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Nursing Section

Baseline Burnout and Coping Strategies among Nurses in Secondary Healthcare Centres of Garo Hills, Meghalaya, India: A Pre-intervention Cross-sectional Study

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ABSTRACT

Introduction: Burnout among nurses is increasingly recognised as a critical workforce and public health issue, especially in geographically remote and resource-constrained healthcare settings. Empirical evidence describing burnout and coping patterns among nurses working in secondary-level facilities in tribal regions of Northeast India remains scarce.

Aim: To assess baseline burnout levels, describe coping strategies, and compare coping patterns between nurses with moderate and high burnout in secondary healthcare centres in Garo Hills, Meghalaya, before the implementation of a burnout prevention and management programme.

Materials and Methods: This pre-intervention cross-sectional study was conducted as the baseline assessment of a larger intervention study, prior to implementation of the burnout prevention and management programme, among nurses in 16 secondary-level healthcare Institutions, including district hospitals and Community Health Centres (CHCs), located across the Garo Hills region of Meghalaya, India, from 11th July 2023 to 19th August 2023. Data entry, cleaning, and analysis were carried out between September 2023 and October 2023. Participants were recruited through purposive sampling with Institutional facilitation. Burnout was measured using the Oldenburg Burnout Inventory (OLBI), while coping behaviours were assessed using the Brief Coping Orientation to Problems Experienced (Brief-COPE) inventory. Data were analysed using Jamovi version 2.7.14. Descriptive statistics were used to summarise burnout levels and coping strategies. Differences in coping patterns between nurses with moderate and high burnout were analysed using Mann-Whitney U tests with effect sizes.

Results: Among 222 nurses, no participants met the criteria for low burnout. Of the total nurses, 170 (76.6%) had moderate burnout while 52 (23.4%) had high burnout. High exhaustion was more common 62 (27.9%) than high disengagement 15 (6.8%), indicating that exhaustion was the more prominent burnout dimension. Religion (median=6, IQR=3.0) and acceptance (median=6, IQR=2.0) were the most commonly used coping strategies, whereas substance use (median = 2, IQR=0.0) was the least used coping strategy. Comparison of coping strategies between moderate and high burnout groups revealed no statistically significant differences after Bonferroni correction for multiple comparisons.

Conclusion: Moderate to high burnout was frequently observed among nurses in underserved secondary-level healthcare settings, with exhaustion emerging as the predominant dimension. The frequent use of adaptive coping strategies suggests existing strengths that can be reinforced through burnout prevention and management interventions. These findings provide context-specific baseline evidence to inform initiatives in resource-limited regions.

Keywords: Emotional exhaustion; Occupational stress; Psychological adaptation; Rural health services

INTRODUCTION

Burnout is an occupational phenomenon characterised by persistent exhaustion and disengagement resulting from prolonged exposure to work-related stress [1,2]. Among nurses, burnout has been associated with excessive workloads, emotional demands, staffing shortages, and inadequate organisational support, ultimately affecting workforce retention, job satisfaction, quality of patient care and patient safety [3,4]. Coping strategies, commonly classified as problem-focused, emotion-focused, and avoidant [5-7], play a crucial role in helping nurses manage workplace stress and mitigate the effects of burnout.

Burnout has emerged as a significant occupational health concern among nurses worldwide. Research has consistently reported high levels of burnout, particularly among nurses working under conditions of excessive workload, staff shortages, and inadequate organisational support [8-11]. In India, existing research has focused on tertiary hospitals in metropolitan settings, with limited attention to nurses working in secondary-level facilities serving rural and tribal populations. In the Garo Hills region of Meghalaya, healthcare services are often delivered under difficult working conditions, such as limited staffing, extended working hours, limited professional support, and restricted access to healthcare resources [12]. These challenges may heighten nurses' vulnerability to burnout and influence their responses to workplace stress.

Given these challenges, understanding how nurses cope with occupational stress is essential. Coping strategies may help nurses manage workplace stress; however, coping responses are influenced by organisational culture, social support systems, and workplace characteristics [13,14]. Although the baseline dataset has been previously reported in relation to nursing competence [15], the present study focused specifically on burnout and coping strategies using separate analytical approaches.

