor of occupational stresses (β = .038, p = .564

5. The study results indicated that occupational stress had a significant influence on the psychological wellbeing of nurses and midwives. This was revealed that occupational stress explained 18.1% variances in psychological wellbeing (R^2 =.181, F(1, 285)=62.895, P=.000). It was also found that occupational stress predicted psychological wellbeing among nurses and midwives in the Catholic Health Service of the Western Region (β = .426, p<0.05).
6. The study found that workplace social relationships are a significant predictor of psychological wellbeing among nurses and midwives in the Catholic Health Service of the Western Region (β = .511, p<0.05). This means that social interactions among health professionals (nurses and midwives) at the workplace significantly determine their psychological wellbeing. Thus, a favourable positive relationship at the workplace will promote better psychological wellbeing, while toxic social relations will breed negative psychological wellbeing.
7. The results of the study revealed that occupational stress has a weak positive significant relationship with coping strategies. This is revealed in the fact that a substantial increase in occupational stress is linked with adopting a variety of coping responses. This indicates that nurses and midwives are likely to adopt several coping strategies in the face of heightened stress levels. In contrast, a lower experience of work-related stress is associated with less adoption of coping strategies.
8. The study found out that there was a significant difference within the age group of nurses and midwives in terms of their experiences of occupational stress. It was revealed in the study that participants within the age category "*30 – 39 years*" and "*40 – 49 years*" experience significantly higher levels of occupational stress than nurses and midwives with the age category "*18 – 29 years*".
9. The study results revealed there was a significant difference in occupational stress among nurses and midwives with regards to duration of service in the Catholic

Health Service of the Western Region. The study results showed that a significant difference exists between "*Less than a year*" and "*more than 6 years*" (p = .027) as well as "*Less than a year*" and "*4 – 6 years*" (p = .000) with regards to experiences of occupational stress. It was also revealed statistically significant differences within participants with a "1 – 3 years" duration of service experience and 4 – 6 years (p = .001).

10. The study found out that there were no significant differences between the experiences of nurses and midwives in terms of occupational stress. The results showed that nurses and midwives in the Catholic Health Service of the Western Region of Ghana experiences did not differ significantly on levels of occupational stress.

5.3 Chapter Summary

The chapter summarizes the research process from the research philosophy adopted through the data collection instrument to data processing. This chapter also summarises the key research findings for the three research questions and seven hypotheses.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.0. Introduction

This chapter provides conclusions and recommendations based on the research study. The first part looks at the conclusions drawn out of the research findings, and the second part looks at recommendations for further action to address the research problem based on the study results.

6.1. Conclusions

This study investigated occupational stress, social relationships at the workplace, psychological wellbeing and coping strategies among nurses and midwives in the Catholic Health Service of the Western Region of Ghana. From the findings of the study, several conclusions are drawn.

Firstly, the study concludes that occupational stress among nurses and midwives in the Catholic Health Service of the Western Region is high. However, positive psychological well-being and positive social relationships among the nurses and midwives help them deal with occupational stress.

Also, occupational stress has a negative impact on the psychological wellbeing of nurses and midwives. Thus, a high level of occupational stress leads to lower psychological wellbeing. Furthermore, high levels of occupational stress have a negative impact on social relationships at the workplace. The study also concludes that positive social relationships at the workplace lead to positive psychological wellbeing at the workplace and vice versa. Social relationship at the workplace thus predicts psychological wellbeing among nurses and midwives, and inversely, psychological wellbeing also predicts social relationships at the workplace.

Added to the above, the study concludes that nurses and midwives in the Catholic Health Service of the Western Region of Ghana employ both problem-focused coping strategies and emotion-focused coping strategies in varying degrees to mitigate the effects of occupational stress. It, however, came out that the predominant coping strategies they employed were problem-focused. The study also concludes that nurses and midwives are likely to adopt several coping strategies in the face of heightened stress levels.

Furthermore, differences in age categories among nurses and midwives is a significant predictor of occupational stress. Nurses and midwives advanced in age experienced significant levels of occupational stress as compared with younger ones. Age, thus, matters in the experience of occupational stress among nurses and midwives. The study also concludes that length of service or duration of service influences the experience of occupational stress among the nurses and midwives. Nurses and midwives who have a long duration of service experience lesser occupational stress than those with a short duration of service. Finally, the study reveals no significant differences between nurses and midwives in their experience of occupational stress. However, the researcher thinks this result is not

probable and that by logic, the job descriptions of nurses and midwives are not the same. There will thus be significant differences between nurses and midwives in their experience of occupational stress.

