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Depression, marital conflict, and coping strategies (problem-focused and emotion-focused) as correlates of family stress among married nurses in selected hospitals in Enugu State, Nigeria

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Abstract

This study examined depression, marital conflict, and coping strategies (problem-focused and emotion-focused) as correlates of family stress among married nurses in selected hospitals in Enugu State, Nigeria. A cross-sectional correlational design was adopted, and 99 married nurses were selected using purposive sampling. Data were collected using standardized instruments, including the Family Stress Scale (Douglas & Omeje, 2025), Zung Self-Rating Depression Scale (1965), Brief COPE Scale (Carver et al., 1989), and Braiker and Kelley Marital Conflict Scale (1979). Data were analysed using Pearson Product-Moment Correlation via SPSS version 27.

Findings showed strong significant relationships among family stress dimensions. Hypothesis one revealed that depression was weakly related to family stress dimensions, with correlations such as argument dimension ($r = .098$), family discord ($r = .065$), and health problems ($r = .020$), indicating non-support for the hypothesis. Hypothesis two showed that marital conflict was negatively related to age ($r = -.233$, $p < .05$) and years of marriage ($r = -.228$, $p < .05$), but weakly related to family stress dimensions. Hypothesis three indicated that problem-focused coping was significantly related to depression ($r = .395$, $p < .01$), family stress ($r = .218$, $p < .05$), and health problems ($r = .244$, $p < .05$), while emotion-focused coping was associated with marital conflict ($r = .308$, $p < .01$). The study concludes that family stress among married nurses is multidimensional and more strongly influenced by coping strategies than depression.

Keywords:

Family stress; married nurses; depression; marital conflict; coping strategies; problem-focused coping; emotion-focused coping; occupational stress; Nigeria.

Introduction

Family stress among married nurses has become an important area of concern in contemporary psychological and occupational health research. It refers to the cumulative strain that arises from disruptions within the family system, including interpersonal conflict, communication breakdown, financial strain, health-related challenges, and external pressures outside the home. In nursing populations, this stress is often intensified by long working hours, shift rotations,

emotional labour, and high job demands, which reduce time for family interaction and recovery. Empirical evidence indicates that nurses frequently experience significant work–family conflict and elevated stress levels due to the demanding nature of their profession, which in turn negatively affects their psychological well-being and family functioning (Roberts et al., 2024; Chinawa et al., 2024).

One of the most significant psychological outcomes associated with prolonged exposure to stress is depression, which is characterized by persistent sadness, loss of interest, emotional exhaustion, and impaired daily functioning. Among nurses, depression is often linked to both occupational stressors and family-related difficulties, particularly when individuals lack adequate coping resources. Studies have shown that marital conflict and chronic stress significantly predict depressive symptoms among married nurses, highlighting the interconnected nature of workplace and family pressures (Chinawa et al., 2025; Chinawa et al., 2024). In practical terms, a married nurse experiencing unresolved family disagreements after long hospital shifts may develop emotional fatigue that gradually contributes to depressive symptoms if not properly managed.

Closely related to this is marital conflict, which refers to tension, disagreement, or persistent dissatisfaction within the marital relationship. It often arises from poor communication, unmet emotional expectations, financial strain, and imbalance in household responsibilities. Among married nurses, irregular work schedules and emotional exhaustion may further intensify marital conflict, thereby increasing overall family stress. Research findings suggest that marital conflict is a significant predictor of both depression and family dysfunction, as strained spousal relationships often spill over into broader family interactions (Chinawa et al., 2024). For instance, a nurse working night shifts may have limited time for spousal communication, which can increase misunderstandings and weaken emotional bonding within the household.

Another critical construct in understanding stress processes is coping strategies, which are generally categorized into problem-focused coping and emotion-focused coping. Problem-focused coping involves active efforts to manage or eliminate the source of stress through planning, decision-making, or seeking solutions, while emotion-focused coping involves regulating emotional responses through avoidance, acceptance, religious coping, or social support. Recent studies among nurses show that coping strategies significantly influence how stress translates into psychological outcomes such as depression and job strain (Abaribe et al., 2025; Chinawa et al., 2024). For example, a married nurse facing financial pressure may adopt problem-solving strategies such as budgeting or seeking additional income, whereas emotional coping may be used when dealing with unavoidable marital conflict.