Despite the growing body of evidence on burnout and coping among nurses, limited information is available regarding these issues among nurses working in secondary healthcare centres in Northeast India. Establishing baseline evidence from this setting is important for informing workforce support measures and future burnout prevention initiatives. Therefore, the present study aimed to assess burnout levels among nurses working in secondary healthcare centres in Garo Hills, Meghalaya, describe their coping strategies,

and compare coping patterns between nurses with moderate and high burnout to guide the development of a contextually relevant burnout prevention and management intervention.

MATERIALS AND METHODS

This pre-intervention cross-sectional study utilised baseline data from a larger intervention study conducted in 16 secondary-level healthcare Institutions, including district hospitals and Community Health Centres (CHC), located across the Garo Hills region of Meghalaya, India. Data were collected from 11th July 2023 to 19th August 2023. Data entry, cleaning, and analysis were carried out between September 2023 and October 2023. Ethical approval was obtained from the Institutional Ethics Committee of Martin Luther Christian University, Shillong (Approval No. III/DDSR/UREC/EA/272/2015-1253; dated 19 May 2023), and administrative permission was granted by the Directorate of Health Services (MI), Meghalaya. Participation was voluntary, with written informed consent obtained and anonymity maintained.

Inclusion criteria: Eligible participants included nurses who had been employed for at least six months in the selected facilities. The study included staff nurses and Auxiliary Nurse Midwives (ANMs) working in selected secondary healthcare Institutions in Garo Hills.

Exclusion criteria: Nurses who were unavailable during data collection or declined participation were excluded.

Sample size estimation: The sample size was estimated using Cochran's formula assuming a prevalence (p) of 50%, a 95% confidence level (Z=1.96), and a 5% margin of error (e).

$$n^0 = \frac{[z^2 p(1-p)]}{e^2} \approx 384$$

Since the estimated nursing workforce across the selected facilities was finite (N = 439), Finite Population Correction (FPC) was applied using the formula:

$$n = \frac{n^0}{\left[\frac{1 + n^0 - 1}{N}\right]} \approx 205$$

After accounting for a 10% non response rate, a final sample size of 226 nurses was obtained. A criterion-based purposive sampling approach was adopted. Eligible nurses from the participating secondary healthcare centres who met the predefined inclusion criteria and were available during the data collection period were recruited until the calculated sample size was achieved. A total of 226 nurses were approached, of whom 222 completed the survey.

Study Procedure

After obtaining Institutional permission, nurses who met the eligibility criteria were approached through the nursing superintendent or nursing in-charge. Written informed consent was obtained, and questionnaires were completed anonymously.

Pilot study: Before the main study, a pilot study involving 22 nurses was conducted to assess the feasibility and clarity of the study instruments and procedures. Based on the feedback, minor modifications were made, and pilot participants were excluded from the final study.

Demographic and work-related questionnaire: A structured questionnaire comprising 13 items was developed by the researcher under the guidance of experts in nursing and public health [APPENDIX]. The questionnaire collected information on socio-demographic characteristics, professional, workload-related, and organisational factors. Variables included age, gender, marital status, educational qualification, employment status, work experience, work shift pattern, weekly working hours, overtime involvement, nurse-to-patient ratio based on Indian Nursing Council (INC) norms [16], health sector, and department of posting. Subject experts reviewed the questionnaire to assess content validity.

Oldenburg Burnout Inventory (OLBI): Burnout was assessed using the OLBI, a validated 16-item instrument consisting of two dimensions: exhaustion (8 items) and disengagement (8 items). Responses were recorded on a four-point Likert scale ranging from 1 (strongly agree) to 4 (strongly disagree), with negatively worded items reverse-scored so that higher mean scores reflect greater burnout. Higher scores indicated higher levels of burnout [1,17,18]. As universally accepted cut-off values for the OLBI are not available, burnout levels were categorised using previously reported cut-off values (<30, 30-44, and >44) described by Glowacz F et al., [19]. These thresholds were adopted to facilitate the descriptive classification of burnout severity, as no validated normative cut-off values specific to Indian nurses are currently available. Permission to use the instrument was obtained, and pilot testing demonstrated acceptable reliability (Cronbach's α=0.74).

