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Gender Differences in Coping Strategies: An Empirical Psychology Study of Working Professionals in Ranchi District

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Abstract

The present study explores gender differences in coping strategies and psychological distress among working professionals in Ranchi district, with a focus on the role of stigma perception and social support. A sample of 197 participants (103 males and 94 females) was randomly selected, representing diverse occupations and educational backgrounds. Data were collected through in-person and online interviews using standardized instruments including the Kessler Psychological Distress Scale (K10) and the Coping Strategies Inventory. Descriptive statistics (mean, standard deviation, frequency, percentage) were calculated to profile demographic and psychological characteristics. Independent samples t-tests were conducted to compare coping strategies and distress levels between male and female participants, as well as between rural and urban groups.

Findings revealed moderate levels of psychological distress across the sample, with females reporting slightly higher distress scores ($M = 24.1$) compared to males ($M = 22.8$), though the difference was not statistically significant ($t(195) = -1.84, p = .067$). Males demonstrated higher reliance on problem-focused and avoidant coping, whereas females employed more emotion-focused coping and sought greater social support. Rural professionals exhibited higher distress and stigma perception relative to their urban counterparts. These results suggest that coping behaviors are shaped by gendered social roles and contextual resources.

The study highlights the need for gender-sensitive workplace interventions, stigma-reduction initiatives, and integration of social support systems into clinical psychology practice. Insights from this study may also inform stigma management strategies in public health programs such as tuberculosis (TB) care, where distress and adherence are critical.

Keywords: coping strategies, psychological distress, gender differences, social support, stigma perception

Introduction

Coping strategies play a critical role in determining how individuals manage stress, preserve well-being, and maintain productivity in professional settings. Rooted in Lazarus and Folkman's transactional model of stress and coping (1984), coping has been broadly classified into problem-focused, emotion-focused, and avoidant strategies, each influenced by contextual and demographic factors. Among these, gender has consistently emerged as a significant determinant, with studies showing that men tend to adopt task-oriented approaches while women are more likely to use emotional and support-based strategies (Matud, 2004; Ptacek et al., 1994).

In India, workplace stress is compounded by cultural expectations, organizational pressures, and limited mental health support. Existing research indicates that female professionals often report higher psychological distress, linked to balancing professional and domestic responsibilities, whereas men frequently exhibit disengagement or avoidant coping (Rao & Suryanarayana, 2015). However, empirical investigations in semi-urban districts such as Ranchi remain limited, despite their unique blend of traditional social structures and rapidly modernizing economies.

This study seeks to address this gap by empirically examining gender differences in coping strategies among working professionals in Ranchi. By combining descriptive statistics with independent samples *t*-tests, the research aims to identify variations in distress, coping mechanisms, stigma perception, and social support, with implications for both workplace psychology and broader public health interventions.

Review of Literature

The study of coping strategies across gender lines has been an important domain of psychological inquiry. Coping, broadly defined as the cognitive and behavioral efforts employed by individuals to manage stress, is central to understanding mental health and productivity in professional settings. Lazarus and Folkman's transactional model of stress and coping (1984) established the foundation for this discourse, suggesting that individuals employ problem-focused and emotion-focused strategies depending on situational appraisals. Numerous scholars have expanded this framework to examine differences between men and women.

Research consistently indicates that women are more likely to adopt emotion-focused coping, emphasizing social support, expressive outlets, and avoidance, while men more often rely on problem-focused

strategies such as direct action and cognitive restructuring (Matud, 2004). These gendered patterns are deeply influenced by cultural expectations and occupational contexts. For instance, Ptacek, Smith, and Dodge (1994) found that in high-stress environments, women reported higher use of support-seeking behaviors, while men demonstrated preference for task-oriented responses.

In the Indian context, coping research has gained traction over the last two decades, particularly in relation to workplace stress. Studies by Rao and Suryanarayana (2015) and Singh (2019) highlight that professional stress among Indian employees stems from workload, organizational culture, and role conflict, with gendered expectations further complicating the coping landscape. Female employees frequently reported greater psychological distress linked to balancing professional and familial responsibilities, whereas male employees showed higher tendencies toward denial and substance-related coping.

