



# **Levels and determinants of perceived stress among psychiatric nurses working at Mathari National Teaching and Referral Hospital, Kenya**

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## **Article History**

*Received: 12.01.2026*

*Revised: 19.04.2026*

*Accepted: 10.05.2026*

*Published: 13.05.2026*

## **Keywords**

Hospital

Mental health

Psychiatric nurses

Stress

## **How to cite:**

Tripathi, S., Changorok, S. C., & Munywoki, V. (2026). Levels and determinants of perceived stress among psychiatric nurses working at Mathari National Teaching and Referral Hospital, Kenya. *Eastern African Journal of Humanities and Social Sciences*, 5(1), 263-276.

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## **Abstract**

Care giving for individuals with demanding mental health conditions exposes psychiatric nurses to unique challenges in their role and the potential for development of stress, which could impact their quality of life. The purpose of this study was to investigate the relationship between perceived stress and the quality of life among psychiatric nurses at Mathari National Teaching and Referral Hospital (MNTRH), Nairobi, Kenya. The study objectives were to assess the levels of perceived stress and examine the factors contributing to perceived stress at MNTRH. This study was anchored on the Systematic Theory of Stress and Lazarus' Theory of Stress. A quantitative approach with a correlational design was used to conduct the study using a census sampling with a sample size of 120 psychiatric nurses. The sample included both male and female aged between 21 and 60 years. Respondents' demographic characteristics were collected using a socio-demographic questionnaire. SPSS V 29 was used in data analysis. The findings showed that the perceived stress levels were moderate (82.8%). Age, gender, marital status, years of experience, qualification, work setting, shift type, and weekly working hours had no statistically significant influence on the stress levels experienced by the psychiatric nurses. The study observed moderate perceived stress among the psychiatric nurses. No demographic factor was observed to significantly influence the perceived stress. The study findings indicate that more emphasis should be placed on the practice rather than the background factors of the psychiatric nurses.

## **Introduction**

Nursing is known as a stressful career because it involves complex job demands and responsibilities. The major stressors have been identified as high expectations and excessive responsibility (Jacobs & Lourens, 2016). Nurses working in less-than-ideal conditions, such as irregular and lengthy hours, which have been shown to increase psychological vulnerability, frequently work in stressful, demanding workplaces (Jang et al., 2016; Yilmaz & Ustun, 2018). Research suggests that stressors such as interpersonal conflict, violent patients, heavy workload, and low pay may negatively affect nurses' well-being and job satisfaction (Cheung et al., 2018; Tarcan et al., 2017).

While nursing, in general, is a high stress occupation globally (Guo et al., 2018; Karimi & Brazier, 2016; Zaki & Barakat, 2018), in particular, nursing personnel in long-term psychiatric facilities have



displayed higher levels of stress than providers working in other types of medical facilities (Ahanchian, 2015). Specifically, psychiatric nurses are exposed to even greater challenges as they frequently face intense interpersonal interactions, dynamic changes in patients' emotional instability, psychological distress, unpredictable behaviours, violence, and aggression from the patients. Dealing with these issues can be extremely stressful and challenging for psychiatric nurses (Edward et al., 2017).

According to Jacobs and Lourens (2016), psychiatric nursing is one of the most stressful jobs in the world. However, the stressors experienced by psychiatric nurses may differ from those of other mental health workers (Kane, 2012). The stress is also emotionally demanding and even traumatic, posing obstacles in maintaining Professional Quality of Life ProQoL (Mizuno et al., 2013). They encounter special hurdles as a result of caring for patients with multiple and intricate requirements caused by a wide range of mental health conditions (López et al., 2015). Confronting these problems may be emotionally tiring. Moreover, they work in a different environment than nurses in general hospitals. Yada and colleagues (2017) Reports about patients who are occasionally hostile on morning, afternoon, or night shift duty instil extreme terror in the psychiatric nurses, causing stress.