6.2. RECOMMENDATIONS

The study investigated occupational stress, social relationships at the workplace, psychological wellbeing and coping strategies among nurses and midwives in the Catholic Health Service of the Western Region of Ghana. Several conclusions have been made based on the study results. The findings and conclusions made have severe implications for healthcare delivery in Ghana. The following recommendations have been made to help policymakers, facility managers and health professionals. Based on the findings and conclusions, the researcher came out with the following recommendations:

1. In dealing with the high levels of occupational stress among nurses and midwives, the Ministry of Health and its agencies, especially the Christian Health Association of Ghana and Ghana Health Service, should ensure the posting of the required number of nurses and midwives to where they are needed the most and ensure that those posted report to where they are posted. This will reduce the workload on nurses and midwives in the facilities. Also, management of the facilities should ensure appropriate and adequate equipment for nurses and midwives to perform their duties. Also, there should be effective and efficient management structures in health facilities in Ghana.
2. The importance of psychological wellbeing for nurses and midwives cannot be overemphasized. However, it was discovered that there were no structures to help nurses and midwives advance their psychological wellbeing in the facilities. The Ministry of Health and its agencies should employ Counselling Psychologists to cater for nurses and midwives' counselling needs in every health facility. Counselling for health staff should be taken seriously to ensure a psychologically sound team for more excellent performance.
3. In organizing Continuous Professional Development workshops and seminars for nurses and midwives, the Nursing and Midwifery Council and other nursing and midwifery associations should include topics that will help build positive psychological wellbeing among nurses

and midwives in the discharge of their duties. This can be done in collaboration with the Ghana Psychology Council. This will give nurses and midwives the necessary internal and external resources to boost their mental health, thereby achieving higher psychological wellbeing.

4. Social relationship at the workplace is a predictor of psychological wellbeing and also help to mitigate the adverse effects of occupational stress. Therefore, it is recommended that facility managers help their staff to understand the importance of such relationships at work by organizing workshops and seminars on the associations of occupational stress, psychological wellbeing, and social relationships at work. Facility managers should also promote social activities such as indoor games, outdoor games, music festivals and others to help build the social bond among the staff.
5. Conflict resolution among staff helps to promote social relationships and help develop psychological wellbeing among staff. There should therefore be effective and efficient conflict resolution structures in all health facilities across the country. This will help resolve conflicts among staff professionally, thereby promoting positive social relationships among them and thus achieving positive psychological wellbeing among them. There should also be effective structures to deal with staff grievances and address them appropriately.
6. Facility managers should organize workshops on coping strategies so that health workers would know the appropriate coping strategies to adopt when occupational stress level heightens. This will help them to balance emotion-focus and problem-focus coping strategies to deal with occupational stress. Orientation programmes for newly posted nurses and midwives should include coping strategies.
7. Nurses and Midwives, and in effect all health workers, must take custody of their psychological wellbeing. Suppose their psychological wellbeing is threatened at the workplace. In that case, they should seek help from a professional therapist. In the absence of such therapists in their facilities, speak to a trusted figure in their lives to help deal with matters before professional help could be sought.
8. Nurses and Midwives should be equipped with stress management strategies to help them deal with the catastrophic effects of stress at the workplace. This can be done through workshops and other capacity-building programmes for nurses and midwives in the various facilities.

9. Mental Health Units in the various facilities should have planned programmes for nurses and midwives and all categories of health staff. Such programmes should empower nurses and midwives to achieve positive mental health to promote optimal health among the staff.

CHAPTER 7

CONTRIBUTIONS TO KNOWLEDGE

This section looks at contributions that this research study has made to knowledge. This will help the academic world to a greater extent, especially regarding research on occupational stress, social relationship at the workplace, psychological wellbeing and occupational stress across different populations.

This research study has made the following contributions to knowledge:

1. The study simultaneously investigated occupational stress, social relationships at the workplace, psychological wellbeing and coping strategies among nurses and midwives in the Catholic Health Service of the Western Region of Ghana. No study seems to have combined these four variables in one study, which is an excellent contribution to the body of knowledge.
2. Most studies on occupational stress and psychological wellbeing were conducted among only nurses. There seems to be no study that combined nurses and midwives. This study conducted among nurses and midwives appears to be the first of its kind, and it is an excellent contribution to knowledge.
3. The study has demonstrated that the age differences of nurses and midwives influence their experience of occupational stress. There seems to be no study investigating the influence of age on the experience of occupational stress among nurses and midwives.
4. Added to the above, there seems to be no study on the influence of duration on the occupational stress of nurses and midwives. This study has shown that duration of service or length of service influences the experience of occupational stress on nurses and midwives in the discharge of their duties.
5. The study further established that there were no differences among nurses and midwives in their experience of occupational stress. The researcher, however, posits by logic that because nurses and midwives have different job descriptions with different characteristics, there will be differences among nurses and midwives in their experience of occupational stress.
6. The study further reveals a correlation among occupational stress, social relationships at the workplace and psychological wellbeing among nurses and midwives in their duties. This is the single study that has established the relationship among these three variables in a study among both nurses and midwives.
7. This research has shown that occupational stress among nurses and midwives affect their social relationships at the workplace. Thus, high levels of occupational stress lead to a low level of social relationships at the workplace. Inversely, low levels of occupational stress lead to positive social relationships at the workplace. There seems to be no study that has established this between these two variables.
8. The study further establishes that positive social relationships at the workplace contribute to the positive psychological functioning of nurses and midwives. This, in turn, reduces

occupational stress. This seems to be the single study that has established this relationship between these two variables.

Conclusion

This study has contributed to knowledge about occupational stress, social relationships at the workplace, psychological wellbeing and coping strategies among nurses and midwives, and by extension to all healthcare workers. The researcher is confident that knowledge from this study would be applied to workers in other professions due to similar characteristics that guide work in different occupations. It is the sincere hope of the researcher that knowledge gained from this research study would be utilized to help improve the situation of nurses and midwives. By extension, all health professionals, in their experience of occupational stress and ultimately adopt the necessary strategies to help them achieve optimal psychological functioning at their various workplaces.

CHAPTER 8

SUGGESTIONS FOR FURTHER RESEARCH

Based on the research findings and conclusions made out of the study, the following recommendations have been made for further investigations and future research concerning the topic of this study.

1. The study was conducted using the quantitative method. It is suggested that future studies on this topic should employ a mixed-method approach.
2. Future studies should focus on occupational stress, social relationships at the workplace, psychological wellbeing and coping strategies among health professionals, especially prescribers.
3. Future studies on the topic of this study should expand the scope of this research to include other health professionals across two or three regions in Ghana.
4. Future studies should focus on occupational stress, work-life balance, job performance and job satisfaction among nurses and midwives.
5. Also, studies should be conducted on occupational stress and the psychosocial wellbeing of nurses and midwives.
6. Again, future studies should concentrate on occupational stress, psycho-economic wellbeing, job satisfaction and job performance among nurses and midwives.
7. Other studies should focus on the role of counselling psychologists in improving the psychological wellbeing of health professionals in healthcare delivery in Ghana.

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APPENDIX

TEXILA AMERICAN UNIVERSITY

RESEARCH QUESTIONNAIRE FOR NURSES AND MIDWIVES

This questionnaire has been developed to investigate nurses and midwives experiences of job-related stress, social relationships at the workplace, their impact on their psychological wellbeing and the coping strategies adopted to mitigate the effects of stress. This exercise is mainly for academic purpose, and your anonymity and confidentiality is strictly assured. You will be contributing immensely towards the success of the research and knowledge if you answer these questions as frankly as possible. Please be open and honest in your response. The information you provide will be confidential, and your identities will be anonymous. The information provided will also be used strictly for academic purposes. Thank you for your assistance.

SECTION A: Demographic Information

Please tick below the responses that best correspond with your demographic information.

1. Age: 18 – 29 { } 30 – 39 { }
   40 – 49 { } 51 – 60 { }
2. Duration of Service:
   Less than a year { } 1 – 3 years { } 4 – 6 years { } More than 6 years { }
3. Category of health profession: Nurse { } Midwife { }

SECTION B: OCCUPATIONAL STRESS

Below is a list of phrases that describe certain feelings that people have. Please rate yourself by ticking the answer which best describes the extent to which you experience significant stress. Select one of the four responses for each statement to indicate your level of agreement, where one = STRONGLY DISAGREE, 2 = DISAGREE, 3 = AGREE, and 4 = STRONGLY AGREE.

