

**Investigating work-life balance
challenges and occupational stress of
nurses in Saudi Arabia: Perspectives of
border management challenges**

**A Thesis Submitted for the
Degree of Doctor of
Philosophy**

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LIST OF ABBREVIATIONS

BMT	Boundary Management Theory
ERI	Effort-Reward Imbalance
GAS	General Adaptation Syndrome
HDI	Human Development Index
HR	Human Resource
ICN	International Council of Nurses
JDC	Job Demand-Control Model
KSA	Kingdom of Saudi Arabia
NHS	National Health Service
SAMA	Saudi Arabian Monetary Agency
SMI	Stress Management Interventions
TA	Thematic Analysis
WHO	World Health Organisation
WLB	Work-life Balance
WLC	Work-life Conflict
IMF	International Monetary Fund

DEDICATION

This thesis is dedicated to the memory of my late father and to my family, in appreciation of their continuous support and encouragement.

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ABSTRACT

Nurses constitute the largest occupational group in the global health workforce, yet the profession remains vulnerable to occupational stress, burnout, and chronic work-life imbalance. While a substantial body of research has examined these phenomena in Western contexts, the lived experiences of nurses in Arab, Islamic, and Middle Eastern settings remain conspicuously undertheorised. This thesis addresses that gap by investigating the work-life balance (WLB) challenges and occupational stress of nurses in the Kingdom of Saudi Arabia (KSA). Guided by three research objectives, the study explores how nurses conceptualise occupational stress and WLB, examines the agency factors that produce boundary management problems, and investigates why cultural and regional peculiarities exacerbate stress and work-life imbalance in this setting.

Grounded in an interpretivist philosophical orientation and adopting a social constructionist epistemology, the study employed an inductive, qualitative research design. Primary data were collected through semi-structured interviews with 70 registered nurses recruited from three hospitals in Mecca — one private specialist hospital and two public general hospitals — using purposive and snowball sampling strategies. Interviews lasted between 45 and 60 minutes, were audio-recorded with consent, and subsequently transcribed using a naturalistic transcription approach. Data were analysed using thematic analysis framework.

The analysis yielded three clusters of findings corresponding to the study's research objectives. First, nurses conceptualised occupational stress across three established theoretical frameworks: as a stimulus (external environmental conditions), as a response (physiological and psychological reactions), and as a transactional interface between demands and individual resources. Four prevalent conceptions of WLB also emerged: as time for family, as attention to personal health, as space for leisure and religious observance, and as access to flexible working arrangements. Second, five agency factors were identified as producing work-life boundary management difficulties: work-home boundary violations arising from the intensity of clinical demands; person-environment incongruence; labour-reward disparities; managerial ignorance of family-friendly policies; and nurses' fears of career damage from utilising WLB entitlements. Third, broader contextual and societal factors, principally masculine hegemony, ingrained Islamic religious norms, and perceptions of preferential treatment and favouritism, were found to constrain nurses' discretionary capacity to construct and maintain satisfactory work-home boundaries.

The findings demonstrate that stress and boundary management are deeply embedded in socially constituted, culturally specific realities; advances border theory through systematic application in an Islamic institutional environment; introduces boundary violation as an analytically distinct phenomenon; and theorises work-life boundary incongruence as a multi-dimensional construct shaped by structural and cultural forces. Practically, the study recommends legislative reform introducing working time protections comparable to global best practices; the development of dedicated WLB functions within hospital HR departments; mandatory training for managers on family-friendly policy implementation; and a wholesome shift toward gender-sensitive, culturally responsive HR practices in Saudi hospitals. The findings challenge policymakers and practitioners to move beyond individual-level coping solutions and address the structural and

cultural determinants of nursing stress and work-life imbalance in the KSA and comparable Middle Eastern contexts.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

The global demand for primary care, community care, and community nursing services continues to intensify in response to far-reaching demographic transformations, including population ageing, rising prevalence of non-communicable diseases, and the growing burden of chronic conditions (World Health Organisation [WHO], 2020; WHO, 2025). The WHO's State of the World's Nursing Report (2025) shared data indicating that nurses constitute the single largest occupational group within the global health workforce, representing an indispensable force in achieving universal health coverage and the health-related Sustainable Development Goals. The global nursing workforce is estimated to have grown from 27.8 million in 2018 to approximately 29.8 million in 2023, with projections suggesting that a figure of 36 million will be required by 2030 to meet escalating healthcare demands (WHO, 2025). Yet, notwithstanding this numerical growth, the nursing profession remains vulnerable to the deleterious effects of work-related stress, burnout, and chronic work-life imbalance threatening both the occupational wellbeing of nurses and the quality and safety of patient care (International Council of Nurses [ICN], 2023; Sipos et al., 2024; Prabhu et al., 2026).

Work-related stress in nursing is widely regarded as a pervasive and multidimensional global occupational health challenge (Abuhammad et al., 2025; Bruza-Augatis et al., 2026). The nursing profession consistently ranks among the most psychologically and physiologically demanding occupations across diverse healthcare systems and cultural contexts (Burgess et al., 2010; Al-Otaibi and Kerari, 2025; Singh et al., 2026). In the United Kingdom, for instance, NHS

nurses are routinely required to work twelve-hour shifts under conditions that restrict access to adequate nutrition, rest, and psychological respite (Farquharson et al., 2013; Dall'Ora et al., 2023). The consequences of such structural stressors are well-documented including reports of diminished psychological and physical health, reduced job satisfaction, escalating sickness absence, elevated staff turnover, and declining organisational commitment (Harkness et al., 2005; Bahlman-van Ooijen et al., 2023; Dall'Ora et al., 2023; Widayana et al., 2025). Whilst stress is recognised as an inevitable feature of professional life, the persistence of unmitigated and excessive stress within nursing environments constitutes a significant concern for healthcare governance, patient safety, and the sustainability of the global workforce (WHO, 2025; ICN, 2023).

The structural vulnerabilities of the nursing profession were brought into stark relief during the COVID-19 pandemic, which began in December 2019 and rapidly escalated into an unprecedented global health emergency (Galanis et al., 2021). During this period, nurses around the world were subjected to extraordinary occupational pressures including protracted shift patterns (Aduni, 2026), severe staffing shortfalls, morally injurious decision-making, exposure to patient mortality, and the psychological burden of working in environments characterised by profound clinical and personal uncertainty (Di Tella et al., 2020; Galanis et al., 2021; Abdel-Azeem et al., 2024). The pandemic also exposed deeply embedded systemic inadequacies, including critical shortages of personal protective equipment, the near-total absence of childcare provision for healthcare workers, inconsistent shift scheduling, and severe financial pressures (Di Tella et al., 2020; Alharbi et al., 2025). Perhaps most disturbingly, evidence emerged of nurses, particularly those from ethnic minority backgrounds, being subjected to harassment, hostility, and bullying from members of the public in connection with their care of COVID-19 patients,

thereby compounding an already overwhelming professional burden (LoGiudice and Bartos, 2021). The ICN (2023) subsequently characterised the post-pandemic nursing workforce situation as a global health emergency, warning that unless decisive systemic action is taken, the projected shortage of nurses will critically impair health systems worldwide.

In the aftermath of the pandemic, empirical attention has increasingly coalesced around the structural and organisational determinants of occupational stress in nursing. The Job Demands-Resources (JD-R) model (Bakker and Demerouti, 2007) provides a well-established theoretical framework through which to understand how excessive job demands, including role overload, role ambiguity, interpersonal conflict, and inadequate autonomy, interact with insufficient job resources to produce burnout, diminished wellbeing, and work-life conflict (Fairbrother and Warn, 2003; Wickramasinghe, 2010). In an epidemiological study of over 8,000 employees drawn from 13 occupational categories in the Eastern region, Barzideh et al. (2014) identified significant statistical associations between occupational stressors and a range of mental health indicators, including anxiety, depression, and addictive behaviours. More recently, a systematic review by Sipos et al. (2024), confirmed that work-life imbalance and emotional exhaustion in healthcare workers not only reduce individual quality of care but generate a cyclical transmission of burnout across successive generations of healthcare professionals. These ongoing issues among others continue to fuel the need for, and importance of work-life balance (WLB) (Hussain et al., 2025; Hsu and Li, 2026)

The concept of WLB has garnered increasing prominence in human resource management and organisational behaviour literatures, particularly as a mechanism through which occupational stress and its attendant consequences may be ameliorated. Felstead et al. (2002, p. 56) define WLB as 'the relationship between the institutional and cultural times and spaces of work and

non-work in societies where income is predominantly generated and distributed through labour markets.' This conceptualisation is notable in its breadth, encompassing the experiences of diverse working adults rather than privileging a single demographic or occupational category. Scholarly and policy debate around WLB emerged primarily in the 1970s and 1980s in the United Kingdom and the United States, substantially anchored in the accelerating participation of women, and particularly mothers, in the labour force and their associated challenges in reconciling employment with the socially ascribed responsibilities of domestic care (Walsh, 2013; Agarwal and Lenka, 2015). However, Clark's (2000) work-life border theory and subsequent contributions have substantially broadened the conceptual frame, reconceptualising WLB as a dynamic negotiation of the frequently permeable and contested boundaries between the domains of paid work and personal life.

The institutional landscape of WLB policy reflects considerable international variation. Sweden has achieved international recognition for constraining the standard working week to thirty hours, with only one percent of employees regularly working excessive hours (Agosti et al., 2017). Similarly, Denmark maintains one of the most favourable WLB profiles in the world, with merely two percent of the workforce engaged in very long working hours (Huber et al., 2011). In the United Kingdom, WLB discourse has progressively transcended its origins as a 'niche' concern limited to working mothers, now firmly embedded within national policy discourse and extending to senior figures in public life, including Members of Parliament, in recognition of the systemic value of WLB for optimal occupational functioning and democratic governance (Weinberg, 2019). Notwithstanding these policy advances, Chandra (2012) has noted a pronounced western-centrism in the extant WLB literature, constituting a significant representational deficit insofar as the lived realities of the vast majority of the world's working

population, situated within Eastern and Middle Eastern societies, remain comparatively under-theorised and empirically under-explored (Bouzzari and Karatepe, 2020).

Eastern societies, in particular, bear the highest burden of excessive working hours. Rajadhyaksha (2012) and Kwase et al. (2013) reported that workers in cities such as Hong Kong, Bombay, Bangkok, New Delhi, and Taipei routinely work among the longest hours of any major urban workforce globally, with Hong Kong workers averaging 50.1 hours per week. These data underscore the urgency of extending WLB research beyond its occidental epistemological roots. It is within this broader scholarly imperative that the present doctoral thesis is situated. Notably, the Kingdom of Saudi Arabia (KSA) is a largely underexplored context for the examination of occupational stress and WLB in nursing. Saudi Arabia has embarked upon a transformative programme of healthcare reform under its Vision 2030 strategic agenda, which seeks to diversify the national economy, expand healthcare capacity, and progressively 'Saudise' the health workforce through the systematic replacement of expatriate labour with Saudi national professionals (Almutairi et al., 2024). This ambitious reform agenda, while generating new opportunities, simultaneously imposes significant structural stressors upon the nursing workforce. The healthcare sector in Saudi Arabia is characterised by rapid expansion of facilities, persistent staff shortages, high patient-to-nurse ratios, and an increasingly complex clinical environment — all of which have been found to contribute to elevated stress and burnout among nursing personnel (Siraj et al., 2023; Alahmari, 2024).

The nursing workforce in Saudi Arabia presents a distinctive socio-demographic profile that amplifies the complexity of occupational stress and WLB dynamics. The workforce is constituted largely by expatriate nurses, primarily from the Philippines, India, and Jordan, who must navigate the compound pressures of acculturative stress, linguistic barriers, socio-cultural

dislocation, and professional isolation alongside the inherent demands of clinical practice (Alahmari, 2024). For Saudi national nurses, particularly women, the intersection of professional obligations and deeply embedded familial and Islamic cultural responsibilities generates distinct and often irreconcilable tensions between the domains of work and home life. AlMuamma et al. (2022) reported that eighty percent of doctors and nurses described symptoms of burnout attributable to excessive patient care demands in Saudi Arabia. Alotaibi and Aldossry (2024) further established that, among working nurse-mothers in Riyadh, approximately seventy-five percent reported significant work-family conflict, manifesting as difficulties in maintaining punctuality, completing daily clinical tasks, and fulfilling overtime obligations due to familial and spousal demands.

Saudi Arabia has also been identified in the empirical literature as a context of high occupational stress for healthcare workers. A cross-sectional study by Almutairi et al. (2024) found a significant prevalence of occupational stress among healthcare providers in Saudi Arabia, linked to factors including high decision-making demands, sustained interpersonal engagement, and the physical exigencies of prolonged shift work. Studies from the COVID-19 period further shed light on the severity of occupational stress in the Saudi healthcare sector. For example, Arafa et al. (2021) found that 37.7 percent of Saudi healthcare workers reported mild to extremely severe levels of occupational stress, while 47.9 percent reported work-related burnout, with rates markedly elevated among frontline nurses. Siraj et al. (2023) corroborated these findings in a national cross-sectional survey, identifying significant associations between burnout, reduced resilience, limited supervisory support, and elevated turnover intentions among Saudi healthcare professionals.

Occupational stress has been extensively theorised as a primary antecedent of work-life imbalance (Wickramasinghe, 2010; Putri et al., 2023; Cukljek et al., 2025). The experience of stress within nursing environments manifests across multiple domains: job overload, role conflict and ambiguity, restricted autonomy, deficient organisational support, exposure to poor leadership, and the broader socio-cultural pressures of working within a gendered and often undervalued profession (Fairbrother and Warn, 2003; Harkness et al., 2005). These stressors interact dynamically to generate diminished capacity for professional performance, weakened organisational commitment, elevated sickness absence, increased turnover intentions, and a progressive erosion of the boundary between occupational and personal life (Rashmi and Kataria, 2023). The downstream consequences for organisational performance and patient care quality are equally well-established: Sipos et al. (2024) and Widayana et al. (2025) confirmed that chronic work-life imbalance among nurses reduces the quality and safety of clinical care while simultaneously deepening workforce attrition cycles.

Notwithstanding the substantial body of scholarship addressing occupational stress and WLB in Western nursing contexts, there remains a conspicuous paucity of rigorous empirical investigation into these phenomena within the Middle Eastern region generally, and the KSA in particular (Chandra, 2012; Bouzzari and Karatepe, 2020). The extant Saudi-based studies, whilst valuable, are frequently characterised by relatively modest sample sizes, methodological constraints, and a tendency to treat occupational stress and WLB as analytically distinct rather than co-constitutive phenomena. Crucially, there is a dearth of doctoral-level qualitative inquiry that addresses the subjective experiences and cultural specificities of nursing work in Saudi Arabia.

It is against this background that the present doctoral thesis is positioned. The study is driven by the recognition that the intersection of occupational stress and work-life imbalance in Saudi nursing constitutes a rich and consequential domain of inquiry, the exploration of which has the potential to contribute substantively to both academic knowledge and practice. The thesis seeks to generate contextually situated, empirically grounded, and theoretically informed understandings of the work-life realities and stress experiences of nurses in Saudi Arabia. In so doing, this study responds to the call of scholars such as Chandra (2012), Bouzzari and Karatepe (2020), and Alotaibi and Aldossry (2024) for more inclusive, culturally reflexive, and geographically diverse approaches to the study of nursing work, occupational wellbeing, and WLB.

The study adopts a qualitative, interpretivist approach to generate contextually grounded evidence rather than testing pre-specified hypotheses. Primary data were produced through semi-structured interviews with 70 registered nurses, purposively and, where necessary, snowball-sampled across three hospitals in Mecca, and analysed inductively through thematic analysis, so that the meanings nurses themselves attach to occupational stress, WLB, and the boundary management practices these entail could emerge on their own terms rather than being imposed by a predetermined instrument. A fuller account of the philosophical orientation, sampling strategy, and analytic procedure is provided in methodology chapter.

1.2 Statement of the Research Problem

Nursing has been theorised through a plurality of conceptual lenses, as a profession (Ten Hoeve et al., 2013), a calling (Kallio et al., 2022), a vocation (White, 2002), and a practice (Liaschenko and Peter, 2004), each underpinned by a distinctive ethics of caregiving that identifies nursing through its unique body of specialised knowledge, commitment to altruistic service, and elevated sense of moral responsibility towards patients and communities. These very attributes, however, generate the structural conditions that render nursing one of the most occupationally demanding professions globally. Professional norms prescribing loyalty to patients, colleagues, and institutional hierarchies (Gustafson, 2005) frequently require nurses to subordinate personal and familial needs to clinical imperatives (Winefield et al., 2014; Dall'Ora et al., 2023). Long working days, unsustainable patient caseloads, irregular shift patterns, and excessively high performance expectations collectively produce elevated rates of burnout, depression, job dissatisfaction, and workplace fatigue (Rutledge et al., 2009; Gmayinaam et al., 2024).

Within the contemporary nursing literature, work-life balance (WLB) denotes the attainment of a sustainable equilibrium between the demands of professional work and the obligations and aspirations of personal life necessary for holistic wellbeing (Poulose and Sudarsan, 2017; Abuhammad et al., 2025; Cukljek et al., 2025). Yet this equilibrium is rarely achieved in practice. Hussain et al. (2025) demonstrated that the absence of effective WLB programmes is directly associated with elevated burnout and diminished professional performance among nurses, whilst Widayana et al. (2025), in a socio-ecological scoping review, identified a convergence of individual, interpersonal, organisational, and sociocultural factors that systematically undermine WLB among hospital nurses globally. Bezuidenhout et al. (2026) have argued that sustainable WLB management requires systemic institutional intervention rather than

individual-level coping alone, a position corroborated by Prabhu et al. (2026), who established significant associations between unresolved job stress, impaired WLB, and elevated turnover intention among healthcare workers. Some scholars have contended that nurses can draw on their professional knowledge to cultivate work-family integration independently of organisational pressures (Kowitlawkul et al., 2019); however, critical scholarship increasingly problematises this individualist framing, arguing that it obscures the structural and cultural constraints that render personal preferences regarding work-life boundaries largely ineffectual for many nurses (Beauregard et al., 2023).

A critical examination of the extant literature reveals a pronounced and persistent geographic and cultural lacuna. The overwhelming majority of empirical research on nursing WLB and occupational stress has been conducted in Western or broadly Anglo-Saxon contexts (Wilkinson et al., 2017), with a more limited literature from West Africa (Akanji et al., 2020) and South Asia (Rajadhyaksha, 2012). The experiences of nurses working within Arab, Islamic, and Middle Eastern institutional and cultural contexts remain conspicuously under-theorised and empirically marginalised. This constitutes a substantive scholarly problem: dominant theoretical frameworks have been developed without reference to the lived realities of a numerically significant portion of the global nursing workforce (Asfahani, 2021; Chandra, 2012). Existing WLB models have also been criticised for failing to account for the roles of ethnicity, nationality, religious affiliation, and cultural background in shaping the subjective experience of work-family conflict and boundary management (Asfahani, 2021). This oversight has consequence in contexts where Islamic values, gendered social structures, and distinctive institutional arrangements constitute the primary normative architecture of professional and personal life (Battar et al., 2024; Alghamdi and Alzahrani, 2025). As Saleh et al. (2026) observed, the mechanisms linking

leadership, organisational support, and WLB are highly sensitive to cultural and socioeconomic context, underscoring the inadequacy of applying Western frameworks without critical adaptation.

It is within this lacuna that the present doctoral thesis is situated. The KSA constitutes the focal context of investigation. KSA is a country of pivotal significance within the Arab world, whose healthcare system is undergoing rapid and far-reaching transformation under the Vision 2030 reform agenda, yet whose nursing workforce remains almost entirely absent from the WLB and occupational stress literatures (Alomar et al., 2025). The values and cultural orientations shaping nursing practice in Saudi Arabia are deeply embedded in Islamic tradition, providing a moral architecture governing relationships between professional duty, familial obligation, and gender roles that is qualitatively distinct from those documented in Western settings (Mebrouk, 2008). Where the subjective experience of care and private life is rooted in Islamic values, existing WLB frameworks are of limited applicability, leaving the experiences of Saudi nurses profoundly under-theorised.

This study is anchored in Clark's (2000) work-life border theory, which conceptualises workers as active agents who construct and negotiate preferred boundaries between professional and personal domains in pursuit of a satisfactory balance between both. This framework has been extended and critiqued by Basile and Beauregard (2021) and Beauregard et al. (2023), who argue that positioning WLB as a matter of personal preference systematically conceals the structural and cultural constraints that limit genuine individual agency in boundary management. This critique carries particular force in Saudi Arabia, where the intersection of masculine institutional hegemony, Islamic socio-cultural prescriptions, and an expatriate-dominant nursing workforce collectively impose constraints upon nurses' capacity to manage work-life boundaries that differ

fundamentally from those encountered in Western contexts. By investigating how Saudi nurses navigate work-life boundaries under conditions of occupational stress and strong sociocultural constraint, this thesis aims both to extend the empirical knowledge base on WLB beyond its Western-centric foundations and to test the cross-cultural limits of border theory's core tenets, responding to calls from Chandra (2012), Asfahani (2021), and Vydrová (2026) for theoretically inclusive and culturally reflexive approaches to the study of nursing work, stress, and life.

1.3 Research Aim and Objectives and Questions

The aim of this study is to make a scholarly contribution to the occupational stress and work-life balance (WLB) literatures by demonstrating the significance of context, specifically the societal, cultural, and religious peculiarities of the Kingdom of Saudi Arabia, for understanding how nurses experience work stress and work-life difficulties. The thesis therefore investigates the management of work-life boundaries among nurses, an occupational group conventionally overlooked within the wider work-life literature, in light of the WLB imbalances and work stress encountered in the course of their daily working lives. Notably, the social constructs of stress and WLB are constrained by a number of limitations, including definitional difficulties, the contested composition of WLB, and methodological issues. Moreover, most of what is known about both constructs has been generated among white- and blue-collar workers in European countries and the United States, resulting in a dearth of illustrative empirical studies from the Middle East, a region historically enmeshed in international conflicts, wars, civil unrest, and geopolitical tension with the western world (Sørli, et al., 2005). There is therefore an urgent need for further studies to be undertaken in other economies, such as eastern regions, using a close-fitted, interwoven, and multilevel conceptual framework capable of revealing the influence of structural and cultural dimensions of national context on stress and WLB research.

1.3.1 Research Questions

To this end, the present study seeks to answer the following research questions:

1. How do nurses in Saudi Arabian hospitals understand and experience occupational stress and WLB challenges?
2. What are the agency-related factors that contribute to work-life boundary management problems among nurses in the KSA?
3. Why do cultural and regional peculiarities exacerbate occupational stress, work-life imbalance, and boundary management difficulties among nurses in the KSA?

1.3.2 Research Objectives

The underlying objectives for formulating the foregoing research questions of this study are as follows:

1. To examine how nurses working in hospitals understand and experience occupational stress and WLB challenges in the KSA.
2. To identify and analyse the agency-related factors contributing to work-life boundary management problems within the nursing profession in the KSA.
3. To explore how cultural and regional peculiarities exacerbate work stress, work-life imbalance, and boundary management difficulties among nurses in the KSA.

1.4 Significance of the Study

This thesis is focused on contributing to academic literature and practical knowledge in the advancement of the implications of context in occupational stress and work-life research. In as much as the main focus of the present study is on the nursing practice and the stressful upheavals

as well as work-life challenges that may make boundary management problematic in this notable care-oriented profession, assessing stress experiences and work-life perceptions may be linked to specificity of context as differences of both constructs across countries are beginning to gain terrain (Dulk et al., 2013). Historically, it is not until the middle of the twentieth century that western scientists started to label the combination of psychological and physiological responses that people manifest when things or environmental conditions are getting too much and out of balance to handle when encountered (Hutmacher, 2021).

However, work stress is commonly understood as a universal phenomenon that exists across times and cultures (Morey et al., 2015). On one hand, this universality claim is correct; the physiological strain occurring makes individuals react negatively to such stressors. On the other hand, the universality claim is potentially problematic: stress has become, but has not always been solely perceived as how people react to stressors. Therefore, the social practices, in which the physiological stress mechanisms are embedded, are not the same across times and cultures (Becker, 2013). Crucially, these social practices are not a negligible by-product, but form an integral part of the way stress is commonly understood and experienced (Viner, 1999). Thus, the significance of this thesis is to extend the frontiers of knowledge that relates stress and work-life conflicts not only to certain situational stressors in the nursing profession but also encompasses broader societal structures and contextual conditions. The importance of this approach to the study of stress and work-life constructs is to disseminate novel information of the broad, versatile and protean nature of both constructs that is able to incorporate a wide range of themes other than those in published literature (Morey et al., 2015).

The essence is to provide academics, policy-makers, HR practitioners, those in managerial and leadership positions in the nursing profession of the need to inculcate peculiarities of context

when proffering stress management practices and family-friendly solutions in the KSA and other similar regions in the Middle East. This doctoral thesis also adds to current thinking of border theory by illustrating that society, work and organisation strongly impact of the nature of work and boundary management practices in the country understudy.

1.5 Originality of the Study

Originality is a fundamental requirement of doctoral research and concerns the generation of new knowledge, insights, interpretations, or applications through systematic inquiry (Murray, 2017; Wilkins et al., 2019). However, originality does not necessarily require the development of an entirely new theory or research method. Guetzkow, Lamont and Mallard (2004) demonstrate that originality in the social sciences can take different forms, including theoretical, methodological, and empirical or evidentiary contributions, with the significance attached to each varying according to disciplinary and research contexts. Similarly, Phillips and Pugh (1994) identify several ways in which doctoral research can demonstrate originality, including investigating new research areas, extending existing studies, developing new syntheses, applying established approaches to new settings, and generating new empirical evidence.

This thesis positions its originality primarily within the empirical/evidentiary domain, with a supporting contribution through theoretical extension. It does not claim methodological originality. Instead, its contribution arises from examining the occupational stress and WLB experiences of nurses in Saudi Arabian hospitals, and from applying an established theoretical perspective, extended to account for the structural and socio-cultural conditions of this setting, to interpret those experiences. The originality claimed by the thesis is therefore located not in the novelty of occupational stress, WLB, or border theory individually, but in the population,

context, empirical evidence, and theoretical extension through which the phenomenon is examined.

1.5.1 Research Category

The research originality of the thesis derives from its focus on the intersection of occupational stress, WLB, boundary management, and the Saudi Arabian nursing context. While occupational stress and WLB have been examined across a range of international healthcare settings, comparatively limited attention has been given to how nurses working within Saudi hospitals experience and negotiate the relationship between clinical demands and personal and family responsibilities.

The Saudi Arabian context is particularly relevant because the healthcare workforce's rapid expansion under the Vision 2030 reform agenda occurs alongside deeply embedded Islamic and familial expectations governing gender roles and caregiving responsibilities (Almutairi et al., 2024; Alahmari, 2024). Although research has examined aspects of occupational stress among Saudi healthcare workers more broadly, the specific WLB and boundary-management experiences of nurses occupying frontline clinical roles remain insufficiently understood. This is significant given the scale of the nursing workforce, its mixed expatriate and Saudi-national composition, and the structural and cultural conditions that may shape the availability and negotiation of work-life boundaries.

The thesis therefore extends existing WLB and border theory research by examining the phenomenon within a context where clinical workload, religious normativity, gendered institutional hierarchies, and an expatriate-dominant workforce intersect. Its originality in the

research category consequently lies in extending an established area of inquiry into a comparatively underexamined population and institutional context, rather than claiming that occupational stress or WLB themselves constitute a new area of research.

1.5.2 Theoretical Extension

The thesis also contributes through the extension of Clark's (2000) work-life border theory into an institutional and cultural setting substantially different from those in which it was originally developed and has predominantly been applied.

Border theory conceptualises individuals as active agents who construct and negotiate preferred boundaries between the domains of work and personal life. This thesis examines how far that agency-based assumption holds when boundary-setting occurs under conditions of masculine institutional hegemony, ingrained religious normativity, and an expatriate-dominant nursing workforce, conditions not directly addressed in the theory's original formulation. In doing so, the thesis surfaces work-home boundary violation as an analytically distinct phenomenon, and develops a nested, multi-layered account of boundary management in which the permeability of individual boundaries is substantially conditioned by structural and cultural forces external to the individual.

The originality here is therefore not the creation of a new theory, but the contextual extension and critical testing of an established theoretical perspective to provide a more comprehensive interpretation of occupational stress and WLB among nurses in Saudi Arabia. This theoretical work provides a basis for explaining how individual experiences of boundary management are

connected to structural conditions and wider expectations surrounding gender, religion, and work in the Saudi context.

1.5.3 Empirical and Evidentiary Category

The strongest originality claim of the thesis lies in its generation of new empirical evidence. Through qualitative interviews with 70 registered nurses working across three hospitals in Mecca, the study provides first-hand evidence of how nurses experience, negotiate, and make sense of occupational stress and WLB.

The empirical contribution is important because occupational stress and WLB experiences are shaped by their organisational and sociocultural environments. Evidence generated in other national settings, predominantly Western, may therefore not fully capture the realities of nurses working in Saudi hospitals. The study provides an opportunity to examine how participants experience clinical workload, boundary violation, managerial support, career-related concerns, and the broader structural and cultural expectations associated with their profession within the Saudi context.

Accordingly, the thesis contributes evidence that can extend existing understanding of occupational stress and WLB beyond the contexts that have dominated previous research. The empirical originality lies in who is studied, where they are studied, and what their experiences reveal about occupational stress and WLB in that setting. The resulting evidence also provides a

basis for developing contextually relevant implications for hospital policy and workforce retention.

1.5.4 Positioning the Overall Original Contribution

The originality of this thesis can therefore be understood as a combination of empirical/evidentiary originality and theoretical extension. Its principal contribution is the generation of new qualitative evidence concerning the occupational stress and WLB experiences of nurses in Saudi Arabia. This empirical contribution is strengthened by extending and critically testing work-life border theory to interpret how individual experiences of boundary management interact with structural conditions and wider institutional and sociocultural expectations.

The thesis does not claim that the concepts, theory, or methods used are individually novel. Rather, its originality lies in the new empirical setting and population examined, the evidence generated from that setting, and the theoretically extended interpretation of those experiences. This represents a bounded and defensible contribution to knowledge: the study extends understanding of occupational stress and WLB by demonstrating how an established phenomenon is experienced and negotiated by nurses within the distinctive institutional and sociocultural context of Saudi Arabian healthcare.