Nurses are exposed to physical and verbal attacks or even have to deal with suicide attempts (Itzhaki et al., 2018; Liu et al., 2019). Violence and hostility meted out to psychiatric nurses can cause dread and anxiety. These variables make it difficult for psychiatric nurses to keep a work-life balance and avoid burnout (Kelly et al., 2015). This affects the professional quality of life of psychiatric nurses (Sun et al., 2016). Dealing with these challenges can be extremely stressful and difficult for psychiatric nurses (Edward et al., 2017; Zaki & Barakat, 2018).

Prolonged exposure to stress can eventually harm psychiatric nurses' health and well-being, resulting in depression, anxiety, poor physical and mental health, absenteeism, high turnover rates, burnout and poor client care (Fahy & Moran, 2018; Itzhaki et al., 2018; Khamisa et al., 2016). Several nursing research studies have suggested that employees experience ongoing stress due to the demands and responsibilities of their work and lives (Weinberg & Creed, 2000).

The purpose of this study was to assess the levels and determinants of perceived stress among the psychiatric nurses at Mathari National Teaching and Referral Hospital in Nairobi County, Kenya.

## **Method**

### ***Study design***

A correlational study design was used to assess the determinants of perceived stress among psychiatric nurses at Mathari National Teaching and Referral Hospital. The focus of correlational research is to expose variables that show systematic relationships (Bhattacharjee, 2012). One distinct advantage of correlational research is its ability to assess behaviour as it occurs in people's daily lives (Stangor, 2011). The design's greatest strength may be that it can be employed when experimental research is not possible because the predictor variables cannot be modified. However, the study design may not establish causation in the influence of demographic factors on stress levels.

### ***Study site***

The study was conducted at Mathari National Teaching and Referral Hospital, Nairobi, Kenya. Nairobi is Kenya's capital. It is located in the south-central region of the country. Nairobi City County is one of the 47 counties of Kenya. It is the third smallest yet the most populous of the counties (Encyclopedia Britannica, 2025).



### *Target population*

The target population for this study comprised 120 psychiatric nurses working at Mathari National Teaching and Referral Hospital in Nairobi, Kenya.

### *Sampling design*

Census was used to obtain data from the study Respondents. A census was used in this study because all the elements of the population were used (Kothari, 2004). The population was small, which allowed a census to obtain comprehensive, detailed data. Colwill and Poullis (2023) state that census data can inform practice guidelines and policy planning in nursing care.

The census sampling technique was used specifically to select the Mathari National Teaching and referral Hospital. Census approach or complete enumeration to include all 120 psychiatric nurses working at the selected hospital. Since there is no selection of a representative group to represent the larger group, the study included the entire group of psychiatric nurses, whose total number 120.

### *Inclusion and exclusion criteria*

All psychiatric nurses employed at Mathari National Teaching and Referral Hospital during the period from September to November 2025 were included in the study. Data were collected from male and female nurses aged between 21 and 60 years. Student nurses or those on internship were excluded from the study.

### *Pre-Testing*

The Pre-test was conducted in the Rehabilitation Centre for Drug Addiction at Mathari National Teaching and Referral Hospital in Nairobi, Kenya. This site was chosen because it provides a setting similar to the one where the main study would take place - psychiatric nursing, which is the target study's population in terms of characteristics and work environment. A total of twelve (12) psychiatric nurses were purposefully selected from the rehabilitation centre, which makes 10% of the study Respondents (Kunselman, 2024). The Respondents in the pre-testing had the same characteristics as those who participated in the final study, but would not be included in the main study sample to prevent data contamination. This was done to check for the reliability and validity of the study tool for the target population.

### *Data collection tools*

Quantitative data were collected using self-administered questionnaires. Two questionnaires were used to obtain data from Respondents: Socio-demographic Questionnaire (SDQ), the Perceived Stress Scale (PSS).