Brief-COPE inventory: Coping strategies were assessed using the Brief-COPE Inventory, a standardised 28-item questionnaire comprising 14 coping subscales [6]. Each subscale consists of two items, with responses rated on a four-point scale ranging from 1 (I haven't been doing this at all) to 4 (I've been doing this a lot). Subscale scores range from 2 to 8, with higher scores indicating greater use of the respective coping strategy. For analysis, the subscales were grouped into problem-focused, emotion-focused, and avoidant coping dimensions [6,7]. The instrument is open-source, and pilot testing showed good internal consistency (Cronbach's α = 0.83).

STATISTICAL ANALYSIS

Data were analysed using Jamovi version 2.7.14. Descriptive statistics were used to summarise burnout levels and coping strategies. As coping data were ordinal, normality was not assumed, and non parametric methods were used. Mann-Whitney U tests were conducted to compare coping strategies between nurses with moderate and high burnout. No participants met the criteria for low burnout. Therefore, comparative analyses were conducted between nurses with moderate and high burnout levels only. Statistical significance was set at p<0.05.

RESULTS

Socio-demographic and Professional Characteristics

As shown in [Table/Fig-1], the majority of nurses were female 206 (92.8%), aged 31-40 years 141 (63.5%), and married 136 (61.3%). Most participants held a general nursing and midwifery qualification 144 (64.9%). Permanent employment 191 (86%) was common, and the largest proportion of nurses had 6-10 years of work experience 73 (32.9%).

Variables	Category	n (%)
Age group (years)	<31	58 (26.10)
	31-40	141 (63.50)
	>40	23 (10.40)
Gender*	Male	16 (7.20)
	Female	206 (92.80)
Marital status	Single	84 (37.80)
	Married	136 (61.30)
	Separated	2 (0.90)
Educational qualification	ANM†	33 (14.90)
	GNM‡	144 (64.90)
	B.Sc.§	23 (10.40)
	P.B.B.Sc.‖	21 (9.50)
	M.Sc.¶	1 (0.50)
Employment status	Permanent	191 (86.00)
	Contractual	31 (14.00)

Work experience (years)	<1	13 (5.90)
	1-5	51 (23.00)
	6-10	73 (32.90)
	11-15	57 (25.70)
	>15	28 (12.60)

[Table/Fig-1]: Socio-demographic and professional characteristics of nurses (n=222).
*The "Others" category under gender had zero responses and was omitted for brevity; †ANM: Auxiliary Nurse Midwife; ‡GNM: General Nursing and Midwifery; §B.Sc.: Bachelor of Science in Nursing; ||PBB.Sc.: Post Basic Bachelor of Science in Nursing; ¶M.Sc.: Master of Science in Nursing

Work-related and Organisational Characteristics

The work-related and organisational characteristics are summarised in [Table/Fig-2]. All nurses worked rotating shifts 222 (100%). Most reported working ≥51 hours per week 215 (96.8%), frequent overtime 184 (82.9%), a frequency of seven days per week 109 (59.20%), and largely inadequate nurse-patient ratios 215 (96.8%). The majority were employed in public-sector facilities 186 (83.8%) and were distributed across critical care 72 (32.4%), clinical departments 62 (27.9%), maternal and child health services 49 (22.1%), and other departments 39 (17.6%).