1.6 The Profile of the Country Understudy

The KSA was founded in 1932 by Ibn Saud, who united four previously distinct regions, namely; Hejaz, Najd, Al-Ahsa and 'Asir. Several years later, in 1938, crude oil was discovered which led to Saudi Arabia becoming one of the world's largest oil producers (Long, D. E. and Maisel, S, 2010). The KSA is a nation of startling contrasts; a very huge landmass; relatively small

population; a barren span of dessert land located over great oil wealth and largest country in the Arabian Peninsula. The KSA shares borders with the Red Sea to the West, with the Arabian Gulf, Qatar, Bahrain and the United Arab Emirates to the east; with Jordan, Iraq, and Kuwait to the north and the Sultanate of Oman and the Yemen



Figure 1.1: Geographical location of Saudi Arabia

Source: The map of the Kingdom of Saudi Arabia and boundaries

The KSA has a total area of 2.2 million square kilometres which occupies nearly four-fifths of the Arabian Peninsula and Central Department of Statistics and Information (CDSI) estimates that the KSA's population in 2023 stood at 36.947 million (www.macrotrends.net/countries/SAU/saudi-arabia/population). Of these, Saudi nationals constituted 20.9 million (67.5 percent), while non-Saudis comprised 10.047 million (32.5 percent) of the Kingdom's population. As such, KSA comprises a number of main regions. These are the western region 'Hijaz' which is along the Red Sea containing the holy cities of Mecca, Medina and Jeddah and they are all major commercial cities in the Kingdom (Abusar, 2014).

Jeddah is the largest port city and the second largest city after the capital city – Riyadh. It is located on the coast of the Red Sea. Thus, it controls most of the economic activity in the KSA due to the presence of both an international airport and seaport. Owing to its high level of urbanisation, diversity, and tolerance compared to other regions of the Kingdom, Jeddah is known as a potential ‘knowledge city’ (Saudi Gazette, 2010).

Giving more details, the eastern part of the Kingdom is a plateau that begins with the ‘Great Nafud Desert’ in the north, continues along the Arabian Gulf, and culminates in the world’s biggest sand desert, Al-Rub Al-Khali (Empty Quarter), in the south (Abusar, 2014). Dammam is the capital of the Eastern Province of the KSA. It is the most oil-rich region in the world. Furthermore, the judicial and administrative bodies of the province and numerous government departments are located in the city. To the west of this plateau is the Central Province ‘Najd’, which is the heartland of the peninsula. This area is known for its spectacular escarpment and sand desert. It is also the location of Riyadh, the country’s capital and largest city of the Kingdom.

1.6.1 The System of Governance in Saudi Arabia

The system of politics and governance in the KSA takes place in the context of a unitary absolute monarchy along traditional Islamic religion, where the King is both the head of state and government (Al-Asfour and Khan, 2014). Traditionally, all decisions, to a large extent, are made strictly after due consultation among the King, the Council of Ministers, Islamic scholars, tribal leaders and other important elites of the society (Long and Maisel, 2010). There have been worldwide criticisms especially from the western columnists accusing the Saudi government of being a dictatorship (Mahboob and Elyas, 2014). However, several political scientists and Islamic scholars have regarded the governance of the KSA as lacking features of dictatorship but

rather categorising it as an authoritarian state (Al-Asfour and Khan, 2014). The Basic Law of Saudi Arabia contains many characteristics of what might be called a constitution in other countries (Hodges, 2017).

The Qur'an and the Sunnah are declared as the official Constitutions of the country. The kingdom's governance is officially proclaimed to be conducted on the basis of Shari'a laws (Al-Atawneh, 2009). The Allegiance Council is responsible to determine the new King and the new Crown Prince. The government is dominated by the vast royal family, the Al Saud, which has often been divided by internal disputes and into factions. The members of the family are the principal political actors allowed by the government. Political participation outside the royal family is limited and women are excluded (Hodges, 2017). Thus, ruling structure is capped by a unique, almost unprecedented, form of oligarchy, whose members are connected through a bloodline and control all sphere of life in the country including the military, corporate organisations, public institutions, health sector amongst others. The next section of this thesis will examine the Saudi's health care and nursing profession which is the main focus of this study.

1.6.2 Socio-Economic background of the Kingdom of Saudi Arabia

The KSA is categorised as a World Bank high-income economy with a high human development index (HDI) (Al-Asfour and Khan, 2014). High-income economies are countries where a gross national income per capita which is equal or bigger than \$12,056. Gross national income per capita in KSA in 2016 was \$53,000 while the estimated value for 2018 was over \$55,000 (Haque and Khan, 2019). As for the HDI, it is defined as a statistic value composed of such indicators like life expectancy, education and income per capita. The HDI for Saudi Arabia in 2018 was 0,853, which puts the kingdom on the 39th spot in the global ranking, outranking countries like Portugal, Latvia, Croatia, Bahrain, Chile and Hungary (Saudi Gazette, 2010).

With regards social relations, employment and gender, Saudi Arabian women represent almost half of the population of the KSA and participation of women in the labour force have been historically low (Central Department of Statistics and Information, 2023). Despite the fact that there were more female undergraduates at university than males in the period 2019–2020 (Saudi Arabian Monetary Agency (SAMA), 2021), women had a higher unemployment rate of 35% compared to 12% for men (International Monetary Fund [IMF]), 2020). Key explanations for women's limited participation in the workforce includes socio-cultural restrictions, religious prohibitions, economic-legal factors and attitudes surrounding gender roles in Arab societies (De Bel-Air, 2015). Although women's agency is different in each Muslim country but restrictions on women's employment participation are far greater in the KSA (Alfarran et al., 2018). Thus, the KSA strictly observes Islamic tenets with a traditionally organised gender-based system and respect for, and acceptance of hierarchy. Similar to the values of other Arab nations, emphasis is placed on family system in which strong ties and obligations forms the basis of a 'social insurance' that often takes priority over personal goals and aspirations existing in the western world (Ghorbani and Tung, 2007). Traditional gender norms expect women to actively engage in home management and caregiving while men are socialised to become breadwinners.

This situation perpetuates a high role overload and caregiving strain, rendering women in the Middle-East particularly those in professional careers sensitive to work-family stress (Asfahani, 2021). Studies have found that within the Arab world, there are a number of key challenges and concerns for working women and these challenges relate to issues within the workplace but also in the difficult attempts at balancing work and family life (Moghadam, 2013). Broader discussions highlight social restrictions on Arab women as one of the main causes of work stress and WLB difficulties they confront. In Saudi Arabia for instance, women couldn't drive, travel

alone or work without their husband's permission. Although radicals such as Princess Ameerah have changed the rule in 2018 which now allows Saudi women to drive (Alfarran et al., 2018). Other common values of the society include deference to authority, acceptance of inequality and polygamy, respect for age and status differentials based on the system of governance.

Like most professional occupations, nurses face difficulties of balancing demands and achievements of care work with those in their private and family lives (Mullen, 2015). More so, occupational stress is a prevalent reality in Saudi Arabia, especially in the healthcare services, driven by long working hours, heavy workloads, insufficient support and resources as well as lack of appreciation (Batan, 2019). The excessively long shift working patterns also exacerbates occupational stress which also makes it harder for nurses to build mental and sometimes even physical barriers as a way to separate their family and work environments (Nippert-Eng, 1996). This and many more contextual proclivities shaping work stress and WLB issues from the Arab world is the main focus of this study.

This thesis will provide a framework for the analysis of the work-life boundary management challenges that nurses face especially in an Arab society where religion and gender stratification dominate the lifestyle of all and sundry. This study therefore aims to open up a rich vein of analysis focussing on the nature of job stress and work-family issues encountered by nurses with particular interest on how they find it difficult to manage and negotiate the work and non-work spheres and the borders between them in order to attain balance because of stress experiences encountered due to the nature of their work as well as contextual complexities of the society they work in. Research of this nature will, it is hoped, contribute to knowledge about the conceptual importance of context which is rarely considered which is rarely considered in work-life border theory.

In summary, chapter one establishes the foundation and context for the study by providing an overview of work-related stress and WLB concerns in the nursing profession are considered common problems worldwide. The chapter further goes to state a clear and concise description of the statement of problem. Hence, the contextual knowledge gap revealed that while significant number of studies on WLB and occupational stress research has been undertaken in western developed nations but there remains paucity of similar research from the Arab world. The problem here is that it leaves the experiences of those in the nursing profession under-theorised. Therefore, this thesis responds to calls for more work-life research focus a very large parts of the world known as the Arab league. Thereafter, the research questions stating the specific issue the study aims to answer as well as research objectives specifying measurable actions the researcher will take to achieve the broader goal of this study were presented. Finally, the profile of the country understudy was highlighted with focus on the system of governance and socio-economic context of the KSA.

1.7 The Structure of the Thesis

An outline of the structure and content of the entire thesis are presented as follows:

Chapter 1: Introduction

As presented earlier, this chapter introduces the background to the study, statement of the problem, research aim, objectives and questions that this study seeks to address. This is followed by stating the significance of the study and elaborately presenting a detailed profile of the country understudy. More intricate information provided about the KSA were the economic and employment features of Saudi Arabia; the country's system of governance while this chapter ends with a focus on the health care and nursing profession in the KSA.

Chapter 2: Literature review

This chapter will be conceptual in nature and will serve to frame the entire study. The chapter begins with definitional properties of both occupational stress and WLB that is well documented in a wide range of literature of various organisational contexts. The chapter further sets the scene for the present thesis by scrutinising the contentious nature of the meaning of work stress and WLB conceptualisations with a focus on the work-life conflict phenomenon. Thereafter, some stress and WLB models were reviewed with the border emerging as the theoretical framework adopted for the present study. Likewise, the chapter critically reviewed relevant research studies relating to the contextual factors that are likely to influence stress and foster WLB challenges. Finally, the chapter end with stress management interventions that are needful to mitigate the adversarial effects of occupational stress and work-life conflicts.

Chapter three: Methodology

This chapter presents methodological approach applied to collect and empirically analyse data. More specifically, the chapter presents philosophical orientation of the research, and what method of data collection and analysis were adopted. The chapter gives detail about how data were collected from participants, sampling technique, sample size, research design and reasons for adopting a qualitative method. The chapter also illustrate and describe the data analysis technique unitised.

Chapter Four: Analysis of findings

This chapter presents a detailed analysis of findings of the study. The themes emerging from the thematic analysis of qualitative interviews are presented. Illustrative excerpts were used to conducted the analysis and implications thereof.

Chapter Five: Discussion of findings

This chapter starts with an overall discussion of the main findings including a vivid description, analysis, and interpretation of study findings. This chapter aims to explain the significance of the results and tie everything back to the research questions.

Chapter Six: Conclusion

This chapter provides the conclusive section of this work. It provides a comprehensive interpretation and synthesis of the study results and how they meet the research aim and objectives in order to highlight the theoretical contribution of the study. Finally, the chapter reflects on the study limitations, practical implications and suggested future research directions.

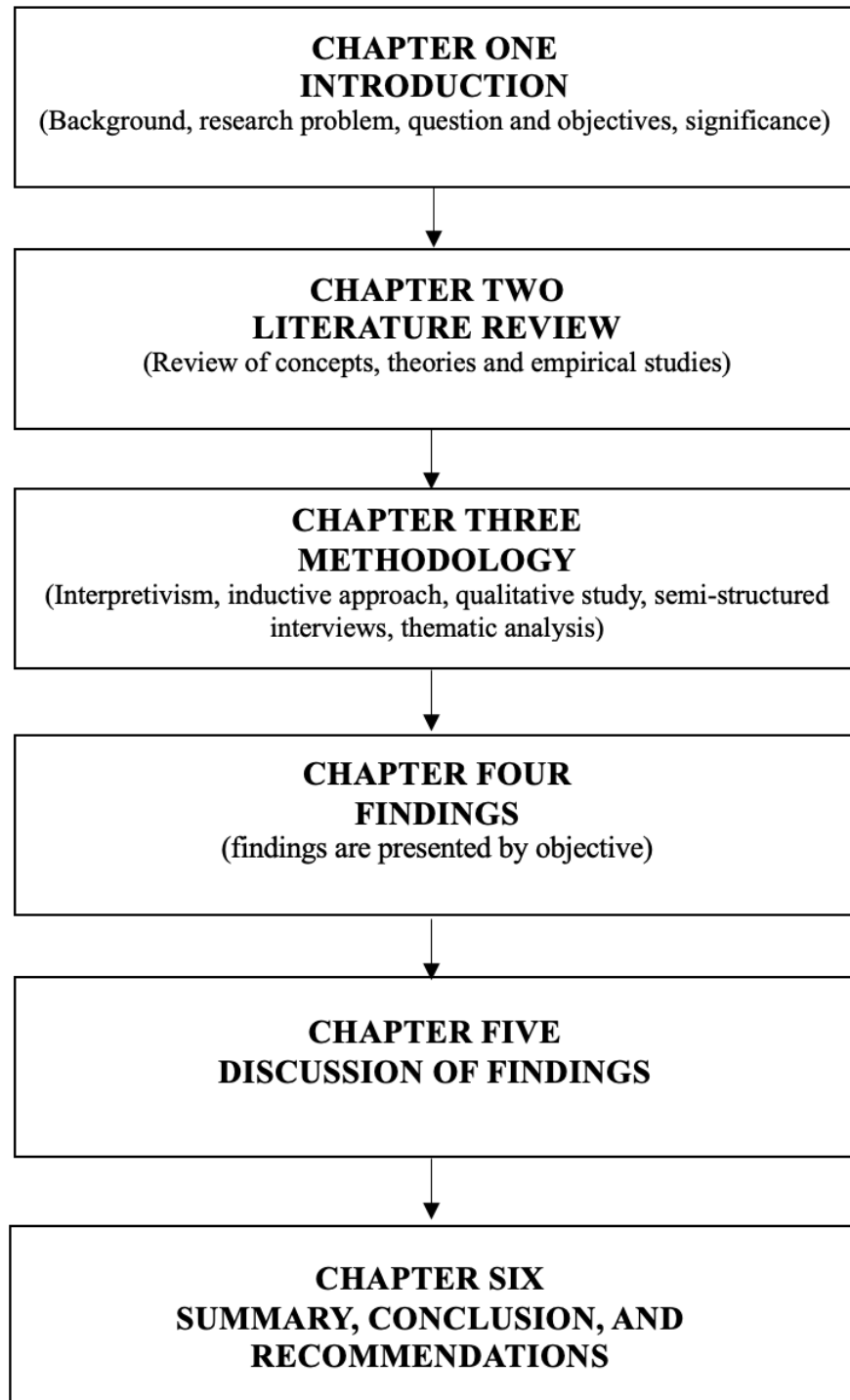


Figure 1.2: Structure of the Thesis

CHAPTER TWO

LITERATURE REVIEW

2.1 Chapter Overview

This chapter develops the conceptual and theoretical foundation for the doctoral thesis. It is organised in two parts. Part One reviews the literature on WLB: its historical antecedents, the ways flexible working practices have shaped the field, the persistent difficulties in defining and conceptualising the construct, and the theories of border management, role, and boundary negotiation through which WLB is analysed in this study. Part Two undertakes a review of occupational stress: its conceptual history, its economic and health costs, the sources of workplace stress, and the principal stress models that have shaped the field, each subjected to explicit critical appraisal and contextualisation to the Saudi Arabian nursing setting. The chapter then draws the two literatures together in a dedicated discussion of the gaps that this thesis addresses, before presenting an explicit conceptual framework that synthesises the reviewed theories into the analytical lens carried forward into the empirical chapters.

2.2 Historical Origins and Antecedents of Work-Life Balance

Scholarly accounts trace the formal origins of WLB discourse to the United Kingdom in the 1970s and the United States in the mid-1980s (Naithani, 2010; Pendleton et al., 2021; Thilagavathy and Geetha, 2021). Before this period, work and family were treated as separate, non-intersecting spheres, an arrangement sustained by the gendered division of labour prevalent across industrialised Western societies. The aftermath of the Second World War permanently disrupted this separation: advances in technology reduced the premium placed on physical strength in the workplace, and the sustained entry of women into paid employment created a more gender-diverse workforce in which the intersection of occupational and domestic responsibilities could no longer be ignored (Naithani, 2010; Cannizzo et al., 2019).

The intellectual foundations of WLB scholarship were laid in the 1960s and 1970s. Kanter's (1977) landmark analysis demonstrated bidirectional spillover between work and family domains, challenging the assumption that both spheres operated independently, while Pleck (1977) showed that women disproportionately experienced family-to-work spillover, and men

the reverse, a gendered asymmetry that became a central preoccupation of subsequent WLB research. WLB gained institutional traction in the 1980s, with organisational initiatives such as the Boston University Centre for Work and Family and Work/Family Directions embedding WLB principles within corporate practice (Harrington, 2007), while Juliet Schor's (1991) documentation of declining leisure time in America broadened public awareness. By the 1990s, the policy focus had expanded from its original preoccupation with working mothers to encompass all working adults irrespective of gender or parental status, reflecting a growing recognition that reconciling work and personal life is a near-universal feature of contemporary employment (Naithani, 2010; Akanji, 2013).

The deeper antecedents lie in the Industrial Revolution, which imposed a sharp and historically novel separation between work and domestic life. In the United Kingdom, factory workers, including children, routinely endured fourteen- to sixteen-hour days, six days a week, at considerable social and physical cost (Raja and Stein, 2014; Naithani, 2010); a comparable picture emerged in the United States, where working weeks of up to one hundred hours were recorded in certain industries (Kossek et al., 2012). Mounting pressure from labour advocates ultimately compelled legislative intervention, successive UK Factory Acts and the US Fair Labour Standards Act, marking the first formal policy acknowledgement that the organisation of working time carries social consequences. The sustained growth of female labour-force participation across the mid-twentieth century constituted a further decisive antecedent: as women entered employment in increasing numbers while retaining primary responsibility for domestic caregiving, the tension between occupational demand and familial obligation intensified and became structurally embedded (Louel et al., 2009; Haar and Brougham, 2022).

It is this convergence of demographic change and unequal domestic arrangement that made WLB an urgent social and organisational problem, one whose origins in Western liberal economies have, this thesis argues, significantly shaped the conceptual boundaries and cultural assumptions of the field ever since.

2.3 Labour Flexibility and Work-Life Balance

Debates on WLB have been closely bound up with debates about work design and working arrangements (Torrington et al., 2011). As organisations respond to market pressures, low

productivity, changing consumer demand, and the WLB expectations of an increasingly assertive workforce, labour flexibility has become one of the most extensively studied managerial strategies, particularly in Western contexts (Peters et al., 2009). Forrest et al. (2011) define flexibility broadly as the ability and sensitivity of firms to respond to changing market circumstances, and scholars distinguish external flexibility, changes in headcount achieved through temporary, short-term, or agency labour, from internal flexibility, the redeployment of an existing pool of human resources.

Atkinson's (1984) flexible-firm model, still the most widely cited framework, identifies four mechanisms of labour control: functional flexibility (multi-skilling, job rotation, and participation in decision-making, often associated with the European model); temporal flexibility (varying patterns of hours worked, including part-time contracts and annualised hours, to respond to business demand and worker need, Raghuran and Weisenfeld, 2004); financial flexibility (remuneration structures that reinforce the other three types, Gajendran and Harrison, 2007); and numerical flexibility (the ability of managers to engage and disengage labour on a just-in-time basis, retaining only a residual permanent workforce). Atkinson's thesis echoes earlier segmented-labour-market theory in describing the flexible firm as an internally divided workforce (Subramaniam et al., 2015); in this sense, labour flexibility is less a neutral organisational technique than an extension of fragmented labour arrangements deployed primarily to extend managerial control (Chung and Van der Lippe, 2020).

For workers, flexibility is double-edged. It can, in principle, help employees find a working pattern that suits their lifestyle (Irawanto et al., 2021; Lewis and Campbell, 2007), yet the established downsides of labour-market flexibility, job insecurity, income instability, reduced training investment, heightened stress, and social isolation, are well documented (Wysocka, 2019; Antunes et al., 2023). This tension is acute in healthcare. The global nursing workforce already faces chronic shortages (Öncü, 2018), and the poor retention that follows from numerically flexible hire-and-fire staffing practices compounds burnout, which is itself exacerbated by an ageing workforce and sustained nurse migration, further undermining both workforce stability and nurses' own WLB (Villamin et al., 2025). This dynamic, whereby an organisational strategy intended to secure institutional flexibility corrodes the very WLB conditions nurses need, recurs throughout the sources-of-stress literature and is one of the

mechanisms through which this thesis argues Saudi nurses' boundary-management difficulties are structurally produced.

2.4 Conceptualising Work-Life Balance

WLB has become one of the most prominent, and most contested, constructs in contemporary human resource management and organisational behaviour scholarship (Sirgy and Lee, 2018; Zaitouni et al., 2024; Saleh et al., 2026). Over four decades it has evolved from a niche concern of occupational welfare into a ubiquitous social, organisational, and policy imperative, tied simultaneously to individual wellbeing, workforce productivity, and organisations' capacity to attract and retain talent (Kelly et al., 2014; Bello et al., 2024; Prabhu et al., 2026). Demographic shifts (Kamboj and Eronimus, 2026), accelerating technological change (Hussain et al., 2025), the COVID-19 pandemic (Caringal-Go et al., 2022), and the spread of remote and hybrid working (Lozie et al., 2024) have all intensified the porosity of the boundary between work and personal life, sharpening the urgency of WLB as both a research agenda and a management priority (Tamunomiebi and Oyibo, 2020; Wood et al., 2020).

However, the construct's scholarly currency conceals serious unresolved questions about its conceptual coherence. Gragnano et al. (2020) observe that academic knowledge of the phenomenon has not kept pace with the ubiquity of its use, a concern echoed by Kossek et al. (2012), who note that the diversity of theoretical development around WLB has failed to match its popularity. Kalliath and Brough (2008) describe WLB as exhibiting a chameleon-like quality, shifting meaning depending on the analytical lens, population, and institutional context applied, while Fleetwood (2007) calls it a multifaceted term whose interpretation is inherently subjective. Atkinson (2025), in a recent critical sociological re-examination, argues that all three components of the label are individually imprecise and collectively misleading: work conflates formal employment with unpaid labour; life is too expansive to be analytically useful; and balance imposes a normative assumption of equilibrium that most empirical research shows to be elusive.

This conceptual fragility is compounded by a geographic one. WLB research has historically concentrated in Western, Anglo-Saxon institutional and cultural settings, principally Australia, the United States, the United Kingdom, and Northern Europe, and the mainstream conceptual

apparatus of the field reflects those origins (Heymann et al., 2004; Chandra, 2012). While there is now broad recognition that WLB concerns extend well beyond advanced Western economies, the theoretical tools developed there are being applied, with uneven adequacy, across very different cultural and national settings (Irawanto et al., 2021). Cross-cultural and single-country studies from non-Western contexts have begun to challenge the generalisability of dominant WLB frameworks (Fayankinnu and Alo, 2007; Mordi et al., 2013), and more recent scholarship points specifically to the limited applicability of Western models in state-led, collectivist, or Islamic institutional environments (Atkinson, 2025; Wood et al., 2020). It is to this critical and expanding literature that the present doctoral thesis contributes.

2.4.1 Defining Work-Life Balance

The absence of a universally accepted definition of WLB is one of the most persistently noted features of the field (Gregory and Milner, 2009; Rashmi and Kataria, 2021). Definitions diverge considerably depending on disciplinary orientation, unit of analysis, and whether WLB is theorised as an individual experience, an organisational policy, or a societal outcome. Table 2.1 sets out a purposive selection of influential definitions spanning the conflict, enrichment, and boundary-control traditions, to illustrate the range that any working definition for this thesis must reconcile.

Table 2.1: Selected Definitions of Work-Life Balance

S/N	Author(s)	Definition
1	Greenhaus and Beutell (1985, p.77)	A form of inter-role conflict in which the role pressures from the work and family domains are mutually incompatible in some respect.
2	Clark (2000, p.349)	Satisfaction and good functioning at work and at home, with a minimum of role conflict.
3	Felstead et al. (2002, p.56)	The relationship between the institutional and cultural times and spaces of work and non-work in societies where income is predominantly generated and distributed through labour markets.
4	Manfredi and Holliday (2004)	Paid work and personal life understood as complementary elements of a full life rather than competing priorities.
5	Greenhaus et al. (2003, p.513)	The extent to which an individual is equally engaged in, and equally satisfied with, his or her work role and family role.
6	Grzywacz and Carlson (2007, p.458)	Accomplishment of role-related expectations that are negotiated and shared between an individual and his or her role-related partners in the work and family domains.
7	Kalliath and Brough (2008)	A person's perception that work and non-work activities are compatible and promote personal growth in accordance with current life priorities.
8	Kossek et al. (2023)	The degree to which individuals can exercise agency over the timing, location, and content of their work, a boundary-control perspective.

9	Vydrová (2026)	A proposed shift from balance to work-life fit, rejecting the static, binary equilibrium implied by the language of balance.
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Reviewed sequentially, these definitions fall into two broad and partly conflicting traditions. Greenhaus and Beutell's (1985) conflict framing treats imbalance as the default condition, directing research towards identifying stressors, role conflicts, and cross-domain spillover, with balance understood as harm reduction (Greenhaus and Allen, 2011). Clark (2000) and Manfredi and Holliday (2004), by contrast, treat balance as an actively constructed state of fulfilment, orienting research towards enrichment and facilitation rather than conflict mitigation (Hirschi et al., 2019; Wayne et al., 2017, 2020). These two traditions have developed largely in parallel and, because they operationalise fundamentally different phenomena, often talk past one another (Greenhaus et al., 2003; Lewis and Humbert, 2010).

Later scholarship has refined both traditions further. Grzywacz and Carlson (2007) advance a relational conceptualisation that treats WLB as socially negotiated rather than an individual psychological state; Rashmi and Kataria (2021) situate WLB within an emancipatory discourse concerned with gender equity, reconnecting the concept to its political origins in the Women's Liberation Movement; and Kossek et al.'s (2023) boundary-control perspective, foregrounding the degree of agency individuals can exercise over their work, has direct relevance to nursing, where such control is typically severely constrained by shift rostering and clinical necessity. Vydrová's (2026) proposed shift to work-life fit is the most recent attempt to escape the binary logic that balance implies.

What the definitions in Table 2.1 show is that despite their differences, there is an implicit reliance on three elements: the integration of multiple life roles, some degree of individual control or agency over role demands, and the pursuit of positive outcomes, whether framed as reduced conflict, enhanced satisfaction, or personal fulfilment (Akanji et al., 2015; Adisa et al., 2021). The life-roles framework in Figure 2.1 offers a visual articulation of this integrative logic, depicting the multiple domains adults seek to harmonise and the potential for both synergy and tension across them (Akanji et al., 2015). Building on this convergence, and consistent with the boundary-control and fit-oriented turn evident in the most recent literature (Kossek et al., 2023; Vydrová, 2026), this thesis adopts a working definition of WLB as the degree of agency an individual is able to exercise in negotiating the boundaries between professional and non-work

roles, such that the demands of each domain are perceived as broadly compatible with, rather than corrosive of, the individual's wellbeing and socio-cultural obligations. This definition is deliberately compatible with border theory, the theoretical lens adopted for the study, and it foregrounds agency and socio-cultural obligation in a way that the predominantly Western definitions have not captured.

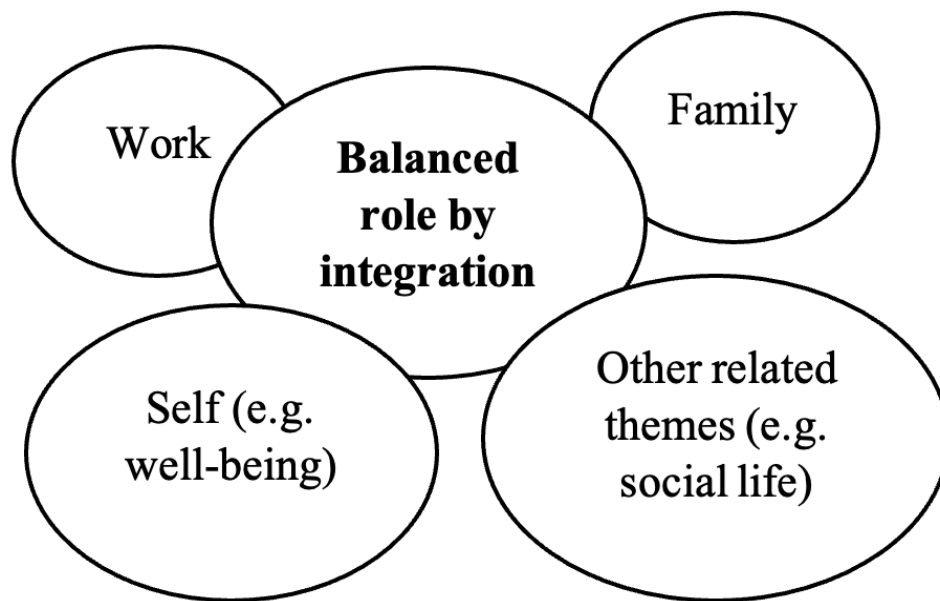


Figure 2.1: Life Roles Framework

Source: Akanji et al. (2015)

2.4.2 The Problematic Composition of the Work-Life Balance Construct

The apparent theoretical consolidation of WLB as a field of inquiry is undermined by unresolved conceptual tensions embedded within the construct itself (Bednarowicz, 2020; Wood et al., 2020; Saleh et al., 2026). The foundational assumption that people's lives divide into two distinct, opposing domains, work and life, has attracted sustained critique. As Atkinson (2025) and Fleetwood (2007) observe, this binary logic is epistemologically reductive: work in most WLB literature is operationalised narrowly as formal, contractual employment, rendering invisible unpaid domestic labour, educational pursuits, commuting time, and out-of-hours professional obligation; life is typically collapsed into a restricted notion of domestic, caregiving activity that

reproduces the very gendered assumptions the concept purports to challenge (Kelly et al., 2014; Özbilgin et al., 2010; Singh et al., 2026).