### *Socio-Demographic Questionnaire (SDQ)*

The SDQ collected data on age, gender, religion, marital status, and educational qualifications.

### *Perceived Stress Scale (PSS)*

The Perceived Stress Scale (PSS) is the most widely used psychological instrument for assessing perceived stress. It is a measure of how stressful life conditions are perceived to be (Cohen et al., 1983). The items reflect how unpredictable, unmanageable, and overburdened respondents find their lives. The test also includes a number of direct questions concerning present levels of perceived stress. The PSS was intended for use in community samples with at least a junior high school education. The items in this test are easy to understand, and the response alternatives are very easy to grasp. Moreover, the questions are of a general nature and are therefore relatively free of content specific to any subpopulation. The questions in the PSS ask about feelings and thoughts during the last month. In each case, respondents are asked how often they felt a certain way (Cohen et al., 1983).



The Perceived Stress Scale was developed by Cohen et al. in 1983. It consists of 14 items that measure thoughts and feelings about stressful events, control, overcoming, coping with stress, and the stress perceived by an individual during the last month. In this questionnaire, a Likert scale (never, very low, medium, relatively high, and high) is used, and the score ranges from 0 to 4 points, with 0 and 56 being the lowest and highest scores, respectively (Cohen et al., 1983).

In interpreting the PSS tool, items 4, 5, 6, 7, 9, 10, and 13 are reverse-coded to ensure proper interpretation, avoid response bias, and align responses on the increasing scoring scale.

### ***Data analysis method***

The quantitative data were analysed using the Statistical Package for the Social Sciences (SPSS) version 29. Descriptive statistics: means, standard deviations, and frequencies, were computed to describe the level of stress and quality of life among psychiatric nurses. Frequency analysis was used to assess prevalence, while the chi-square test was used to analyse the association between demographic factors and levels of perceived stress among psychiatric nurses.

### ***Ethical considerations***

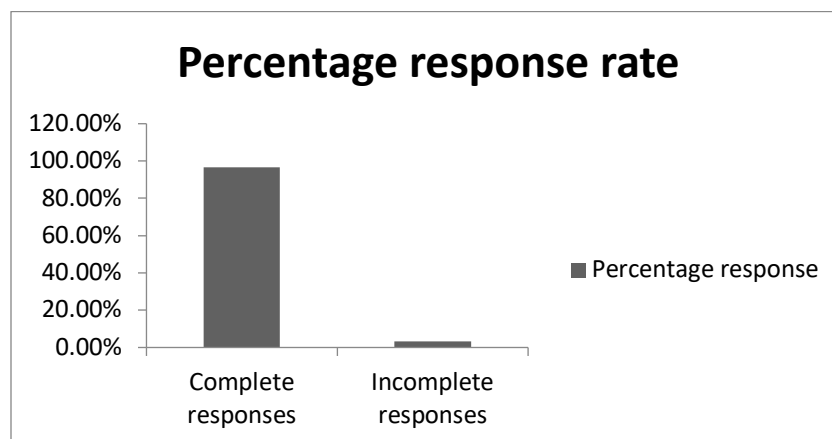
Informed consent was obtained from the respondents before the tools were administered. Debriefing was conducted with the respondents, providing a full explanation of the study's purpose, methods, and outcomes after their participation. The PI provided a prompt opportunity for Respondents to obtain appropriate information about the nature, results, and conclusions of the research, and took reasonable steps to correct any misconceptions that Respondents had about the study. Confidentiality and privacy of the data were assured to the respondents through the informed consent form. There was no harm during the assessment. The data collected was also to be used mainly for academic purposes only

## **Results**

### ***Response Rate***

The study had a response rate of 116 (96.67%), while the remaining 4 (3.33%) responses were not fully completed in some sections. This is an acceptable range of responses for the study, given its sample size (Figure 1).