SN	STATEMENT	1	2	3	4
1.	I have to bear negative sentiment from patients or their relatives				

2.	Excessive duties in the workplace prevent me from attending to patients				
3.	I have to maintain professional units other than my own				
4.	The burden of work affects my domestic life				
5.	The burden of work makes it difficult for me to undertake my personal chores and/or engage in my hobbies				
6.	I have to adapt my schedules for family activities /outings to accommodate my work responsibilities				
7.	Doctor' temperamental nature agitates me				
8.	I worry that my colleagues' incompetence will affect patient safety				
9.	I feel stressed because primary caregivers do not execute their tasks appropriately				
10.	I feel stressed due to psychological abuse such as threats, discrimination, bullying, and harassment.				
11.	The on-call system affects my life.				
12.	The organization usually remunerates my overtime work at a low rate of pay.				
13.	Not achieving a promotion (e.g., level 1 or 2) within the expected period affects my income.				
14.	I feel stressed considering that my patients might have contagious diseases such as COVID-19 or AIDS.				
15.	I need to transport patients or equipment				
16.	I cannot ask for leave for household emergencies.				
17.	I cannot excuse myself for feeling strong discomfort.				
18.	It upsets me if patients' conditions do not improve.				
19.	I have insufficient time to offer mental health care to patients during working hours				

20.	I have no time to fulfill my personal needs (e.g., water consumption and toilet breaks).				
21.	I cannot take an uninterrupted 30-minute mealtime break.				
24.	In general, how satisfied have you been with yourself during the last year?				

SECTION C: PSYCHOLOGICAL WELLBEING

Instructions: Below are five statements that you may agree or disagree with. Using the 1 - 7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding. 7 = Strongly Agree, 6 = Agree, 5 = Slightly Agree, 4 = neither Agree nor Disagree, 3 = Slightly Disagree, 2 = Disagree *and* 1 = Strongly Disagree.

SN	STATEMENT	1	2	3	4	5	6	7
1.	I like most parts of my personality.							
2.	When I look at the story of my life, I am pleased with how things have turned out so far.							
3.	Some people wander aimlessly through life, but I am not one of them.							
4.	The demands of everyday life often get me down.							
5.	In many ways I feel disappointed about my achievements in life.							
6.	Maintaining close relationships has been difficult and frustrating for me.							
7.	I live life one day at a time and don't really think about the future.							

8.	In general, I feel I am in charge of the situation in which I live.							
9.	I am good at managing the responsibilities of daily life.							
10.	I sometimes feel as if I've done all there is to do in life.							
11.	For me, life has been a continuous process of learning, changing, and growth.							
12.	I think it is important to have new experiences that challenge how I think about myself and the world.							
13.	People would describe me as a giving person, willing to share my time with others.							
14.	I gave up trying to make big improvements or changes in my life a long time ago							
15.	I tend to be influenced by people with strong opinions							
16.	I have not experienced many warm and trusting relationships with others.							
17.	I have confidence in my own opinions, even if they are different from the way most other people think.							
18.	I judge myself by what I think is important, not by the values of what others think is important.							

SECTION D: COPING STRATEGIES INVENTORY – SHORT FORM (CSI-SF)

The following section is about Coping Strategies adopted following a medical error.

Please read the following questions carefully and indicate your responses as honest as possible, using the scale provided.

Responding Scores (1= never, 2= seldom, 3= sometimes, 4= often, 5= almost always)

		RATINGS				
ITEMS		1	2	3	4	5
1	I make a plan of action and follow it					
2	I look for the silver lining or try to look on the bright side of things					
3	I try to spend time alone					
4	I hope the problem will take care of itself					
5	I try to let my emotions out					
6	I try to talk about it with a friend or family					
7	I try to put the problem out of my mind					
8	I tackle the problem head on					
9	I step back from the situation and try to put things into perspective					
10	I tend to blame myself					
11	I let my feelings out to reduce the stress					
12	I hope for a miracle					
13	I ask close friend or relative that I respect for help or advice					
14	I try not to think about the problem					
15	I tend to criticize myself					
16	I keep my thoughts and feelings to myself					

SECTION E: SOCIAL RELATIONSHIP AT THE WORKPLACE

For the following scale please rate how much you agree with the following statements by circling the appropriate number where: 1=Very Strongly Disagree (VSD), 2= Strongly Disagree (SD), 3=Disagree (D), 4= Uncertain, 5=Agree (A), 6=Strongly Agree (SA), and 7=Very Strongly Agree (VSA)

SN	STATEMENT	RESPONSES						
1.	Some co-workers are hard to work with	1	2	3	4	5	6	7
2.	There are certain co-workers that I come into conflict with	1	2	3	4	5	6	7
3.	I find it hard to work with at least one group of workers	1	2	3	4	5	6	7
4.	I am valued by my supervisor	1	2	3	4	5	6	7
5.	My supervisor respects me	1	2	3	4	5	6	7
6.	I find it hard to work with my supervisor	1	2	3	4	5	6	7
7.	A culture of harmonious working relationships is encouraged in this organisation	1	2	3	4	5	6	7
8.	Positive working relationships are encouraged in this organisation	1	2	3	4	5	6	7
9.	The organisation favours certain groups or individuals over others	1	2	3	4	5	6	7