Balance itself is equally contested, having been operationalised as role enrichment and the absence of conflict (Greenhaus and Allen, 2011), as time equivalence between domains (Grzywacz and Carlson, 2007), as satisfaction with one's allocation across domains (Todd and Binns, 2013), and as effectiveness in both arenas (Chandra, 2012). These formulations are not equivalent, and combining them within a single measure risks conflating analytically distinct phenomena (Casper et al., 2019); Delecta (2011) further cautions that the absence of active role participation does not automatically constitute balance.

The gendered character of WLB scholarship constitutes a further, deeply embedded limitation. The field has been extensively critiqued for treating the working mother as its implicit subject, prioritising flexible employment and maternal-leave policy (Eikhof et al., 2007), and focusing disproportionately on dual-income heterosexual couples with dependent children (Lewis and Humbert, 2010; Mushfiqur et al., 2018). This framing renders the experiences of childless workers, single individuals, and workers in non-Western family structures analytically peripheral, and, by extension, fails to account for the experience of nurses in the Kingdom of Saudi Arabia, whose familial obligations, gender-role expectations, and Islamic socio-cultural prescriptions differ sharply from the Anglo-American nuclear-family template on which the construct was built (Alomar et al., 2025; Al-Otaibi and Kerari, 2025). The terminological shift from work-family balance to work-life balance was intended precisely to address this exclusivity (Özbilgin et al., 2010), yet the field's conceptual apparatus has been slower to follow the semantic adjustment: the continued exclusion from most WLB frameworks of leisure, religious participation, community engagement, and extended-family obligation, all highly salient dimensions of non-work life in Saudi Arabia, illustrates the persisting parochialism of mainstream WLB research (Battar et al., 2024; Alghamdi et al., 2025).

These blind spots carry practical consequences. Bednarowicz (2020) argues that the restrictive assumptions underpinning WLB conceptualisations impede their applicability and generalisability, making the translation of WLB theory into policy and practice difficult for HR managers, while Reiter (2007) contends that the absence of a coherent conceptual definition limits the progression of ideas and renders policy programmes elusive. In response, alternative

frameworks, work-life enrichment (Greenhaus and Powell, 2006), work-life facilitation (Rotondo and Kincaid, 2008), boundary management (Kossek et al., 2012, 2023), and work-life fit (Vydrová, 2026), have each been advanced as conceptual alternatives capable of accommodating the diversity of human experience that conventional WLB frameworks foreclose. For this thesis, these critiques are not merely academic: they provide the theoretical justification for approaching WLB in Saudi Arabia through border theory (Clark, 2000; Alharbi et al., 2025), which centres the active, contextually situated negotiation of boundaries rather than presupposing that any single configuration of work and life roles constitutes a universal standard of balance.

2.4.3 Work-Life Conflict

A substantial tradition within WLB scholarship situates the concept not as an achievable equilibrium but as a struggle defined primarily by conflict between competing demands (Chandra, 2012; Todd and Binns, 2013). Work-life conflict (WLC) holds that most working adults face persistent difficulty performing multiple life roles simultaneously, and that the resulting tensions render genuine balance structurally elusive. The foundational theoretical resource is the resource-scarcity hypothesis, originally articulated by Kahn et al. (1964), which holds that an individual's physiological and psychological resources are finite, so that investment in one domain necessarily depletes the resources available to the other, producing a zero-sum dynamic in which full engagement in both spheres cannot simultaneously be achieved (Baral and Bhargava, 2010; Roche and Haar, 2010). This positions WLC as a structural condition, a product of institutional arrangements that routinely demand more of workers than their bounded personal resources can sustain, rather than a matter of individual time-management failure.

Greenhaus and Beutell (1985) established an enduring taxonomy of three forms of inter-role conflict: time-based conflict, where the hours demanded by one role leave insufficient time for another; strain-based conflict, where stress generated in one domain spills over to impair functioning in the other; and behaviour-based conflict, where the conduct required in one role is incompatible with that demanded in the other. WLC operates bidirectionally: conflict may originate at work and encroach on domestic life (work-to-life conflict), or flow in the reverse direction (life-to-work conflict), with each pathway generating distinct patterns of strain, reduced performance, and diminished wellbeing (Shein and Chen, 2011; Tamunomiebi and Oyibo, 2020).

Hetrick et al. (2024) demonstrate, through meta-analytic evidence, that these three dimensions are not equivalent in their consequences, with strain-based conflict consistently producing the strongest associations with burnout, health impairment, and turnover intention.

At the organisational level, the consequences of sustained WLC are well documented: reduced productivity, weakened commitment, elevated sickness absence, heightened turnover intention, and deteriorating physical and psychological health (Tamunomiebi and Oyibo, 2020; Cho et al., 2025; Bezuidenhout et al., 2026). The capacity to set and maintain boundaries between domains has emerged as a central protective factor, with individuals who exercise greater control over when, where, and how they work experiencing lower levels of both time-based and strain-based conflict (Kossek et al., 2023). For nurses, whose shift patterns, patient-care obligations, and professional ethics characteristically constrain individual autonomy over precisely these parameters, the structural conditions for sustained WLC are embedded in the occupational role itself (Abuhammad et al., 2025; Cukljek et al., 2025). The theories reviewed in the following section provide the analytical apparatus through which this thesis examines the specific mechanisms by which Saudi Arabian nurses navigate these conditions.

2.5 Theoretical Review of Work-Life Balance

Three theories dominate this ground: border theory, role theory, and boundary management theory. Rather than reviewing each in isolation as a static definitional summary, the discussion below treats each theory as a proposition to be tested: what does the theory claim, on what evidential basis, against what criticism, and with what modification does it survive translation into the Saudi Arabian nursing setting. The section closes by showing how the three, despite emerging from distinct research traditions, can be read as complementary rather than competing accounts.

2.5.1 Border Theory

Clark's (2000) work/family border theory is the single most influential attempt to theorise WLB as an act of ongoing individual negotiation rather than a fixed state to be achieved or missed. Its central proposition is that work and family constitute separate but interdependent domains, connected by borders, physical, temporal, and psychological demarcations that mark when,

where, and how domain-appropriate behaviour is expected to occur (Clark, 2000). Individuals are theorised not as passive recipients of a given work-life arrangement but as active border-crossers, continuously negotiating the location and permeability of these borders (Clark, 2000; Peng et al., 2021), as illustrated in Figure 2.2. Two properties of a border determine how this negotiation unfolds: permeability, the degree to which elements of one domain, a phone call, a worry, a physical presence, are able to intrude into the other; and flexibility, the extent to which the border's spatial and temporal location can be adjusted to absorb competing demand (Clark, 2000; Bulger et al., 2007). The theory's second distinctive contribution is the concept of the border-keeper, a supervisor, colleague, spouse, or family member positioned within a domain who helps define, defend, or, when appealed to, relax the border (Clark, 2000).

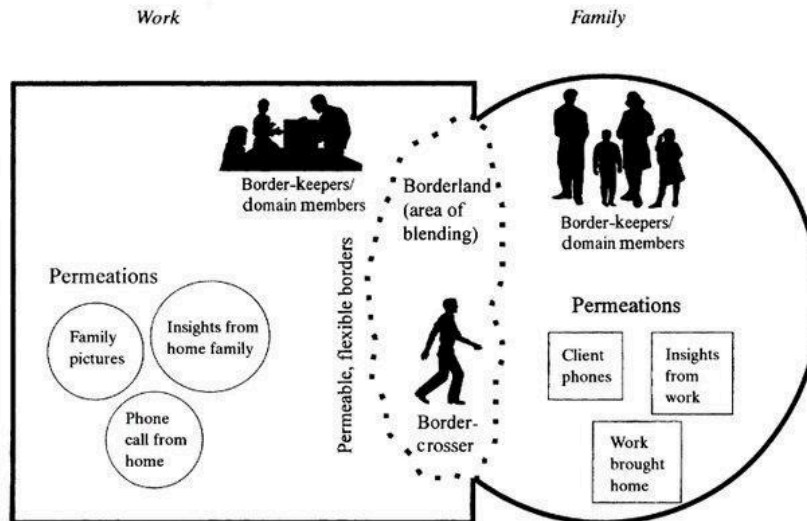


Figure 2.2: Border Theory

Source: Adapted from Clark (2000)

Empirically, the theory has travelled well beyond the Western, dual-earner-couple samples on which it was originally built, and the accumulated evidence broadly substantiates its central mechanisms while also complicating them. Peng et al.'s (2022) structural equation analysis of 504 Chinese preschool teachers found that family-boundary flexibility mediated the relationship between family-based border-keeper support and family-to-work enrichment, but that the parallel work-boundary-flexibility pathway from organisational support to work-to-family enrichment was not significant, evidence that permeability and flexibility, although theoretically paired, can

operate asymmetrically depending on which domain and which border-keeper is in play, a possibility Clark's (2000) original formulation left underspecified. Bulger et al. (2007) similarly found that boundary flexibility and permeability were empirically distinguishable rather than a single underlying construct, a distinction later formalised in the boundary-management measurement literature (see McCloskey, 2016, cited in Allen et al., 2022). At the level of gendered application, Wall and Arnold (2007) and Blair-Loy et al. (2015) report that women's work-life borders are consistently more permeable than men's, a pattern they attribute to women's disproportionate responsibility for unpaid domestic labour rather than to any inherent difference in border-management capability; this asymmetry is especially consequential in occupations characterised by long hours and high emotional demand, such as nursing, where the norm of professional self-sacrifice intersects with domestic caregiving expectation to compound pressure on women (Fahlén, 2014; Bressler and Tark, 2025). A further body of work has examined the double-edged character of permeability itself: greater permeability can facilitate enrichment, by allowing positive resources generated in one domain to benefit the other, but more commonly amplifies conflict when the intrusion is experienced as unwanted rather than chosen (Bulger et al., 2007; Ashforth et al., 2000).

Notwithstanding this empirical support, border theory's applicability outside the Western, salaried, dual-income context in which it was developed remains its principal and, for this thesis, most consequential limitation. Three specific criticisms are relevant here. First, and most fundamentally, the theory's assumptions regarding the separability of work and family domains, the nature of individual agency in border construction, and the identity of border-keepers reflect a particular socio-cultural configuration, one built on the presumption of a largely autonomous, individually agentic worker, that does not translate unproblematically to more collectivist or institutionally governed settings (Adisa et al., 2021; Özdemir, 2023). Second, the theory's original formulation of the border-keeper role is comparatively narrow: it envisages supervisors and family members acting in an individual capacity, and has little to say about diffuse, non-personified normative authorities, religious doctrine, extended kin networks, or state gender policy, that can themselves function as border-keepers in more collectivist and religiously governed societies, a gap Peng et al.'s (2022) study, for all its methodological rigour, does not close, since its Chinese sample still models border-keepers as identifiable individuals. Third, the theory's central metaphor of crossing presumes a degree of voluntary mobility between domains

that is considerably more constrained for shift workers bound by rostered clinical schedules than for the salaried, largely autonomous professionals on whom the original theory was built, a limitation that becomes acute precisely in the occupational group this thesis examines.

In Saudi Arabia, where Islamic principles provide a pervasive normative architecture governing both professional conduct and domestic life, where gender roles are shaped by deeply embedded religious and cultural prescriptions, and where the workforce includes a large and socially distinctive population of professional migrants, the assumptions of border theory cannot be applied without contextualisation. Tahir (2025) specifically calls for greater theoretical attention to the ways religious programming, patriarchal social structures, and gendered divisions of labour in Islamic societies modify the dynamics of border construction and negotiation posited by Clark (2000). This is precisely the gap this thesis addresses empirically: it investigates the extent to which border theory's tenets, that individuals actively construct and negotiate permeable, flexible borders, hold when the border-keepers in question include not only supervisors and family members but also religious and cultural normative structures that individual nurses have comparatively limited power to negotiate with. Border theory nonetheless remains the anchoring theoretical lens for the thesis (see section 2.7.4), because its emphasis on active negotiation, rather than a fixed equilibrium, is best suited to capturing how Saudi nurses exercise whatever agency is structurally available to them, even where, as the criticisms above suggest, that agency is more circumscribed than the original theory assumes.

2.5.2 Role Theory

Where border theory supplies an account of the mechanism by which domains are kept apart or allowed to intermingle, role theory addresses a prior question: what happens, psychologically, when an individual occupies multiple roles simultaneously. Two long-standing and empirically competing propositions dominate this literature. The scarcity perspective, whose theoretical roots lie in Goode's (1960) role-strain thesis and Kahn et al.'s (1964) resource-scarcity hypothesis discussed in section 2.6, holds that human energy is finite and non-expandable, such that engagement in multiple roles generates competition for a fixed pool of time and psychological resources (Barnett and Gareis, 2006; Stock et al., 2014); on this account, intensive investment in a professional role necessarily depletes the resources available for family, personal, and

community roles (Peters et al., 2009; Maertz and Boyar, 2011; Adisa et al., 2021). The enhancement perspective inverts this logic. Sieber (1974), and subsequently Marks (1977), proposed that human energy is expandable rather than fixed, and that involvement in multiple roles can generate cumulative psychological benefit, extrinsic rewards such as social recognition, intrinsic rewards such as mastery and purpose, that replenish rather than deplete individual resources; Greenhaus and Powell's (2006) work-family enrichment theory formalises this logic empirically, specifying the resource types, skills, psychological capital, positive affect, social support, that can be actively transferred from one role to enhance functioning in another.

The empirical record does not resolve this dichotomy in favour of either camp outright; rather, more recent scholarship treats scarcity and enhancement as coexisting processes whose relative weight depends on the demands, resources, and cultural context of the occupational group under study (Stock et al., 2014; Vyas, 2022), a dialectical reading with direct relevance to nursing, an occupation that is simultaneously among the most resource-depleting, in its physical, emotional, and temporal demands, and among the most widely reported as a source of intrinsic vocational and, in religiously inflected settings, spiritual meaning (Bressler and Tark, 2025; Alghamdi et al., 2025).

The principal weakness of role theory, for the purposes of this thesis, is that the scarcity-versus-enhancement dichotomy is typically treated as a property of the individual worker's psychological orientation, largely abstracted from the institutional and cultural conditions that determine which of the two dynamics is even available to a given worker. A nurse working mandatory night shifts in an under-staffed ward may, in principle, be capable of experiencing role enhancement, yet the objective scarcity of time and recovery resources imposed by the roster may foreclose that possibility regardless of her psychological disposition; role theory, in other words, risks individualising what is, in the Saudi nursing context, substantially a structural constraint. A second, related limitation is the theory's comparative silence on religio-cultural role expectations: the family role in role theory is typically modelled as a generic caregiving or breadwinning function, without differentiating the specific religious and familial duties, prayer observance, care of extended family, guardianship norms, that constitute the non-work role for many Saudi nurses, a gap that is not merely descriptive but

analytically significant, since it is precisely these duties that this thesis's empirical chapters find nurses weighing against clinical obligation.

In the Saudi nursing context, both dynamics identified by role theory are empirically plausible and, this thesis argues, likely to coexist unevenly across nurses depending on staffing conditions, shift allocation, and family structure. The enhancement perspective is analytically valuable in that it allows the thesis to avoid the deficit-only framing that dominates much of the WLC literature reviewed in section 2.6, and to remain open to the possibility that Saudi nurses derive genuine psychological and religious meaning, not merely strain, from the intersection of their professional and familial roles. Role theory is therefore retained in this thesis as a complementary, rather than primary, theoretical lens: it sensitises the analysis to the possibility of enrichment, while border theory (section 2.7.1) supplies the primary analytical vocabulary for how the boundaries between roles are constructed and negotiated.

2.5.3 Boundary Management Theory (BMT)

Nippert-Eng's (1996) boundary management theory extends and complements border theory by shifting the analytical focus from the properties of the border itself to the strategies individuals actively employ to manage it. BMT proposes that boundaries may be spatial, temporal, cognitive, behavioural, relational, or emotional, and that individuals draw on these boundary types in varying combinations to navigate the demands of multiple role domains (Ashforth et al., 2000; Clark, 2000; Nippert-Eng, 1996). Its core theoretical contribution is the distinction between two opposing boundary orientations: segmentation, in which clear, firm boundaries are maintained between work and personal life, protecting each domain from mutual intrusion; and integration, in which boundaries are rendered more permeable, allowing the activities, relationships, and obligations of both domains to overlap (Nippert-Eng, 1996; Boyar and Mosley, 2007). A third, hybrid orientation, in which individuals alternate between segmentation and integration tactics depending on situational demand, has been identified in more recent literature, though separation and integration remain the dominant strategies studied empirically (Boyar and Mosley, 2007; Kossek et al., 2012).

Empirical work testing this distinction has consistently found that the choice of orientation carries measurable conflict and enrichment consequences. Ashforth et al. (2000) established that

integrating work and family within a shared spatial and temporal frame increases boundary permeability, rendering both domains susceptible to disruption and elevating the probability of WLC; subsequent studies confirm the directionality Ashforth et al. propose, work-boundary permeability predicts work-to-family conflict more strongly than family-to-work conflict, while family-boundary permeability shows the reverse pattern (Bulger et al., 2007; Adisa and Gbadamosi, 2021). Kreiner et al.'s (2009) qualitative study of Episcopal clergy, an occupation that, like nursing, combines vocational meaning with poorly bounded, on-call working time, found that clergy who actively pursued segmentation tactics, refusing calls during designated family time, physically separating study and living space, reported markedly lower work-family conflict than those who allowed the two domains to remain undifferentiated, though this protective effect came at the acknowledged cost of reduced opportunity for the kind of spontaneous enrichment that integration can produce. This enrichment-conflict trade-off is a central theoretical tension within BMT with direct practical implications for nursing work in Saudi Arabia, where shift-based scheduling typically forecloses the option of active segmentation regardless of an individual nurse's preferred orientation.

BMT's central limitation is that segmentation and integration are typically presented, as in Kreiner et al.'s (2009) clergy study above, as strategies chosen by the individual, when for many workers, and nurses in particular, the degree of segmentation or integration achievable is substantially dictated by the employer. A nurse cannot unilaterally segment her work domain from her family domain if her roster is published with insufficient notice, or if mandatory overtime is imposed at short notice; what BMT frames as a matter of individual boundary-management style may, in such conditions, be more accurately described as boundary imposition. Kossek et al.'s (2023) more recent reframing around boundary control, discussed below, goes some way to addressing this, but the earlier, more individual-agency-centred version of BMT that still dominates much applied research retains this limitation. A second criticism is that BMT, like border theory, was developed and validated overwhelmingly on North American and Western European samples, Kreiner et al.'s (2009) sample of American Episcopal clergy being a case in point, and its instruments have rarely been tested for measurement invariance in Gulf healthcare settings, a methodological gap taken up in section 2.15.3.

More recent studies have attempted to refine BMT in ways directly relevant to this study. Kossek et al. (2023) argue that the critical variable is not integration or segmentation per se, but the degree of boundary control, the extent to which individuals can exercise genuine agency over where the boundaries of their working life are drawn and maintained; Cho et al. (2025) demonstrate that boundary-management tactics operate as dynamic, goal-directed behaviours responding to perceived discrepancies between actual and preferred states of work-family separation, rather than as stable individual dispositions, and underscore the importance of contextual and institutional enablers of boundary agency. For nurses in Saudi Arabia, whose capacity for individual boundary control is constrained by shift scheduling, patient-care imperatives, gendered social expectations, and Islamic cultural prescriptions, this more nuanced, boundary-control account of BMT is analytically essential (Battar et al., 2024; Alghamdi et al., 2025), and it is the version of BMT carried forward into the conceptual framework in section 2.16.

The three theories reviewed above are complementary rather than competing, and each survives its translation into the Saudi nursing context only in modified form. Border theory supplies the primary analytical vocabulary for this thesis: its account of permeable, negotiated borders and their border-keepers most directly captures the active, ongoing work of boundary negotiation that Saudi nurses must undertake, even though, as section 2.7.1 showed, the theory's original conception of the border-keeper must be extended beyond individual supervisors and family members to accommodate diffuse religious and institutional normative authority. Role theory contributes a necessary corrective against a purely deficit-oriented reading of that negotiation, sensitising the analysis to the possibility of enrichment alongside conflict, while flagging, as section 2.7.2 showed, that whether enrichment or scarcity predominates for a given nurse is substantially a function of staffing and rostering conditions rather than psychological disposition alone. Boundary management theory, in its recent boundary-control formulation (Kossek et al., 2023), supplies the analytical language for distinguishing between boundaries nurses choose and boundaries imposed upon them by rostering practice, institutional demand, and socio-cultural obligation, a distinction that Kreiner et al.'s (2009) clergy study illustrates in a different occupational setting and that this thesis argues is decisive for understanding WLB in the Saudi nursing context, and that could not be captured by any one of the three theories alone. This

synthesis is formalised in the conceptual framework presented in section 2.16, after the parallel review of occupational stress theory that follows.

2.6 Historical Antecedents of Occupational Stress

The terms occupational stress, work stress, and job stress are used interchangeably throughout this thesis to denote the harmful physical and psychological responses that arise when job demands exceed the needs, capacities, and resources of workers (Lee et al., 2022; Bezuidenhout et al., 2026). The conceptual lineage of stress as a scientific and organisational concern considerably predates its contemporary institutional prominence (Gmayinaam et al., 2024). The seventeenth-century philosopher Robert Hooke used the term metaphorically to describe the structural load experienced by physical objects subjected to external forces, distinguishing the load bearing down on a structure from the strain produced by the interaction of that load with material resistance (Shapin, 1989; Dewe et al., 2010; Prabhu et al., 2026).

The modern scientific study of stress is most closely associated with Hans Selye (1936, 1956), who shifted the discourse from mechanical analogy to biological theory by conceptualising stress as a non-specific physiological response of the body to any demand placed upon it. Selye's General Adaptation Syndrome (GAS) identified three sequential phases of the stress response, alarm, resistance, and exhaustion, and demonstrated how sustained exposure to stressors disrupts physiological homeostasis, generating inflammatory responses and increasing susceptibility to disease (Selye, 1956; Bahlman-van Ooijen et al., 2023). Of particular significance for subsequent WLB and occupational-health research was Selye's distinction between eustress, positive, performance-enhancing stress, and distress, harmful stress associated with overwhelm and exhaustion, which established the principle that stress responses are not uniformly pathological but depend on intensity, duration, and individual appraisal (Le Fevre et al., 2006; Ebner and Singewald, 2017). This recognition that subjective interpretation mediates the stress experience paved the way for the cognitive and transactional models reviewed in section 2.13.6.

2.6.1 The Exacerbating Realities of Work Stress

Within contemporary organisations, occupational stress remains one of the most significant and costly challenges in workforce management globally (Gmayinaam et al., 2024; Bezuidenhout et

al., 2026; Kamboj and Eronimus, 2026). Its detrimental impacts extend across emotional wellbeing, physical health, WLB, job satisfaction, organisational commitment, and individual performance (Kozuszkis et al., 2012; Bostock et al., 2019). The most pervasive stressors in modern workplaces include unsustainable work demands, role ambiguity, person-job misfit, dysfunctional interpersonal relationships, inadequate managerial support, and adverse physical working conditions (Kamboj and Eronimus, 2026; Prabhu et al., 2026), all of which are exacerbated by the accelerating pace of technological change, the demands of digital connectivity, and the instability of contemporary employment relations (Collie and Mansfield, 2022; Pandey, 2020).

The economic burden is considerable. In Western economies, documented estimates suggest organisations incur losses in the region of \$500 billion annually from absenteeism, presenteeism, elevated turnover, and the legal and healthcare costs associated with poor occupational health (Tentama et al., 2019; Hassard et al., 2018); in the United Kingdom, between 2020 and 2021, approximately 1.7 million cases of work-related stress, depression, or anxiety were recorded, accounting for a disproportionate share of total working days lost to ill health (Fetherston et al., 2021). These figures must be interpreted with caution, however: as Park (2007) and Şanlıtürk (2021) observe, the definitional inconsistency of stress across disciplines and institutional contexts makes precise quantification inherently approximate, and cross-national comparisons are hazardous given the divergent methodologies used in national datasets.

In the Middle East, and Saudi Arabia specifically, occupational stress is shaped by a distinctive configuration of regional, institutional, and socio-cultural factors. Recurrent geopolitical instability, including the Persian Gulf War, the ongoing Houthi-Saudi conflict, and the regional ramifications of the Israeli-Palestinian conflict, has generated sustained stress among working populations (Alghamdi, 2020; Battar et al., 2024); at the institutional level, uneven enforcement of labour legislation, autocratic management practices, high unemployment, and precarious employment across formal and informal sectors have been documented as chronic stressors among the Saudi working population (Alomar et al., 2025). These contextual specificities mean that Western occupational-stress frameworks, while analytically valuable, require critical adaptation before they can be applied to the Saudi nursing context with scholarly credibility, a requirement addressed model-by-model in section 2.13.

2.6.2 The Nature and Definition of Occupational Stress

The conceptualisation of occupational stress is characterised by the same fragmentation that affects the WLB literature. Decades of research have failed to produce a universally accepted definition, and the multiple disciplinary traditions, psychology, biology, physiology, epidemiology, sociology, and management, that have engaged with the phenomenon have each generated their own conceptual apparatus (Fink, 2010; Koolhaas et al., 2011; Giebels and Janssen, 2020). Table 2.2 sets out the three broad definitional orientations that can be distinguished in the literature.

Table 2.2: Three Definitional Perspectives on Occupational Stress

Perspective	Core Proposition	Key Sources
Stimulus-based (engineering)	Stress is a property of the external environment: a noxious stimulus (excessive noise, workload, physical danger, poor conditions) impinging on the individual. Objective and measurable, but neglects individual variation in appraisal.	Cox (1978); Kuchinke et al. (2010)
Response-based (physiological)	Stress is an internal state: the non-specific physiological response of the body to any demand placed upon it. Foregrounds individual differences, but struggles to distinguish stress responses from other forms of physiological arousal.	Selye (1936, 1956, 1974); Russell and Lightman (2019)
Interactional/transactional	Stress arises from a perceived imbalance between environmental demands and the individual resources available to meet them, a dynamic relationship, not a property of either party alone. The dominant framework in contemporary occupational-stress research.	Cox and Griffiths (1995); Sulsky and Smith (2005); Lazarus and Folkman (1984)

The transactional perspective has become the most widely adopted framework in occupational-stress research precisely because it integrates the other two: it accommodates individual variation, recognises the role of cognitive appraisal, and admits the possibility that the same objective conditions may generate different stress responses depending on personal resources, organisational support, and cultural context (La Torre et al., 2019; Rochette et al., 2023). The WHO's expert committee observed as early as 1982 that the lack of definitional consensus around stress was materially limiting the development of effective preventive strategies, a concern that retains its validity today: the absence of a unified definition continues to complicate the development of comparably designed studies, the aggregation of evidence across national contexts, and the formulation of evidence-based policy responses (Colligan and Higgins, 2005; Rochette et al., 2023). For this reason, and consistent with its capacity to accommodate the interaction between the structural demands of nursing work in Saudi Arabia

and the individual, cultural, and institutional resources available to nurses in that context, the transactional model is adopted as the thesis's primary analytical framework for occupational stress.

2.6.3 Cost Implications of Occupational Stress

Hassard et al. (2018) characterise work stress as a costly organisational epidemic, and the empirical record substantiates this assessment. At the individual level, sustained occupational stress generates well-established adverse outcomes: reduced cognitive performance and decision-making capacity, elevated sickness absence, heightened susceptibility to cardiovascular disease and immune dysfunction, clinical burnout, depression, and anxiety (Bostock et al., 2019; Fetherston et al., 2021). At the organisational level, the costs manifest as decreased productivity, elevated staff turnover, rising healthcare and insurance expenditure, and reputational damage associated with high-profile failures of occupational-health governance (Tentama et al., 2019; Hassard et al., 2018). Precise financial quantification remains methodologically fraught, resting on contested attribution of absence and healthcare costs to stress rather than other causes, but the directional evidence of significant economic burden is robust across national contexts and methodologies (Park, 2007).

2.6.4 Sources of Work Stress

Despite the definitional controversies reviewed above, there is considerable empirical consensus regarding the principal sources of work-related stress. The literature distinguishes stressors embedded in the content of work from those arising from its organisational and social context (Şanlıtürk, 2021; Chen et al., 2016). Content-based stressors include job overload and time pressure, task monotony and under-stimulation, inadequate autonomy over work processes, unpredictable or poorly designed shift systems, and a mismatch between effort expended and reward received (Chen et al., 2016; Lukan et al., 2022). Context-based stressors encompass job insecurity, restricted career development, unfair performance evaluation, inadequate supervisory support, poor interpersonal relationships, organisational restructuring, and work of low perceived social value (Lukan et al., 2022; Collie and Mansfield, 2022). In nursing, both categories are persistently present and mutually reinforcing: content stressors, high patient-to-nurse ratios, emotionally demanding care interactions, the moral weight of clinical decision-making, are

compounded by context stressors, hierarchical management structures, limited professional autonomy, and, in the Saudi Arabian context, the additional weight of cultural and religious expectations governing the conduct and identity of nurses.

Michie (2002) synthesises these dimensions into a schematic framework of work-stress factors and outcomes, reproduced in Figure 2.3, which distinguishes stressors relating to job content (workload, control latitude, physical conditions) from those relating to role within the organisation (role conflict, role ambiguity, role overload and under-load), career development (under- or over-promotion, job insecurity), work relationships (bullying, harassment, unsupportive management), and organisational culture (formalisation, poor management style, exclusion from decision-making). Reactions to these stressors are, the model proposes, moderated by individual differences, personality, coping style, and demographic characteristics, so that the same objective stressor set can produce markedly different outcomes across individuals exposed to it (Le Fevre et al., 2006).