Overall, the relationship between depression, marital conflict, coping strategies, and family stress is best understood as an interactive and dynamic system rather than a linear process. Family stress can intensify marital conflict, which may contribute to depression; however, the extent of this impact largely depends on the coping strategies employed by individuals. In line with contemporary nursing research, coping mechanisms play a moderating role in determining whether stress leads to psychological distress or adaptive adjustment (Chinawa et al., 2024; Chinawa et al., 2025). This study therefore examines these variables among married nurses to provide a more comprehensive understanding of how stress operates within both their professional and family environments.

This study is grounded in Lazarus and Folkman's Transactional Model of Stress and Coping, which emphasizes that stress is not a direct outcome of external events but a product of how individuals appraise and respond to those events using available coping resources. Within this framework, family stress among married nurses is understood as a multidimensional experience arising from argument patterns, family discord, health-related challenges, and external pressures that interact with marital and occupational demands. Depression and marital conflict are viewed as potential outcomes of prolonged exposure to these stressors, while coping strategies (problem-focused and emotion-focused) serve as key mediating processes that determine whether stress escalates into psychological distress or is effectively managed. In this sense, the model provides a useful explanation for why individuals exposed to similar family stressors may differ significantly in their emotional and psychological outcomes depending on how they interpret and cope with stress.

Despite growing attention to occupational stress among nurses, a key gap in the literature is that many studies tend to examine family stress, marital conflict, depression, or coping strategies in isolation rather than as an integrated system, particularly within African nursing populations. Existing research has also largely focused on general healthcare workers or students, with limited attention to married nurses who simultaneously experience professional demands and complex family responsibilities. Furthermore, there is insufficient empirical evidence on how problem-focused and emotion-focused coping differentially relate to specific dimensions of family stress in this population. This study addresses these gaps by examining depression, marital conflict, and coping strategies as joint correlates of family stress among married nurses.

Based on this framework, the study is guided by the following hypotheses:
(1) Depression will significantly relate to family stress and its dimensions among married nurses;
(2) Marital conflict will significantly relate to family stress and its dimensions among married nurses; and
(3) Coping strategies (problem-focused and emotion-focused) will significantly relate to family stress and its dimensions among married nurses.

Method

Participants

Ninety-nine (99) married nurses participated in the study. The participants had a mean age of 31.20 years (SD = 6.32). They were drawn using purposive sampling from one federal and three private hospitals in Enugu State, Nigeria. The hospitals included University of Nigeria Teaching Hospital (n = 36), Enugu State University of Science and Technology Teaching Hospital (n = 31), and National Orthopaedic Hospital Enugu (n = 33), located along the Enugu–Abakaliki Expressway. The inclusion criterion was being a married nurse actively working in any of the selected hospitals.

Instruments

Four standardized instruments were used for data collection:

Family Stress Scale (Douglas & Omeje, 2025)
The Family Stress Scale is a 19-item instrument designed to assess stress within the family context. It is structured on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree) and measures four dimensions: argument dimension, family discord, health problems, and difficulties outside the home. The scale demonstrates strong internal consistency, with Cronbach's alpha values of .915 (argument), .831 (family discord), .858 (health problems), and .706 (difficulties outside the home), with an overall reliability coefficient of .946. Evidence of construct validity was established through significant intercorrelations among subscales, indicating a coherent multidimensional structure.

Zung Self-Rating Depression Scale (Zung, 1965)
The Zung Self-Rating Depression Scale (SDS) is a 20-item instrument designed to assess depressive symptoms across cognitive, affective, somatic, psychomotor, and interpersonal domains. Items are rated based on symptom frequency and summed to obtain a total score. Established cut-off points classify depression as mild (50–59), moderate (60–69), and severe (70–80). In Nigerian samples, Obiora (1995) reported mean scores of 48.77 (males) and 47.87 (females). The scale has demonstrated strong psychometric properties, including a concurrent validity coefficient of .79 and test–retest reliability of .93. In the present study, a pilot test conducted among 30 nursing students from the University of Nigeria, Enugu Campus yielded a Cronbach's alpha of .86, indicating good internal consistency.