Variables	Category	n (%)
Work shift pattern*	Rotational shift	222 (100.00)
Work hours (per week)†	41-50 h	7 (3.20)
	≥51 h	215 (96.80)
Overtime involvement	Yes	184 (82.90)
	No	38 (17.10)
Overtime frequency‡	Not reported	35 (19)
	1-2 days	8 (4.30)
	3-4 days	18 (9.80)
	5-6 days	14 (7.60)
	7 days	109 (59.20)
Nurse-patient ratio	Adequate	7 (3.20)
	Inadequate	215 (96.80)
Health sector	Private	36 (16.20)
	Public	186 (83.80)
Department of posting	Clinical department§	62 (27.90)
	Maternal and child health units ‖	49 (22.10)
	Critical/specialised units¶	72 (32.40)
	Other departments**	39 (17.60)

[Table/Fig-2]: Work-related and organisational characteristics of nurses (N = 222).
* Categories "day shift and night shift" under work shift pattern with zero responses were omitted for brevity; † The "≤ 40 hours per week" category under work hours was omitted for brevity ‡Percentages for overtime frequency is calculated using nurses who reported overtime (n = 184); §Clinical departments include medical, surgical, psychiatric, orthopaedic, ENT, eye, extension ward, isolation ward, UTP, and oncology units; ||Maternal and child health units include maternity ward, labour room, NBSU: Newborn stabilisation unit; SNCU: Special newborn care unit; NRC: Nutrition rehabilitation centre paediatric, postoperative, and gynaecology units; ¶Critical/specialised units include HDU: High dependency unit;, ICU: Intensive care unit; emergency department, operating theatre, blood bank, endoscopy unit, and dialysis unit; **Other departments include Community Health Centres (CHC), Outpatient Department (OPD), cold chain, and the office of the nursing superintendent

Burnout Levels

Burnout levels among the nurses are presented in [Table/Fig-3]. Based on the adopted OLBI score classification, none of the nurses was categorised as having low burnout. Of the 222 nurses, 170 (76.6%) were classified as having moderate burnout, while 52 (23.4%) were classified as having high burnout 52 (23.4%). High exhaustion was observed in 62 (27.9%) nurses, whereas high disengagement was less common, affecting only 15 (6.8%) nurses.

Coping Strategies

Religion (Median=6, IQR=3.0) and acceptance (Median=6, IQR=2.0) were the most commonly used coping strategies among the nurses, as shown in [Table/Fig-4]. Active coping, use of informational support, positive reframing, planning, and self-distraction were also frequently reported, each with a median score of 5 (IQR=2.0). In contrast, substance use (Median=2, IQR=0.0) and behavioural disengagement (Median=3, IQR=3.0) were less commonly used.

Burnout dimension	Burnout level	n (%)
Total	High	52 (23.40)
	Moderate	170 (76.60)
Exhaustion	High	62 (27.90)
	Moderate	160 (72.10)
Disengagement	High	15 (6.80)
	Moderate	206 (92.80)
	Low	1 (0.40)

[Table/Fig-3]: Prevalence and levels of burnout among nurses (N=222).
The low total burnout and low exhaustion categories contained 0 (0.0%) participants and were therefore omitted from the table. The low disengagement category was retained for descriptive completeness

Coping strategy subscale	Median (IQR)
Active coping	5 (2.0)
Use of informational support	5 (2.0)
Positive reframing	5 (2.0)
Planning	5 (2.0)
Emotional support	4 (1.0)
Venting	4 (2.0)
Humour	3 (3.0)
Acceptance	6 (2.0)
Religion	6 (3.0)
Self-blame	3 (3.0)
Self-distraction	5 (2.0)
Denial	3 (3.0)
Substance use	2 (0.0)
Behavioural disengagement	3 (3.0)

[Table/Fig-4]: Coping strategies among nurses using the Brief-COPE (N = 222).

Comparison of Coping Strategies by Burnout Level

Coping strategies were compared between nurses with moderate and high burnout using the Mann-Whitney U tests, as presented in [Table/Fig-5]. Prior to adjustment for multiple comparisons across the 14 coping subscales, nurses with high burnout reported significantly lower emotional support (U=3545, p=0.024, r=-0.20) and higher self-blame (U=3571, p=0.031, r=0.19) than those with moderate burnout. However, these differences did not remain statistically significant after Bonferroni correction (adjusted significance level: p<0.0036). The effect sizes for both associations were small.