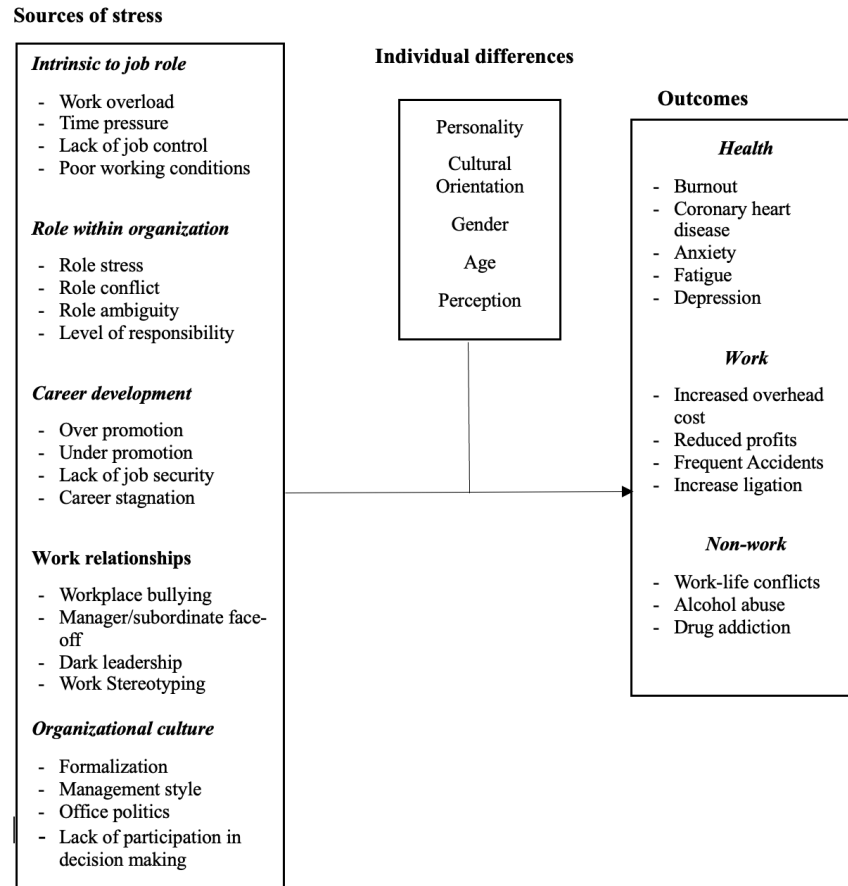


Figure 2.3: Schematic Framework of Work-Stress Factors and Outcomes.

Source: Adapted from Michie (2002)

Two sources within Michie's (2002) framework merit particular emphasis for their salience to nursing. Role stressors, conflict, ambiguity, overload, and under-load, arise when the expectations attached to an occupational role are unclear, incompatible, or exceed an individual's capacity to fulfil them (Ghorpade et al., 2011), and Bhui et al. (2016), studying organisational stress across six national contexts, found that unclear expectations about work-related duties and responsibilities were a consistent predictor of psychological strain. Relationship stressors, encompassing bullying, biased treatment, harassment, and unsupportive management, generate the interpersonal conflict that Colligan and Higgins (2005) link to counterproductive workplace behaviours capable of degrading organisational performance more broadly. Taken together, the sources catalogued in Figure 2.3 confirm that workplace stress is rarely reducible to a single cause; it is the layered accumulation of role, relational, developmental, and cultural stressors,

moderated by individual difference, that produces the strain outcomes this thesis investigates among Saudi nurses.

2.7 Theoretical Review of Occupational Stress

Section 2.10 established that the transactional perspective now dominates occupational-stress scholarship precisely because it integrates the stimulus-based and response-based traditions it superseded. This section examines, in more analytical depth than a purely chronological account would allow, six models that have shaped that scholarship: the Job Characteristics Model, the Effort-Reward Imbalance Model, the Job Demand-Control Model, the Person-Environment Fit Model, the Vitamin Model, and, closing the section, the Transactional Model of Stress and Coping itself. Each model is treated as a testable proposition rather than a settled fact: its founding claim and seminal source, the empirical evidence that has accumulated for and against it, the criticisms that limit its explanatory reach, and, where this has not already been addressed, its contextualisation to nursing practice in Saudi Arabia.

2.7.1 Job Characteristics Model

Hackman and Oldham's (1980) Job Characteristics Model (JCM) proposes that five core job characteristics, skill variety, task identity, task significance, autonomy, and feedback, generate three critical psychological states, experienced meaningfulness, experienced responsibility, and knowledge of results, which in turn produce desirable work outcomes: high internal motivation, quality performance, and job satisfaction (see Figure 2.4). The model has been used for decades as a conceptual framework for addressing employee dissatisfaction, stress, demotivation, and marginal performance (Bohlander and Snell, 2013).

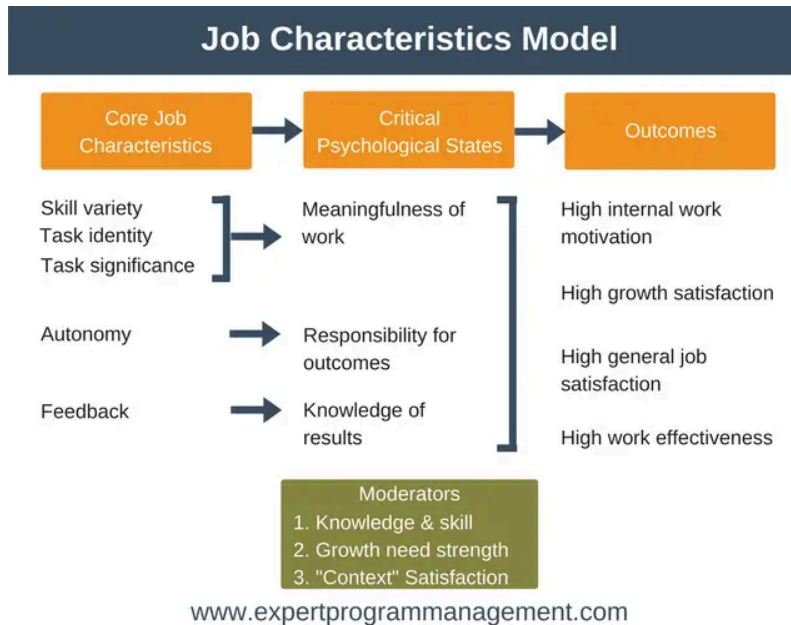


Figure 2.4: Job Characteristics Model

Source: Adapted from Hackman and Oldham (1980)

Applied empirically to stress rather than to its original motivational focus, Johari et al.'s (2022) study found that two of the five characteristics, task identity and autonomy, correlate most strongly with perceived stress: where task identity is unclear and employees have little authority over how tasks are carried out, stress experiences are more likely, and where neither autonomy over schedules nor control over the working environment is available, job dissatisfaction and stress levels rise correspondingly (Havlovic and Keenan, 2020). It is precisely these two findings, that autonomy and task identity are the JCM's most stress-relevant characteristics, that expose the model's principal limitation for nursing research: the JCM's explanatory power is grounded in generic industrial and clerical job-design research in which autonomy and task identity are, in principle, redesignable at the level of the individual job. In clinical nursing, by contrast, task sequencing, patient allocation, and clinical decision boundaries are substantially fixed by hospital policy and physician hierarchy rather than negotiable at the level of individual job design, so the model identifies the correct predictive variables while offering comparatively little practical guidance for a profession in which those variables are structurally, rather than managerially, constrained. This limitation is directly relevant to the Saudi nursing context, where

clinical protocol, physician hierarchy, and rostering practice together leave limited room for the kind of job-redesign intervention the JCM implicitly recommends.

2.7.2 Effort-Reward Imbalance Model

Siegrist's (1996) Effort-Reward Imbalance (ERI) model, shown in Figure 2.5, was developed to explain the health-adverse effects of stressful work conditions on both employee health and organisational performance (Siegrist et al., 2004). Its central proposition is that occupational stress arises when the efforts an employee expends in meeting work demands are not adequately reciprocated by the rewards received in return, where effort denotes the extrinsic demands and obligations imposed by the work role, and reward encompasses salary, career advancement, esteem from supervisors and colleagues, and job security.

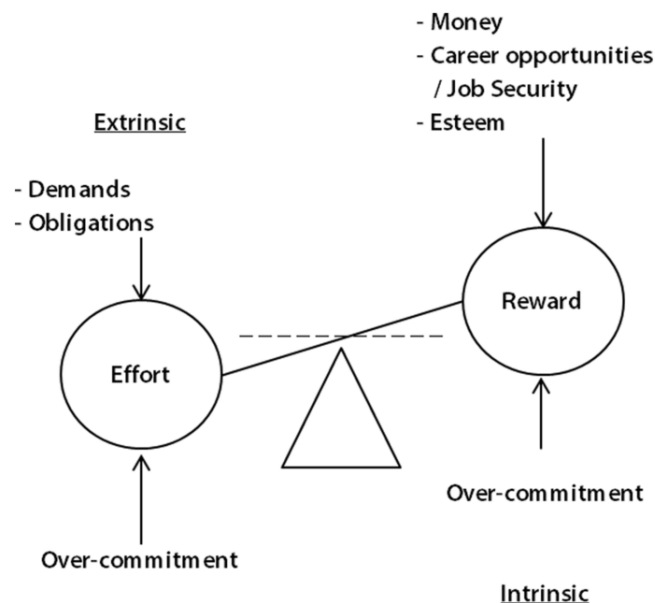


Figure 2.5: Effort-Reward Imbalance Model

Source: Siegrist (1996)

Siegrist identifies three conditions under which this imbalance is most likely to persist: a structural condition, in which poorly defined roles or precarious, low-mobility labour markets trap employees within unfavourable reward structures; a volitional condition, in which workers consciously accept an unfavourable ratio as a calculated short-term sacrifice for longer-term career advancement; and, most distinctively, a dispositional condition, overcommitment, an

excessive work-related dedication and inability to disengage that renders certain individuals chronically susceptible to experiencing high costs against low gains regardless of the objective reward structure. The model has attracted substantial and sustained empirical support in nursing specifically: Liang et al.'s (2023) structural equation study of Taiwanese hospital nurses found that overcommitment amplified the relationship between effort-reward imbalance and emotional labour, which in turn degraded self-reported quality of working life, while a recent systematic review and meta-analysis of ERI among nurses internationally confirmed a consistently elevated incidence of imbalance across health systems and concluded that ERI is a robust and generalisable predictor of nurse burnout (see also Le Huu et al.'s, 2022, parallel meta-analysis of ERI among physicians, which found comparably high prevalence across specialties and national settings). This body of evidence establishes ERI as one of the most consistently replicated occupational-stress models in healthcare research.

Nonetheless, the model's principal limitation, for this thesis, is its implicitly economic conception of reward: salary, promotion, and esteem are framed as extrinsic, individually accrued goods, in a manner consistent with Western labour-market assumptions but arguably incomplete for a workforce for whom religious merit, familial honour, and communal recognition may constitute equally or more salient reward dimensions. A Saudi nurse who perceives her care work as an act of religious duty, *ihsan*, may tolerate an effort-reward ratio that the standard ERI instrument would classify as severely imbalanced, not because she is in Siegrist's volitional category, calculating a future professional payoff, but because the reward she is weighing against her effort is not adequately captured by the model's extrinsic categories at all. This is a genuine conceptual gap in the ERI literature as applied to religiously inflected caring professions, rather than a mere measurement nuance, and it is one of the reasons this thesis does not adopt ERI as its primary stress-theoretical lens, notwithstanding the model's considerable empirical support elsewhere.

2.7.3 Job Demand-Control(-Support) Model

Robert Karasek's (1979) Job Demand-Control (JDC) model remains one of the most influential and empirically robust frameworks for understanding how workplace conditions generate occupational stress. Its foundational proposition is that strain emerges not from high job demands

in isolation, but from the interaction between those demands and the degree of control, or decision latitude, employees are afforded in responding to them (see Figure 2.6): the most harmful outcomes arise when employees face high demand alongside low control (Karasek, 1979; Chen et al., 2023). The interaction of demand and control produces four job categories: high-strain jobs (high demand, low control), theorised to carry the greatest risk of adverse health outcomes; low-strain jobs (low demand, low control); active jobs (high demand, high control), considered broadly protective because decision latitude enables problem-solving resources that buffer demanding work; and passive jobs (low demand, high control), associated with skill under-utilisation and motivational disengagement.

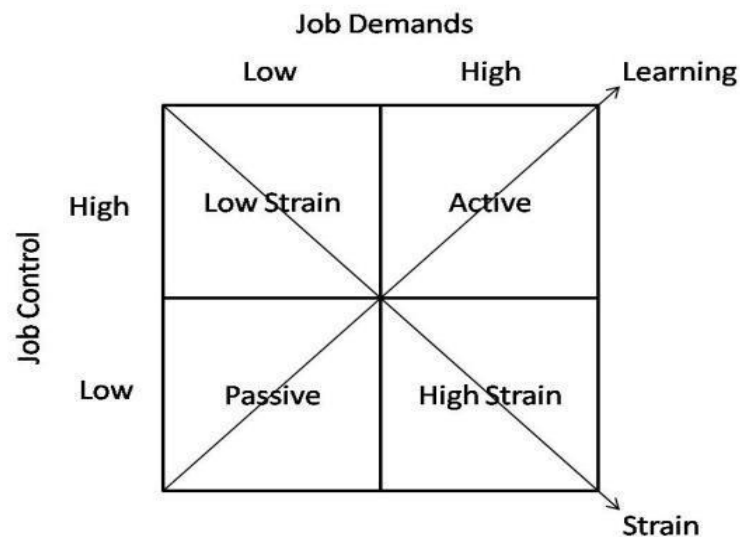


Figure 2.6: Job Demand-Control Model

Source: Karasek (1979)

Baka (2020) extended the original model by incorporating social support as a third moderating dimension, proposing that collegial and supervisory support buffers the health-adverse effects of high-strain work, the Job Demand-Control-Support (JDSCS) model, and subsequent empirical work has tested this extension specifically among nurses. Gameiro et al.'s (2020) person-centred latent-profile analysis of 6,357 Portuguese workers, including a substantial nursing subsample, identified not the four theoretically predicted job-strain profiles but five, an additional moderate-active profile emerged empirically, and found support for both the additive iso-strain hypothesis and, more tentatively, the buffering hypothesis, suggesting that job control functions

as a genuinely protective resource against burnout even after demand is accounted for. A longitudinal two-wave study of 217 Italian nurses similarly found that changes in psychosocial job characteristics, not merely their static level, predicted corresponding changes in burnout over a fourteen-month period, evidence that the JDCS model's constructs are not simply cross-sectional artefacts of common-method variance but track a genuinely dynamic process.

The JDC model's influence on occupational-health research owes much to its structural parsimony and empirical testability across diverse occupational settings (Chen et al., 2023), but the framework has not escaped critical scrutiny on grounds independent of the JDCS extension. Mark and Smith (2008) argue that the JDC framework considers too restricted a range of job characteristics to capture the multidimensional, dynamic nature of stress in contemporary workplaces, and more recent scholarship extends this critique by noting that the model's two- or three-dimensional structure cannot adequately account for emotional demands, role ambiguity, relational stressors, or the cultural and institutional contexts within which demand and control are differentially experienced across occupational groups and national settings (Chen et al., 2023). For this thesis, the JDC(S) model provides a useful, if necessarily partial, lens on nursing stress in Saudi Arabia, where the interaction between intense clinical demand and severely constrained professional autonomy represents a near-textbook configuration of high-strain work, and where Gameiro et al.'s (2020) finding that job control buffers burnout even under high demand offers a testable proposition for the Saudi setting; the model's silence on cultural and religious moderators, addressed via the socio-cultural moderator identified in the conceptual framework in section 2.16, nonetheless limits its explanatory sufficiency on its own.

2.7.4 Person-Environment Fit Model

The Person-Environment Fit (P-E Fit) Model has been widely used in organisational stress research and remains one of the most influential frameworks for understanding workplace wellbeing. It is grounded in the premise that organisations and their employees must find common ground whereby individual characteristics, skills, abilities, personality, and core competencies, align meaningfully with the demands and conditions of the organisational environment: specific tasks, job roles, and workplace culture. The foundational conceptualisation, attributed to French (1973) and depicted in Figure 2.7, proposes that

workplace wellbeing is most readily achieved when discrepancies between individual and environmental characteristics are minimised: the greater the congruence between person and environment, the lower the likelihood of occupational stress and the higher the potential for satisfaction and performance.

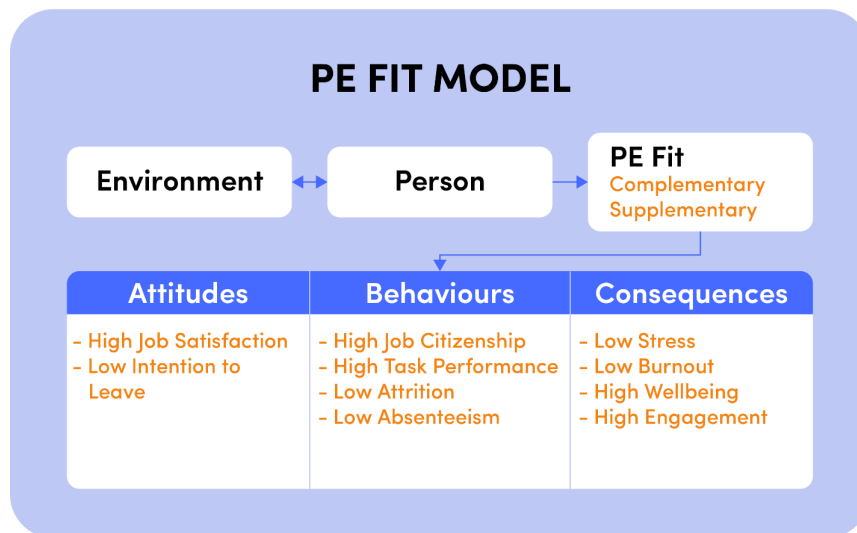


Figure 2.7: Person-Environment Fit Model

Source: French (1973)

Using the P-E Fit framework, occupational stress occurs when job specifications and role demands overshadow an individual's abilities and competences, and this misfit generates deleterious physiological, psychological, and behavioural outcomes that can impair workplace productivity and morale (Van Vianen, 2018). Though the P-E Fit model has added empirical value to stress research, its central relationship between person and environment is modelled in a comparatively static and structural way (Armitage and Amar, 2021): the framework does not adequately account for individual differences and the diverse relational factors that vary personal or situational experiences of misfit over time (De Cooman and Vleugels, 2022), and it offers limited purchase on how a fit that is adequate at one career stage, for example, a newly qualified nurse still building clinical confidence, may become a misfit at another, as demands, competencies, and expectations shift. This dynamic limitation is significant for a workforce, such as Saudi nursing, in which career stage, migration status, and language competency vary considerably across the workforce and change over time.

2.7.5 The Vitamin Model

Warr's (1987) Vitamin Model proposes that certain work characteristics affect employees' mental state in a manner analogous to the way vitamins affect the human body. Some job features, Warr argues, exhibit constant effect (CE) patterns, in which wellbeing rises with increasing dose up to a subjective optimum and then plateaus, for example, salary, physical security, and clarity of role; others exhibit additional decrement (AD) patterns, in which wellbeing rises with increasing dose up to a point but then actively declines with further increase, for example, autonomy, skill use, task variety, and social contact, so that both too little and too much of these characteristics can be harmful (see Figure 2.8). The value of the analogy lies precisely in this second, counter-intuitive category: for AD-type features, more is not simply better, a proposition that distinguishes the Vitamin Model sharply from job-design frameworks such as the JCM, which implicitly treat autonomy and skill variety as unambiguously beneficial in unlimited quantity, a contrast that is not merely theoretical: it is precisely the JCM's autonomy-maximising assumption, flagged as needing religio-cultural qualification in section 2.13.1, that the Vitamin Model's AD curve calls into question.

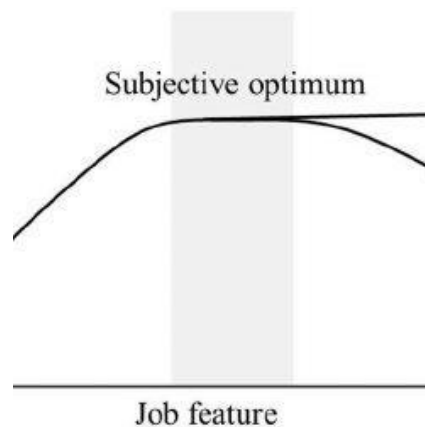


Figure 2.8: The Vitamin Model

Source: Warr (1987)

The Vitamin Model's principal weakness is measurement imprecision: unlike physiological vitamin thresholds, which can be established through clinical trial, the subjective optimum at which an AD-type job characteristic tips from beneficial to harmful is neither stable across individuals nor straightforwardly measurable in organisational research, which limits the model's

predictive, as opposed to descriptive, utility (Warr, 2007). A second limitation, specific to this thesis, is that the model has rarely been applied within Gulf healthcare settings, where the AD-type characteristics Warr identifies, notably autonomy and social contact, interact with religiously and culturally prescribed limits on inter-gender social contact and hierarchical deference to physicians in ways the original Western industrial samples underpinning the model did not anticipate. Its analytical value for this thesis lies chiefly in the AD-curve logic itself, which offers a useful corrective to any assumption that greater nurse autonomy is unambiguously protective against stress, an assumption several of the other models reviewed above, the JCM and JDC in particular, risk implying.

2.7.6 Transactional Model of Stress and Coping

Lazarus and Folkman's (1984) transactional model of stress and coping remains one of the most influential frameworks in stress research, reconceptualising stress as a dynamic process emerging from the interaction between individuals and their environments. Central to the model are the processes of cognitive appraisal and coping: stressful encounters are first subjected to primary appraisal, in which individuals evaluate whether a situation poses a threat, harm, or challenge to their wellbeing, followed by secondary appraisal, in which individuals assess the resources and options available to manage the demand. Coping responses are formulated on the basis of these evaluative processes, and the model's central claim, and the reason it is adopted as the thesis's primary stress-theoretical lens (section 2.10), is that stress is inherently subjective: the impact of external stressors depends on how individuals perceive and interpret them within their specific social and cultural context.

Lazarus and Folkman (1984) distinguish problem-focused coping, proactive measures used to reduce or alter distressful conditions, from emotion-focused coping, strategies used to manage painful emotional reactions when a stressor cannot itself be altered. Problem-focused coping tends to predominate when a situation is appraised as amenable to constructive action; emotion-focused coping becomes more prominent when the stressor is appraised as something that must be endured. Although this binary distinction has proved durable, it has also been criticised as overly simple: subsequent qualitative research has identified a far more granular repertoire of coping styles than the original two-category taxonomy implies. Newton and Keenan

(1985), in one of the earliest qualitative studies of coping, thematically coded 159 distinct coping dimensions among engineering professionals, while Rotondo et al. (2003) identify direct action, positive thinking, help-seeking, and avoidance/resignation as further differentiated strategies. Most consequentially for this thesis, Bhagat et al.'s (2010) cross-national study of six countries found that employees in industrialised nations were more likely to favour problem-focused coping, while employees in more collectivist developing-country contexts more frequently relied on emotion-focused coping, a pattern the authors attribute tentatively to differing individualist and collectivist cultural orientations (see also Mazzola et al., 2011; Xiao and Cooke, 2012). Bhagat et al.'s finding is directly relevant to Saudi Arabia's collectivist, family- and religiously oriented social structure, and offers this thesis a testable expectation, namely that Saudi nurses may lean toward emotion-focused and religiously mediated coping strategies, prayer, reframing hardship as trial or test, reliance on extended family, more heavily than the problem-focused strategies that dominate coping research conducted on Western samples, though Rotondo and Kincaid (2008) caution that neither coping category is inherently superior, and that individuals commonly deploy both within a single cultural context, and even within a single stressful episode, depending on which elements of the situation are appraised as changeable, a caution this thesis takes seriously in avoiding the assumption that emotion-focused coping is evidence of maladaptation rather than a contextually rational response.

2.7.7 Synthesis of the Stress Models

The six models reviewed above expose a field whose multiplicity of frameworks is best explained not by the accumulation of successive improvements on a single settled construct, but by persistent disagreement over how stress should be defined in the first place: as a property of the person, the environment, or their interface (Dewe et al., 2012; Koolhaas et al., 2011). Mark and Smith (2008) attribute this fragmentation partly to a trade-off between parsimony and comprehensiveness: models such as the JDC gain empirical testability and predictive clarity precisely by restricting the range of variables considered, a parsimony Gameiro et al.'s (2020) large-sample latent-profile analysis exploited effectively, while models such as the transactional framework gain explanatory comprehensiveness at the cost of the measurement difficulty Crum et al. (2020) identify, namely that reliable, stable measurement of stressors, strains, and moderating individual traits is inherently difficult when the relationships between those variables

are themselves constantly shifting under conditions of rapid technological, economic, and social change (Phillips-Wren and Adya, 2020; Stone, 2023).

A second, methodological, critique cuts across all six models as conventionally operationalised: the majority of empirical studies applying them, including several reviewed above, rely on cross-sectional, self-report survey data collected at a single point in time (Rudland et al., 2020), a design ill-suited to capturing the evolving, processual character that the transactional model in particular attributes to stress; the Italian nurses study discussed in section 2.13.3, precisely because it adopted a longitudinal rather than cross-sectional design, is consequently one of the more methodologically persuasive pieces of evidence reviewed in this chapter. Dewe et al. (2010) and Mark and Smith (2018) argue that subjective-oriented, process-sensitive methodologies, diary studies, contextual conversation, and qualitative interviewing, are better placed to trace cognitive appraisal, emotional adaptation, and coping behaviour close to their real-time occurrence, notwithstanding the time and interpretive complexity such methods demand (Hurst et al., 2013; Mazzola et al., 2011). This methodological critique directly motivates the qualitative design adopted in Chapter Three of this thesis.

Attempts to resolve this fragmentation by constructing a single unified theory of occupational stress have not succeeded. Mark and Smith's (2008) Demands, Resources, and Individual Effects model, which sought to integrate the JDC, P-E Fit, and ERI job-characteristics models with the individual-differences dimension of the transactional model, has attracted only limited empirical uptake, and its own authors acknowledge that the resulting framework reads more as a review of existing models than as a genuinely novel synthesis, a difficulty compounded by its quantitative testing, which sits awkwardly against the inductive validity concerns the model was partly designed to address. Even where a technically satisfactory unified theory might eventually be constructed, Mazzola et al. (2012) caution that the pace of technological and organisational change threatens to render any such theory obsolete before it can be validated. This thesis therefore follows Mostert et al. (2008) in treating the multiplicity of stress models not as a problem to be solved by further theoretical unification, but as a resource: rather than searching for a single integrated stress theory, the approach adopted here is to draw selectively on the models with the greatest explanatory power for the specific working environment under study, principally the transactional model (section 2.10) as the primary lens, supplemented by the

JDC(S) model's demand-control logic and the Vitamin Model's non-linear dose-response corrective, while treating ERI's economic reward construct and the JCM's autonomy-maximising assumption as requiring the religio-cultural qualification identified in sections 2.13.1 and 2.13.2. It is precisely this combination of models, rather than any one of them taken alone, that is formalised in the conceptual framework in section 2.16.

While there are numerous theoretical debates about the definitions and models of stress in the literature, McVicar et al. (2013) argue that addressing the negative outcomes of stress should be given priority in research and practice. Stress management interventions (SMIs) are defined as any purposeful action taken to reduce or alleviate the stress experience by organisational citizens in the execution of their work functions (Le Fevre et al., 2006, p.548). A critical first step in designing any preventive stress-management intervention is to examine the impact of stress on employees and the organisation as a whole, before adopting health and safety policies aimed at sustaining the physical, mental, and social wellbeing of employees (Hargrove et al., 2011). The literature typically distinguishes three levels of intervention.

Primary interventions act to eliminate, reduce, or modify sources of stress inherent in the workplace, and are therefore proactive and prevention-oriented (Dewe et al., 2010): examples include zero-tolerance harassment policies, work redesign, flexible working patterns, career-development programmes, shared leadership, and enhanced managerial support. Secondary interventions are designed to help employees cope with stress once it has arisen, including wellness programmes, recreational provision, and stress-management training. Tertiary interventions are remedial and therapeutic, aimed at employees already experiencing the signs and symptoms of stress-related illness, and include counselling, rehabilitation, employee assistance programmes, and injury-claim support (Hargrove et al., 2011).

Occupational stress is, in sum, a significant and enduring challenge to organisational health, workforce productivity, and individual wellbeing, one that demands both structural and psychological responses from management. Effective intervention requires action at multiple levels simultaneously: at the structural level, the redesign of job demands and control mechanisms, the adjustment of workloads, the optimisation of shift scheduling and staffing levels, and the clarification of roles and responsibilities to reduce ambiguity and role conflict (Dewe et al., 2010); at the psychological level, attention to employee engagement, organisational

commitment, peer and supervisory support, and affective wellbeing (Bostock et al., 2019). Primary preventive measures, managerial stress-awareness training, systematic hazard identification, and the development of social support structures, are widely endorsed as foundational to sustainable stress management (Hassard et al., 2018), though, critically, no single intervention approach is universally applicable: working conditions must be sensitively adapted to individual differences, occupational characteristics, and the cultural contexts within which stress is experienced and managed, if interventions are to achieve meaningful and lasting organisational benefit (La Torre et al., 2019).

2.8 Gaps in the Literature

The preceding review has identified critical limitations at several points within both the WLB and occupational-stress literatures. This section draws those threads together into four explicit gaps that jointly justify this doctoral study and are addressed empirically in the chapters that follow.

As established in sections 2.3 and 2.9, both the WLB and occupational-stress literatures were substantially theorised and empirically validated within Western, and predominantly Anglo-Saxon, institutional settings (Heymann et al., 2004; Chandra, 2012). Existing Gulf-region and Saudi Arabian studies of nursing stress remain comparatively sparse and rarely engage systematically with the WLB literature at all, treating stress and work-life imbalance as separate research problems rather than as the interconnected phenomena this thesis argues they are. A study that examines WLB and occupational stress jointly, within the specific institutional and geographic context of Saudi Arabian hospital nursing, therefore addresses a contextual gap that neither literature, considered on its own terms, currently fills.