Brief COPE Scale (Carver et al., 1989)
The Brief COPE is a 28-item self-report instrument developed as a shortened version of the original COPE inventory. It assesses adaptive and maladaptive coping strategies in response to stress. Items are rated on a 4-point scale reflecting frequency of use. Previous validation studies reported acceptable reliability coefficients above .60 (Nunnally & Bernstein, 1995), with strong inter-scale correlations observed between subcomponents such as active coping and planning. In this study, pilot testing with 30 nursing students from the University of Nigeria, Enugu Campus produced a Cronbach's alpha of .63 and a standardized item coefficient of .68, indicating acceptable reliability for research purposes.

Braiker and Kelley Marital Conflict Scale (1979)
The Braiker and Kelley Marital Conflict Scale is a 5-point Likert-type instrument designed to assess the extent of overt behavioural conflict and negative emotional communication within marital relationships. It has demonstrated acceptable internal consistency reliability ($\alpha = .81$). In the present study, pilot testing conducted among 30 nursing students yielded a Cronbach's alpha of .76, indicating satisfactory reliability for the study population.

Procedure
Data collection was carried out using purposive sampling to identify married nurses who met the inclusion criteria. Participants were recruited from the selected hospitals in Enugu State with the assistance of trained research assistants, who were matrons in the respective institutions. The instruments were administered directly to eligible participants, who were instructed to respond by selecting the option that best reflected their level of agreement with each statement.

A total of 111 questionnaires were distributed. Of these, 104 were returned, while 5 were improperly completed and excluded from analysis. Ultimately, 99 correctly completed

questionnaires were retained for data analysis. Ethical considerations, including voluntary participation and confidentiality, were observed throughout the process.

Design and Statistics

The study adopted a cross-sectional correlational research design, which is appropriate for examining relationships among variables without experimental manipulation. Data were analysed using Pearson Product-Moment Correlation Coefficient with the aid of SPSS version 27 to determine the relationships among depression, marital conflict, coping strategies, and family stress dimensions.

Result

Table 1: Descriptive Statistics and Intercorrelations for Study Variables (N = 87–97)

Variable	M	SD	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Argument dimension	12.63	5.59	—													
2. Family discord	13.35	4.77	.911**													
3. Difficulties outside home	9.88	2.08	.219*	.266**												
4. Health problems	16.31	5.35	.719**	.823**	.286**											
5. Family stress	52.54	15.83	.943**	.939**	.410**	.859**										
6. Age	36.77	9.65	.082	.014	.096	-.060	.044									
7. Gender	1.48	0.50	.020	.107	.098	.025	.061	.031								
8. Educational qualification	5.55	0.95	.056	.017	.087	-.046	.045	.400**	-.146							
9. Marital status	1.78	0.41	-.080	-.083	.114	-.181	-.087	.287**	.309**	.092						
10. Years of marriage	7.33	9.58	.077	.125	.166	-.004	.093	.555**	.490**	.202*	.323**					
11. Marital conflict	12.92	3.90	-.073	-.075	-.018	.060	-.045	-.233*	-.153	.008	-.032	-.228*				
12. Depression	58.74	15.41	.098	.065	.189	.020	.092	.056	.075	.031	.053	.042	-.367**			
13. Problem-focused coping	20.44	5.60	.180	.208	.150	.244*	.218*	-.125	.019	-.156	-.043	-.043	-.070	.395**		
14. Emotion-focused coping	47.01	11.25	-.055	-.021	.064	.185	.035	-.177	-.081	.010	-.049	-.171	.308**	-.180	.181	

Note.
Means (M) and standard deviations (SD) are reported on the diagonal variables only once for clarity. Pairwise sample sizes vary across variables (family-related variables, $n = 97$; psychological/coping variables, $n = 87$).
$p < .05$. **p** < .01

Descriptive statistics and intercorrelations among study variables are presented in Table 1. Overall, participants reported moderate levels of family-related stress indicators, with means ranging from 9.88 (Difficulties outside the home) to 52.54 (Family stress). Specifically, argument dimension (M = 12.63, SD = 5.59), family discord (M = 13.35, SD = 4.77), difficulties outside the home (M = 9.88, SD = 2.08), and health problems (M = 16.31, SD = 5.35) collectively reflected the broader construct of family stress. Participants also reported moderate levels of marital conflict (M = 12.92, SD = 3.90) and depression (M = 58.74, SD = 15.41). Regarding coping strategies, emotion-focused coping (M = 47.01, SD = 11.25) was more

frequently endorsed than problem-focused coping (M = 20.44, SD = 5.60). The demographic profile indicated that participants were on average middle-aged (M = 36.77, SD = 9.65) with moderate variability in years of marriage (M = 7.33, SD = 9.58).

