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INFLUENCE OF HEALTH EDUCATION ON STRESS MANAGEMENT SKILLS AMONG NIGERIAN UNDERGRADUATES: EVIDENCE FROM BABCOCK UNIVERSITY

*Kio JO[1], Akinboye DO[2], Olayinka EF[3] and Omeonu PE[2]
[1]Department of Nursing Science, Babcock University
[2]Department of Public Health, Babcock University, Nigeria
[3]Department of Medicine, Obafemi Awolowo University, Nigeria

ABSTRACT

The present study assessed the influence of health education on stress management among undergraduates in Nigeria, focusing on Babcock University. Selected students were stratified into control and experimental groups with 50 participants in each group. Descriptive factors examined included age, gender, religion and marital status. Also, the respondents were classed into different stress personality types using standardized Emotional Stress Inventory Questionnaire. Students in the experimental group were exposed to health education intervention and their responses to Standardized Stress Behaviour Inventory Questionnaire (SSBIQ) at baseline were compared to endline report and the response from the control group using t-test at $p<0.05$. The majorities of the respondents (78%) were less than 20 years old, female (54%), single (96%), belong to the Yoruba ethnic group (56%) and are Christians (91%). Also, at baseline 60% and 58% of the respondents belonged to the high stress level personality type A in the control and experimental groups respectively. At post-intervention, the health education had significantly influenced the behaviour of the students in the experimental group as measured by SSBIQ. Furthermore, frequency of stress type A reduced to 46%. Policies and programmes geared towards enhancing effective stress coping strategies should be put in place by appropriate educational ministries and by the University administration.

Keywords: Nigeria, health education, stress management, personality type, undergraduate.

INTRODUCTION

Stress has been defined as a condition or feeling that a person experiences when they perceive that the demands exceed the personal and social resources the individual is able to mobilize (Davis and Robin, 2000). For most people, stress is a negative experience. Stress may cause physiological, behavioral or even psychological effects (Chandra and Batada, 2006). Stress can cause serious ill health or diminish resistance to sickness (Akinboye *et al.,* 2012). Stress characterises individuals to different personality types. Personality types are a collection of personality traits which are believed to occur together consistently, especially as determined by a certain pattern of response to a personality inventory. This personality trait predisposes an individual to behave in a fairly broad and consistent pattern (Tan and Winkelman, 2012). Several past studies have shown that stress can occur in educational institutions among students (Sayiner, 2006; Kio *et al.,* 2015) however, students do not seek help because of the stigma attached to mental illness (Meglio, 2012).

*Corresponding author e-mail: akindan15ster@gmail.com

According to Kio *et al*. (2015) and Seeley *et al*. (2005), stress may be induced when the body prepares to fight or flee from an imposing danger, when there is a change of routine or following an emotional upheaval or pressure (distress). Stress therefore could be mild or moderate or may not even be observed (Huether and McCance, 2009). However, without adequate coping strategies or management, stress conditions can be aggravated and serious physiological disturbance may occur (Seltzer and Bare, 2008; Kio *et al*., 2015). In literature, stress has been recognised as an inevitable aspect of life, but what makes the difference in human functioning is how people cope with it (Kim and Duda, 2003). Another study, Folkman (2005) added that most people are able to maintain reasonable health and functioning under stressful conditions. There are several stressors in students' lives which may lead to stressful situations and in turn may affect their personality types and behaviours. In accessing stressors, a planning process has been suggested by the Academic Skills Center (ASC, 2010) which include identifying source of stress; listing and prioritizing the sources of stress; identifying appropriate stress management techniques and finally, creating a stress management plan.

Stress Management

It has been established, as a planned method, to influence and/or change the attitude and behaviour of individuals and communities by increasing their knowledge and understanding of health and disease (Akinsola, 2006). Stress management can be learned through exposure to well designed health education (Kio *et al*., 2015). The focus of health education intervention would be to develop a holistic health programme that would bring about changes of attitudes and behaviours for good health to designated respondents. Tantayati *et al*. (2005) stated that stress is usually defined from a demand perception. This refers to response to stressor in the environment. These authors therefore, integrated this view into a cognitive theory of stress that has become the most widely applied theory in the study of stress and coping styles. Cognitive Theory is a learning theory of psychology that attempts to explain human behaviour by understanding the thought processes. The assumption is that humans are logical beings capable of making the choices that make the most sense to them (Fritscher, 2011).