Coping strategy	Moderate burnout (n=170) Median (IQR)	High burnout (n=52) Median (IQR)	U	P	Bonferroni adjusted p-value	r
Active coping	5 (2.00)	5 (2.25)	4036	0.336	1.000	-0.086
Use of informational support	5 (2.00)	5 (2.00)	4030	0.325	1.000	-0.088
Positive reframing	5 (2.00)	5.5 (2.25)	4090	0.402	1.000	0.074
Planning	5 (2.00)	5 (2.25)	4306	0.775	1.000	0.025
Emotional support	4 (1.75)	4 (1.25)	3545	0.024*	0.336	-0.198
Venting	4 (2.00)	4.5 (2.00)	3928	0.214	1.000	0.111
Humour	3 (2.00)	3 (4.00)	3930	0.207	1.000	0.110

Acceptance	6 (2.00)	7 (3.00)	3956	0.244	1.000	0.104
Religion	6 (2.75)	6 (4.00)	4143	0.487	1.000	-0.062
Self-blame	3 (2.00)	4 (2.00)	3571	0.031*	0.434	0.192
Self-distraction	5 (2.00)	5 (2.00)	3740	0.088	1.000	0.153
Denial	3 (1.00)	3 (3.00)	4405	0.971	1.000	0.003
Substance use	2 (0.00)	2 (0.00)	4076	0.210	1.000	-0.077
Behavioural disengagement	3 (3.00)	3 (3.00)	3997	0.280	1.000	-0.095

[Table/Fig-5]: Comparisons of coping strategies between nurses with moderate and high burnout levels using the Mann-Whitney U tests.
U=Mann-Whitney U statistic; r: effect size; p<0.05 * Significant at unadjusted p<0.05 only; not statistically significant after Bonferroni correction

DISCUSSION

The present study examined burnout and coping strategies among nurses working in secondary healthcare centres in Garo Hills, Meghalaya. Most nurses reported moderate levels of burnout, while nearly one-quarter experienced high burnout. Exhaustion emerged as the predominant dimension, while disengagement remained relatively low. Religion and acceptance were the most commonly used coping strategies, and only emotional support and self-blame differed significantly between nurses with moderate and high burnout.

Burnout Levels and Dimensions

Most nurses in the present study experienced moderate to high levels of burnout. This finding is similar to research from other studies conducted among nurses in India and elsewhere, which have documented high levels of burnout, particularly in resource-constrained healthcare settings [3,8]. In Meghalaya, Tiwari S reported moderate levels of burnout among nurses in West Garo Hills and found that occupational stress was significantly associated with burnout [20]. Together, these findings suggest that workplace stressors remain an important contributor to burnout among nurses in the region. In contrast, lower burnout levels have been reported among Nepalese nurses, possibly reflecting differences in workload, staffing, and organisational support [21].

Exhaustion was the most prominent burnout dimension in this study. Similar findings have been reported globally and within India, where emotional exhaustion has been identified as a key feature of burnout among healthcare professionals [3,8]. Findings from emergency nurses in Guwahati also suggest that heavy workload contributes substantially to fatigue and burnout [22]. Although exhaustion levels were high, disengagement remained relatively low, suggesting that many nurses continued to stay engaged with their work despite the challenges of their working environment.

Workforce and Organisational Context

The high levels of burnout observed in this study may be partly explained by the demanding work environment of the participants. Most nurses worked rotational shifts, long hours, and frequent overtime, often with inadequate nurse-patient ratios. Similar workplace challenges have been identified as important contributors to burnout among nurses [3,9-11,23]. Likewise, De Beer LT et al., reported that prolonged work overload increases the likelihood of burnout over time [24]. These workplace characteristics may provide contextual explanations for the high burden of burnout observed in this sample.

Coping Strategies Used by Nurses

Religion and acceptance were the coping strategies most frequently used by the nurses in the current study. Similar findings have been reported in resource-limited settings, where nurses often rely on emotion-focused strategies to manage workplace stress [25]. The frequent use of religion may reflect the important role of faith and spirituality in coping with stressful situations [26].