Correlation analysis revealed strong and statistically significant positive relationships among the family stress indicators. Family stress showed a very strong association with argument dimension ($r = .943$, $p < .01$), family discord ($r = .939$, $p < .01$), and health problems ($r = .859$, $p < .01$), indicating that these variables are highly interrelated and collectively reflect a coherent family stress construct. Similarly, family discord was strongly related to health problems ($r = .823$, $p < .01$) and moderately related to difficulties outside the home ($r = .266$, $p < .01$). These findings suggest that disruptions within the family system tend to co-occur with external stressors and health-related challenges.

Age, gender, and educational qualification showed generally weak and non-significant relationships with most family stress variables, indicating limited demographic influence on perceived family stress in the present sample. However, age was positively associated with educational qualification ($r = .400$, $p < .01$) and years of marriage ($r = .555$, $p < .01$), suggesting that older participants tended to have higher educational attainment and longer marital duration. Educational qualification was also positively related to marital status ($r = .309$, $p < .01$) and years of marriage ($r = .202$, $p < .05$), reflecting expected socio-developmental patterns.

Marital conflict demonstrated a significant negative relationship with age ($r = -.233$, $p < .05$) and years of marriage ($r = -.228$, $p < .05$), suggesting that marital strain tends to reduce as couples age and accumulate longer marital experience. Depression was significantly and negatively associated with marital conflict ($r = -.367$, $p < .01$), indicating that lower marital conflict was paradoxically linked with higher depressive symptoms in this sample, a finding that may reflect underlying unmeasured psychosocial factors.

Regarding coping strategies, problem-focused coping was positively associated with health problems ($r = .244$, $p < .05$), family stress ($r = .218$, $p < .05$), and depression ($r = .395$, $p < .01$), suggesting that individuals experiencing higher stress and psychological distress tended to engage more in active coping efforts. Emotion-focused coping, although not strongly related to most family stress variables, showed a significant positive association with marital conflict ($r = .308$, $p < .01$), indicating greater reliance on emotional regulation strategies among individuals experiencing relational strain.

Overall, the pattern of results indicates a tightly interconnected family stress system, where interpersonal conflict, health challenges, and external stressors co-occur strongly, while psychological outcomes such as depression and coping responses demonstrate more selective and context-dependent relationships.

Discussion of Findings

The first hypothesis proposed that depression would be significantly related to family stress and its dimensions among married nurses. The findings did not support this hypothesis, as depression showed weak and inconsistent relationships with the various dimensions of family stress, including argument patterns, family discord, health problems, and external difficulties. This suggests that depressive symptoms among married nurses in this study may not be

primarily determined by family functioning variables alone. Rather, depression appears to be influenced by a more complex combination of psychosocial and occupational factors that extend beyond the immediate family environment.

From a theoretical standpoint, this pattern suggests that depression in nursing populations may be better understood as a multidimensional outcome influenced by both work-related and personal-life stressors. Nurses operate in high-demand clinical environments where emotional labour, shift work, and exposure to patient suffering are constant. These occupational pressures may interact with, or even overshadow, family-related stressors in shaping psychological distress. As a result, even when family stress is present, it may not be sufficient on its own to produce clinically significant depressive symptoms unless compounded by work-related strain or inadequate coping resources.

Furthermore, the weak associations observed may reflect the presence of psychological buffering mechanisms such as professional resilience, emotional compartmentalization, or adaptive coping strategies developed through clinical experience. Nurses often learn to separate personal distress from professional functioning, which may reduce the direct impact of family stress on mood disorders. This suggests that depression among married nurses is less a direct reflection of family dysfunction and more a product of cumulative stress exposure across multiple life domains.

In a real-life hospital setting in Enugu State, a married nurse working consecutive night shifts in a busy emergency ward may return home physically exhausted and emotionally depleted. Even if minor disagreements occur within the family, her depressive symptoms may be more strongly linked to workload pressure, sleep deprivation, and repeated exposure to critical patient cases rather than the family interaction itself. This illustrates how occupational stress may overshadow family stress in influencing depression.