Chandra and Batada (2006) reported that stress can have a significant effect on a young adult and adolescent's long-term physical and mental well-being. An understanding of the role of managed stress during early adolescence is critical for the prevention of chronic diseases such as depression later in life. The clamour for University education and the determination of students to achieve set goals are bound to be stressful (Ahsan *et al*., 2009). In a recent study Eweniyi (2009) has established the nexus between stress management skills development and University students' academic behaviour. His study recommended that stress management skills training should be given prominence in the Universities' guidance and counselling programmes, while concerned authorities should endeavour to provide facilities that may help to reduce the risk of academic stress.

Since response to stress affects personality types as well as academic behaviour of students (Chandra and Batada, 2006; Hall and College, 2012), an understanding of the role of managed stress during early adolescence is critical for prevention of negative personality behaviours and chronic diseases such as depression in later life. It is against this backdrop that this study evaluated the effects of Health Education Intervention Programme on stress reduction skills based on personality types among two hundred level students of Babcock University.

Theoretical Framework

Transactional Model

Stress has been conceptualised in various ways, but the most comprehensive theoretical framework proposed to date is the transactional model put forth by Lazarus and Folkman (1984). This model is built on the assumption that stress depends on a number of subjective cognitive judgments of the students based on their stress reduction skills of their personality types, which arise from the dynamic interplay between the person and the environment. Appraisals also address judgments of resource available to the individual, such as coping strategies and the degree of control he or she perceives to have in meeting the demands of the situation (Zakowski *et al*., 2001). Stress does not affect all people equally, but stress can lead to illness and negative experiences. Coping with stress is therefore an important factor; it affects how people search for medical care and social support and how they believe the advice of the professionals.

It was earlier reported that stress was considered to be a transactional phenomenon dependent on the meaning of the stimulus to the perceiver (Glanz *et al*., 2008). The Transactional Model of stress and coping as used in this study is consistent with previous studies on health education, health promotion and disease prevention (Glanz *et al*., 2008; Eweniyi, 2009).

Transactional model construed stressful experiences as person-environment transactions, in which the impact of an external stressor or demand is mediated by the person's appraisal of the stressor and the psychological, social and cultural resources at his or her disposal (Glanz *et al*., 2008). The approach to processing of this transactional model can be based on the following assumptions, which reflects the physical and behavioural science perceptiveness: Primary Appraisal, Secondary Appraisal, Coping efforts, Meaning-based coping, Outcome of coping adaptation and Moderators, (Dispositional coping style and social support), Optimism (Glanz *et al*., 2008). The health education intervention programme (as used in this study) exposed the participants to a planned programme to help them manage their coping strategies based on personality types. This intervention programme stimulated the students to use these coping strategies they have learnt to reduce or modify their stressors based on personality types.

MATERIALS AND METHODS

Description of the Population

The study was carried out in Babcock University, Ogun State, Nigeria. Babcock University received approval to run as one of the first private Universities in the Federal Republic of Nigeria in 1999 with a major objective to improve on the learning environment offered for University education without jeopardising quality delivery. The University is located in Ilishan-Remo which sixty-eight (68) kilometres, north/west of Lagos, 60 kilometres to Abeokuta, the Capital of Ogun State and 60 kilometres south/west of Ibadan. Thus, the school is well accessible to the major cities in South-West Nigeria.

The multi-stage sampling was employed to select 100 participants especially among the second year students (with relatively the same workload) across 5 out of the 9 schools in the University. The selected students were stratified into experimental (50 students) and control (50 students) groups. Special care was maintained (isolating control group from experimental group) throughout the experiment to avoid contamination. Table 1 shows the distribution of participants by the selected schools.

Ethical clearance was obtained from the Ethical Review Committee, Federal Medical Centre Abeokuta, Ogun State and consent forms were filled by all participants. Data gathered were subjected to descriptive and inferential analysis and presented in distribution tables.