Section 2.7 demonstrated that the three principal WLB theories, border theory, role theory, and boundary management theory, and, in section 2.13, that the six principal occupational-stress models, were each developed and validated on samples drawn overwhelmingly from Western, non-religiously-governed institutional contexts, and that even where the empirical base has since extended beyond that origin, as in Peng et al.'s (2022) Chinese study of border theory or Gameiro et al.'s (2020) Portuguese test of the JDCS model, it has not extended to a setting in which Islamic religious doctrine, patriarchal social structure, and a large migrant professional

workforce jointly condition how individuals construct, negotiate, and control the boundaries between work and personal life. This thesis addresses that theoretical gap directly, by empirically investigating the extent to which border theory's, role theory's, and boundary management theory's core propositions hold, and where they require modification, in the Saudi Arabian nursing context, and by proposing the integrated conceptual framework set out in section 2.16 as a contribution towards closing it.

Section 2.13.7 showed that the dominant methodological approach across the occupational-stress literature, cross-sectional, quantitative self-report survey research, is poorly suited to capturing the dynamic, appraisal-mediated processes that the transactional model itself identifies as central to the stress experience (Rudland et al., 2020; Mark and Smith, 2018). This limitation is compounded, in the specific case of Saudi Arabian nursing research, by the still-limited body of qualitative, inductive work capable of accessing nurses' own framings of stress and WLB in their own terms, rather than through the a priori categories of imported survey instruments such as the ERI and JDC(S) scales discussed above. This thesis's qualitative, semi-structured interview design, detailed in Chapter Three, is a direct methodological response to this gap.

Finally, and most directly responsive to the Joint Examiners' observation that the chapter should culminate in an explicit conceptual framework, sections 2.4 and 2.10 demonstrated that neither the WLB nor the occupational-stress literature, reviewed independently, offers a framework that specifies how socio-cultural and religious moderators interact with structural work demands to shape both boundary negotiation and stress outcomes simultaneously. Existing WLB frameworks (Table 2.1) largely omit religious and communal dimensions of life altogether; existing stress models (Table 2.2 and section 2.13) treat individual differences as a residual moderating category rather than as socio-culturally patterned. The conceptual framework developed in section 2.16 is this thesis's response to that conceptual gap: it is not merely descriptive summary but an original synthesis that positions socio-cultural and religious moderators as a structural input into the boundary-negotiation process, on equal footing with institutional and individual-resource antecedents, rather than as an afterthought to a fundamentally Western analytical architecture.

2.9 Conceptual Framework

Building on the theoretical review in sections 2.7 and 2.13, and directly addressing the conceptual gap identified in section 2.15.4, this section sets out the conceptual framework that structures the empirical investigation reported in Chapters Four and Five. The framework integrates four components. First, structural and institutional antecedents, shift patterns, staffing ratios, professional autonomy, and role load, correspond to the demand and control constructs foregrounded by the JDC(S) model (section 2.13.3) and to the structural condition identified within ERI (section 2.13.2). Second, socio-cultural and religious moderators, gender-role expectations, Islamic normative prescription, and familial obligation, correspond to the contextual qualification this review has argued each Western-derived theory requires (sections 2.7.1 to 2.7.3, 2.13.1 to 2.13.2), and are elevated here to the status of a structural input rather than a residual moderating variable. Third, individual appraisal and resources, coping style, boundary-control beliefs, and professional experience, draw on the transactional model (section 2.13.6) and on role theory's enhancement perspective (section 2.7.2).

These three antecedent categories feed into the central process the framework identifies: border construction and negotiation, drawing on Clark's (2000) border theory (section 2.7.1) as the anchoring lens, through which individuals actively, and unequally, construct and defend the permeability and flexibility of the boundary between their professional and personal domains. This process in turn shapes the boundary management strategies, segmentation, integration, or the hybrid alternation between them, that individuals adopt in practice, understood, following Kossek et al.'s (2023) boundary-control reformulation (section 2.7.3), as constrained choices rather than freely available options. These strategies produce two related but analytically distinct sets of outcomes: occupational stress outcomes (strain, exhaustion, and health and performance effects) and WLB outcomes (conflict or enrichment, and perceived fit).

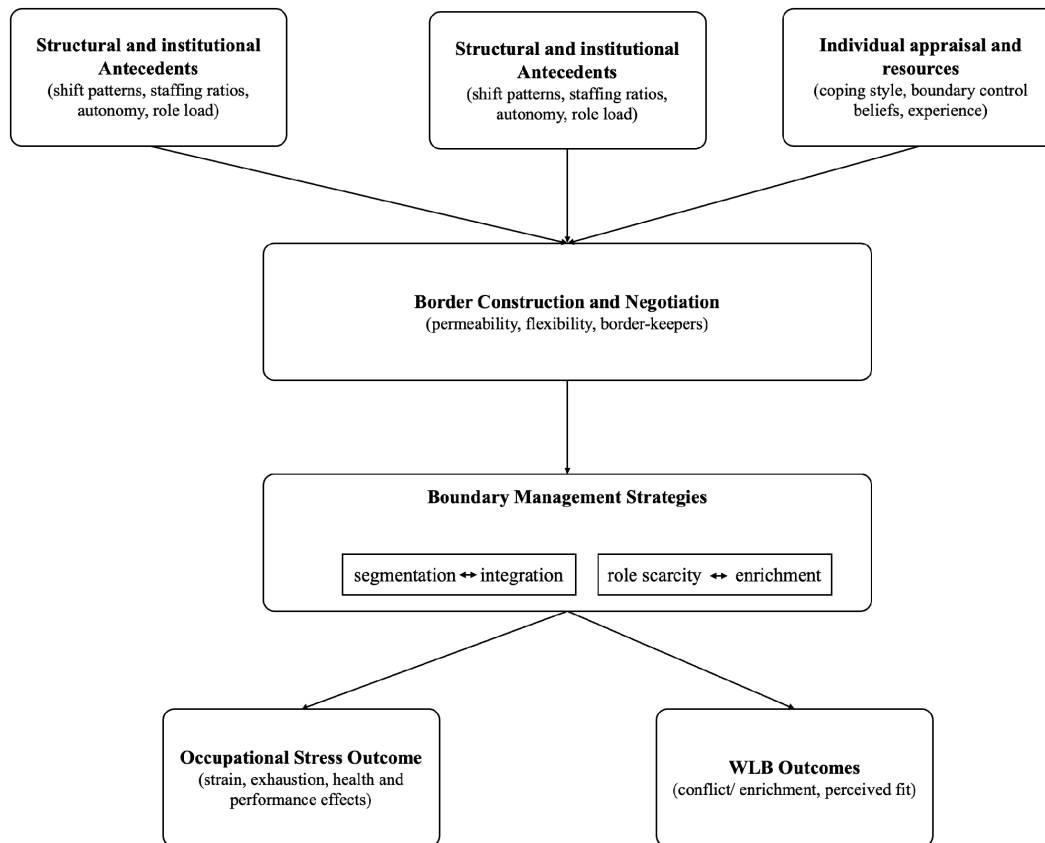


Figure 2.9: Conceptual Framework for the Study.

Source: Author's own construction (2026)

This framework makes an original contribution in two respects. First, it treats socio-cultural and religious moderators as a co-equal antecedent alongside structural and individual factors, rather than folding culture into a generic individual differences category, as the stress models reviewed in section 2.13 tend to do; this repositioning is what allows the framework to accommodate the religio-cultural qualifications identified for ERI and the JCM (sections 2.13.1 and 2.13.2) without abandoning those models' useful demand-and-reward logic. Second, it synthesises what section 2.7.4 established are complementary WLB theories, border theory, role theory, and boundary management theory, with what section 2.13.7 established are complementary stress models, principally the transactional and JDC(S) models, into a single explanatory sequence running from antecedent conditions through negotiation and strategy to dual stress and WLB outcomes, with an explicit feedback loop. It is this integrated sequence, rather than any of the

individually reviewed theories or models, that is carried forward as the analytical lens for the empirical chapters of this thesis.

2.10 Summary of Chapter Two

This chapter has undertaken a critical review of the two literatures central to this doctoral thesis: work-life balance and occupational stress. Part One traced the historical origins and contested conceptualisation of WLB, presented a purposive table of definitions culminating in a working definition adopted for this study, examined the problematic composition of the construct and the nature of work-life conflict, and subjected the three principal WLB theories, border, role, and boundary management, to explicit criticism, empirical scrutiny, and contextualisation to Saudi Arabian nursing before synthesising them. Part Two traced the historical and conceptual development of occupational stress, presented a table of the three definitional perspectives that structure the field, examined the costs and principal sources of workplace stress, and subjected six occupational-stress models to the same critical, evidence-based, and contextualising treatment, closing with a synthesis that positions the transactional model as the primary analytical lens, supplemented selectively by the other models reviewed.

The chapter then identified four explicit gaps, contextual and geographic, theoretical, methodological, and conceptual, that jointly justify this study, and it closed by presenting an original conceptual framework that integrates the WLB and occupational-stress literatures reviewed in Parts One and Two into a single analytical sequence, from structural, socio-cultural, and individual antecedents, through border construction and boundary-management strategy, to occupational-stress and WLB outcomes, with an explicit feedback mechanism. This framework, rather than any single theory or model reviewed in isolation, provides the analytical lens through which the empirical findings presented in Chapters Four and Five of this thesis are interpreted.

3 CHAPTER THREE

METHODOLOGY

3.1 Chapter Overview

The methodology section is an integral part of research as it presents the procedures of carrying out the research inquiry of this work and the justification for the methodological choices made. In doing this, chapter three of the doctoral thesis describes the methodological underpinnings of this research and is structured into three sections. The first section starts with detailing the evaluating various paradigms and philosophical orientations to research while more emphasis will be placed on the underlying philosophy of interpretivism which is philosophical stance of the researcher of this thesis. Key aspects such as epistemological, ontological and methodological claims framing the existing research inquiry are discussed.

The second section covers the discussions on the research approach (inductive) research design used, qualitative method. Here, critical discussions on the issues, controversies and complexities surrounding the contentious knowledge framework of qualitative research in terms of its epistemological diversity, theoretical fluidity and methodological variations are presented. This section also describes and examines conceptualisations of qualitative research especially critical explanations of judging good qualitative inquiry popularly known as the 'criteriology debate' in the literature. Thereafter, the sampling technique used to select participants of study and other data collection criterion are presented. The third and final section gives a detailed overview of the data analysis method used for the study.

3.2 Philosophical Orientation

In the social and management sciences, research philosophy refers to the overarching system of beliefs, assumptions, and principles that undergird a researcher's understanding of the world and their approach to investigating it (Young and Collin, 2004; Saunders et al., 2019). Although philosophical foundations are frequently implied in empirical studies, treated as self-evident rather than explicitly examined (Leavy, 2017), they shape the manner in which knowledge is conceptualised, what counts as legitimate evidence, which methods are deemed appropriate, and how findings are ultimately interpreted and presented (Creswell and Cresswell, 2018). As

Easterby-Smith et al. (2012) observed, the research paradigm encapsulates the nature of knowledge the researcher seeks to generate, whilst Given (2008) similarly noted that research philosophy reflects the researcher's beliefs about the kind of insights attainable through systematic inquiry and the relationship between those insights and the processes through which they are developed. Accordingly, making one's philosophical commitments explicit is not merely a procedural requirement but a condition of intellectual honesty in social inquiry.

Research philosophy operates across several interrelated dimensions that together constitute the researcher's paradigmatic worldview. The ontological dimension concerns assumptions about the fundamental nature of social reality and whether that reality exists independently of human perception or is constituted through social interaction and meaning-making (Creswell and Creswell, 2018). The epistemological dimension addresses what counts as legitimate knowledge and the means by which such knowledge may be acquired (Leavy, 2017). The axiological dimension concerns the role of values in the research process, including the researcher's own positionality and the extent to which value-neutrality is either achievable or desirable (Saunders et al., 2019). Finally, the methodological dimension, shaped by the foregoing philosophical commitments, determines the strategies and techniques through which the research question is investigated and through which data are collected and analysed (Saunders et al., 2019; Creswell and Creswell, 2018). The following sections articulate the researcher's position across each of these dimensions, establishing the philosophical foundation upon which the methodological design of this doctoral thesis rests.

3.2.1 Epistemology of the Study

Epistemology is widely described as the 'theory of knowledge' (Saunders et al., 2019). It constitutes the branch of philosophy concerned with the scope, nature, sources, and limits of human knowledge (DeRose, 2009). Within the context of social inquiry, epistemological questions take a particularly foundational form: What can be known about the social world? What constitutes valid and credible knowledge within a given field of study? By what standards is knowledge justified and legitimated? (Given, 2008). In the production of social scientific knowledge, a researcher's philosophical commitments invariably shape the epistemological position that in turn frames the choice of design, methods, and interpretive strategies deployed

throughout the research process (Easterby-Smith et al., 2012). The epistemological position adopted in this thesis is that of social constructionism, situated within the broader interpretivist tradition.

Social constructionism proceeds from the ontological premise that the social world is not a fixed, objective entity existing independently of human consciousness, but is rather constructed and reproduced through the meanings that social actors hold, negotiate, and enact in relation to social practices and relations (Cassell and Symon, 2004). This stands in marked contrast to positivist epistemologies, which conceive of social reality as external to the knowing subject and amenable to measurement and law-like generalisation (Cohn et al., 2011). A positivist epistemology was considered and rejected for this thesis precisely on these grounds: its commitment to measuring pre-specified, researcher-defined constructs would have foreclosed the kind of participant-generated, culturally situated understanding that the study's research questions require, substituting the researcher's a priori categories for the meanings nurses themselves attach to stress and imbalance. From the social constructionist perspective, as Fernando (2012, p. 468) articulates, reality can be seen as an on-going and dynamic process, constantly reproduced by people acting upon their representations of it. Knowledge production, under this view, is itself a social act embedded in particular historical, cultural, and linguistic contexts.

Burr (2003) cautioned against any singular definitional approach to social constructionism, noting that a variety of theoretical rubrics underpin this paradigm. Nevertheless, she identifies several distinctive features that lend social constructionism its particular character. First, social constructionism demands that researchers adopt a critical stance towards taken-for-granted assumptions about social life, treating commonsense knowledge not as transparent access to an objective world, but as itself constituted through experiential learning and culturally mediated social processes. Second, people's understanding of the world is not timeless but is historically, culturally, and socially contingent, evolving across temporal and spatial contexts. Third, the variety of such contextually-specific understandings gives rise to multiple possible social constructions of any given phenomenon. Fourth, language occupies a central and performative role in social constructionism: it is through language, through discourse, conversation, and narrative, that social realities are brought into being, sustained, and potentially transformed. Fifth, the different interpretations of social reality generate specific forms of social action,

individual and collective, that in turn recursively shape the very conditions of social life. As Fernando (2012, p. 468) observes, people and the social structures they inhabit exist in a continuous dialectical process of influencing one another.

The adoption of social constructionism in this doctoral thesis is directly motivated by the nature of the research questions it pursues. The inquiry seeks to understand how and why the challenges of work-life imbalance and occupational stress affect the quality of life of nurses employed in Saudi Arabian hospitals. Social constructionism is particularly well-suited to this investigative endeavour because it enables the researcher to attend to the manner in which employees and their social workplace environments are mutually constitutive: it illuminates how social contexts shape the ways in which workers make sense of stress, how such stress spills over into non-work domains, and how both individuals and organisations respond to its consequences. Furthermore, and crucially for the cross-cultural character of this study, the constructionist frame attends to the manner in which the nursing profession and the specific cultural and institutional context of the KSA are in continuous interaction, generating situated and contextually embedded understandings of WLB that cannot be adequately captured by decontextualised survey instruments developed within Western research traditions.

3.2.2 The Researcher's Ontological Position

Ontological paradigm directs attention to the prior question of what that reality fundamentally is. Ontology, conceived as an enquiry into the nature and constitution of reality, operates along a continuum spanning from objectivist to subjectivist assumptions about the character of social existence (Easterby-Smith et al., 2012). Objectivism holds that social reality, including social phenomena, institutions, and structures, exists independently of the social actors who populate it, and that reliable knowledge of this reality is available to the researcher who approaches it with methodological rigour and a commitment to value-neutrality. By contrast, subjectivism, which is the ontological orientation adopted in this thesis, proceeds from the recognition that social realities are, in significant measure, the products of the perceptions, interpretations, and meaning-making activities of the social actors who inhabit them (Creswell, 2008). This orientation was adopted because adopting an objectivist ontology would have required the researcher to treat WLB and occupational stress as measurable properties existing independently

of nurses' own interpretive frameworks, an assumption that this thesis's research questions, concerned with how and why these phenomena are experienced and made sense of, cannot sustain (Easterby-Smith et al., 2012). As Endres and Wood (2006, p. 222) conceptualise, subjectivist research is behaviourally defined, directing its analytical attention to the internal mental processes and personalised meanings through which social phenomena are constituted.

The researcher of the current study positions himself as a subjectivist, oriented towards making meaningful scholarly contributions through the description and interpretation of participants' socially constructed understandings of occupational stress and work-life imbalance within the Saudi nursing context. This ontological commitment carries significant methodological consequences. Adopting a subjectivist position means acknowledging that the researcher cannot stand wholly outside the social phenomena under investigation; the boundary between the inquirer and the inquiry is, to some degree, always permeable. As Willig (2001) and Burr (2003) observe, researchers who embrace social constructionism necessarily bring their own prior conceptualisations, experiential frameworks, and interpretive resources to the research encounter, both consciously and otherwise. This epistemic involvement is not a deficiency to be minimised but a constitutive feature of interpretivist inquiry to be acknowledged and managed through reflexivity.

In line with this position, the researcher of this study is committed to making the dimensions of his reflexivity explicit. His background as a Saudi national, his lived familiarity with the cultural and institutional context of the Kingdom, and his direct experience of the demands placed upon healthcare workers during extended periods of hospitalisation in Saudi Arabia, together constitute a prior orientation that has animated and shaped his interest in this inquiry. As Nightingale and Cromby (1999) suggest, personal reflexivity requires the researcher to reflect on how their background, lived experiences, emotional investments, and situational embeddedness have illuminated and shaped both the motivation to pursue a particular line of inquiry and the manner in which the inquiry unfolds. Following the approach employed by Uracha (2009) in her doctoral research, the present thesis incorporates reflexive engagement as an explicit methodological component rather than a post-hoc addendum. This is not merely a gesture towards transparency; it is an epistemological acknowledgement that, in research of this nature,

the researcher's involvement in the production of knowledge is deeply inherent and analytically consequential.

3.3 Methodological Conduit

A conceptual distinction of considerable practical significance in social inquiry is that between methodology and method, terms that are frequently and incorrectly used interchangeably in the research literature (Willig, 2001). Methodology, as Saunders et al. (2012) define it, constitutes a theoretical analysis defining a research problem and how research should proceed, providing the broad intellectual framework within which specific methods are selected and deployed. Method, by contrast, refers to specific techniques or tools for data collection and analysis. The relationship between them is not merely procedural but philosophical: methodological choices require the researcher to step beyond the routine application of techniques and to justify the underlying philosophical commitments that govern the inquiry. It is in this spirit that the following sections present the methodological rationale for the present doctoral thesis, engaging not merely with what was done but with why a particular approach to knowledge production was judged most appropriate for the questions pursued.

3.3.1 Critical Reflections on the Qualitative Research Framework

Qualitative research has long occupied a contested position within the social and management sciences, characterised by ongoing epistemological debates, theoretical pluralism, and methodological diversity that together resist reduction to any single, unified paradigm. Johnson et al. (2007, p. 24) describe the term 'qualitative research' as a broad-based conceptual device that people regularly use to make sense of their worlds by signifying particular forms of management research, an abstraction that enables researchers to give order to their impressions by enabling the categorisation of certain aspects of lived experience. The contested nature of this abstraction reflects the fact that qualitative methodologies encompass a wide range of theoretical traditions, epistemological commitments, and design strategies, each carrying distinct implications for the production, assessment, and validity of knowledge claims.

Drawing on the work of Guba and Lincoln (1994), research paradigms in the social sciences can be broadly organised into four categories: positivism, critical realism, critical theory, and social

constructivism. Positivism, which is the dominant paradigm of the natural sciences, assumes that a singular, discernible reality exists independently of the observer, and that surveys, experiments, and other quantitative methodologies constitute the most appropriate means of measuring objective facts about that reality (Lincoln and Guba, 1985). Positivist epistemology regards the researcher as a detached, value-neutral observer who approaches the social world through what Guba and Lincoln (1994) evocatively describe as a 'one-way mirror,' maintaining a strict boundary between the observer and the observed. Critics of positivism within the social sciences have argued persuasively that its foundational assumptions are ill-suited to the study of human experience, which is inherently interpretive, contextually contingent, and resistant to the law-like generalisations that positivism seeks to produce.

The remaining three paradigms, critical realism, critical theory, and social constructivism, are in various ways more liberal to the kinds of interpretive engagement that characterise qualitative inquiry. Critical theory is directed towards understanding social phenomena and towards their emancipatory transformation, attending to the operations of power, ideology, and structural inequality that shape social life (Healy and Perry, 2000). Critical realism acknowledges the existence of an independently existing social reality whilst simultaneously recognising that human access to that reality is always mediated through frameworks of interpretation, culture, and language (Fleetwood, 2007; Symon and Cassell, 2012). It was for this reason considered, alongside positivism, and set aside as the epistemological foundation for the present study: critical realism's residual commitment to an observer-independent reality existing beneath participants' interpretations sits uneasily with a set of research questions concerned precisely with how meaning, rather than an antecedent objective condition, constitutes the experience of stress and imbalance for Saudi nurses. Social constructionism, as elaborated in the preceding sections, holds that social realities are constituted through the interpretive activities of social actors, making language, narrative, and social interaction the primary sites of meaning-production.

The epistemological diversity of qualitative research has generated a corresponding proliferation of methodological approaches, including grounded theory, ethnography, phenomenological inquiry, discourse analysis, feminist research, hermeneutics, and narrative methods, among others (Cohen et al., 2011; Saunders et al., 2019). Each of these methodological traditions brings

with its distinctive assumptions about the relationship between the researcher and the researched, the nature of the data appropriate to the inquiry, and the criteria by which findings may be assessed. This methodological pluralism, whilst one of the great intellectual strengths of qualitative inquiry, also generates considerable complexity for researchers who must navigate competing frameworks and justify their choices within a particular philosophical and disciplinary context.

3.3.2 Judging Good Qualitative Inquiry: The Criteriology Debate

One of the most enduring controversies within qualitative methodology concerns the criteria by which the quality and rigour of qualitative research may be judged. The major concern here is that in the absence of agreed-upon assessment standards, qualitative inquiry risks either uncritical acceptance or wholesale dismissal by scholarly and policy communities accustomed to the operationalised criteria of positivist research such as validity, reliability, objectivity, and generalisability (Saunders et al., 2019). Applying these quantitative criteria to qualitative research is, however, philosophically incoherent, given that qualitative inquiry is premised on ontological and epistemological commitments that fundamentally contest the assumptions underlying such criteria. The challenge, therefore, is to develop criteria that are both appropriately rigorous and philosophically coherent with the interpretivist tradition.

The most influential response to this challenge was advanced by Guba and Lincoln (1989, 1994), who proposed 'trustworthiness' and 'authenticity' as the guiding criteria for evaluating qualitative studies. Their trustworthiness framework comprises four sub-criteria that are explicitly constructed as philosophical analogues to their quantitative counterparts: credibility (analogous to internal validity), transferability (analogous to external validity), dependability (analogous to reliability), and confirmability (analogous to objectivity). Credibility requires that research findings accurately represent the social phenomena and participant perspectives under investigation, and may be established through extended field engagement, persistent observation, and member-checking, this relates to the practice of returning transcribed data to participants for verification prior to analysis (Lincoln and Guba, 1985). Transferability does not imply the statistical generalisation associated with positivist research, but rather the provision of sufficiently rich, 'thick' contextual description to enable readers to judge the applicability of

findings to comparable settings. Dependability requires that the research process be documented in sufficient detail to allow for independent audit and replication. Confirmability demands transparency regarding the manner in which the researcher's own values and perspectives have been managed throughout the inquiry (Lincoln and Guba, 1985).

However, the Guba and Lincoln's (1985) framework has not gone unchallenged. Critics contend that any attempt to establish predetermined, universal criteria for assessing qualitative research is fundamentally at odds with the epistemological pluralism and contextual sensitivity that define the qualitative paradigm (Bansal and Corley, 2011). These divergent perspectives form the criteriology debate in qualitative research (Cassell and Symon, 2011). Proponents of the anti-criteriology stance, such as Garratt and Hodgkinson (1998), argue that establishing universal, predefined criteria for judging research quality can impose artificial standards and preconceived expectations about what research ought to look like. Such pre-specification risks constraining inquiry by enforcing a priori conditions that may not be suitable across diverse methodological contexts. In this sense, quality frameworks may function as regulatory mechanisms that delimit what kinds of research practices are considered legitimate.

Critics therefore contend that applying fixed evaluative benchmarks, often derived from positivist traditions, can undermine the flexibility, creativity, and exploratory nature of qualitative inquiry (Seale, 1999; Saunders et al., 2019). Rather than seeking definitive epistemological guarantees, Schwandt (1996) proposes embracing uncertainty and fallibilism as inherent features of interpretive research. From this perspective, quality should emerge through ongoing dialogue, critical reflection, and deliberation, acknowledging that knowledge claims remain provisional and contextually situated rather than finally validated.

Notwithstanding the force of these critiques, the position adopted in the present thesis is that some evaluative framework is both necessary and desirable for the production of accountable, credible qualitative scholarship. In this respect, the researcher concurs with Symon and Cassell (2012, p. 29-30), who suggest that the authenticity and credibility of qualitative inquiry are best assessed by reference to: (1) the transparency with which the researcher discloses their philosophical orientations, motivations, and presuppositions; (2) the coherence between the epistemological commitments underpinning the methodology and the methods employed to collect and analyse data; (3) the rigour of the research design, evaluated in a manner that is

philosophically consistent with the researcher's paradigmatic commitments; and (4) the analytical integrity with which the data are examined in light of the study's epistemological and ontological assumptions. Each of these dimensions is addressed within the present chapter and, reflexively, throughout the thesis as a whole.

3.3.3 The Relevance of the foregoing Discussions on the Current Study

Notwithstanding the theoretical complexities and contested debates described above, the present study adopts a qualitative methodology as the most epistemologically coherent and contextually appropriate approach for addressing its research questions. The grounds for this choice are both philosophical and empirical.

Philosophically, the study's commitment to social constructionism and interpretivism makes qualitative inquiry the most appropriate and natural methodological choice. Qualitative methods are uniquely suited to this research because they prioritise interpretation over quantification and embrace subjectivity as a legitimate and valuable source of knowledge rather than a limitation to be controlled. This approach offers considerable flexibility in the research process, maintaining an orientation toward understanding process rather than simply measuring outcomes. Crucially, qualitative inquiry recognises that behaviour and context are inextricably linked in shaping human experience, while also explicitly acknowledging the influence of the research process itself on the situation being studied (Cassell and Symon, 1994). As Omeihe and Harrison (2024) observe in their overview of qualitative methods for business and management research conducted across diverse global settings, qualitative approaches are especially well placed to surface the situated, culturally inflected dynamics of organisational life that standardised, Western-derived research instruments frequently overlook, a consideration of direct relevance to a study conducted within the specific institutional and cultural setting of Saudi Arabian healthcare.

Empirically, the choice of qualitative inquiry reflects the character of the research field and the limitations of existing scholarship. Research on occupational stress in healthcare settings has been dominated by quantitative designs, typically employing pre-structured survey instruments

to measure predetermined stressor and strain constructs (McGuire and McLaren, 2009). Whilst such approaches yield important epidemiological data, they are limited in their capacity to capture the full complexity of stress as a lived, contextually embedded, and processual experience. As Mazzola et al. (2012, p. 94) contend, qualitative research can play a role in the discovery of stressors, strains and coping behaviours that were not originally thought of by researchers using structured instruments. The overreliance on self-report questionnaires in occupational stress research has attracted considerable criticism. As Mazzetti and Blenkinsopp (2012) argue, such instruments are limited in their capacity to capture the full complexity of stress experiences, as they only record a static moment in time, assuming that any given stressful encounter is representative of an individual's broader life situation. This approach risks extracting isolated 'bits' of the stress process from their relational and contextual dimensions, thereby undermining the depth and authenticity of the findings.

Moreover, most cross-cultural studies on work stress and WLB in non-Western settings continue to employ survey instruments developed and standardised within Western cultural contexts, raising serious concerns about their construct validity when applied in markedly different social, cultural, and institutional environments (Liu et al., 2007; Idris et al., 2010). This problem is particularly acute in the Saudi Arabian context, where religious values, gender stratification, and distinctive institutional arrangements shape the experience of work and family life in ways that are unlikely to be adequately captured by standardised Western instruments. Qualitative methods, by contrast, enable the researcher to attend closely to the participants' own framings and vocabularies, generating contextually grounded, culturally sensitive accounts of their lived experiences (Sanchez et al., 2007; Kortum et al., 2008; Idris et al., 2010).

The present thesis thus employs qualitative inquiry not because quantitative approaches are inherently inferior, but because the nature of the research questions, which seek to illuminate the meanings, processes, and contextual conditions through which nurses in the KSA make sense of occupational stress and work-life imbalance, requires precisely the kind of richly contextualised, interpretive understanding that qualitative methods are uniquely positioned to provide.

Table 3.1: Characteristic Features of Qualitative Research Inquiry

Component	Paraphrased Description
Purpose of Qualitative Research	Qualitative research is conducted through sustained and in-depth engagement with participants in their natural settings. It seeks to explore and understand the

	everyday or unique experiences of individuals, groups, cultures, societies, and organisations.
Researcher's Role	The researcher aims to develop a comprehensive and integrated understanding of the context under investigation. This includes examining social structures, motivations, perceptions, attitudes, and behavioural patterns that shape participants' experiences.
Instruments Utilised	Qualitative studies rely minimally on standardised tools. The researcher serves as the primary research instrument, using methods such as structured, semi-structured, and unstructured interviews, observations, field notes, document analysis, reflective memos, and artefacts.
How Data Is Captured	Data are gathered through careful observation, active listening, and empathetic engagement. Researchers strive to understand participants' perspectives deeply, often bracketing or setting aside personal assumptions about the phenomenon being studied.
Analytical Process	Analysis involves iterative reading and interpretation of the data to identify recurring themes, patterns, and categories (codes), which may be refined and validated with participants.
Implication of the Study	Qualitative research aims to situate participants' perspectives within their specific contexts, enabling a nuanced understanding of lived experiences in everyday settings.
Outcomes	Findings typically contribute to the development of theoretical insights and conceptual frameworks grounded in participants' narratives and experiences.