The second hypothesis posited that marital conflict would significantly relate to family stress and its dimensions among married nurses. The findings provided partial support for this hypothesis. Marital conflict demonstrated a negative relationship with both age and years of marriage, suggesting that older nurses and those with longer marital experience tend to report lower levels of relational conflict. This may reflect the development of emotional maturity, improved communication patterns, and better conflict resolution skills over time within marital relationships.

However, marital conflict showed generally weak associations with the broader dimensions of family stress, such as argument patterns, family discord, health problems, and external difficulties. This indicates that marital conflict, while an important relational factor, may not always translate directly into broader family system dysfunction. Instead, it may function as a more isolated interpersonal issue that does not necessarily disrupt overall family stability, particularly in households with strong extended family support or adaptive coping structures.

Additionally, the findings suggest that marital conflict may be influenced more by relational dynamics and role expectations than by general family stressors. In nursing populations, irregular work schedules, emotional fatigue, and limited time for spousal interaction can create misunderstandings, but these do not always escalate into systemic family breakdown. Over

time, couples may develop tolerance, acceptance, and adaptive strategies that reduce the intensity and impact of conflict.

In a typical family setting in Benin City, a married nurse working rotating shifts may occasionally disagree with her spouse over household responsibilities or time allocation. However, if the couple has established strong communication habits and receives support from extended family members, these disagreements may remain isolated incidents rather than escalating into broader family instability. This reflects how marital conflict can exist independently without necessarily disrupting the entire family system.

The third hypothesis proposed that coping strategies—specifically problem-focused and emotion-focused coping—would significantly relate to family stress and its dimensions. The results partially supported this hypothesis. Problem-focused coping was positively associated with higher levels of family stress, health problems, and depression, indicating that individuals experiencing greater stress tend to engage more actively in attempts to solve or manage the stressors they face. This suggests that problem-focused coping is often a response to heightened stress rather than a preventive factor.

Emotion-focused coping, on the other hand, was more strongly associated with marital conflict, indicating that individuals experiencing relational tension are more likely to rely on emotional regulation strategies such as avoidance, acceptance, or seeking emotional support. This reflects the idea that when stressors are perceived as less controllable such as interpersonal disagreements within marriage individuals tend to focus on managing emotional responses rather than directly addressing the source of conflict.

Overall, the pattern of findings highlights the situational and flexible nature of coping among married nurses. Nurses appear to adjust their coping strategies depending on the type and controllability of stressors they encounter. Occupational or task-related stress may trigger active problem-solving, while interpersonal stress tends to evoke emotional coping responses. This adaptability reflects the psychological demands of nursing, where individuals must constantly shift between professional problem-solving and emotional regulation in both work and family contexts.

In a real hospital environment, a nurse experiencing financial strain due to irregular overtime payments may engage in problem-focused coping by budgeting expenses or seeking additional shifts. However, when faced with emotional tension at home following disagreements with a spouse after a long shift, she may instead rely on emotion-focused coping strategies such as withdrawal, prayer, or discussing her feelings with a trusted colleague. This demonstrates how coping responses vary depending on the nature of the stressor and its perceived controllability.

Beyond the tested hypotheses, the demographic pattern of findings provides additional insight into how married nurses experience stress within both their professional and personal lives. Age, educational qualification, and years of marriage were positively interrelated, suggesting a clear life-course progression among participants. Older nurses tended to have longer marital duration and higher levels of educational attainment, which may reflect gradual professional advancement alongside increasing family stability. This pattern implies that with age and experience, nurses are more likely to develop both occupational competence and relational

maturity, which together may enhance their capacity to manage stress more effectively across multiple life domains.

Interestingly, gender and marital status showed minimal and largely non-significant relationships with the psychological and family stress variables examined in the study. This indicates that stress experiences among married nurses are relatively consistent regardless of these demographic differences. One possible explanation is that the nursing profession itself imposes a highly structured and demanding work environment that standardizes stress exposure across individuals. The emotional demands of patient care, shift rotations, and workload intensity may therefore overshadow personal demographic differences, resulting in a more uniform stress experience across male and female nurses and across varying marital classifications.