Data Collection Instruments

The instruments used to obtain data were the Emotional Stress Inventory Questionnaire (ESIQ) and the Standardised Stress Behaviour Inventory Questionnaire (SSBIQ), which were developed by Akinboye *et al.* (2002). These instruments were reviewed and adapted for the study by permission from the authors. They had been previously tested and validated to ensure reliability.

The health education intervention procedure

The Health Education Intervention Programme on Stress Reduction Skills (HEIPSRS) was offered to the experimental group, while the control group was isolated. The health education intervention programme lasted for six weeks; each session lasted for 40 minutes. The stress behaviour inventory questionnaire (SSBIQ) was administered as post-test both to the experimental group and the control group after six weeks of the intervention.

The method of instruction consisted of three methods, namely: lecture method, group discussion and group dynamic. The 50 participants were lectured collectively

Table 1. Schools and distribution of participants.

Schools	**Code**	**Number of participants**	
		Experimental	Control
Babcock Business School	BBS	16	15
Basic and Applied Sciences	BAS	9	7
Computing and Engineering Sciences	BCE	10	11
Education and Humanities	BEH	7	8
Public and Allied Health	BPH	8	9
Total		50	50

Table 2. Distribution of demographic characteristics of the participants

VARIABLES	Experimental (N=50)		Control (N=50)	
	Frequency	Percent %	Frequency	Percent %
Age distribution:				
< 20	34	68.0	39	78.0
21-30	13	26.0	10	20.0
> 30	3	6.0	1	2.0
Gender:				
Male	24	48.0	23	46.0
Female	26	52.0	27	54.0
Ethnic group:				
Yoruba	28	56.0	30	60.0
Igbo	13	26.0	11	22.0
Hausa	2	4.0	7	14.0
Other languages	7	14.0	2	4.0
Religion:				
Christian	46	92.0	45	90.0
Islam	4	8.0	5	10.0
Marital status:				
Single	48	96.0	47	94.0
Married	2	4.0	3	6.0

(Source: Computed from field survey, 2013).

on specific topics on stress management. At different times the participants were divided into smaller groups of ten each. Each group had a leader and a recording secretary. The topics included stress overview, emotional control, developing coping strategies, how to adapt personality types and stress reduction skills. Each of the groups reported salient points to the larger group. They also pointed out other things they had learnt and how they would implement those stress reduction skills in their daily lives. At other times the group members were rotated and allowed to generate discussions on specific issues related to stress which they had deduced from the health education intervention programme. Examples were: lf to various competences. Each group was mandated to report back to

Methods of Data Analysis

Scores were assigned according to the responses selected in the instruments filled. The t-test was used to determine the significant differences in stress management behaviour of the experimental group and control group before and after the experiment. All data were analyzed using Statistical Package for Social Sciences (SPSS) version 17 and set at 5% level of significance ($p \leq 0.05$).

RESULTS AND DISCUSSION

Demographic Characteristics of the Participants

Results in table 2 shows that, for both experimental and control groups, the majority of the respondents were less than 20 years of age and are composed of slightly more female than the male. The result further showed that most of the respondents (both groups) are single, are from the Yoruba ethnic group and largely Christians. The similarities in the descriptive results of the two groups are of good fit especially for an experimental study.

Results of Intervention

The SSBIQ was administered to the respondents in both the control and experimental groups prior to the conduction of the heath education intervention programme and re-administered to the experimental group at post-intervention. The differences in response to set statements (Table 3) were tested for statistical significance. The results are presented in tables 4 and 5.

Results in table 4 shows no significance difference in the responses of the respondents in both the control and experimental groups to the statements in SSBIQ. This is consistent with *a priori* expectation since the descriptive results revealed similarities between the two groups. At post-intervention, there were significant differences in the mean response of the experimental and control groups to statements Q2, Q4, Q12, Q22 and Q27 at $p<0.05$ or less. This difference can be attributed to the effect of the health education intervention.

Table 3. Standardized Stress Behaviour Inventory Questionnaire (SSBIQ) Statements.