Problem-focused strategies, including active coping, informational support, positive reframing, and planning, were also commonly used. This finding is consistent with previous studies reporting that nurses frequently use active coping and planning strategies to manage work-related stress [27-29].

In contrast, substance use and behavioural disengagement were among the least frequently reported coping strategies. This finding differs from some studies that have reported greater use of avoidant coping behaviours among nurses [30-32]. The lower use of these strategies in the present study may reflect sociocultural influences and professional norms that discourage such behaviours.

Burnout Level and Coping Differences

Although nurses with high burnout tended to report lower emotional support and higher self-blame than those with moderate burnout, these differences were not statistically significant after Bonferroni correction. No significant differences were observed for the other coping strategies. Previous studies have reported associations between coping strategies and burnout with social support linked to lower burnout and better psychological well-being, and self-blame associated with greater emotional exhaustion and distress [30,33-37]. However, such differences were not evident in the present study.

Limitation(s)

The cross-sectional design precludes causal inference, and reliance on self-reported measures may introduce response bias. Purposive sampling with Institutional facilitation, necessitated by workforce availability and time constraints, may limit generalisability. Furthermore, contextual factors such as organisational culture, leadership dynamics, and availability of formal support systems were not assessed and may have influenced burnout and coping behaviours. The burnout classifications were based on OLBI cut-off values adopted from previous literature; validated normative thresholds for Indian nurses are currently unavailable, which may affect the interpretation and comparability of the findings. Although a Bonferroni correction was applied for multiple comparisons, its conservative nature may have obscured small differences between burnout groups.

CONCLUSION(S)

The present pre-intervention baseline study demonstrated a substantial burden of burnout among nurses in secondary healthcare centres in Garo Hills, Meghalaya, with exhaustion emerging as the most prominent dimension. Although nurses reported using a variety of coping strategies, adaptive approaches such as religion, acceptance, positive reframing, and planning were most commonly employed. The current study findings underscore the importance of addressing burnout within resource-constrained healthcare settings and provide an empirical foundation for the design, implementation, and evaluation of contextually relevant burnout prevention and management strategies aimed at supporting nurse well-being and maintaining quality patient care.

Authors' contribution: All three authors were involved in the conceptualisation and design of the study and contributed to its intellectual development. KAS: Undertook the literature review, data collection, statistical analysis, and preparation of the initial draft of the manuscript; GCK: Provided methodological guidance and critically reviewed and edited the manuscript. ESD: As the subject expert, contributed to the study conceptualisation, interpretation of findings, and critical revision of the manuscript. All authors reviewed and approved the final version, and Author 1 acts as the guarantor of the study.

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[APPENDIX]

1 A. Structured Questionnaire for Collection of Socio-Demographic and Work-Related Data of Nursing Participants

Instruction: **Code No:** _____

- All questions are compulsory.
- Please tick (√) the appropriate one (only one response for each item)

Section A: Socio-Demographic Characteristics

1. Age group in years
   a) < 25 b) 26- 30 c) 31- 35 d) 36- 40 e) 41 – 45 f) 46- 50 g) > 50
2. Gender
   a) Male b) Female c) Others
3. Marital status
   a) Single b) Married c) Divorced d) Separated
4. Educational qualification
   a) ANM b) GNM c) B.Sc. d) P.B.BSc. e) MSc.
5. Employment status
   a) Permanent b) Contractual
6. Work experience (in years)
   a) < 1 b) 1-5 c) 6-10 d) 11-15 e) > 15