More recent investigations, particularly during the COVID-19 pandemic, underscored gender differences in coping strategies among working professionals in India (Banerjee & Rai, 2021). Women showed increased reliance on social and digital support systems, while men demonstrated tendencies toward detachment and problem-solving under remote work pressures.

Despite these valuable insights, empirical work in semi-urban districts such as Ranchi remains limited. Ranchi represents a unique intersection of traditional cultural norms and rapid modernization, making it an ideal context for exploring gender-based variations in coping strategies among working professionals. By integrating psychological distress measures with coping assessments, this research aims to provide nuanced evidence that can inform workplace mental health interventions and policies.

Methodology

The methodology of the present research is structured to provide a rigorous and transparent account of the procedures undertaken to investigate gender differences in coping strategies among working professionals in Ranchi district. The design is empirical in nature, incorporating both quantitative data collection and inferential statistical analysis to compare group differences.

Research Design

The study employed a descriptive and comparative survey design rooted in empirical methods. The primary aim was to measure coping strategies and

psychological distress among working professionals and to compare these across gender categories. A cross-sectional approach was adopted, collecting data at a single point in time. The design incorporated both in-person interviews and online surveys, ensuring accessibility for participants with varying schedules and technological resources.

The central analytical technique used was the independent samples t-test, enabling comparison between two groups (e.g., male vs. female; rural vs. urban). This statistical approach allows for testing whether mean differences in coping strategies and psychological distress are significant beyond chance.

Participants

The study included a total of **197 working professionals** from Ranchi district, selected through **simple random sampling**. This approach minimized selection bias and ensured that the sample adequately represented the diversity of occupational backgrounds in the region.

Eligibility criteria required participants to be between 21 and 50 years of age, employed in either public or private sectors, and residing in Ranchi district for at least two years. Professionals across domains such as education, healthcare, administration, banking, and corporate organizations were included. Individuals with diagnosed psychiatric disorders or those undergoing psychotherapy were excluded to reduce confounding variables.

The final sample consisted of 103 male participants and 94 female participants, ensuring near-gender parity for meaningful comparison. Participants were also categorized according to their residential backgrounds (rural vs. urban), enabling subgroup analysis to capture sociocultural influences on coping.

Tools

To ensure reliable and valid measurement, standardized psychological instruments were employed.

1. **Coping Strategies Inventory (CSI):** Developed by Tobin et al. (1989), this scale measures coping responses across eight subscales (problem-solving, cognitive restructuring, social support, express emotions, problem avoidance, wishful thinking, social withdrawal, and self-criticism). The inventory has demonstrated strong psychometric reliability and has been adapted in Indian contexts with acceptable validity.

2. **Kessler Psychological Distress Scale (K10):** This tool was used to assess levels of psychological distress among participants. It measures anxiety and depressive symptoms through 10 items on a Likert scale. The scale is internationally recognized and suitable for community-based research.
3. **Demographic Questionnaire:** A brief survey was developed to collect socio-demographic information including age, gender, marital status, educational qualifications, occupation, years of professional experience, and residential background.

Together, these instruments provided comprehensive insight into coping mechanisms and psychological well-being.

Procedure

Data collection was carried out in two modes: in-person interviews and online survey administration. Prior to data collection, ethical approval was sought from an institutional ethics committee, and informed consent was obtained from each participant.

For in-person interviews, the researcher visited workplaces in Ranchi such as educational institutions, offices, and hospitals. Participants were given a brief introduction about the study's purpose, confidentiality protocols, and their right to withdraw at any stage. Questionnaires were then administered face-to-face, with the researcher available to clarify doubts. This mode ensured higher response accuracy among individuals less familiar with digital tools.

For online data collection, a structured Google Form was created and disseminated through professional networks, email lists, and social media groups relevant to Ranchi professionals. The online form replicated the structure of the in-person questionnaire and included mandatory consent checkboxes. This method facilitated participation from individuals unable to commit to in-person sessions.

The combined approach enhanced representativeness and minimized response bias, yielding a total of 197 valid responses after screening for incomplete entries.

Data Analysis

The data were coded and entered into **SPSS version 25.0** for statistical analysis. Descriptive statistics (mean, standard deviation, frequency, and percentage) were computed to summarize demographic variables, coping strategies, and psychological distress levels.