Source: Adapted from Miles et al. (2014)

3.4 The Research Method

The design of a research method is shaped by the manner in which research questions are formulated, whether they are explanatory, seeking to account for causal relationships between variables; descriptive, aiming to provide accurate representations of a phenomenon or population; or exploratory, oriented towards the generation of new theoretical insights and conceptual understanding (Saunders et al., 2019). The present doctoral thesis is fundamentally exploratory in character. Its aim is to generate new conceptual understanding of the nature, experience, and consequences of occupational stress and work-life imbalance among nurses within the specific cultural and institutional context of the KSA, an area that, to the best of the researcher's knowledge, remains substantially underexplored at the doctoral level of investigation.

Explanatory research designs, as Saunders et al. (2019) observe, are primarily suited to investigations of causal relationships and are more naturally aligned with quantitative paradigms. Descriptive research, whilst sometimes dismissed as insufficiently analytical, can yield valuable and veracious profiling of persons, events, and social contexts, particularly when it serves as a forerunner to more theoretically ambitious inquiry (Robson, 2002). Both methods were

considered for, and set aside from, the present study. A descriptive design was set aside because, whatever its value in profiling a population, it is not itself oriented towards the generation of the conceptual and theoretical understanding that this thesis seeks to produce, and would therefore have understated the study's ambitions. An explanatory design was set aside for the more fundamental reason that it presupposes a set of variables and hypothesised causal relationships to be tested, a presupposition that the absence of an adequately validated theoretical account of WLB and occupational stress among Saudi nurses renders premature; testing relationships between constructs not yet properly identified in this population risks producing precise but conceptually hollow findings (Saunders et al., 2019; Yin, 2011). Exploratory research, by contrast, is oriented towards discovering new ideas, making interpretive enquiries, and understanding social phenomena from fresh perspectives. The modes of questioning most associated with exploratory inquiry, 'what?', 'why?', and 'how?', are those that animate the research agenda of this thesis, which is concerned with what occupational stress and work-life imbalance mean for nurses in Saudi Arabia, why these experiences take the forms they do in this particular cultural and institutional context, and how nursing professionals navigate the complex and often blurred boundaries between their work and personal lives.

The exploratory orientation of the present study is further warranted by the comparative underdevelopment of the existing research literature on occupational stress and WLB in non-Western, and particularly Middle Eastern, healthcare contexts. As Bhagrat et al. (2010) emphasise, extending research on organisational stress and its multiple facets across national borders and into non-Western cultural settings is of considerable importance for the theoretical development of the burgeoning interdisciplinary field of culture, stress, and WLB scholarship. The present thesis represents, to the researcher's knowledge, a foundational doctoral-level contribution to this literature within the Saudi Arabian nursing profession.

3.5 Deductive and Inductive Research Approaches

The choice of research approach, either deductive or inductive, constitutes a foundational methodological decision that is intimately bound up with the researcher's philosophical orientation and the character of the research questions being pursued (Saunders et al., 2019). The deductive approach, most closely associated with positivism and the natural sciences, proceeds

by moving from theory to data (Cresswell and Cresswell, 2018). Here, the researcher begins with an existing theoretical framework or hypothesis and tests it against empirical evidence through operationalised measurement and controlled analysis (Bryman and Bell, 2011; Saunders et al., 2019). This 'top-down' strategy places a premium on logical rigour, operationalisation, and the capacity for statistical generalisation. The deductive paradigm also carries the expectation that the researcher maintains a position of independence and objectivity in relation to the phenomena under investigation.

The inductive approach, which provides the epistemological and methodological foundation for the present doctoral thesis, proceeds in the opposite direction. Induction moves from specific empirical observations to the development of more abstract theoretical propositions. Rather than testing pre-specified hypotheses against data (Cresswell and Poth, 2018), inductive inquiry begins with the data itself, exploring the lived experiences, narratives, and interpretations of social actors, and builds upward towards conceptual frameworks and theoretical generalisations that are grounded in those empirical particulars (Bryman and Bell, 2011). This 'bottom-up' orientation is well-suited to exploratory research in contextually novel or theoretically underdeveloped areas, where the imposition of predetermined theoretical categories risks distorting or pre-empting the insights that close engagement with empirical material might otherwise yield.

The inductive approach adopted in this thesis is directly consonant with its interpretivist philosophical commitments. Both the epistemological emphasis on contextually situated, participant-generated meanings and the ontological recognition that social realities are constructed rather than discovered point towards an approach that privileges theoretical emergence over prior deductive specification. In addition, because no adequately validated deductive framework or instrument yet exists for measuring WLB and occupational stress among Saudi nurses specifically, as opposed to nurses or professionals in Western or other Gulf settings, a deductive design would have obliged the researcher either to import an unvalidated Western instrument, with the construct-validity risks this carries (Liu et al., 2007; Idris et al., 2010), or to construct a novel instrument without the prior qualitative groundwork needed to specify its items meaningfully; induction avoids both difficulties by allowing the relevant constructs to be identified from the data itself, before any instrument is built or any relationship between them is

tested (Bryman and Bell, 2011). The study thus proceeds by engaging deeply with nurses' accounts of their working lives, their experiences of stress and imbalance, and the contextual conditions, cultural, institutional, and interpersonal, that shape these experiences, and by constructing from these accounts a theoretical understanding that contributes to the existing scholarly literature.

Table 3.2: Differences Between Deductive and Inductive Research Approaches

Deductive Approach	Inductive Approach
Proceeds from theory to data; concerned with causal explanation between variables.	Proceeds from data to theory; concerned with contextual understanding and theoretical emergence.
Grounded in scientific principles and hypothetico-deductive logic.	Grounded in interpretive principles and the close analysis of research context.
Favours highly structured methodological protocols and standardised instrumentation.	Favours methodological flexibility and sensitivity to participant meanings and interpretive variation.
Researcher as independent, objective observer, separate from the phenomena under study.	Researcher as constitutive participant in the research process, reflexively engaged with the inquiry.
Primarily collects and analyses quantitative data amenable to statistical testing.	Primarily collects and analyses qualitative data prioritising contextual depth over breadth.
Concerned with statistical generalisation across populations.	Less concerned with generalisation; prioritises theoretical contribution grounded in empirical data.

Source: Adapted from Saunders et al. (2019)

3.6 Research Design of the Study

Research design constitutes the overall strategic plan through which a research project is operationalised: it encompasses the framework within which data are collected, analysed, and interpreted in order to answer the research questions that motivate the inquiry (Cooper and Schindler, 2001). The choice of research design is neither arbitrary nor merely technical; it reflects the researcher's philosophical commitments and the character of the phenomena being investigated. In the qualitative tradition, a range of design strategies is available, including case studies, ethnography, grounded theory, action research, narrative inquiry, and archival research, each suited to particular kinds of research questions and epistemological orientations (Easterby-Smith et al., 2012; Yin, 2011).

For the present doctoral thesis, a qualitative research design was selected as the most appropriate vehicle for investigating occupational stress and work-life imbalance within the Saudi nursing context. This choice is consistent with the study's exploratory character and its inductive, interpretivist orientation. Other qualitative design strategies available to the researcher were considered and, for specific and defensible reasons, not adopted. Ethnography was set aside

because it demands prolonged, immersive fieldwork within a single organisational setting (Hammersley and Atkinson, 2007), a level of sustained access that was neither practically obtainable across three separate hospitals operating under distinct public and private governance arrangements, nor necessary given that the research questions concern nurses' own accounts of their experience rather than the researcher's direct observation of ward-level interaction. Grounded theory was considered more closely, given its shared commitment to theoretical emergence from data, but was ultimately not adopted because its full procedural apparatus, particularly theoretical sampling conducted iteratively until categories are saturated, and constant comparison pursued to the point of generating an entirely new substantive theory (Glaser and Strauss, 1967; Charmaz, 2006), presupposes that no adequate prior theoretical vocabulary exists for the phenomenon under study; this thesis, by contrast, engages critically with an established, if predominantly Western-derived, body of WLB and occupational-stress theory (Chapter Two) and seeks to test, extend, and contextualise that vocabulary rather than to bracket it entirely in pursuit of an *ab initio* theory. A single-organisation case study (Yin, 2011; Stake, 1995) was similarly set aside, since the research questions are concerned with patterns across the Saudi nursing profession rather than with the bounded particularity of one institutional site. Narrative inquiry (Clandinin and Connelly, 2000; Riessman, 2008), whilst attractive for its close attention to the storied structure of individual accounts, was judged less well suited than thematic analysis to a study seeking cross-participant patterns across a comparatively large sample of seventy nurses, where the priority lies in identifying shared and divergent themes rather than in the deep reconstruction of a small number of individual life narratives. As Creswell (2010) argues, qualitative inquiry is most appropriate when the researcher's intent is to gain a deep, contextually rich understanding of the phenomena under study, especially when the aim is not to measure or test but to interpret, to give voice to the perspectives of those most directly implicated in the phenomena, and to generate theoretical understanding from the ground up (Saunders et al., 2019). The central aspiration of qualitative design is thus not to fit data to pre-existing theory, but rather to allow theoretical propositions to emerge from sustained, empathic engagement with the empirical material (Robson, 2002; Yin, 2011).

Moreover, qualitative research is uniquely positioned to capture the reciprocal determinism between the researcher and the field of study. This means the ways in which the researcher's values, presuppositions, and interpretive frameworks shape the collection and analysis of data,

and how, reciprocally, the phenomena encountered in the field inflect and transform the researcher's understanding (Creswell, 2010; Cresswell and Poth, 2018). This reflexive interplay is not a methodological weakness to be controlled for, but a constitutive feature of interpretivist inquiry to be made analytically productive (Pickard, 2017). It is for these reasons that qualitative design was adopted in the present study as the methodological framework within which the experiences of nurses in Saudi Arabia could be explored with the depth, contextual sensitivity, and interpretive rigour that the research questions demand.

3.6.1 Sampling Strategy

The selection of research participants in qualitative inquiry is guided by a fundamentally different logic from that which governs sampling in quantitative research. Whereas quantitative sampling is typically oriented towards statistical representativeness, qualitative sampling is oriented towards purposeful depth of engagement and the achievement of informational richness relevant to the research questions at hand (Creswell, 2010; Patton, 2015). Qualitative researchers adopt non-probability sampling approaches not as a concession but as a principled choice consistent with the epistemological goals of their inquiry. The aim is not to produce a statistically representative cross-section of a population, but to access participants whose experiences, knowledge, and perspectives are most pertinent to the research questions, and through whose accounts rich, contextually grounded theoretical insight can be generated (Saunders et al., 2019). A convenience sample, drawn simply from whichever nurses were most readily accessible to the researcher, was considered and rejected, since it would have offered no principled assurance that participants possessed the specific combination of professional experience and parental responsibility that the research questions require; purposive sampling, by contrast, allowed eligibility to be tied explicitly to the theoretical constructs under investigation, at the cost of the statistical representativeness that a probability sample would have offered but that this exploratory, theory-generating study does not require (Patton, 2015).

In the present doctoral thesis, a purposive sampling strategy was employed to recruit participants. Purposive sampling, sometimes described as deliberate or judgement sampling, involves the intentional selection of participants based on specific, theoretically motivated criteria judged to be most relevant to the research inquiry (Patton, 2015). The researcher does not

aim for statistical representativeness but for the purposeful selection of information-rich cases. Three eligibility criteria governed recruitment in this study. First, participants were required to be registered and qualified nurses actively practising within their respective hospital settings. Second, they were required to possess a substantive level of nursing practice experience, operationalised as a minimum of three years of professional nursing work. This criterion was designed to ensure that participants had accumulated sufficient professional experience to speak authoritatively about the occupational stressors, institutional dynamics, and work-life challenges that constitute the object of enquiry. Third, all participants were required to have children, irrespective of their formal marital status, on the grounds that the lived experience of managing competing demands between a demanding professional role and parental responsibilities is central to the WLB dynamics that this research seeks to understand. Each of these three criteria was thus selected not as an arbitrary demographic filter but as a theoretically motivated inclusion condition tied directly to the constructs under investigation: registered, practising status ensured that participants could speak to the structural demands of the role as currently experienced rather than retrospectively or hypothetically; the three-year experience threshold was set with reference to the point at which nurses in comparable healthcare settings are typically judged to have moved beyond initial role socialisation and to have accumulated a stable pattern of boundary-management practice worth investigating (Almalki et al., 2011); and the parental-status criterion operationalises, at the level of sampling, this thesis's border-theoretic definition of WLB, since the negotiation of borders between professional and familial roles that border theory foregrounds is most acutely and continuously enacted by nurses who are simultaneously responsible for the care of children (Clark, 2000; Peng et al., 2021).

Recruitment was conducted through a combination of email outreach, personal contacts established through the researcher's professional and social networks, and a snowballing approach whereby initial participants were asked to refer colleagues meeting the eligibility criteria (Saunders et al., 2012). Snowballing, whilst sometimes criticised on grounds of potential sampling bias, is particularly appropriate in contexts where the target population is embedded within specific institutional settings and where access may be contingent on trust and social proximity (Patton, 2015). The participants' ages ranged from 25 to 50 years. This range encompasses the period of peak professional activity and, relatedly, the years in which the

demands of parenting and career advancement are most likely to intensify and compete with one another (Almalki et al., 2011).

A total of 70 nurses were recruited from three hospitals, one private specialist hospital and two public general hospitals, all located in Mecca. The sample comprised 60 female and 10 male nurses, reflecting the gendered composition of the nursing workforce in the KSA and thus broadly representative of the professional demographic that the study aims to understand. The rationale for this sample size warrants brief discussion. Qualitative inquiry generally prioritises depth of engagement over breadth of coverage, and data saturation. Data saturation describes the point at which further data collection yields no additional conceptual insight. It is typically achieved with considerably smaller sample sizes than those employed in quantitative research (Saunders et al., 2019).

However, as Akanji et al. (2020) observe, studies exploring complex, multidimensional psychological and professional concerns in under-researched cultural contexts, and particularly those drawing on a range of specialisations and institutional settings, may justifiably require larger participant numbers to achieve genuine conceptual saturation. Following 59 interviews, it was determined that saturation had been reached, in the sense that subsequent interviews were generating no substantive new themes or conceptual insights (Bowen, 2008). Six additional interviews were then conducted to confirm this judgement and to provide additional corroborating evidence for the emergent themes.

3.6.2 The Healthcare and Nursing Landscape in the Kingdom of Saudi Arabia

In order to contextualise the empirical setting within which the research was conducted, it is important to provide an overview of the healthcare system and the nursing profession as they are structured and practised within the KSA. An understanding of these structural features is necessary for situating the experiences of the study participants and for appraising the specific institutional, cultural, and professional conditions that shape their working lives.

The healthcare system of the KSA is characterised by a dual-sector structure comprising an extensive government-funded public health service and a growing private sector. The primary governmental authority responsible for the provision of healthcare is the Ministry of Health

(MoH), which administers a network of primary healthcare centres and referral hospitals providing preventive, curative, and rehabilitative care to the Saudi population (Rahman and Al-Borie, 2021; Almalki et al., 2011). Beyond the MoH, a range of other governmental agencies, including the Ministry of Defence and Aviation, the Ministry of Interior, the Saudi Arabian National Guard, and university teaching hospitals, provide healthcare services to their respective employees and, in some instances, to segments of the wider population (Aldossary et al., 2008). The private sector has expanded significantly in recent decades, encompassing an extensive network of hospitals, specialist clinics, dispensaries, and pharmacies integrated into a referral system alongside the public sector. According to data from the Saudi Ministry of Health Statistical Yearbook (2021), the KSA hosts 287 MoH hospitals, 159 private sector hospitals, and 51 other governmental health facilities, staffed collectively by approximately 122,356 doctors and 201,489 nurses and midwives.

The history of nursing in the KSA is, by any measure, a rich and culturally distinctive one. The origins of organised nursing care in the Islamic world are frequently traced to Rifaida Al-Asalmiya, a figure who provided nursing care and first aid to Muslim armies during the holy wars of the Prophet Mohammed's era, and who subsequently established training programmes for women in the art of nursing and health education, using tented facilities adjacent to mosques (Aboul-Enein, 2002; Sebai et al., 2001; Tumulty, 2001). Rifaida's legacy, widely regarded as the first nurse and founder of nursing in the Islamic era, establishes a cultural and historical lineage for the profession that is of more than merely antiquarian significance. It speaks to the deep embeddedness of nursing within Islamic and cultural traditions that continue to shape both the gendered character of the profession and the social expectations placed upon its practitioners in the contemporary KSA.

In the contemporary period, nursing in the KSA is a highly specialised and demanding profession, encompassing a wide range of clinical specialisations including advanced nursing practice, nursing education, consultant nursing, cardiovascular care nursing, clinical specialist nursing, community health nursing, midwifery, paediatrics, parent-child nursing, home health nursing, neuroscience, and ambulatory care, among others. The Kingdom has, in recent decades, made substantial investments in healthcare infrastructure and nursing education as part of its broader Vision 2030 agenda, positioning the development of indigenous healthcare capacity as a

national priority (Almansour et al., 2023). Nevertheless, as the present thesis demonstrates, the demanding character of nursing practice in the KSA, combined with the specific cultural and institutional pressures that characterise the Kingdom's social landscape, including gender role expectations, limited childcare infrastructure, and the particular pressures facing both Saudi national and expatriate nurses, generates significant occupational stress and work-life imbalance among practitioners.

3.6.3 The Demographic Profile of Research Participants

A total of 70 nurses were recruited from three hospitals in Mecca: the Healthcare General Hospital, the Whole Health Government Hospital, and the Wellness Private Specialist Hospital. The sample comprised 60 female participants and 10 male participants, reflecting the gendered composition of the nursing workforce in the Kingdom. Participants ranged in age from 25 to 50 years and in nursing experience from 3 to 20 years, capturing a breadth of career stages and professional contexts. In order to honour the commitments of confidentiality and anonymity made to participants at the point of recruitment, pseudonyms, Participant 1, Participant 2, and so forth, were assigned to all interviewees, and the names of the three hospitals have been fictionalised. The demographic profiles of the participants across the three hospital sites are detailed in Tables 3.3, 3.4, and 3.5 below.

No.	Participant	Age	Gender	Years of Experience	Work Speciality
1	Participant 1	21	Female	3	Clinical Nursing
2	Participant 2	40	Female	5	
3	Participant 3	32	Female	7	
4	Participant 4	42	Female	8	
5	Participant 5	38	Female	4	
6	Participant 6	35	Male	6	Community Health Nurse
7	Participant 7	50	Female	9	
8	Participant 8	28	Female	8	
9	Participant 9	36	Male	10	
10	Participant 10	30	Female	6	
11	Participant 11	26	Female	5	Parent-Child Nursing
12	Participant 12	45	Female	9	
13	Participant 13	40	Female	8	
14	Participant 14	39	Female	9	

15	Participant 15	32	Female	7	
16	Participant 16	34	Male	8	
17	Participant 17	40	Female	9	Paediatrics
18	Participant 18	26	Female	2	
19	Participant 19	42	Male	6	
20	Participant 20	50	Female	10	Nursing Consultant
21	Participant 21	41	Male	12	
22	Participant 22	35	Female	10	Midwifery
23	Participant 23	24	Female	9	
24	Participant 24	31	Female	4	
25	Participant 25	29	Female	5	
26	Participant 26	30	Female	8	
27	Participant 27	33	Female	7	
28	Participant 28	50	Female	11	
29	Participant 29	27	Female	6	

Table 3.4: Whole Health Government Hospital — Participant Demographic Profile

No.	Participant	Age	Gender	Years Experience	of Work Speciality
30	Participant 30	30	Female	4	Ambulatory Care
31	Participant 31	21	Female	5	
32	Participant 32	40	Male	8	
33	Participant 33	28	Female	6	
34	Participant 34	24	Female	4	
35	Participant 35	32	Female	5	Cardiovascular Care Nurse
36	Participant 36	50	Female	3	
37	Participant 37	37	Male	18	Nursing Consultant
38	Participant 38	25	Female	7	General Nursing Practice
39	Participant 39	42	Male	6	
40	Participant 40	31	Female	5	
41	Participant 41	39	Female	8	
42	Participant 42	50	Female	10	
43	Participant 43	48	Female	16	
44	Participant 44	35	Female	9	
45	Participant 45	22	Female	5	Midwifery
46	Participant 46	27	Female	3	

47	Participant 47	40	Female	8
48	Participant 48	36	Female	10
49	Participant 49	31	Female	9

Table 3.5: Wellness Private Specialist Hospital — Participant Demographic Profile

No.	Participant	Age	Gender	Years of Experience	Work Speciality
50	Participant 50	40	Female	10	General Nursing Practice
51	Participant 51	35	Female	8	
52	Participant 52	35	Female	5	
53	Participant 53	39	Female	7	
54	Participant 54	26	Female	9	
55	Participant 55	30	Female	3	Midwifery
56	Participant 56	44	Female	12	
57	Participant 57	26	Female	8	
58	Participant 58	39	Female	5	
59	Participant 59	30	Female	7	
60	Participant 60	35	Female	9	Neuroscience
61	Participant 61	50	Female	20	Consultant Nursing
62	Participant 62	45	Female	13	Paediatrics
63	Participant 63	25	Female	5	
64	Participant 64	31	Female	6	
65	Participant 65	28	Male	7	
66	Participant 66	27	Female	5	Paediatrics
67	Participant 67	29	Female	7	
68	Participant 68	31	Female	8	
69	Participant 69	25	Female	3	
70	Participant 70	40	Female	9	

3.6.4 Data Collection: The Semi-Structured Interview

The primary instrument employed to collect empirical data in this study was the qualitative interview. Interviews occupy a central and well-established place within the methodological repertoire of qualitative inquiry in the social and management sciences, offering researchers a means of accessing the subjective dimensions of social experience in a manner that few other data collection instruments can match (Saunders et al., 2019). The fundamental aim of a qualitative interview, as Yin (2012) articulates it, is to gather a narrative description of the participant's lifeworld, including their perceived experiences, interpretations, and understandings

of the phenomena under investigation, in ways that are responsive to the specific epistemological goals of the research.

Within the broad category of qualitative interviewing, three principal formats may be distinguished: structured, semi-structured, and in-depth (unstructured) interviews. Structured interviews, in which a predetermined and fixed set of questions is posed to each participant in the same sequence and format, are most appropriate when the researcher has prior, detailed knowledge of the relevant dimensions of the phenomenon and wishes to ensure comparability across interviews. They are closely analogous to the administration of a verbal questionnaire and offer limited scope for probing, elaboration, or participant-driven thematic deviation (Saunders et al., 2019). In-depth interviews, by contrast, are substantially unstructured interactions that allow the conversation to develop organically in response to the specific concerns and framings of individual participants. They are particularly well-suited to the exploration of sensitive or personally significant topics, where the cultivation of rapport and the creation of a non-directive conversational space may be essential preconditions for the honest and detailed disclosure of experience (Creswell, 2010).

Semi-structured interviews occupy a methodologically productive middle ground between these poles. They provide the researcher with a framework of guiding themes and questions, ensuring that all interviews engage with the core dimensions of the research inquiry, whilst retaining sufficient flexibility to accommodate the emergence of new themes, to pursue participant-led digressions that reveal unanticipated analytical dimensions, and to probe responses in depth as the conversation warrants (Saunders et al., 2019). This combination of structure and responsiveness renders semi-structured interviewing particularly appropriate for exploratory research in areas where the theoretical landscape is underspecified and where participants' own framings of their experience may contain insights that prior theory has failed to anticipate.

For the present doctoral thesis, a semi-structured interview approach was adopted as the most epistemologically consistent and empirically productive means of accessing the lived experiences of nursing professionals in the KSA. This format enabled the researcher to explore the complex, contextually embedded, and sometimes sensitive dimensions of occupational stress and work-life imbalance with appropriate depth and flexibility, whilst ensuring that the thematic coverage of each interview remained pertinent to the guiding research questions. This choice is

further supported by Omeihe and Harrison's (2024) observation that semi-structured interviewing represents the format most consistently favoured within contemporary qualitative business and management research precisely because it balances comparability across a relatively large participant group with the interpretive depth that fully unstructured interviewing affords to individual accounts. The decision to employ interviews rather than other data collection instruments, such as surveys or observational methods, was motivated further by the paucity of extant research on gendered experiences of work stress and WLB in Middle Eastern healthcare settings, which renders the pre-specification of a comprehensive hypothesis structure premature and potentially misleading (Patton, 2015).

Each interview lasted between 45 and 60 minutes and was conducted following the receipt of informed consent from both participants and their respective hospital authorities. Interviews were audio-recorded, subject to participants' consent, and subsequently transcribed for analysis. Questions were designed to elicit detailed, narrative accounts of participants' experiences of occupational stress, their perceptions of WLB and imbalance, the strategies they employed to manage competing demands, and the ways in which the specific cultural and institutional context of the KSA shaped their experiences. The open-ended character of the questions gave participants considerable latitude to define and frame these phenomena in their own terms, providing detailed and nuanced accounts grounded in their own conceptual frameworks and cultural reference points.

3.6.5 Reflexivity and Positionality

Any credible account of a qualitative research design must attend to the researcher's positionality, i.e. the ways in which their social location, personal background, and professional identity shape the conduct of the inquiry and the interpretation of the data (Cho and Yi, 2019). In the present study, the researcher occupied a complex and multidimensional positional relation to the participants and the phenomena under investigation.

Several dimensions of positionality merit explicit discussion. First, the researcher is a Saudi national with lived familiarity with the cultural, religious, and institutional context of the Kingdom. This insider knowledge conferred significant advantages in terms of access and communicative depth: the shared cultural, social, and linguistic background of the researcher and

participants created a degree of 'lived familiarity' that facilitated honest disclosure and enabled the researcher to recognise and appropriately contextualise culturally specific references, values, and modes of expression that might be opaque to an outsider (Gary and Holmes, 2020). The researcher's prior direct experience of Saudi healthcare settings, derived from extended periods of hospitalisation in the Kingdom, further deepened his empathic attunement to the working conditions of the nurses being studied.

Second, a potential dimension of positional complexity arose from the gender dynamics of the research situation. The researcher is male, while a substantial majority of participants were female, reflecting the composition of the nursing workforce in the KSA. As Cho and Yi (2019) observe, gender constitutes one of several dimensions of positionality that are culturally ascribed and broadly regarded as fixed, and as such carries the potential to introduce power asymmetries into the interview relationship. Particular care was taken to manage these dynamics through the design of the interview environment, the tone and framing of questions, and an explicit commitment to creating a non-directive and non-evaluative relational space in which participants were encouraged to speak freely and in their own terms.

Third, in line with the reflexive commitments of social constructionist methodology, the researcher remained attentive throughout the data collection and analysis process to the possibility that his cultural familiarity, gendered positionality, and personal investment in the topic might introduce interpretive biases into the analysis. To mitigate these risks, the transcribed interview data were returned to participants for member-checking prior to analysis, and the analytical process was conducted with an explicit commitment to grounding interpretive claims in the empirical data rather than in the researcher's prior theoretical assumptions.

3.7 Data Analysis

The process of data analysis in the present study began with the transcription of all audio-recorded interview data into written format. Transcription is not a neutral or mechanical activity in qualitative research; it is, as Davidson (2009) observes, a practice integral to the production of good qualitative scholarship. Oliver et al. (2005, p. 1273) argue, persuasively, that transcription should be treated not merely as a background task carried out behind the scene but as an object of research in its own right. The choices made in transcription, about what to

include, how to represent speech, and what to omit, are analytical choices that shape the interpretive resources available in subsequent stages of analysis.

Transcription can be undertaken using different conventions. A naturalistic approach seeks to capture every dimension of spoken interaction, including pauses, false starts, overlaps, non-standard pronunciations, and paralinguistic features, in an attempt to preserve as faithfully as possible the texture of the original speech event (Oliver et al., 2005). A de-naturalist approach, by contrast, tidies the transcript for readability: correcting grammatical irregularities, removing hesitations and non-content vocalisations, and standardising dialectal variation. Each approach carries its own analytical affordances and limitations, and the choice between them should be governed by the analytical purposes of the inquiry.

In the present study, a naturalistic transcription approach was adopted, with the aim of preserving as faithfully as possible the actual form of participants' speech. Given the large volume of data to be transcribed, this was a labour-intensive and cognitively demanding process. As Poland (1995) noted, the 'inter-subjective nature' of human interaction introduces significant complexity into the task of transcription, raising difficult questions about accuracy and interpretive fidelity. In response to these challenges, the researcher replayed all digital recordings multiple times and listened attentively to ensure the most accurate possible rendering of participants' speech in written form. In order to verify the accuracy of the transcriptions and to ensure that the written texts faithfully represented participants' intended meanings, all transcripts were returned to the relevant participants for member-checking prior to analysis (Birt et al., 2016).

3.7.1 Thematic Analysis

The analytical strategy employed in this doctoral thesis is thematic analysis (TA). First comprehensively systematised by Braun and Clarke (2006), TA is a qualitative method for identifying, analysing, and reporting patterns or themes within a data set. One of the most widely used analytical approaches in qualitative research across the social sciences, TA is distinguished, as Boyatzis (1998) observes, not by its status as a named method attached to a particular theoretical tradition, but by its character as a flexible analytical tool that can be deployed within a range of epistemological frameworks. This flexibility is simultaneously one of TA's principal strengths and, as Braun and Clarke (2006) themselves acknowledge, one of its potential

weaknesses: the absence of prescribed procedural constraints means that the quality of thematic analysis depends heavily on the analytical rigour and reflexive discipline that the researcher brings to the process. Thematic analysis was preferred over several alternative qualitative analytic strategies considered during the design of the study. Interpretative phenomenological analysis was set aside because its idiographic commitment to the detailed case-by-case analysis of a small number of participants, typically fewer than ten, is not well matched to a data set generated from seventy interviews, where the analytical priority lies in identifying patterns that recur, and diverge, across a substantially larger and more heterogeneous group. A full grounded-theory coding procedure was considered, given its affinity with the study's inductive orientation, but was not adopted for the reason given in relation to research design above: grounded theory's constant-comparative method is directed towards the generation of a novel substantive theory from data treated as free as possible of prior conceptual commitment, whereas this study's analysis is conducted in explicit dialogue with the conceptual framework developed in Chapter Two. Discourse analysis was also considered, but rejected as insufficiently aligned with the study's aims, since its analytical focus falls on the linguistic and rhetorical construction of accounts rather than on the substantive content of participants' experiences, which is the primary concern of this thesis's research questions. Thematic analysis, by contrast, offered the combination of interpretive flexibility, compatibility with the study's social constructionist epistemology, and capacity to handle a comparatively large qualitative data set that the alternatives, in different ways, could not (Braun and Clarke, 2006; Boyatzis, 1998).