Overall, the findings suggest that family stress, marital conflict, and coping strategies are deeply interconnected but do not operate as uniform predictors of depression among married nurses. Instead, psychological well-being appears to emerge from a more complex interaction of occupational demands, individual coping resources, and accumulated life experience. While stressors within the family and marital domains are important, their psychological impact is shaped by how nurses manage competing demands between work and home life, as well as the adaptive skills developed over time through both professional exposure and personal growth.

Implication of the findings

The findings are best understood through Lazarus and Folkman's Transactional Model of Stress and Coping (1984), which explains stress as a dynamic process shaped by how individuals evaluate stressful events and the coping strategies they deploy. In this study, family stress, marital stress, coping strategies, and depression among married nurses did not show simple one-directional relationships. Instead, stress outcomes appeared to depend on how nurses interpret and manage stressors within both their professional and family lives. For example, experiences such as family discord, health-related pressures, and external difficulties are not inherently distressing in isolation; their psychological impact is influenced by whether the individual appraises them as manageable or overwhelming and whether adequate coping resources are perceived to be available.

The pattern of results further supports this model by showing that coping plays a central mediating role in how stress is experienced. Problem-focused coping was more likely when stress levels were higher, suggesting active attempts to manage or resolve stressors, while emotion-focused coping was more closely associated with marital stress, reflecting efforts to regulate emotional responses when stressors are less controllable. Importantly, the weak and inconsistent direct relationship between depression and family stress dimensions indicates that depressive symptoms are not simply a direct consequence of family stress, but are shaped by appraisal processes and coping effectiveness. In practical terms, two married nurses may experience similar family pressures, yet differ in psychological outcomes depending on how they interpret these stressors and the coping strategies they employ, highlighting the transactional and context-dependent nature of stress in this population.

The findings carry important practical implications for supporting the psychological well-being of married nurses. First, the strong interconnections among family stress dimensions suggest

that interventions should not treat marital, family, and external stressors in isolation. Hospital administrators and occupational health units should consider integrated support systems that address both workplace and home-related pressures. For example, flexible shift scheduling, family-friendly work policies, and access to counselling services can help reduce the cumulative burden of stress that spills over from clinical duties into family life. In real-world terms, a nurse working consecutive night shifts in Benin City, for instance, would benefit not only from workload adjustments but also from structured opportunities to decompress and manage family-related responsibilities.

Second, the findings highlight the central role of coping strategies, indicating that psychological interventions should focus on strengthening adaptive coping skills. Training programs in stress management, emotional regulation, and problem-solving can help nurses respond more effectively to both marital and occupational challenges. Encouraging problem-focused coping, such as time management and active communication skills, may improve their ability to handle controllable stressors, while teaching healthy emotion-focused strategies—such as mindfulness, peer support, and relaxation techniques—can help manage unavoidable emotional strain. For instance, a nurse experiencing marital tension after a demanding shift may benefit from learning constructive communication techniques rather than emotional withdrawal.

Finally, the weak direct link between family stress and depression suggests that improving coping resources may be more effective than solely targeting stress reduction. This implies that mental health programs for nurses should prioritize resilience-building rather than only reducing exposure to stressors. Hospitals and nursing institutions can incorporate routine psychological screening, peer-support groups, and access to professional counselling to prevent the escalation of stress into depressive symptoms. Overall, the findings emphasize that enhancing coping capacity and providing structured institutional support are key to improving the well-being of married nurses in demanding healthcare environments.

Limitations of study

One key limitation of this study is its reliance on a cross-sectional design, which means all data were collected at a single point in time. As a result, it is not possible to establish causal relationships among family stress, marital stress, coping strategies, and depression. In practical terms, while the findings show that these variables are related, we cannot confidently say, for example, whether family stress leads to depression or whether individuals already experiencing depressive symptoms perceive greater stress in their families. A longitudinal approach would have provided stronger evidence on how these experiences develop and change over time, especially in a demanding profession like nursing where stress levels can fluctuate with shifts, workload, and life events.

Another limitation relates to self-report measures, which may be influenced by personal bias, memory errors, or social desirability. Married nurses, for instance, may underreport marital conflict or emotional distress due to cultural expectations of privacy or professional identity concerns. This is particularly relevant in a healthcare setting where emotional strength is often valued, potentially leading participants to minimize symptoms of depression or exaggerate coping effectiveness. Such reporting tendencies can affect the accuracy of the observed relationships.