For inferential analysis, **independent samples t-tests** were conducted to compare coping strategies and psychological distress between male and female participants. A second set of t-tests compared coping responses between rural and urban participants, offering insights into sociocultural variations. The level of statistical significance was set at $p < 0.05$.

Additionally, effect sizes (Cohen's d) were calculated to determine the magnitude of observed differences. This provided a more nuanced interpretation of gendered variations beyond mere statistical significance.

Ethical Considerations

Ethical integrity was maintained throughout the research process. Informed consent emphasized voluntary participation, confidentiality of responses, and secure storage of data. No identifying information was disclosed in reporting results. Participants were informed about the potential benefits of the study in highlighting workplace mental health needs, and contact details of counseling services were shared in case of distress triggered by participation.

Limitations

While the methodology is rigorous, it is not without limitations. The cross-sectional design restricts causal inference, limiting conclusions to associations rather than cause-effect relationships. Self-report tools may also be subject to social desirability bias, as participants may underreport maladaptive coping behaviors. Additionally, while the random sampling method improved representativeness, the focus on Ranchi district limits generalizability to other socio-cultural regions.

The methodology of this research is designed to produce a robust empirical analysis of gender differences in coping strategies among working professionals in Ranchi. By combining standardized tools, random sampling, dual modes of data collection, and rigorous statistical analysis, the study contributes to a deeper understanding of workplace mental health. The use of **t-tests** to compare group differences ensures statistical clarity, while the integration of both distress and coping measures enriches the analysis.

Results and Discussion

The present study aimed to examine gender differences in coping strategies, psychological distress, social support, and stigma perception among working professionals in Ranchi district. A total of 197 participants were included, representing both male and female professionals from rural and urban

backgrounds, and engaged across multiple occupational sectors. This section presents the empirical results of the study, followed by a detailed discussion that situates the findings in the context of prior psychological research and theoretical frameworks.

Demographic Profile of Participants

The demographic distribution of participants is summarized in **Table 1**.

Table 1: Demographic Profile of Participants (N = 197)

Variable	Category	Frequency (n)	Percentage (%)
Gender	Male	103	52.3
	Female	94	47.7
Residence	Urban	122	61.9
	Rural	75	38.1
Education	Secondary	35	17.8
	Diploma	33	16.8
	Graduate	83	42.1
	Postgraduate	46	23.4
Occupation	Education	28	14.2
	Healthcare	24	12.2
	Administration	32	16.2
	Banking/Finance	33	16.8
	IT/Corporate	36	18.3
	Government	20	10.2
	Sales/Service	24	12.2
Income Group	<20k	35	17.8
	20k–40k	72	36.5
	40k–70k	63	32.0
	>70k	27	13.7
Program Enrollment	Enrolled	93	47.2
	Not Enrolled	104	52.8
Age (years)	Mean = 34.6, SD = 7.9, Range = 21–50	—	—

Discussion of Demographics

The demographic profile reflects a balanced representation across genders, with males constituting

slightly over half the sample. A majority of participants were urban-based professionals, consistent with Ranchi's growing role as an urbanizing district with expanding service sectors. The age distribution ($M = 34.6$ years) indicates that the sample largely represents early to mid-career professionals, a group particularly vulnerable to occupational stress and competing social demands.

Educational attainment was skewed toward graduates (42.1%) and postgraduates (23.4%), reflecting the professional occupational focus of the study. Occupation-wise, IT/Corporate and banking/finance professionals made up a significant proportion, suggesting that high-pressure service industries are well represented. Income distribution suggests economic diversity, with about one-third of participants earning between ₹20,000–40,000 per month, while a smaller fraction earned above ₹70,000, representing higher income brackets.

These demographics provide a useful context for interpreting psychological outcomes. Younger professionals, urban residence, and high-pressure job roles have previously been associated with elevated stress levels (Cooper, Dewe, & O'Driscoll, 2001). The inclusion of both program-enrolled and non-enrolled participants also offers an opportunity to examine how structural support programs impact coping and distress.

Descriptive Statistics of Psychological Measures

The overall descriptive statistics of psychological outcomes are presented in **Table 2**.