*Figure 1: Response rate of the study*





**Socio-Demographic Characteristics of the Respondents**

The respondents were predominantly female psychiatric nurses aged 25–34 years, reflecting the common gender distribution in the nursing profession. Most participants were Christians, married, and had between 1 and 11 years of work experience. The majority held a Diploma in Nursing and worked in acute wards, with many assigned to day or rotating shifts. Most nurses reported working 30–40 hours per week, although a notable proportion worked more than 40 hours, indicating variation in workload and work demands among respondents (Table 1).

*Table 1: Socio-Demographic Distribution of Respondents*

Demographic profile	Factors	Frequencies	Percentage (%)
<b>Age</b>	Under 25	6	5.2
	25-34	46	39.7
	35-44	32	27.6
	45-54	19	16.4
	55 and above	13	11.2
<b>Gender</b>	Male	29	25.0
	Female	87	75.0
<b>Religion</b>	Christian	109	94.0
	Muslim	7	6.0
<b>Marital Status</b>	Single	36	31.0
	Married	75	64.7
	Divorced	1	.9
	Widowed	4	3.4
<b>Years of experience</b>	1-5 years	40	34.5
	6-11 years	39	33.6
	12-17 years	15	12.9
	18-23 years	11	9.5
	24 years and above	11	9.5
<b>Qualifications</b>	Diploma in nursing	94	81.0
	Bachelor in nursing	18	15.5
	Masters in nursing	4	3.4
<b>Work setting</b>	Acute-ward	94	81.0
	Outpatient	22	19.0
<b>Work shift</b>	Day shift	55	47.4
	Night shift	19	16.4
	Rotating shift	42	36.2
<b>Average weekly working hours</b>	less than 30 hours	5	4.3
	30-40 hours	78	67.2
	41-50 hours	28	24.1
	more than 50 hours	5	4.3

Source: Author, 2025

**Responses to perceived stress**

The findings from the Perceived Stress Scale indicate that psychiatric nurses commonly experience moderate levels of stress, with many frequently encountering emotionally demanding situations, nervousness, and feelings of being overwhelmed. Although several nurses demonstrated positive coping mechanisms and confidence in handling personal challenges, many still reported difficulties managing workload, emotional irritation, anger, and accumulating pressures. Additionally, a large proportion frequently thought about pending tasks and responsibilities, suggesting ongoing mental strain despite efforts to maintain emotional control and effective time management (Table 2)



*Table 2: Responses on Perceived stress scale*

Factors	1	2	3	4	5
1	7 (6.0)	8 (6.9)	65 (56)	22(19)	14(12.1)
2	13(11.2)	24(20.7)	43(37.1)	29(25.0)	7 (6.0)
3	6(5.3)	12(10.3)	47(40.5)	33(28.4)	18(15.5)
4	27(23.3)	42(36.2)	36(31.0)	10(8.6)	1(0.9)
5	36(31.0)	42(36.2)	31(26.7)	6(5.2)	1(0.9)
6	44(37.9)	50(43.1)	17(14.7)	4(3.4)	1(0.9)
7	22(19.0)	40(34.5)	42(36.2)	10(8.6)	2(1.7)
8	4(3.4)	23(19.8)	45(38.8)	31(26.7)	13(11.2)
9	23(19.8)	48(41.4)	36(31.0)	7(6.0)	2(1.7)
10	14(12.1)	36(31.0)	42 (36.2)	15(12.9)	9(7.8)
11	4(3.4)	19(16.4)	45(38.8)	37(31.9)	11(9.5)
12	1(0.9)	9 (7.8)	23(19.8)	39(33.6)	44(37.9)
13	35(21.6)	49(42.2)	31(26.7)	9(7.8)	2(2.17)
14	10(8.6)	15(12.9)	48(41.4)	28(24.1)	15(12.9)

Source: Author, 2025

**Levels of perceived stress among psychiatric nurses**

The study assessed perceived stress levels among psychiatric nurses at Mathari National Teaching and Referral Hospital in Nairobi County, Kenya, using the PSS. The findings are presented in table 3. Perceived stress levels are categorised as 0-18 for low, 19-37 for moderate, and 38-56 for high. The findings of this study show moderate stress levels for most respondents (96, 82.8%), followed by respondents with low perceived stress levels (17, 14.7%), and finally respondents with high stress levels (3, 2.6%), as shown in Table 22. This finding suggests that the perceived work stress for the psychiatric nurses was moderate for more than 80% of the sample size, followed by 14.7% of the low perceived stress and a very low number of respondents with high perceived stress (2.6%).