Phases of thematic analysis

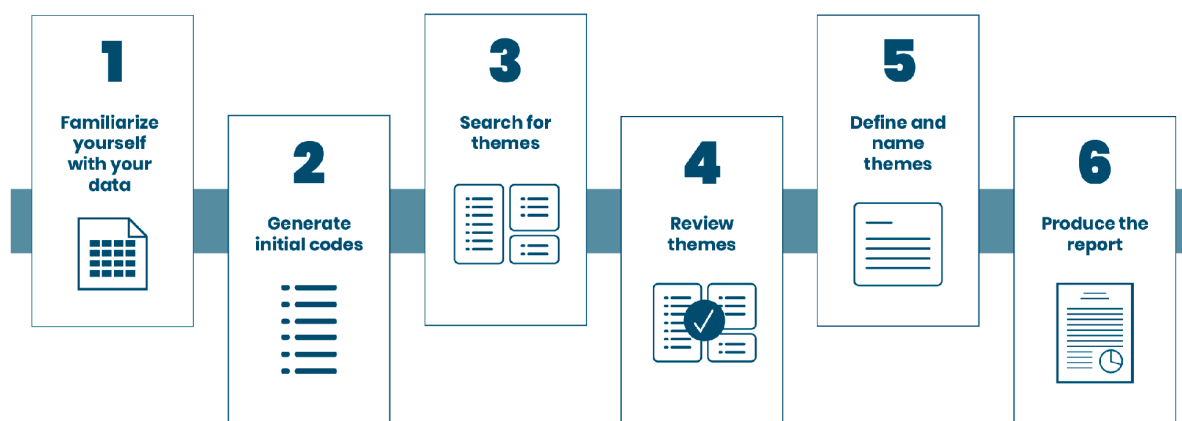


Figure 3.1: Thematic Analysis Procedure

Source: Braun and Clarke (2006)

The TA procedure employed in this study followed the framework set out by Braun and Clarke (2006) and was conducted through three principal stages. In the first stage, the researcher engaged in open coding through a process of close, repeated reading of the transcribed interview data. Provisional first-order codes were generated by identifying textual units, words, phrases, or passages, that carried analytical significance in relation to the research questions. Following the qualitative approach recommended by Miles and Huberman (1994), a contact summary form was employed to document the provisional categories that emerged from each interview transcript, providing a systematic record of the early coding decisions. First-order codes were written on colour-coded sticker pads to facilitate visual mapping and comparative analysis across transcripts.

In the second stage, first-order codes were systematically consolidated into second-order, theoretical categories. This process of consolidation involved identifying patterns of conceptual connection between first-order codes, relationships of similarity, contrast, and theoretical coherence, and grouping them into more abstract, analytically productive categories. As Pratt et al. (2006, p. 240) observe, this move from first-order to second-order categories renders the coding 'more theoretical and more abstract,' transforming the descriptive texture of the original data into analytically generative conceptual structures.

In the third and final stage, the second-order theoretical categories were further consolidated and refined to generate the overarching themes of the study. Key themes were thus constructed pertaining to participants' perceptions of occupational stress, WLB, and boundary management practices within the Saudi nursing context. A process of cross-comparison and iterative validation was pursued until a consensus was reached on the structure and content of the final thematic framework, grounded robustly in the empirical data. These themes are elaborated in detail in the subsequent chapter.

3.8 Ethical Considerations

The conduct of this research was governed throughout by the principles and protocols of social scientific research ethics. The foundational commitment of research ethics is to the protection of participants' rights, welfare, and dignity, whilst simultaneously ensuring the integrity, validity, and accountability of the research process itself (Saunders et al., 2012; Hasan et al., 2021). In line with established principlist approaches to research ethics, these foundational commitments were operationalised throughout the study with explicit reference to four interlocking principles, respect for participants' autonomy, beneficence, non-maleficence, and justice, each of which informed a distinct set of procedural safeguards at different stages of the research process, from recruitment through to the eventual dissemination of findings (Beauchamp and Childress, 2001; Omeihe and Harrison, 2024). Prior to the commencement of data collection, ethical approval was sought and obtained from the relevant institutional ethics committee, and formal authorisation was secured from the hospital authorities responsible for the participating institutions.

Informed consent was obtained from all participants before any interview commenced. This process involved a clear explanation of the nature and purposes of the research, the methods to be employed, the manner in which data would be stored and used, and the participant's rights in relation to the research, including the right to withdraw from the study at any stage without obligation to provide a reason and without adverse consequences (Bryman and Bell, 2006). Participants completed formal consent forms acknowledging their understanding of and agreement to these terms. This process was designed above all to uphold the principle of respect for autonomy, ensuring that participation was voluntary, adequately informed, and free from any expectation that consent, once given, was irrevocable; the researcher's willingness to answer

participants' questions about the study prior to consent being sought reflected a broader procedural commitment to transparency as a precondition of ethical engagement (Israel and Hay, 2006).

Justice and fairness were addressed at the closely related level of who was given the opportunity to consent in the first place, and how participants were subsequently treated once enrolled (Israel and Hay, 2006; Saunders et al., 2019). The eligibility criteria governing recruitment, registered nursing status, a minimum of three years' professional experience, and parental status, were applied consistently across all three hospital sites and irrespective of participants' seniority, nationality, or department, so that access to participation in the study was not distributed disproportionately toward any particular group of nurses within the three institutions. Given that recruitment proceeded partly through the researcher's own professional and social networks and partly through snowball referral, particular care was taken to ensure that no nurse felt obliged to participate as a consequence of a supervisory or otherwise unequal relationship with an existing participant or with the researcher himself; invitations to participate were extended directly by the researcher rather than relayed through line managers, and it was made explicit to every prospective participant that the decision to take part, or to decline, would have no bearing whatsoever on their standing, appraisal, or continued employment within their hospital. This same commitment to fairness extended to the conduct of the interviews themselves: every participant was afforded a comparable opportunity to shape the direction of the conversation, to review their own transcript, and to withdraw any statement they no longer wished to have included, so that the relative institutional or professional seniority of individual participants did not translate into an unequal capacity to control how their own account was represented within the study.

Confidentiality and anonymity were treated as inviolable commitments throughout the research. All participants were assigned pseudonymous identifiers, for example, Participant 1, Participant 2, and so forth, and the names of the hospitals in which they worked were fictionalised. No data that could enable the identification of individual participants were included in the research records or presented in the thesis. The audio recordings and transcribed interview data were stored securely in password-protected digital formats accessible only to the researcher, and will be destroyed in accordance with institutional data management requirements at the conclusion of

the doctoral project. These safeguards were adopted principally in service of non-maleficence (Kaiser, 2009). Given the hierarchical and relatively close-knit character of hospital employment in the KSA, the most significant potential harm arising from participation was judged to be the risk that colleagues, supervisors, or hospital administrators might identify individual participants from their responses, particularly where these touched upon critical remarks about institutional practices, staffing decisions, or line management; the anonymisation and secure-storage protocols described above were designed specifically to foreclose this risk, and no hospital authority was granted access to individual transcripts, recordings, or participant identities at any stage of the research.

The potential ethical sensitivities specific to the research context also warrant acknowledgement. Several of the topics addressed in the interviews, including occupational stress, gender dynamics in the workplace, and the pressures of combining professional and familial responsibilities, are potentially sensitive for participants, particularly within the cultural context of the KSA. Beneficence was operationalised, in this connection, in a manner attentive to the modest but genuine benefits realistically available within a study of this kind (Israel and Hay, 2006): no direct material or financial incentive was offered to participants, in order to avoid the risk of undue inducement affecting the voluntariness of consent, and the anticipated benefit of participation was instead conceived in terms of the opportunity the interviews afforded nurses to articulate experiences that are rarely solicited within their ordinary occupational environment, together with the prospect that the findings might, in time, inform hospital-level and policy-level improvements to nurses' working conditions; participants were, accordingly, offered a plain-language summary of the study's findings on completion of the doctoral project. Special care was taken in the design of the interview guide and the conduct of individual interviews to ensure that participants did not feel obligated to disclose more than they were comfortable sharing, and that the interview environment was experienced as non-judgmental and respectful of participants' personal and cultural values. Where an interview touched upon matters of evident personal distress, the researcher paused proceedings to check on the participant's wellbeing, reiterated the participant's right to decline to continue or to redirect the conversation, and, where appropriate, drew attention to the employee wellbeing and counselling services available through the participant's own hospital, a precautionary protocol that functioned as a further safeguard against non-maleficence. The semi-structured format of the interviews, with its built-in

flexibility and emphasis on participant-led narrative, was particularly well-suited to managing these sensitivities.

3.9 Limitation of Study

First, there was a geographic limitation to the study because the respondents for this research work were drawn from one country. Second, the study is based on an interpretive constructionist methodology, which means the findings come from a purely qualitative design and a small sample size was used which may make generalisability of findings challenging.

3.10 Summary of Chapter Three

In summary, this chapter presented the qualitative procedure used to carry out the research inquiry of this work as well as the justification for the methodological choice made. The starting point was to evaluate the various paradigms and philosophical orientations to qualitative research while more emphasis was placed on the underlying philosophy of interpretivism which is philosophical stance of this thesis. Key aspects such as epistemological, ontological and methodological claims framing the existing research inquiry are discussed. Thereafter, there were critical discussions on the research approach (inductive) qualitative research design employed in the study. The section discusses critical contentions and debates around the tenets of qualitative research including its epistemological stance, theoretical fluidity, and the variance in methodologies. The chapter also described and examined the conceptualisations of qualitative research especially critical explanations of judging good qualitative inquiry popularly known as the 'criteriology debate' in the literature. In addition, the sampling technique used to select participants of study, how reflexivity was handled, and other data collection criterion are presented. Finally, the chapter gives a detailed overview of the data collection and thematic analysis method used for the study.

4 CHAPTER FOUR

STUDY FINDINGS

4.1 Chapter Overview

This chapter presents findings from interview sessions with study participants. The results are organised thematically in accordance with the three research objectives of this study. Illustrative quotations from participants are presented verbatim to support the 'storytelling' function of qualitative inquiry, providing readers with findings that reflect participants' lived experiences and contexts (Cresswell, 2010). Each quotation is subjected to sustained analytical commentary designed to illuminate its theoretical and contextual significance rather than merely cataloguing participant views. Following the presentation of each objective's findings, a thematic summary table captures the emerging themes, sub-themes, first-order codes, and abridged illustrative quotes. The three research objectives guiding the structure of this chapter are:

Objective 1: To explore how nurses working in hospitals understand occupational stress and WLB challenges in Saudi Arabia.

Objective 2: To examine the agency factors causing work-life boundary management problems in the nursing profession in Saudi Arabia.

Objective 3: To investigate why cultural and regional peculiarities are exacerbating work stress, work-life imbalance and difficult boundary management practices of nurses in the KSA.

4.2 Objective 1: Understanding Occupational Stress and Work-Life Balance Challenges

The first research objective aimed to understand how nurses conceptualise occupational stress and WLB within the specific context of the nursing profession in Saudi Arabia. Two dominant thematic clusters emerged from the data: nurses' definitions of occupational stress; and nurses' notions of WLB. The analysis revealed that these conceptualisations are deeply shaped by the demanding nature of care work, prevailing cultural norms, and individual coping strategies. Rather than reproducing a uniform, textbook understanding of either phenomenon, participants articulated conceptualisations that are contextually embedded, professionally inflected, and experientially grounded.

4.2.1 Occupational Stress in the Nursing Profession

Participants' conceptualisations of occupational stress broadly aligned with three established models in the scholarly literature: the stimulus-based model, the response-based model, and the stimulus-response interface or transactional model (See Table 4.1). Importantly, these conceptualisations were not encountered as abstract definitional positions but as experientially derived frameworks, embedded within the specific material and institutional conditions of nursing practice in the KSA. The emergence of all three models within the participant data reflects the theoretical pluralism of stress understanding among frontline nurses.

4.2.1.1 Stimulus-Based Conceptualisation of Stress

The first cluster of conceptualisations encompasses participant accounts in which occupational stress is understood primarily through the lens of external stimuli such as the environmental, physical, and organisational conditions that impose demands upon nurses irrespective of individual characteristics or responses. Here, stress is perceived to inhere in the situation rather

than in the person; it is something that exists in the world and bears down upon those who inhabit it. Several participants located the source of stress outside themselves, in the situation rather than the person. The salience of this framework among participants reflects the degree to which the material conditions of nursing in Saudi Arabia such as its built environments, staffing configurations, and institutional structures constitute the primary lens through which occupational stress is made intelligible. For example, Participant 1 offered an elaborated account of how the physical environment of the open ward generates occupational stress through its acoustic and interpersonal properties:

"My understanding of work stress within the context of my job is embedded in the nature of our profession. For instance, the high level of noise from both patients and medical personnel treating such patients in the open ward where I work as a nurse is one of the most stressful experiences I encounter on a daily basis at work. We provide direct care, and providing this high level of care is an interpersonal activity characterised by expert nursing, interpersonal sensitivity, and close connections, as well as by effective communication and the use of professional knowledge and abilities which is very strenuous because of the open nature of the large public wards. Consequently, the nursing profession is highly stressful based on these external conditions I previously highlighted." (Participant 1)

This account shows that the noise level and open ward configuration are identified as objective, external conditions that impose strain upon the nurse's capacity to deliver the communicative, relational, and technical demands of their role. The stressor is not the nurse's reaction to the environment but the environment itself particularly, its acoustic properties, its spatial openness, its simultaneous hosting of multiple care interactions. The reference to noise is particularly significant in the Saudi Arabian hospital context, where large public wards serving diverse patient populations create environments of sustained sensory intensity that are rarely ameliorated by structural redesign. Participant 3 extended this environmental framing to include both the diversity of clinical cases and the conduct of ward management as additional external stressors:

"Job stress is a complex phenomenon to define but I define stress as characteristics of an environment that places strain and pressure on its target. So, work stress experienced on my job as a nurse are numerous such as employment location, variety of hospitalised cases, lack of manpower, forced overtime hours, and the attitude of the ward manager which often imposes tremendous stress on me and my other colleagues who work here." (Participant 3)

This perspective considers stress as 'characteristics of an environment that places strain and pressure on its target'. The subsequent enumeration of stressors reinforces this environmental orientation: each item is an objectively identifiable feature of the work context, not a subjective psychological state. The inclusion of 'employment location' as a stressor is particularly noteworthy in the Saudi Arabian context, where geographic assignment to peripheral hospital settings may impose social isolation and professional limitation upon nurses. Crucially, the observation that these stressors affect not only the individual but 'other colleagues' signals a recognition that stimulus-based stressors in hospital settings are experienced collectively, as a shared occupational condition, rather than as privately negotiated personal challenges.

4.2.1.2 Response-Based Conceptualisation of Stress

A second cluster of conceptualisations positions stress not as an external load but as the individual's internal reaction either physiological, psychological, or adaptive to the demands of nursing work. Here, stress is described not as something external but as the nurse's own bodily or emotional reaction to the demands of the work. Participant 4 shared an account of stress as a physiological response, disclosing the development of hypertension as a direct consequence of chronic occupational overload:

"The daily chronic stress I am exposed to from caring for a lot of patients that I am unable to handle has now made me hypertensive. The excess workload due to shortage of nurses in my hospital makes me psychologically drained and physically burnout after my shift." (Participant 4)

This statement constitutes a response-based understanding of stress in its most literal sense. The body has mounted a sustained physiological response, chronically elevated blood pressure, to the unrelenting demands of the work environment. The participant describe having been biologically transformed by chronic stress exposure. The participant describes a lasting physical change rather than a passing sensation. The phrase 'I am unable to handle' signals that this response has exceeded what the participant feels able to cope with. The conjunction of 'psychologically drained' and 'physically burnout' demonstrates that this participants understands stress as producing a dual-register response, simultaneously somatic and psychological, which together constitute the depleted state that follows a shift.

By contrast however, Participant 5 articulated a deliberately counter-normative response-based understanding, one that foregrounds positive, adaptive, and growth-promoting reactions rather than pathological or depleting ones:

"Since stress is an inevitable component of life, people often use the term 'stress' to describe negative experiences with the underlying believe that stress is bad and damaging, which I think otherwise. I believe the experience serves an essential function of this job that enables me to respond positively to the threats and challenges of my profession. What I do is to always keep a positive attitude even in the face of patient provocation, excessive responsibilities and minimal authority over care demands." (Participant 5)

This account explicitly contests the prevailing negative understanding of stress responses and reconstructs them as functionally indispensable to professional performance. The deliberate cultivation of a 'positive attitude' is itself a form of response regulation, an active shaping of

one's internal reaction to stressors, that demonstrates sophisticated self-regulatory capacity.

Participant 6 extended this when he shared that:

"Stress to me is an intrinsic and unavoidable aspect of human existence, manifesting as the body and mind's natural response to any excruciating demand or challenge that disrupts mental and physical health. As a nurse, I have trained my mind that stress is part and parcel of my job which triggers a wide array of internal processes such as keeping my emotions in check and not allowing the various types of hospitalised cases I deal with on a daily basis to affect my mental health. In doing this, I read a lot of health-related books on stress management and how to thrive on my job despite the pressures associated with my profession."
(Participant 6)

The phrase 'trained my mind' is among the most analytically fertile in the dataset. It positions the stress response as a modifiable process subject to intentional cultivation over time. The 'wide array of internal processes' triggered including emotion regulation, cognitive reframing, professional boundary maintenance, constitute a sophisticated repertoire of adaptive responses that this participant has systematically developed through reading and reflective practice. The use of professional literature as a mechanism for response enhancement is notable, suggesting that intellectual engagement with stress science functions for this participant as both a coping tool and an affirmation of professional identity. These accounts illustrate a positive, growth-oriented understanding of stress, in which the response is not framed as uniformly harmful but as something that can support professional competence.

4.2.1.3 Stimulus-Response Interface (Transactional) Conceptualisation of Stress

The third cluster of conceptualisations encompasses participant accounts in which occupational stress is understood as an emergent phenomenon arising from the dynamic, bidirectional transaction between the stimulus and response. Here, stress is described as arising from the relationship between the demands nurses face and the resources they feel they have to meet

them, rather than from either alone. The emergence of this framework within participant accounts speaks to the experiential sophistication of nurses who have, through sustained professional practice, arrived at an understanding of stress that implicitly transcends both purely environmental and purely psychological explanations. For example, Participant 15 shared that:

"As a nurse, my definition of occupational stress is individualised reactions occurring when job requirements do not match the capabilities and resources of the worker concerned. Stress could cause physical or psychological harm depending on personal reaction. Work stress can damage one's physical and mental health and ultimately have a negative impact on job performance. I will define stress within the context of the nursing profession as the rate of wear and tear on our body system as nurses caused by the high workload and difficult interpersonal with patients coupled with one's capability to adapt to work stress."
(Participant 15)

The tripartite structure of this definition including job requirements, capabilities and resources of the worker, and the mismatch between them is a precise rendering of the transactional model's core proposition. Stress is constituted here not by the job requirements alone nor by the individual's reaction alone, but by the relational gap that opens when the former exceeds the latter. The acknowledgement that 'personal reaction' determines the nature of harm, whether physical or psychological, further reflects a transactional sensitivity to individual differences in appraisal and vulnerability. This suggests that the daily navigation of fluctuating demands and personal resources, cultivates an intuitive understanding of stress that Similarly Participant 11 highlighted how the stress-outcome relationship is mediated by the specific character of the clinical encounter:

"Stress experienced at work is a composite term that sums up physical, mental and emotional strains or tension on those affected... there are sometimes when the amount of stress improves my mental functionality particularly when I find the task is challenging but presents an opportunity for me to learn something new about children care. Sometimes I feel distressed on my job especially when I am

on night shifts and there has been a number of deaths in the ward that needs to be moved to the mortuary." (Participant 11)

This account suggests that distress is precisely situated within a specific temporal and experiential context such as the night shift, multiple deaths, the physical task of moving deceased patients while the potential for eustress is identified in the encounter with challenging but developmentally productive clinical tasks. This dual articulation captures the transactional model's core insight that the same objective conditions may produce qualitatively different stress experiences depending on the individual's appraisal and available resources.

Table 4.1: Thematic Summary: Nurses' Conceptualisations of Occupational Stress

Inquiry	Theme	First-Order Codes	Illustrative Quote
<i>How do nurses working in hospitals in Saudi Arabia understand occupational stress?</i>	Theme 1: Stimulus-Based Conceptualisation	• Noise and sensory overload in open wards • Physical environment as external stressor • Architecture impeding quality care • Collective experience of structural stress	<i>"The high level of noise from both patients and medical personnel treating such patients in the open ward where I work as a nurse is one of the most stressful experiences I encounter on a daily basis at work."</i> (Participant 1)
		• Institutional demand exceeding individual capacity • Manpower shortages as structural stressor • Forced overtime as material imposition • Ward manager conduct as shared stressor	<i>"Job stress is a complex phenomenon to define but I define stress as characteristics of an environment that places strain and pressure on its target. Work stress experienced on my job as a nurse are numerous such as employment location, variety of hospitalised cases, lack of manpower, and forced overtime hours."</i> (Participant 3)
	Theme 2: Response-Based Conceptualisation	• Chronic stress producing hypertension • Physical burnout after shifts • Allostatic load and bodily depletion • Stress exceeding adaptive capacity	<i>"The daily chronic stress I am exposed to from caring for a lot of patients that I am unable to handle has now made me hypertensive. The excess workload due to shortage of nurses in my hospital makes me psychologically drained and physically burnout after my shift."</i> (Participant 4)
		• Collective burnout among colleagues • Professional invisibility and devaluation • Distress tied to patient mortality • Night shift as intensifier of stress	<i>"I feel Saudi doctors are too demanding and care less that we are understaffed. These increases stress and burnout among us as nurses working in the medical and critical units of the hospital."</i> (Participant 5)
		• Positive reframing of stress as functional • Deliberate cultivation of emotional regulation • Knowledge-driven self-regulation practices • Eustress as professional competence	<i>"As a nurse, I have trained my mind that stress is part and parcel of my job which triggers a wide array of internal processes such as keeping my emotions in check and not allowing the various types of hospitalised cases I deal with on a daily basis to affect my mental health."</i> (Participant 6)
	Theme 3: Stimulus-Response Interface (Transactional) Conceptualisation	• Stress as mismatch between job demands and worker capacity • Individual appraisal mediating stress outcomes • Wear and tear as transactional outcome • Stress causing physical and psychological harm depending on personal reaction	<i>"As a nurse, my definition of occupational stress is individualised reactions occurring when job requirements do not match the capabilities and resources of the worker concerned. Stress could cause physical or psychological harm depending on personal reaction."</i> (Participant 15)
		• Nurse-physician relational dynamics as stress source • Cross-cultural power asymmetry compounding stress • Collective stress arising from shared relational encounters • Context-specific appraisal mediating distress and eustress	<i>"Stress experienced at work is a composite term that sums up physical, mental and emotional strains or tension on those affected... there are sometimes when the amount of stress improves my mental functionality particularly when I find the task is challenging but presents an opportunity for me to learn something new."</i> (Participant 11)

4.2.2 Emerging Conceptions of Work-Life Balance

The second thematic cluster within Objective 1 centres on how nurses conceptualise WLB. Based on the analysis, four sub-themes emerged from the data: WLB as time for family, attending to health concerns, time for personal leisure and religious activities and WLB as flexible working arrangements (See Table 4.2). Each of these subthemes reflect the complex interplay between professional demands, personal responsibilities, and the broader socio-cultural context of the KSA. Significantly, participants did not define WLB in abstract or aspirational terms but in relation to the specific constraints and deprivations that the nursing role imposes upon their non-work lives.

4.2.2.1 *WLB as Time for Family*

The most widely articulated conception of WLB among participants defined it in terms of the capacity to give satisfactory attention to family commitments while succeeding professionally. This family-centred understanding is not culturally incidental but deeply embedded in the Islamic context of Saudi Arabian society, where family obligations carry both normative weight and religious sanction. For many participants, the inability to achieve meaningful family time was a violation of culturally fundamental obligations. This context amplifies the psychological cost of work-family conflict beyond what Western-oriented WLB frameworks typically capture. Participant 10, a mother, articulated this conception in terms that simultaneously invoke managerial, institutional, and cultural pressures:

"I am of the view that work-life balance, as the name implies is about managing working time and balancing employment with other obligations such as family affairs. Saudi Arabia is faced with chronic shortage of nurses which is creating a lot of tension for me at home as a mother because I am always put on night shift most of the time." (Participant 10)

The account belies the structural complexity of WLB perception and inability of nurses to achieve it. The chronic nursing shortage to which Participant 10 alludes is not a peripheral contextual detail but the institutional mechanism through which WLB aspirations are systematically frustrated. By locating the source of imbalance in a structural deficit rather than in personal inadequacy, this participant constructs an understanding of WLB failure that is sociologically astute. The problem is not that she does not know how to balance but that the conditions for balancing have been institutionally withdrawn. The negative spillover from professional to domestic life is palpable in the phrase 'creating a lot of tension for me at home'. Participant 41 extended this family-centred conception to include weekend availability, foregrounding the temporal dimension of WLB as it is experienced in the nursing profession:

"For me, WLB means being able to spend quality time outside work, especially with my husband and children. I am still required to go to work during weekends which makes it practically impossible for me to spend enough time with my family." (Participant 41)

The language of impossibility is analytically significant. It does not describe WLB as difficult to achieve but as structurally precluded condition in which the simultaneous fulfilment of work and family obligations is rendered structurally inconceivable by the design of occupational schedules. Participant 40 reinforced this understanding through a specifically embodied account, in which the physical residue of occupational demand renders the nurse 'useless' upon returning home.

"I get home always exhausted from the overwhelming workload in patients care. Most of us, nurses in surgical wards and operating theatres experience stress related to administrative, environmental, and staff relationship situations on operating days which makes me useless when I get home and struggle to enjoy family time." (Participant 40)

This account illuminates the mechanism through which work-family conflict operates at the embodied level: the physical and emotional resources required for family engagement are consumed by occupational demands, leaving a residual state of depletion that is carried across the work-home boundary. The specific reference to surgical wards and operating theatres is contextually precise, pointing to the particular intensity of stress in high-acuity settings where administrative, environmental, and relational pressures converge simultaneously.

4.2.2.2 WLB as Attending to Health Concerns

A second and closely related conception of WLB centred on health management. Participants viewed the capacity to address their own and their families' physical and mental health as a constitutive dimension of balance. This health-centred understanding reflects the particular vulnerability of individuals whose occupational role demands the sustained giving of care but whose own health needs are frequently subordinated to institutional imperatives. In the Saudi hospital context, where chronically high workloads and staffing deficits compound the physical demands of care work, health deterioration is not an occasional occupational hazard but a predictable structural outcome. Participant 39 articulated this conception with particular clarity, connecting WLB directly to the management of a diagnosed health condition:

"Work-life balance is about achieving good health which is integral to enjoying work and non-work activities. I have been diagnosed with high blood pressure and placed on BP medication. My wife has had to remind me of the importance of always using my drugs because I sometimes forget due to the overwhelming nature of my work as a nurse." (Participant 39)

The causal chain embedded in this account is analytically compelling. The 'overwhelming nature' of nursing work has not only generated a chronic health condition but has impaired the participant's capacity to manage that condition by displacing medication adherence from the forefront of daily consciousness. This is a form of health-WLB deterioration that operates through cognitive displacement as the occupation consumes attentional resources so thoroughly that self-care practices are crowded out. The role of the spouse as a health management intermediary further illustrates the domestic consequences of occupational overload, as family members are drawn into compensatory roles that extend the reach of institutional failure into the household. Participants 52 and 42 provided accounts in which the health consequences of nursing work take a specifically musculoskeletal form, generating impairments that colonise domestic life with particular thoroughness:

"Over the years, my job for instance, have made me incur some back problems from manually lifting and moving patients all the time in the wards. This situation has restricted my physical movements when doing domestic work at home and thereby affecting the length of time I can stand to cook in the kitchen."
(Participant 52)

"I currently suffer from musculoskeletal conditions from long hours of standing and lifting heavy hospital beds during patient treatment which now significantly limit my mobility and dexterity. At home I now struggle to bend when doing my children's laundry and sometimes feel lower back pain when I assume some sleeping postures at night."
(Participant 42)

These accounts reveal a bidirectional health-WLB nexus in which occupational injury does not remain confined to the professional domain but penetrates the most intimate dimensions of domestic life such as cooking, childcare, and sleep. Participant 42's account of lower back pain

during sleep is particularly instructive: the injury persists through the body's own restorative processes, meaning that even the boundary of rest affords no protection from the consequences of occupational overload. These accounts point to a cycle in which deteriorating physical health limits participants' capacity to fulfil roles at home, while the physical demands of nursing work continue to affect that health.