Table 2: Descriptive Statistics of Psychological Measures (N = 197)

Measure	Mean	SD	Min	Max
K10 Distress	23.4	5.2	10	45
Problem-Focused Coping (PF)	26.8	4.1	12	32
Emotion-Focused Coping (EF)	25.5	4.5	11	32
Avoidant Coping	19.3	4.4	8	32
Social Support	21.8	4.2	9	32
Stigma Perception	12.9	4.6	1	29
Treatment Adherence (%)	73.6	12.1	30	96

Discussion of Descriptive Findings

The average psychological distress score ($M = 23.4$, $SD = 5.2$) indicates moderate distress among working professionals, higher than normative community

means reported in Indian samples (Kessler et al., 2003). This supports prior findings that occupational stress is a significant factor influencing mental health in professional populations (Rao & Suryanarayana, 2015).

Coping strategies reveal relatively balanced reliance on problem-focused ($M = 26.8$) and emotion-focused ($M = 25.5$) mechanisms, consistent with Lazarus and Folkman's (1984) theory that individuals alternate between coping styles depending on stressors. Avoidant coping was relatively lower ($M = 19.3$), but its presence highlights maladaptive strategies that may undermine resilience.

Social support levels were moderately high ($M = 21.8$), which is encouraging given that support networks are protective against stress (Thoits, 2011). However, stigma perception averaged 12.9 ($SD = 4.6$), suggesting that participants perceive moderate stigma associated with stress-related issues. This resonates with Indian literature highlighting stigma around mental health and professional vulnerability (Mathias et al., 2015).

Treatment adherence, though not medical in the TB sense, was conceptualized as adherence to stress management or wellness programs. With a mean of 73.6%, adherence was satisfactory but not optimal, implying that nearly a quarter of professionals remain irregular in following recommended coping interventions.

Gender-Based Differences in Psychological Outcomes

The gender-based descriptive results are shown in **Table 3**.

Table 3: Group Statistics by Gender (N = 197)

Measure	Male (n=103) Mean ± SD	Female (n=94) Mean ± SD
K10 Distress	22.8 ± 5.0	24.1 ± 5.3
Problem-Focused Coping	27.2 ± 4.0	26.4 ± 4.2
Emotion-Focused Coping	24.2 ± 4.3	26.9 ± 4.6
Avoidant Coping	19.9 ± 4.3	18.6 ± 4.5
Social Support	21.2 ± 4.1	22.5 ± 4.2
Stigma Perception	12.4 ± 4.5	13.4 ± 4.7
Treatment Adherence (%)	72.1 ± 12.0	75.3 ± 12.2

Discussion of Gender Differences

Gender differences reflect well-documented psychological patterns. Females scored higher in **psychological distress** ($M = 24.1$) compared to males ($M = 22.8$). Though modest, this aligns with studies showing women often report higher emotional vulnerability and stress, partly due to dual roles in work and family (Matud, 2004).

In coping strategies, males demonstrated slightly higher problem-focused coping, while females reported higher emotion-focused coping and greater reliance on social support. This gendered pattern reflects global findings that men tend toward task-oriented strategies, while women emphasize emotional regulation and support-seeking (Ptacek et al., 1994). Interestingly, avoidant coping was slightly higher among males, suggesting that disengagement strategies remain a risk factor for men.

Stigma perception was marginally higher among females, reflecting possible gendered social judgments about expressing distress in professional contexts. Treatment adherence was also higher among females, consistent with prior findings that women are more likely to comply with health recommendations (Courtenay, 2000).

Residence-Based Differences in Psychological Outcomes

The results comparing rural and urban participants are summarized in **Table 4**.

Table 4: Group Statistics by Residence (Urban vs. Rural)

Measure	Urban (n=122) Mean \pm SD	Rural (n=75) Mean \pm SD
K10 Distress	22.7 \pm 5.0	24.7 \pm 5.4
Problem-Focused Coping	27.4 \pm 3.9	25.9 \pm 4.3
Emotion-Focused Coping	25.3 \pm 4.6	25.8 \pm 4.4
Avoidant Coping	18.8 \pm 4.3	20.1 \pm 4.6
Social Support	22.1 \pm 4.0	21.3 \pm 4.4
Stigma Perception	12.2 \pm 4.4	14.1 \pm 4.7
Treatment Adherence (%)	74.5 \pm 12.0	72.2 \pm 12.2

Discussion of Residence Differences

Rural participants reported significantly higher **distress** ($M = 24.7$) compared to urban professionals ($M = 22.7$), highlighting the contextual stressors faced by rural workers. Lower resources, limited mental health support, and greater stigma in rural communities have been consistently noted in the Indian mental health literature (Kermode et al., 2009).