*Table 3 Levels of perceived stress*

Levels of stress	Frequency	Valid Percent
Low stress (0-18)	17	14.7
Moderate stress (19-37)	96	82.8
High stress (38-56)	3	2.6
Total	116	100.0

Source: Author, 2025

**Factors Contributing to Perceived Stress**

The study also examined the factors contributing to perceived stress among psychiatric nursing professionals at Mathari National Teaching and Referral Hospital in Nairobi County, Kenya

The findings of the study are presented in Table 4. On age and stress levels, the distribution of stress levels across age categories showed that most respondents in all age groups experienced moderate to high stress. Nurses aged 25–34 years constituted the largest group, with the majority reporting moderate or high stress. However, the chi-square test indicated no statistically significant association between age and stress levels ( $\chi^2 = 7.348$ ,  $df = 8$ ,  $p = 0.5$ ), suggesting that perceived stress was similarly distributed across age groups. On the basis of gender, among male nurses, stress was predominantly moderate to high, while female nurses also largely reported moderate and high stress levels. The association between gender and stress levels was not statistically significant ( $\chi^2 = 1.922$ ,  $df = 2$ ,  $p = 0.383$ ), indicating that stress levels did not differ meaningfully between male and female nurses. Based on the religion of the Respondents, both Christian and Muslim respondents primarily reported moderate and high stress levels. The chi-square analysis showed no significant association between religious affiliation and perceived stress ( $\chi^2 = 1.292$ ,  $df = 2$ ,  $p = 0.524$ ), suggesting that religion did not



influence stress levels in this sample. Marital status showed a statistically nonsignificant association with stress levels ( $\chi^2 = 9.070$ ,  $df = 6$ ,  $p < .170$ ). Married nurses were more likely to report high stress compared to other marital groups, while single nurses were more concentrated in the moderate stress category. Divorced and widowed respondents were few in number but showed varying stress patterns. This finding suggests that marital status may play a role in shaping perceived stress among nurses, though not significantly. Across all experience categories, most respondents reported moderate to high stress. However, the chi-square test revealed no significant association between years of working experience and stress levels ( $\chi^2 = 8.268$ ,  $df = 8$ ,  $p = 0.408$ ), indicating that stress levels were relatively consistent regardless of length of professional experience. Diploma, bachelor's, and master's degree holders all demonstrated similar distributions of stress levels, with moderate and high stress predominating. The association between academic qualification and stress was not statistically significant ( $\chi^2 = 2.234$ ,  $df = 4$ ,  $p = 0.693$ ), suggesting that educational level did not significantly influence perceived stress. Nurses working in acute wards and outpatient settings both predominantly reported moderate to high stress. The association between work setting and stress levels was not statistically significant ( $\chi^2 = 3.124$ ,  $df = 2$ ,  $p = 0.210$ ), indicating that stress levels were comparable across clinical settings. Stress distributions were similar across day, night, and rotating shifts, with most nurses reporting moderate or high stress. The chi-square analysis showed no significant association between shift type and stress levels ( $\chi^2 = 1.447$ ,  $df = 4$ ,  $p = 0.836$ ). Regardless of weekly working hours, the majority of nurses experienced moderate to high stress. The chi-square test indicated no statistically significant association between average weekly working hours and stress levels ( $\chi^2 = 1.415$ ,  $df = 6$ ,  $p = .965$ ).