S. No.	Statements
Q1	I am terribly impatient with slow speakers.
Q2	I am aggressive when arguing a point.
Q3	I am driven by excessive competitive force when seeking for promotions.
Q4	I strongly feel time is money
Q5	I am forced to struggle with others, if they want to cheat me.
Q6	Sometimes I feel I am struggling with myself.
Q7	At times circumstances of life confuse me.
Q8	Time waits for nobody is my opinion
Q9	Life is a struggle
Q10	If a person annoys me, I show hostility.
Q11	At times I am a victim of inferiority feelings.
Q12	I am fond of repeating key words in other people's speech
Q13	I drive very fast when I am late.
Q14	I enjoy eating my favorite food rapidly.
Q15	I feel terribly annoyed when a car stands before me in a hold-up.
Q16	I hate standing on line for long in the bank
Q17	I take on more work than I can comfortably do at a time
Q18	I do not like to compete on task in which I will not be the best
Q19	I am definitely one of the people who can change the world for the better
Q20	I do not care if my life is short as long as I succeed within the short period.
Q21	One can forgo his or her holiday to compete for an important task.
Q22	Early to rise and late to sleep is a good policy for successful persons.
Q23	I do not care what people feel about my working too hard, I have no choice.
Q24	I hate boring conversations.
Q25	I like to do many things at the same time.
Q26	Relaxation is a waste of time.
Q27	I feel my success is due to my good intelligence to do things quickly.
Q28	I talk to others only on things that interest me

(Source: Computed from field survey, 2013).

Results of the Analysis of Personality Types

The scores for classifying personality types were calculated following Akinboye *et al*. (2002) and Kio *et al*. (2015). The personality Type A ranged greater than or equal to 77 % of the maximum point of score on scale of measure; personality Type B ranged between 49% and 76%; personality Type C ranged between 14 and 48% while, personality Type D ranged less than or equal to 13%.

Table 4. Comparing Experimental and Control groups for stress behaviour statements at pre-intervention.

Items	Groups	Mean	Std. Dev	Std. Error Mean	t-ratio	Sig. (2-tailed)
Q1	Ex-control	.385	1.609	.446	0.862	0.406
Q2	Ex-control	-.077	1.498	.415	-0.185	0.856
Q3	Ex-control	-.077	1.605	.445	-0.173	0.866
Q4	Ex-control	.462	1.561	.433	1.066	0.307
Q5	Ex-control	.615	1.805	.500	1.230	0.242
Q6	Ex-control	-.385	1.805	.500	-0.768	0.457
Q7	Ex-control	-.769	1.833	.508	-1.513	0.156
Q8	Ex-control	.077	2.397	.665	0.116	0.910
Q9	Ex-control	.923	1.656	.459	2.009	0.068
Q10	Ex-control	.077	1.801	.500	0.154	0.880
Q11	Ex-control	-.462	1.127	.312	-1.477	0.165
Q12	Ex-control	-.538	1.761	.489	-1.102	0.292
Q13	Ex-control	.231	1.536	.426	0.542	0.598
Q14	Ex-control	.385	2.329	.646	0.595	0.563
Q15	Ex-control	-.462	2.025	.562	-0.822	0.427
Q16	Ex-control	.000	2.121	.588	0.000	1.000
Q17	Ex-control	.615	1.557	.432	1.425	0.180
Q18	Ex-control	.846	1.573	.436	1.939	0.076
Q19	Ex-control	-.692	1.182	.328	-2.112	0.056
Q20	Ex-control	.308	1.797	.499	0.617	0.549
Q21	Ex-control	-.769	1.641	.455	-1.690	0.117
Q22	Ex-control	.385	1.850	.513	0.750	0.468
Q23	Ex-control	.077	1.382	.383	0.201	0.844
Q24	Ex-control	-.154	1.519	.421	-0.365	0.721
Q25	Ex-control	-462	1.561	.433	-1.066	0.307
Q26	Ex-control	.615	1.387	.385	1.600	0.136
Q27	Ex-control	.385	1.193	.331	1.162	0.268
Q28	Ex-control	.462	1.664	.462	1.000	0.337

(Source: Computed from field survey, 2013)

From table 6, at pre-intervention, the majority of the respondents, both in the control (60%) and experimental (58%) groups, belonged to personality type A followed by type B and type C. There were no students belonging to the personality type D. This is consistent with previous studies that the personality type A and B are the most common and that personality type C and D are rarely found in colleges (Friedman and Roseman, 1994; Yasmine, 2010; Lala, 2010; Kanade, 2011). At post intervention, there were no changes in the personality type distribution for the control group however, in the experimental group, the respondents in personality type A reduced while those in personality type B increased. This may be adduced to overall gain in stress coping behaviour among the students in the experimental group as a result of the intervention. The intervention programme laid credence to the suggestions of Campbell *et al*. (2012) who suggested health education intervention programmes are needed to assist the students in coping with the stress they experience.