Section B: Workplace Factors

1. Work shift pattern
   a) Day shift b) Evening shift c) Night shift d) Rotational shift
2. Working hours per week
   a) ≤ 40 b) 41 - 50 c) ≥ 51
3. Did you ever experience overtime?
   a) Yes b) No
   3 (i) If you answer "YES" to question no. 3, what is the most overtime you have ever worked?
   a) 1 - 2 days b) 3 - 4 days c) 5 - 6 days d) 7 days
4. Nurse-patient Ratio
   a) Adequate b) Inadequate
5. Type of health sector
   a) Private Sector b) Public Sector
6. Current department where posted?
   a) Looks after all department (No designated department in CHC)
   b) Medical Ward
   c) Surgical Ward
   d) Children/Paediatric Ward
   e) NRC (Nutritional Rehabilitation Centre)
   f) Maternity Ward and Labour Room
   g) Orthopaedic Ward
   h) ENT (Ear Nose Throat) Ward
   i) Eye Ward
   j) Oncology Ward
   k) Psychiatric Ward
   l) ICU (Intensive Care Unit)
   m) NICU (Neonatal Intensive Care Unit)
   n) PICU (Pediatric Intensive Care Unit)
   o) SNCU (Special Newborn Care Unit)
   p) NBSU (Newborn Stabilisation Unit)
   q) HDU (High Dependency Unit)
   r) Others

1 B. Oldenburg Burnout Inventory (OLBI)

Instruction:

Below is a series of statements with which you may agree or disagree. Using the scale, please indicate the degree of your agreement by selecting the number corresponding to each statement. (Please tick (√) 1 option only)

1= Strongly Agree 2 = Agree 3 = Disagree 4 = Strongly Disagree

S. No.	Possibilities	1	2	3	4
1.	I always find new and interesting aspects in my work.				
2.	There are days when I feel tired before I arrive at work.				
3.	It happens more and more often that I talk about my work in a negative way.				
4.	After work, I tend to need more time than in the past in order to relax and feel better.				
5.	I can tolerate the pressure of my work very well.				
6.	Lately, I tend to think less at work and do my job almost mechanically.				
7.	I find my work to be a positive challenge.				
8.	During my work, I often feel emotionally drained.				
9.	Over time, one can become disconnected from this type of work.				
10.	After working, I have enough energy for my leisure activities.				
11.	Sometimes I feel sickened by my work tasks.				
12.	After my work, I usually feel worn out and weary.				
13.	This is the only type of work that I can imagine myself doing.				
14.	Usually, I can manage the amount of my work well.				
15.	I feel more and more engaged in my work.				
16.	When I work, I usually feel energised.				

1 C. The Brief-COPE Inventory

Instruction:

- All questions are compulsory.
- The following questions ask how you have sought to cope with hardship in your life.
- Indicate how much you have been using each coping style (Please tick (√) 1 option only)

1 = I have not been doing this at all 2 = A little bit

3 = A medium amount 4 = I have been doing this a lot

S. No.	Possibilities	1	2	3	4
1.	I have been turning to work or other activities to take my mind off things.				
2.	I have been concentrating my efforts on doing something about my situation I am in.				
3.	I have been saying to myself "this isn't real"				
4.	I have been using alcohol or other drugs to make myself feel better.				
5.	I have been getting emotional support from others.				
6.	I have been giving up trying to deal with it.				
7.	I have been taking action to try to make the situation better.				
8.	I have been refusing to believe that it has happened.				

9.	I have been saying things to let my unpleasant feelings escape.				
10.	I have been getting help and advice from other people.				
11.	I have been using alcohol or other drugs to help me get through it.				
12.	I have been trying to see it in a different light, to make it seem more positive.				
13.	I have been criticising myself.				
Sl No.	Possibilities	1	2	3	4
14.	I have been trying to come up with a strategy about what to do.				
15.	I have been getting comfort and understanding from someone.				
16.	I have been giving up the attempt to cope.				
17.	I have been looking for something good in what is happening.				
18.	I have been making jokes about it.				
19.	I have been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.				
20.	I have been accepting the reality of the fact that it has happened.				
21.	I have been expressing my negative feelings.				
22.	I have been trying to find comfort in my religion or spiritual beliefs.				
23.	I have been trying to get advice or help from other people about what to do.				
24.	I have been learning to live with it.				
25.	I have been thinking hard about what steps to take.				
26.	I have been blaming myself for things that happened.				
27.	I have been praying or mediating.				
28.	I have been making fun of the situation.				