In summary, findings of the association between various demographic and work-related characteristics and the levels of perceived stress among psychiatric nurses revealed no statistically significant associations with stress levels ( $p > 0.05$  across all tests), indicating that none of the examined factors had a measurable influence on whether nurses reported low, moderate, or high stress.



Table 4 Chi- Square table

Demographic factors	Stress Levels			Total	X <sup>2</sup>	df	Sig
	Low stress	Moderate stress	High Stress				
<b>Age</b>	25-34 years	1	5	0	7.348	8	0.500
	35-44 years	3	42	1			
	45-54 years	7	25	0			
	55 and above	4	14	1			
	under 25 years	2	10	1			
<b>Gender</b>	Male	2	26	1	1.922	2	0.383
	Female	15	70	2			
<b>Religion</b>	Christian	15	91	3	1.293	2	0.524
	Muslim	2	5	0			
<b>Marital Status</b>	Divorced	2	33	1	9.070	6	0.170
	Married	13	60	2			
	Single	1	0	0			
	Widowed	1	3	0			
<b>Years of working experience</b>	1-5 years	3	36	1	8.268	8	0.408
	6-11 years	8	31	0			
	12-17 years	2	12	1			
	18-23 years	3	8	0			
	> 24 yrs	1	9	1			
<b>Qualifications</b>	Diploma	4	14	0	2.234	4	0.693
	Bachelor	13	78	3			
	Masters	0	4	0			
<b>Settings</b>	acute-ward	16	75	3	3.124	2	0.210
	outpatient	1	21	0			
<b>Shift Type</b>	Day shift	7	46	2	1.447	4	0.4836
	Night shift	4	15	0			
	Rotating shift	6	35	1			
<b>Average weekly working hours</b>	< 30 hours	0	5	0	1.415	6	0.965
	30-40 hours	12	64	2			
	41-50 hours	4	23	1			
	> 50 hours	1	4	0			

Source: Author, 2025

**Discussion**

The present study found that the majority of psychiatric nurses experienced moderate levels of stress. These findings suggest that perceived stress is highly prevalent among psychiatric nursing professionals in this setting, although extreme stress levels were less common.

These results are consistent with existing empirical evidence indicating that nursing is a highly stressful profession, particularly within psychiatric and mental health facilities. Multiple studies report that moderate stress levels are the most common among nurses globally. For instance, Sarafis et al. (2016) found that moderate perceived stress predominated among Greek general nurses, attributing this to workload pressures, emotional demands, and patient acuity. Similarly, a study in Ethiopia by Dagget et al. (2016) reported a high prevalence of moderate stress among mental health



nurses, noting that constant exposure to aggressive patients and emotionally charged interactions contributed to this burden. A study conducted in Jordan employed a descriptive, cross-sectional, predictive design with a sample of 140 psychiatric nurses, reporting a mean perceived stress score of 22.73 (SD = 3.54), indicating a moderate level (Hamaideh et al., 2025).

The findings also align with earlier work by McTiernan and McDonald (2015), who demonstrated that psychiatric nurses experience substantial emotional strain. As in the current study, they noted that high stress levels occur, but typically in smaller proportions. However, the relatively low proportion of high stress (1.7%) in the present study appears lower than that reported in some international studies. For example, Manomenidis et al. (2017) found that a significant proportion of mental health nurses experienced high levels of stress. The comparatively lower prevalence of high stress in this study may reflect contextual factors such as nurses' coping resilience, familiarity with the demands of psychiatric care, or the availability of informal peer support mechanisms. Additionally, cultural differences in stress-reporting and institutional support structures could explain these discrepancies.

Another explanation is methodological: variations in PSS cut-off interpretation, sample characteristics, or data collection periods can produce different stress distributions across studies. For example, Cohen and Williamson (1988) emphasise that PSS scores exhibit contextual variability and should be interpreted within the specific occupational and cultural environment in which they are assessed.