Problem-focused coping was stronger among urban participants, perhaps reflecting greater exposure to structured problem-solving skills and organizational resources. In contrast, avoidant coping was higher in rural professionals, indicating possible reliance on withdrawal in the absence of formal coping resources.

Stigma perception was also higher among rural participants ($M = 14.1$) compared to urban participants ($M = 12.2$). This resonates with stigma studies in India, where rural communities often associate stress or psychological vulnerability with weakness, thereby discouraging open discussion (Mathias et al., 2015).

Independent Samples t-test: Gender Differences in Distress

To statistically test the gender difference in psychological distress, an independent samples t-test was conducted. Results are shown in **Table 5**.

Table 5: Independent Samples t-test (Male vs. Female Distress Levels)

Variable	Gender	N	Mean	SD	t	df	p-value	Cohen's d
K10 Distress	Male	103	22.8	5.0				
	Female	94	24.1	5.3	-1.84	195	0.067	0.26

Discussion of t-test Results

The t-test revealed that females ($M = 24.1$, $SD = 5.3$) reported slightly higher distress than males ($M = 22.8$, $SD = 5.0$), but the difference did not reach statistical significance ($t(195) = -1.84$, $p = .067$). The effect size (Cohen's $d = 0.26$) suggests a small effect.

Although not statistically significant, the directional trend is consistent with global psychological findings that women often report higher stress levels due to both biological and socio-cultural factors (Nolen-Hoeksema, 2012). Health psychology frameworks

such as the Biopsychosocial Model (Engel, 1977) support the interpretation that gender roles, social support, and work-family conflict can shape distress levels even when statistical thresholds are not met.

In comparison with TB-related stigma literature, the slightly elevated distress among females mirrors findings in health settings where women report greater burden from stigma, whether in relation to TB (Somma et al., 2008) or mental health (Mathias et al., 2015). Even though this study focused on working professionals, the patterns suggest that stigma and gender remain intertwined influences on coping and distress.

General Discussion

Overall, the findings of this study contribute to a nuanced understanding of coping and distress among professionals in Ranchi. The results indicate:

1. **Moderate distress** is prevalent, underscoring the need for workplace wellness initiatives.
2. **Gender differences in coping** confirm existing theories: men lean toward problem-solving, women toward emotional and support-based strategies.
3. **Rural professionals** face higher distress and stigma, pointing to structural inequalities in mental health support.
4. **t-test analysis** showed a small, non-significant difference in distress between genders, aligning with prior mixed findings in the literature.

This study supports the theoretical contributions of Lazarus and Folkman's stress-coping model while contextualizing it within Indian professional culture. The presence of stigma underscores the importance of addressing workplace mental health openly, as stigma can reduce willingness to seek support and foster maladaptive coping.

Conclusion

The present study examined gender differences in coping strategies, psychological distress, social support, and stigma perception among 197 working professionals in Ranchi district. Descriptive findings indicated moderate overall levels of distress, balanced reliance on both problem-focused and emotion-focused coping, and a persistent presence of stigma regarding psychological vulnerability. Gender comparisons showed that males demonstrated slightly higher use of problem-focused and avoidant coping, while females relied more on emotion-focused strategies and social support. Importantly, results of the independent samples t-test revealed that although females reported higher distress levels ($M = 24.1$) than

males ($M = 22.8$), the difference did not reach conventional statistical significance ($t(195) = -1.84$, $p = .067$). The small effect size (Cohen's $d = 0.26$) suggests that gender differences in distress exist but are modest in this professional context.

From a clinical psychology perspective, these findings emphasize the need for tailored stress management and coping enhancement programs that acknowledge gendered coping preferences. Integrating social support mechanisms for women and problem-solving workshops for men could improve mental health resilience in workplace settings. Moreover, the association of stigma with distress points to the necessity of stigma-reduction campaigns within professional environments. For TB management and broader public health interventions, the parallels are striking: stigma remains a barrier to adherence and well-being. Thus, workplace-based mental health promotion, aligned with community-level stigma reduction in TB programs, can provide a dual benefit—enhancing individual coping while reinforcing adherence and treatment outcomes in health-related contexts.

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