Additionally, the study's sample size and context may limit the generalizability of the findings. Since the participants were drawn from a specific group of married nurses, likely within a particular geographical and institutional setting, the results may not fully reflect the experiences of unmarried nurses, other healthcare workers, or married individuals in non-health professions. For example, stress patterns among nurses working in urban tertiary hospitals may differ from those in rural clinics due to differences in workload, staffing, and resource availability. This contextual specificity means the findings should be interpreted with caution when applied to broader populations.

Finally, the study did not fully account for other potentially important variables such as personality traits, workplace support systems, or financial status, all of which could significantly influence stress and coping outcomes. In real-life settings, two nurses with similar family stress levels may experience very different psychological outcomes depending on whether they have strong social support, stable income, or resilient personality characteristics. The absence of these moderating or mediating factors limits the depth of interpretation and suggests that future research should incorporate a more comprehensive model of influencing variables.

Suggestion for further study

Future research should build on these findings by adopting a longitudinal design to better capture how family stress, marital stress, coping strategies, and depression evolve over time among married nurses. This would allow researchers to move beyond simple associations and better understand directionality—such as whether prolonged exposure to family stress eventually leads to depressive symptoms, or whether pre-existing emotional distress influences how stress is perceived within the family system. Tracking nurses across different stages of their careers and marital life would also provide a clearer picture of how adaptation and resilience develop in real-life settings.

In addition, future studies should consider expanding the range of psychological and contextual variables included in the model. Factors such as personality traits (e.g., neuroticism, resilience), workplace support, shift patterns, financial strain, and quality of spousal communication may play important roles in shaping both stress experiences and coping responses. Including these variables would provide a more comprehensive and realistic explanation of mental health outcomes among nurses, especially in high-demand healthcare environments where stress is multidimensional and cumulative.

It would also be valuable for future research to adopt a mixed-methods approach, combining quantitative surveys with qualitative interviews. While quantitative data can show patterns and relationships, qualitative insights would help explain how nurses personally experience family and marital stress, and how they make sense of their coping strategies in everyday life. For example, interviews might reveal how night shifts interfere with parenting roles or how cultural expectations influence emotional expression in marriage. This would deepen understanding beyond numerical relationships.

Finally, future studies should consider comparative and broader sampling strategies. Comparing married nurses with unmarried nurses, or with professionals in other high-stress occupations such as teaching or law enforcement, could help clarify whether the observed

patterns are unique to nursing or reflect a more general occupational phenomenon. Expanding the study across multiple hospitals, regions, or healthcare systems would also improve generalizability and strengthen the external validity of the findings.

Summary and Conclusion

This study examined depression, marital conflict, and coping strategies (problem-focused and emotion-focused) as correlates of family stress among married nurses. The findings showed that family stress dimensions (argument patterns, family discord, health problems, and external difficulties) were strongly interrelated, indicating that family stress operates as a unified and multidimensional construct. However, depression demonstrated weak and inconsistent relationships with family stress variables, suggesting that depressive symptoms among married nurses are not solely driven by family-related stressors but are likely influenced by broader occupational and psychosocial demands. Similarly, marital conflict showed limited direct association with overall family stress, although it decreased with age and length of marriage, indicating possible adaptation and improved relational adjustment over time.

The study further revealed that coping strategies play an important role in how stress is experienced and managed. Problem-focused coping was more frequently used among individuals experiencing higher levels of stress, reflecting active efforts to manage or resolve stressors. Emotion-focused coping, on the other hand, was more strongly associated with marital conflict, suggesting reliance on emotional regulation strategies when stressors are perceived as less controllable. Demographic findings also indicated that age, educational qualification, and years of marriage were positively related, while gender and marital status had minimal influence on stress outcomes, suggesting that occupational demands may override certain demographic differences in shaping stress experiences among nurses.

In conclusion, the study demonstrates that family stress among married nurses is a complex and interconnected phenomenon influenced by both marital dynamics and coping processes, but not uniformly predictive of depression. Instead, psychological well-being is shaped by an interaction of occupational demands, relational experiences, and coping effectiveness. The findings underscore the importance of strengthening adaptive coping strategies and providing institutional support systems that address both workplace and family-related stressors. Overall, the results highlight the need for integrated psychological and organizational interventions to promote better mental health outcomes among married nurses in demanding healthcare environments.

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