The findings confirm that moderate stress is the dominant pattern among psychiatric nurses, a trend widely reported across global studies. However, the unusually low rate of high stress in this study suggests a need for further qualitative exploration to determine whether nurses have developed adaptive coping strategies, whether organisational buffers exist, or whether underreporting could have played a role. No study has reported high stress levels.

The present study finds that demographic or work-related factors were not statistically significant ( $p > 0.05$ ). This indicates that age, gender, religion, marital status, years of experience, academic qualifications, work setting, and shift type did not significantly influence nurses' stress levels (low, moderate, or high). Across all categories, most nurses fell within the moderate stress range, mirroring the earlier descriptive findings.

Age was not significantly associated with stress. This finding aligns with a study that found stress levels to be stable across age groups, particularly in highly structured healthcare environments where job tasks are similar regardless of age (Sarafis et al., 2016). However, findings made by Kołodziej et al. (2025) showed that perceived stress increased with age, length of service in psychiatric wards, and overall work experience. This trend may reflect the cumulative impact of prolonged exposure to emotional strain, gradual depletion of psychological resources, and limited opportunities for recovery. These results align with the findings of Eita and Alhalawany, who also observed a positive relationship between years of work experience and perceived stress among psychiatric nurses. Conversely, other studies indicate that younger nurses tend to report higher stress due to limited experience (Moustaka & Constantinidis, 2010). The absence of such patterns here may be due to strong peer support or standardised clinical demands across age categories in the psychiatric setting.

The lack of association between gender and stress level suggests that male and female psychiatric nurses experienced comparable stress. This corresponds with studies showing that occupational stress in nursing is more strongly influenced by work demands than by gender identity (Sveinsdóttir et al., 2006; Labrague et al., 2018). However, some studies have reported higher stress among female nurses due to dual work-family responsibilities (Carvalho et al., 2018), making the current finding somewhat divergent. This is consistent with a study by Kołodziej et al. (2025), which found that perceived stress



was significantly higher among women than among men. Contrary to these two findings on high perceived stress among females (Krausz et al., 2000), a study comparing male and female nurses working in psychiatric units showed that male nurses experienced a higher degree of emotional exhaustion. They viewed that male nurses had less coping ability than female nurses. However, the uniformity in stress levels within this facility may reflect shared workplace exposures that overshadow gender-based differences.

The findings also showed no significant relationship between religion and stress. Past research suggests that religious involvement can buffer stress through meaning-making and emotional support (Pargament, 2011). Yet in this study, both Christians and Muslims reported similar stress levels. This could be due to limited institutional integration of spiritual coping resources, thereby making religious affiliation less impactful in relation to workplace stressors.

In this study, marital status demonstrated a statistically nonsignificant association with perceived stress levels among psychiatric nurses. This finding suggests that the social context of marriage may not strongly influence how stress is experienced among healthcare professionals. Several mechanisms may underlie this association. It is known that married individuals often juggle multiple roles, including family caregiving, parenting, and professional commitments, which can compound daily stressors and elevate perceived stress. Family responsibilities and the emotional labour involved in maintaining household stability may also intensify stress perceptions among married workers (McTiernan & McDonald, 2015).

This study aligns with other studies, such as a study of healthcare workers in India, in which marital status was not significantly associated with perceived stress, even though married individuals showed higher percentages of stress (Gulavani & Shinde, 2014). Likewise, research among medical technologists found no statistically significant effect of marital status on stress levels, despite descriptive differences in stress prevalence between married and single respondents (Mosadeghrad, 2014). Moreover, this finding reflects those of McTiernan and McDonald (2015), who argued that workplace demands in psychiatric nursing in cases such as patient management, emotional labour, and role strain; often outweigh family-related influences on stress. Moreover, broader psychological research indicates that marriage can be protective against stress and depressive symptoms in some populations. Twin studies suggest that marriage may buffer genetic influences on stress and depressive psychopathology, consistent with the idea that spousal support can diminish the impact of stress (Robles et al., 2014). Conversely, the complexity of marital relationships means that in some circumstances, marital demands may increase environmental stress effects even while reducing other risk factors (Beam et al., 2017).