CONCLUSION AND RECOMMENDATIONS

This study assessed the influence of health education on stress management among undergraduates in Nigeria, specially focusing on Babcock University as case study. One hundred students were selected from 5 out of the 6 schools in the University to participate in the study. These students were further stratified into control and experimental groups with 50 participants in each group. The demographic factors examined in this study include age, gender and religion affiliation and marital status of the respondents. Also, the respondents were classed into different stress personality types using the previously standardized Emotional Stress Inventory Questionnaire (ESIQ). Students in the experimental group were exposed to health education package designed by the researcher and their responses to Standardised Stress Behaviour Inventory Questionnaire (SSBIQ) at baseline were compared to end line report and the response from the control group. Based on the results, the high numbers of

Table 5. Comparing Experimental and Control groups for stress behaviour statements at post intervention.

Items	Groups	Mean	Std. Dev	Std. Error Mean	t-ratio	Sig. (2-tailed)
Q1	Ex-control	-.565	1.996	.416	-1.358	0.188
Q2	Ex-control	.826	1.614	.337	2.455*	0.022
Q3	Ex-control	-.261	1.789	.373	-0.699	0.492
Q4	Ex-control	.870	1.740	.363	2.397*	0.025
Q5	Ex-control	.739	1.888	.394	1.877	0.074
Q6	Ex-control	-.304	1.690	.352	-0.863	0.397
Q7	Ex-control	.478	1.904	.397	1.205	0.241
Q8	Ex-control	-.043	1.224	.255	-0.170	0.860
Q9	Ex-control	.478	2.172	.453	1.056	0.302
Q10	Ex-control	.087	2.043	.426	0.204	0.840
Q11	Ex-control	.304	2.077	.433	0.703	0.490
Q12	Ex-control	-.652	1.465	.305	-2.135*	0.044
Q13	Ex-control	.783	2.044	.426	1.836	0.080
Q14	Ex-control	.478	1.928	.402	1.190	0.247
Q15	Ex-control	.304	1.917	.400	0.761	0.455
Q16	Ex-control	.435	1.562	.326	1.335	0.195
Q17	Ex-control	.391	1.924	.401	0.975	0.340
Q18	Ex-control	.522	2.020	.421	1.239	0.228
Q19	Ex-control	.304	1.820	.379	0.802	0.431
Q20	Ex-control	.348	1.722	.359	0.969	0.343
Q21	Ex-control	.696	1.845	.385	1.808	0.084
Q22	Ex-control	1.130	1.546	.322	3.506*	0.002
Q23	Ex-control	.348	2.036	.425	0.819	0.421
Q24	Ex-control	.652	1.613	.336	1.939	0.065
Q25	Ex-control	-.087	1.311	.273	-0.318	0.753
Q26	Ex-control	.217	2.066	.431	0.505	0.619
Q27	Ex-control	.826	1.826	.381	2.170*	0.041
Q28	Ex-control	.348	1.668	.348	1.000	0.328

(Source: Computed from field survey, 2013).

Table 6. Analysis of personality types before and after the experiment.

Personality type	**Control group**		**Experimental group**	
	Pre-intervention	Post-intervention	Pre-intervention	Post-intervention
Type A	30 (60%)	30 (60%)	29 (58%)	23 (46%)
Type B	19 (38%)	19 (38%)	18 (36%)	23 (46%)
Type C	1(2%)	1(2%)	3 (6%)	4 (8%)
Type D	-	-	-	-

(Source: Computed from field survey, 2013)

individuals belonging to the high stress level of the personality type A suggests vulnerability to the "fight or flight" response pattern and susceptibility to stress related illnesses among the study population. The health education intervention significantly influenced the behaviour of the students positively with respect to stress management. Policies and programmes geared towards facilitating seminars and workshops enhancing effective stress coping strategies should be included in school calendar as co-curricular activities by appropriate educational ministries and by the University administration.

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