On the contrary, some previous studies provide evidence showing that married healthcare workers can exhibit higher stress levels compared to their unmarried counterparts. For example, a comparative analysis of nurses reported that married staff nurses experienced higher levels of stress than unmarried nurses, suggesting that marital obligations may amplify work-related stress (Al-Aameri, 2003; Lambert et al., 2004). Similarly, studies conducted during pandemic contexts observed that married healthcare workers tended to report greater psychological distress, with some evidence indicating that marriage and family demands contributed to stress reactions under high workload conditions (Mehta et al., 2022). Also, studies have reported significantly higher ( $p < 0.005$ ) perceived stress levels among nurses (Kolodziel et al., 2025). However, the literature on marital status and stress is not unequivocal. The significant association between marital status and perceived stress in this study suggests that marital obligations may not constitute an important psychosocial factor



influencing stress levels among psychiatric nurses at Mathari National Teaching and Referral Hospital.

The absence of a relationship between years of experience and stress mirrors research showing that prolonged exposure to psychiatric work may normalise stress responses rather than eliminate stressors (Hamaideh, 2012). In agreement, Ho et al. (2014) explained that nurses with 6 - 10 years of experience have a higher level of job stress than nurses with less than 5 years or more than 11 years' experience. Likewise, the finding from Yada and colleagues (2017) recognised that middle aged nurses i.e. with 6 - 10 years' experience are given full accountabilities at work, and many roles during this phase clarify why middle-aged nurses experience job stress more often. Some studies have found that more experienced nurses manage stress more effectively (Adriaenssens et al., 2015), but the current findings suggest that psychiatric environments may exert similar pressures on novices and veterans alike. Academic qualifications also showed no significant association with stress. This aligns with findings from Khamisa et al. (2015), who argue that higher education does not necessarily mitigate stress, as clinical realities, workload, and patient acuity remain equally challenging for diploma-, bachelor-, and master-trained nurses. However, a study by Kołodziej et al. (2025) established that perceived stress was significantly less among those with higher degrees. No significant relationship was found between work setting and stress, indicating that nurses in acute wards and outpatient departments experienced comparable stress. This is somewhat inconsistent with the literature showing that acute psychiatric wards often exhibit higher emotional strain due to increased patient aggression and unpredictability (Bowers et al., 2011). The uniformity observed in this study may reflect organisational factors such as staffing, safety protocols, or teamwork, mitigating differences between departments. Finally, shift type (day, night, or rotating) was not significantly associated with stress. This differs from studies that highlight night and rotating shifts as major stressors due to circadian rhythm disruption (McDowall et al., 2017; Nena et al., 2018). The absence of such effects may suggest effective shift rotation policies or cultural adaptation to shift work at this institution.

The study was limited by a small sample size, the use of a single psychiatric hospital, and reliance on self-report questionnaires, which may have introduced bias and limited generalizability. The quantitative design also excluded subjective experiences. However, standardised tools and statistical controls were used to reduce these limitations.

### **Conclusion**

It can be concluded that most psychiatric nurses reported moderate stress levels, followed by a few reporting high perceived stress levels and others low perceived stress levels. This suggests that while stress is widespread, it may not be extreme in intensity. The uniformity in the distribution of perceived moderate and high stress reflects the demanding nature of psychiatric nursing, but also suggests a degree of adaptation or resilience within the workforce.

This study recommends that the uniformity of moderate stress reflects the demanding nature of psychiatric nursing, but also suggests a degree of adaptation or resilience within the workforce. In addition, on the demographic factors, it was notable that stress arises primarily from the nature of psychiatric nursing itself rather than personal or background factors. Hence, more emphasis should be placed on the practice rather than background factors.

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