4.2.2.3 WLB as Time for Personal Leisure and Religious Activities

Several participants also defined WLB in terms of having discretionary time for personal leisure and spiritual practice. Within Islamic practice in Saudi Arabia, participation in spiritual activities carries existential and religious weight. In a society governed by the rhythms of Islamic observance, the inability to fulfil daily prayer obligations or to engage in community-oriented spiritual life is a form of WLB failure that spills into the domain of religious and cultural identity. Participant 53 articulated the leisure dimension of this conception with particular clarity, connecting the absence of WLB to the systematic curtailment of embodied self-care practices:

*"WLB is for me is keeping work and leisure in balance. My work shift restricts me from doing a whole lot of things that actually adds as a balance to my life such as going to the gym or taking a relaxation walk around my neighbourhood."
(Participant 53)*

The activities cited here such as gym attendance, neighbourhood walks are notable for their ordinariness and are at baseline of health-sustaining physical activity that occupational schedules have placed beyond reach. The verb 'restricts' locates the agency of foreclosure firmly in the occupational structure rather than in personal choice, affirming once again the structural character of WLB failure in the Saudi nursing context. Participant 54's account introduced the

specifically Islamic dimension of this conception, making explicit the theological framework within which WLB is understood:

"I will define WLB as being able to have time for work as well as religious worship. I for one cannot miss my Muslim five times each day prayers. This verse encourages us to seek a balance in our personal and professional lives while overworking or neglecting self-care leads to imbalance, which is contrary to the teachings of Islam." (Participant 54)

This account positions WLB as a theological imperative derived from Islamic teaching. Where Western HRM discourse typically constructs WLB as a desirable individual and organisational outcome, for this participant it is a religiously mandated state of being whose violation constitutes a form of transgression. The five daily prayers are obligatory acts of worship with precise temporal requirements and they create a structure of time commitments that is non-negotiable within Islamic observance. The failure of the occupational schedule to accommodate these requirements therefore constitutes an inconvenience and a religiously significant harm.

4.2.2.4 WLB as Flexible Working Arrangements

A final sub-theme linked WLB directly to the availability of flexible working patterns, with participants viewing flexibility as an enabling condition for balance. The participants viewed flexible working arrangements as a structural mechanism through which the competing temporal demands of professional and personal life might be reconciled. In the Saudi hospital context, where rigid shift patterns and chronic understaffing create inflexible occupational schedules, the absence of flexibility functions as an institutional barrier to WLB that is felt acutely by nurses with complex domestic obligations. Participant 55's positioned flexible working arrangements as constitutive of WLB itself:

"From a definitional standpoint, WLB is closely linked with taking advantage of flexible working arrangements based on individual lifestyle and circumstances. However, my long shift patterns as a nurse make it very difficult for me to take care of my home front." (Participant 55)

The contrast between the definitional aspiration and the experiential reality articulated in this brief account captures, with considerable economy, the structural gap between WLB as a normative ideal and WLB as a lived possibility in the Saudi hospital system. The 'individual lifestyle and circumstances' that flexibility is meant to accommodate including children, ageing relatives, health conditions, religious obligations, are precisely the dimensions of non-work life that rigid shift patterns systematically override. Participant 57 extended this analysis to the organisational level, situating the absence of flexibility in the institutional constraints under which ward management operates:

"To me, WLB balance is meant to give workers freedom to choose where and when to work. But we, as nurses do not enjoy the luxury to these different flexible arrangements because our senior matrons find it difficult to coordinate the requests of us all because of the extremely high workload of patient care we face on a daily basis." (Participant 57)

This account is notable for its institutional empathy: rather than attributing the absence of flexibility to managerial indifference, Participant 57 locates it in the operational impossibility of coordinating flexible requests under conditions of severe staffing constraint. This perspective positions the ward manager as a fellow victim of institutional under-resourcing. The shortage of nurses and high patient care demands thus function not only as direct sources of WLB impairment but as the institutional conditions that render flexibility structurally undeliverable.

Table 4.2: Thematic Summary: Nurses' Conceptions of Work-Life Balance

Inquiry	Theme	First-Order Codes	Illustrative Quote
How do nurses working in hospitals in Saudi Arabia conceptualise work-life balance challenges?	Theme 1: WLB as Time for Family	• Balancing employment with family obligations • Night shifts preventing family engagement • Weekend work precluding quality family time • Occupational depletion leaving nurses unable to fulfil domestic roles • Work-to-family negative spillover	<i>"Saudi Arabia is faced with chronic shortage of nurses which is creating a lot of tension for me at home as a mother because I am always put on night shift most of the time."</i> (Participant 10)
	Theme 2: WLB as Attending to Health Concerns	• WLB as prerequisite for health maintenance • Occupational injury restricting domestic capacity • Cognitive displacement of self-care by work demands • Bidirectional health-WLB deterioration cycle • Musculoskeletal impairment colonising home life	<i>"Work-life balance is about achieving good health which is integral to enjoying work and non-work activities. I have been diagnosed with high blood pressure and placed on BP medication. My wife has had to remind me of the importance of always using my drugs because I sometimes forget due to the overwhelming nature of my work."</i> (Participant 39)
	Theme 3: WLB as Time for Personal Leisure and Religious Activities	• Work shifts restricting physical self-care activities • Islamic religious observance as WLB imperative • Five daily prayers as non-negotiable time commitment • Occupational schedule conflicting with religious obligations • WLB as theologically mandated state	<i>"I will define WLB as being able to have time for work as well as religious worship. I for one cannot miss my Muslim five times each day prayers... overworking or neglecting self-care leads to imbalance, which is contrary to the teachings of Islam."</i> (Participant 54)
	Theme 4: WLB as Flexible Working Arrangements	• Flexibility as enabling condition for WLB • Rigid shift patterns overriding personal circumstances • Nursing shortage rendering flexibility undeliverable • Inability of matrons to coordinate flexible requests • Structural precluding of work-personal life reconciliation	<i>"To me, WLB balance is meant to give workers freedom to choose where and when to work. But we, as nurses do not enjoy the luxury of these different flexible arrangements because our senior matrons find it difficult to coordinate the requests of us all because of the extremely high workload of patient care."</i> (Participant 57)

4.3 Objective 2: Agency Factors Causing Work-Life Boundary Management Problems

The second research objective sought to examine the agency-level and organisational factors causing work-life boundary management challenges in the nursing profession in Saudi Arabia. Work-life boundary management in this context refers to the difficulties nurses experience in creating, maintaining, adjusting, and classifying their work and non-work demands into satisfactory patterns (Nippert-Eng, 1996; Kreiner, 2006). Five interconnected themes emerged from the data analysis: work-home boundary violations, incongruence between nurses and their work, labour-reward disparity, managerial ignorance of family-friendly policies (See Table 4.3). Each theme captured a distinct dimension of the structural and relational aspect that constrains nurses' capacity to enact preferred boundary strategies.

4.3.1 Work-Home Boundary Violations

The first and most immediately experienced factor inhibiting effective boundary management was the systematic violation of the boundary between work and home life. This relates to the intrusion of professional demands into the personal domain, and the inverse, whereby domestic concerns penetrated the occupational sphere. Among many participants, boundary violations were reported as emotionally taxing in a qualitatively distinctive way. They generated a specific form of distress arising from the enforced prioritisation of one domain over another, in conditions where neither could be legitimately neglected. Participant 30 provided a vivid account of work-to-family boundary violation, describing the institutional prohibition of emergency family contact during a child's health crisis:

"I find it emotionally draining when the overwhelming nature of my job does not give me room to attend to any personal family emergencies when occasion arises. I remember one day receiving a call from my 4-year-old son's school that he developed a serious cold and headache which needed my urgent attention. But I was disallowed from leaving the hospital on that day. I felt so bad that I was not given permission to attend to my son at that moment." (Participant 30)

The particularity of this account involving a 4-year-old, the school call, the cold and headache transforms what might otherwise be an abstract claim about work-family conflict into a specific, recoverable event whose affective charge is entirely legible. The use of the passive construction 'I was disallowed' is analytically significant as it locates the agency of boundary violation firmly in the institutional structure, rendering the nurse not as an agent who chose work over family but as a subject subjected to an institutional prohibition. Here, the nurse's own boundary preferences were overridden by the operational demands of the clinical setting. Participant 31 described a complementary but inverse form of boundary violation, in which domestic responsibilities intrude into the professional sphere during a night shift:

"The stressful experiences I go through at work especially when I am on night shift is alarming. Being a mother of 4 children, I sometimes call my nanny at home to make sure she has put my children to bed. As I am going on with my ward round at the hospital, I try and settle quarrels over the phone within my children. This is one of the struggles I go through as a nurse and mother." (Participant 31)

This account illuminates domestic concerns infiltrating the professional domain, in ways that divide attention and deplete the cognitive and emotional resources available for patient care. The image of a nurse conducting a ward round while simultaneously managing a household dispute by telephone captures, with considerable vividness, the psychic cost of boundary dissolution

under conditions of care labour and domestic obligation. Participant 37's account of supporting a spouse with a cancer diagnosis while continuing to work added a further dimension of boundary-related distress, characterised by sustained, unresolvable role conflict.

"My wife was diagnosed of having breast cancer a couple of years. As her carer I still find it difficult to offer all the medical support she needs when I am in the hospital working. I call her from time to time at home to find out her welfare but feel bad sometimes because I am supposed to be by her bedside always."
(Participant 37)

The phrase 'I am supposed to be by her bedside always' reveals the normative dimension of boundary violation. In this case, the participant is not only experiencing a practical difficulty but is failing to fulfil what they understand as an unconditional caregiving obligation. In a cultural context where marital and family duties carry strong normative weight, this sense of failure has a moral register that compounds its psychological cost.

4.3.2 Incongruence Between Nurses and Their Work Environment

A second major factor inhibiting effective boundary management was the perceived incompatibility between individual nurses' capabilities and the characteristics of their work environment. This theme captures how mismatches between what nurses feel able to offer and what the work environment demands generate significant stress and boundary difficulties that extend into the domestic sphere. Participant 22 described this incongruence in terms of the physiological and cognitive consequences of extended shift patterns, illuminating the mechanism through which person-environment misfit translates into domestic incapacity:

"One of the issues that is making it problematic a times for me to manage my work and home affairs well is because occasionally I am asked to work lengthy hours without getting enough rest especially when I am placed on night shifts with other colleagues. The long hours we work causes a lot of brain drain and stress. When I get home the next day, I find it strenuous to attend to my family needs due to the hectic nature of work the previous day." (Participant 22)

The concept of 'brain drain' deployed here captures a qualitatively specific form of person-environment incongruence: it is not merely that the demands are high but that they systematically deplete the cognitive and physical resources required for domestic functioning. The temporal extension of this depletion e.g. persisting through the journey home and into the following day, illustrates how the effects of work-environment misfit are not bounded by the shift's conclusion but carry forward as a residue that colonises time designated for non-work life. Here, the demands of the work environment appear to exceed what the participant feels able to sustain. Participant 50 extended this analysis to include the emotional register of incongruence, describing how the affective depletion generated by person-environment misfit produces displacement effects in the family domain:

"My struggles as a nurse are concerns I confront when I realise that my physical abilities and energy do not match with the high expectations of patient care I am exposed to on a daily basis. Patients can occasionally be challenging, scared, or angry, and we may find ourselves responding with increasing irritation and anger. I sometimes unknowingly transfer my frustration at work home which negatively affects my home management." (Participant 50)

The phrase 'unknowingly transfer my frustration at work home' is analytically significant: the transmission of affective residue across the work-home boundary is described as involuntary, a process that occurs below the threshold of conscious intention. Here, feelings generated at work appear to persist beyond the shift and surface in the home. In the Saudi hospital context, where

high patient acuity, emotional complexity, and inadequate staffing create conditions of sustained person-environment incongruence, such involuntary spillover is not an exceptional occurrence but a predictable structural consequence.

4.3.3 Labour-Reward Disparity

Effort-reward imbalance (ERI) emerged as a third and significant factor underlying boundary management difficulties. Participants articulated a strong and recurring sense that the considerable physical, emotional, and cognitive investment they made in patient care was not commensurate with the extrinsic rewards they received, including financial compensation, flexible working arrangements, and adequate leave provisions. This perceived disparity between investment and return constituted a structural condition that made effective boundary management demonstrably more difficult. Participant 4, whose contributions appear across multiple themes in this analysis, offered a detailed account of the multiple dimensions of reward insufficiency that compound ERI in the Saudi nursing context:

"The extended hours of working 12-14 hours and sometimes 7 days a week without having sufficient access to flexible shift patterns, casual leave and we could be recalled when on leave at any time when there is an emergency shows how we are made to invest so much energy in clinical practices which is not comparable to the flexible working benefits we should be granted." (Participant 4)

The lexical choice of 'made to invest' rather than 'choose to invest' constructs the effort side of the ERI equation as compelled rather than voluntary. This characterisation intensifies the normative injustice of unrewarded labour. The practice of leave recall is particularly significant as an institutional mechanism through which the work-home boundary is rendered structurally permeable. Participants expressed that even the formal boundary of annual leave offers no protection from institutional demand when understaffing reaches critical levels. Participant 21

extended this analysis to the financial dimension of labour-reward disparity, articulating the gap between occupational investment and monetary compensation with considerable specificity:

"The shortage of nurses, long night shift frequency and high-intensity work responsibilities that are not equivalent to the salary and night duty allowance I receive despite my many years and experience in the nursing practice. The compensation I get on my job as a nurse is far short of meeting all my personal and family needs when compared to the hard work I put into my profession. This is a source of stress for me." (Participant 21)

The reference to 'my many years and experience' introduces the dimension of professional seniority as a further axis of perceived injustice: the participant has invested not only current labour but decades of accumulated expertise, the return on which remains inadequate. The phrase 'far short of meeting all my personal and family needs' suggests a link between remuneration insufficiency and domestic inadequacy. This suggests that nurses in Saudi Arabia perceive that high-effort and low-reward conditions are prominent structural features of their profession.

4.3.4 Managerial Ignorance of Family-Friendly Policies

A fourth obstacle to effective boundary management was the reported ignorance or indifference of ward managers and line managers regarding family-friendly employment policies. Unlike the preceding themes, which locate boundary management difficulty in structural factors beyond individual control, this theme identifies a specific organisational actor — the manager — as a proximate cause of WLB deprivation. The findings reveal that managerial decision-making in this area often relied on common sense, personal bias, and cultural assumption rather than structured, evidence-informed policy implementation. Participant 19 offered an account of

managerial ignorance that is particularly revealing in its intersection with the gendered cultural expectations of the KSA:

"One stressful experience for me on this job is the way my superiors demonstrate little knowledge on how to effectively allocate work-life balance policies based on individual needs and preferences. My manager feels since I am a male nurse and married, the belief system in the KSA is that women are naturally caregivers and home keepers. I feel managers here are inexperienced on handling sensitive matters such as implementing family-friendly employment policies in this hospital." (Participant 19)

This account illuminates how managerial ignorance of family-friendly policy operates not as a neutral knowledge deficit but as a culturally saturated practice. The supervisor's failure to implement policy is governed by gendered cultural assumptions about who bears domestic responsibility, such that male nurses are systematically excluded from provisions designed to support the work-family interface. Where managerial support for WLB is absent or discriminatory in this way, nurses' ability to enact their preferred boundary strategies is compromised. Participant 47 described a form of managerial indifference that operates not through cultural bias but through an explicit prioritisation of operational demands over employee welfare:

"Having an insensitive manager to my work-life plights even makes the matters worse for me. My manager feels that implementing family-friendly policies are less important but what matters are the operational arrangements of nurses running their shifts based on patient needs and hospital demands. Therefore, I do not enjoy the benefits of family-friendly policies because my manager is totally oblivious of such policies." (Participant 47)

The manager's framing 'what matters are the operational arrangements' suggests a conception of hospital management in which patient service delivery and staff welfare are constructed as

competing rather than complementary imperatives. This perspective advances the belief that attending to employee WLB needs is understood as detracting from patient care, constitute an institutional barrier to the meaningful implementation of family-friendly employment provisions.

4.3.5 Perceptions of Career Damage

From the analysis, the fifth agency-level factor was the fear that utilising WLB policies would be interpreted by senior management as a sign of limited commitment to the hospital and the nursing profession. This perception created a chilling effect on nurses' willingness to access family-friendly provisions, even when such provisions formally existed. The resulting culture of presenteeism in which continued physical availability was valued as a signal of professional seriousness, regardless of its consequences for individual health and family life, constitutes a particularly insidious form of WLB deprivation, in which the formal infrastructure of support is rendered practically inaccessible by informal institutional norms. Participant 26 articulated the career-damage calculus with considerable analytical precision, revealing the logic through which individual nurses internalise institutional expectations:

"The challenge I often face in managing my work and home affairs well is because I always have to sacrifice family time to always be at the hospital so that my career progression will not suffer. If you want to progress in the nursing profession, you must make sure you are not going on leave and that you are not making use of all the WLB initiatives. Such 'quick responses' count positively for you during performance appraisals." (Participant 26)

The formulation 'I always have to sacrifice family time' is revealing in its passivity. The participant does not describe choosing career over family but being compelled to sacrifice the latter in order to protect the former. The reference to 'quick responses' as a performance appraisal criterion further illuminates the institutional mechanism through which presenteeism is

reproduced: availability is rewarded formally, through the appraisal system, creating rational incentives for behaviour that is individually harmful and institutionally self-defeating. Participant 35 also shared that:

"I find it excruciating to successfully integrate my work-life demands in a way I want by taking up WLB initiatives that I know exist simply because it may have negative career implications. Nurses who use these initiatives may be seen as not being serious. It is often stressful for me to manage opposing pressures from work and family as I struggle to keep up with facetime at work so that I get promoted as at when due and also try not to fail as a responsible parent." (Participant 35)

The word 'excruciating' drawn from the same lexical register as physical pain, captures the intensity of the subjective experience of this double bind. The participant does not merely describe a practical difficulty, but a condition of sustained psychological suffering generated by a structural contradiction that individual agency cannot resolve. The simultaneous imperatives to 'keep up with facetime at work' and 'not fail as a responsible parent' relates to work-to-family conflict. In essence, the nurses experienced a form of inter-role tension in which the energy and time required by one role systematically undermined the fulfilment of the other, under institutional conditions that privilege one over the other.

Table 4.3: Thematic Summary : Agency Factors Causing Work-Life Boundary Management Problems

Inquiry	Theme	First-Order Codes	Illustrative Quote
What agency factors cause work-life boundary management problems for nurses in Saudi Arabia?	Theme 1: Work-Home Boundary Violations	• Institutional prohibition of emergency family leave • Family-to-work interference during night shifts • Sustained role conflict from caregiving obligations outside work • Enforced prioritisation of work domain over family • Normative obligation to be present for family members	<i>"I find it emotionally draining when the overwhelming nature of my job does not give me room to attend to any personal family emergencies when occasion arises... I was disallowed from leaving the hospital on that day."</i> (Participant 30)
	Theme 2: Incongruence Between Nurses and Their Work Environment	• Demand-capability mismatch generating cognitive depletion • Extended shifts causing brain drain persisting beyond work • Involuntary transfer of work frustration into home domain • Physical exhaustion limiting domestic functioning • Stress spillover as involuntary affective transmission	<i>"The long hours we work causes a lot of brain drain and stress. When I get home the next day, I find it strenuous to attend to my family needs due to the hectic nature of work the previous day."</i> (Participant 22)
	Theme 3: Labour-Reward Disparity	• Compelled rather than voluntary investment of labour • Leave recall dissolving the work-home boundary • Insufficient remuneration relative to workload intensity • Seniority unrecognised in compensation structures • Financial inadequacy failing to meet personal and family needs	<i>"The extended hours of working 12-14 hours and sometimes 7 days a week without having sufficient access to flexible shift patterns... shows how we are made to invest so much energy in clinical practices which is not comparable to the flexible working benefits we should be granted."</i> (Participant 4)
	Theme 4: Managerial Ignorance of Family-Friendly Policies	• Culturally biased policy allocation excluding male nurses • Managerial knowledge deficit on WLB policy implementation • Operational demands prioritised over employee welfare • Zero-sum framing of patient care versus staff WLB • Absence of evidence-informed policy practice	<i>"My manager feels since I am a male nurse and married, the belief system in the KSA is that women are naturally caregivers and home keepers... I feel managers here are inexperienced on handling sensitive matters such as implementing family-friendly employment policies."</i> (Participant 19)
	Theme 5: Perceptions of Career Damage from WLB Policy Use	• Presenteeism culture rewarding continuous availability • Fear that leave-taking signals limited professional commitment • WLB policy use perceived as career-limiting behaviour • Availability formally rewarded in performance appraisals • Structural double-bind between career progression and family fulfilment	<i>"If you want to progress in the nursing profession, you must make sure you are not going on leave and that you are not making use of all the WLB initiatives. Such 'quick responses' count positively for you during performance appraisals."</i> (Participant 26)

4.4 Objective 3: Cultural and Regional Peculiarities Exacerbating Work Stress, WLB Imbalance and Boundary Management Challenges

The third research objective investigated the macro-level cultural and regional contextual factors unique to the KSA that compound organisational and individual boundary management challenges. Three overarching themes emerged from the data: masculine hegemony and patriarchal culture; ingrained religious belief systems; and preferential treatment and favouritism (*wasta*) (See Table 4.4).

4.4.1 Masculine Hegemony and Patriarchal Culture

The extensively patriarchal character of the KSA was widely acknowledged by female participants as a major contributory factor to WLB imbalance and boundary management difficulties. Hegemonic masculinity, deeply ingrained in the broader societal culture, was reported to frustrate women's aspirations for WLB by perpetuating unequal domestic labour burdens, restricting their ability to enact boundary preferences, and creating pervasive gender-based inequalities in both the workplace and the broader society. In the nursing context, these patriarchal structures actively constitute a second shift of care work that follows the completion of the professional shift. For example, Participant 27, a third wife in a polygamous household, offered an account of patriarchal constraint that is remarkable in its structural specificity:

"The occupational stress and WLB problems I experience in the hospital as a nurse is also influenced the wider cultural system in the KSA that favours men over women both at work, and society at large. I am the third wife of my husband. As a nurse, you can imagine the struggles and stress I go through in managing my work as well as children care in a country where we get little or no spousal support from our husbands because it is a 'man's world' here in the KSA. It is so strenuous to separate boundaries between my work and family life." (Participant 27)

This account operates at the intersection of institutional and domestic patriarchal system that 'favours men over women' shaping both the occupational conditions within which nursing is performed and the domestic conditions to which nurses return. The participant's polygamous family structure intensifies these pressures by reducing the spousal support available and multiplying the domestic labour demands upon each wife. The phrase 'it is a man's world here' describes a cultural system in which masculine prerogative is institutionally legitimated across all domains of life, leaving female nurses structurally positioned at the intersection of occupational overload and domestic dependency. Participant 44 corroborated this sharing that:

"Everyone knows my profession is stressful given the variety of patient care I attend to on a daily as well as the disruptive nature of my work night shifts. But the kids feel Saudi men are not wired to be child minders because of the hierarchy-enhancing status of men legitimising myths based on rigid gender role allocation that relegates us to domestic servitude." (Participant 44)

From the quote, it is apparent that the participant deploys the concept of 'legitimising myths' to characterise the cultural narratives through which gendered domestic role allocation is naturalised and reproduced. By identifying these myths as 'hierarchy-enhancing', the participant reveals an understanding of patriarchal culture as a system of ideological power. This account reflects how deeply gender inequality and patriarchal structures in the KSA constrain the boundary management strategies available to women. Participant 64 articulated the quotidian experience of this double burden with particular economy:

"WLB is not easy to achieve as a woman in the KSA where the system is extremely patriarchal. I feel a lot of tension between meeting clinical demands on a daily basis at work and later rush home to discharge my familial responsibilities as if I never went to work. In doing this, the strain is sometimes enormous as I do my

best to integrate my work and family roles this way in order to meet-up with culture demands." (Participant 64)

The phrase 'as if I never went to work' captures the phenomenological reality of the second shift. The nurse leaves the hospital and immediately re-enters a regime of domestic labour that is as demanding, and structurally as compulsory, as the professional one. The imperative to 'meet-up with culture demands' reveals that this integration is not a freely chosen boundary strategy but a culturally mandated compliance requirement, enforced by social norms that carry strong normative weight in the Saudi Arabian context.

4.4.2 Ingrained Religious Belief System

The Islamic religious belief system was also identified by participants as a significant contextual force shaping work-home boundary preferences in the KSA. Islam was described as governing all aspects of life, including the relationship between spouses, the organisation of daily routines, and the ethical framework within which professional obligations are understood. The result is a polychronic orientation i.e. a cultural tendency to blend rather than separate life domains, that creates a specific and contextually distinctive set of boundary management challenges for nurses who are simultaneously subject to the temporal demands of professional shift work. Participant 58 articulated the tension between Islamic polychronism and occupational scheduling:

"Because patient care cannot be confined to usual working hours (9am-5pm), almost all the nurses in this hospital work non-traditional hours or shift which sometimes has negative consequence on me especially when I work long demanding night shifts which increases stress level, causes insomnia and disrupts my social and family life. I am a devote Muslim and my religion and Saudi culture demands people to place their private lives and family obligations as equal to the demands of their work. I therefore combine elements of both domains, essentially removing boundaries between my work and family responsibilities and blending facets of each." (Participant 58)

The participant position of blending work and family domains in response to the dual imperatives of Islamic teaching and professional shift patterns illustrates the cultural logic through which boundary integration is chosen in the Saudi context. This integration orientation is not a failure of boundary management but a culturally coherent response to a specific normative environment. However, when overlaid with the demands of non-traditional shift patterns, insomnia, and social disruption, the integration strategy becomes a source of strain rather than a resolution of it. This account shows how religious values encourage an integration of work and home domains, while the material demands of the nursing profession make that integration increasingly strained. Participant 33 also shared how religious teaching and patriarchal cultural norms converge to multiply the domestic labour burden on female nurses:

"Although in Islam, the role of a women covers many things, from domestic affairs to roles in the society. The Qur'an glorifies women who are perceived as helpers to their husbands in household affairs. This is why I do my best to combine my work and family responsibilities in ways that pleases my husband as required by the Almighty Allah. It is not easy sometimes given the nature of my work as a nurse. It is not easy most times to harmonise both my profession and private life but what I do is that I try to have some flexibility by taking advantage of being able to be at home in the middle of the day." (Participant 33)

The theological framing of domestic service 'as required by the Almighty Allah' transforms what might otherwise be understood as a practical boundary management difficulty into a site of religious identity and marital obligation. The participant frames labour as a divinely endorsed expression of her role as a wife and Muslim woman. The integration of work and domestic responsibilities as observed is theologically mandated, making psychological detachment from

domestic obligations during the work shift both practically difficult and normatively transgressive.

4.4.3 Preferential Treatment and Favouritism (*Wasta*)

Another Saudi cultural factor identified in the analysis was the pervasive influence of *wasta*. *Wasta* is the Arabic term for the system of social connections and familial networks that facilitates nepotistic practices in the Arab world (Tlaiss and Kauser, 2011). Nurses reported that access to WLB policies, leave approvals, and flexible working arrangements was frequently contingent on personal connections with hospital management and powerful families, rather than being distributed equitably on the basis of professional need or established criteria. In this way, *wasta* functions not merely as a cultural practice but as an institutional mechanism through which structural inequality in the distribution of WLB provisions is reproduced and legitimated. Participant 49 provided a detailed account of *wasta's* operation within the leave approval process, revealing the subjective experience of systematic inequity:

"Some of our ward managers are partial when approving annual leave requests which should normally be dealt with based on our needs. The nurses who are properly connected use their family connections with senior management of the hospital to get their leave requests prioritised and approved while those on the queue maybe turned down. I feel stressed when I am declined my leave or told to monetise it as an alternative because some other nurses have taken the slot based on relationships they have with influential people which is seen as a normal custom of this society." (Participant 49)

The participant's observation that preferential treatment 'is seen as a normal custom of this society' positions *wasta* as a socially normalised mechanism of resource distribution, the refusal to acknowledge which would itself constitute a form of cultural naivety. This normalisation renders resistance to *wasta* particularly difficult. There is no widely recognised injustice norm

against which the practice can be contested, because the practice is itself the operative norm. The stress generated by leave denial or leave monetisation is therefore doubly compounded as their tends to be the recognition that this deprivation is culturally sanctioned and institutionally un-remediated. Participant 65 added a further dimension of intersectional disadvantage, describing how *wasta* interacts with gender to compound the inequitable distribution of WLB provisions:

"Our HR office in the hospital keeps informing me that the policies are always utilised on a first come, first served basis, but I noticed that flexible work patterns and job sharing are reserved exclusively for female nurses with children. Obviously, I am denied because I am a male nurse. Favouritism is a common practice in this part of the world. If I was connected to the family who own this hospital, I would enjoy almost all benefits of WLB policies existing here but I am not." (Participant 65)

This account reveals the double marginalisation experienced by male nurses in the Saudi hospital system. (1) excluded from provisions formally targeted at female nurses, and (2) excluded by social capital from the informal allocation system through which provisions are effectively distributed. The gap between formal policy — 'first come, first served' — and informal practice — ownership-connected access — illustrates the degree to which *wasta* subverts institutional mechanisms of equitable distribution. The Participants accounts paint a narrative of a WLB distribution landscape in which structural inequality is reproduced through the interaction of formal institutional inadequacy, informal social capital networks, and gender-based allocation norms.

Table 4.4: Thematic Summary: Cultural and Regional Peculiarities

Inquiry	Theme	First-Order Codes	Illustrative Quote
Why do cultural and regional peculiarities exacerbate work stress, WLB imbalance, and boundary management challenges for nurses in the KSA?	Theme 1: Masculine Hegemony and Patriarchal Culture	• Cultural system legitimating male privilege across work and domestic domains • Polygamous family structure multiplying domestic burden • Absence of spousal support in caregiving and home management • Legitimising myths naturalising gendered role allocation • Second shift of domestic labour following professional shift	<i>"As a nurse, you can imagine the struggles and stress I go through in managing my work as well as children care in a country where we get little or no spousal support from our husbands because it is a 'man's world' here in the KSA."</i> (Participant 27)
	Theme 2: Ingrained Religious Belief System	• Islamic teaching mandating integration of work and family domains • Polychronic orientation blending professional and private life • Non-traditional shift patterns disrupting religious observance • Domestic labour framed as divinely endorsed obligation • Theological imperative to prioritise family alongside work	<i>"I am a devote Muslim and my religion and Saudi culture demands people to place their private lives and family obligations as equal to the demands of their work. I therefore combine elements of both domains, essentially removing boundaries between my work and family responsibilities."</i> (Participant 58)
	Theme 3: Preferential Treatment and Favouritism (Wasta)	• Family connections determining leave approval outcomes • Social capital access as prerequisite for WLB policy benefits • Wasta normalised as culturally accepted resource distribution mechanism • Formal first-come-first-served policy subverted by informal networks • Intersecting gender bias and wasta compounding marginalisation	<i>"The nurses who are properly connected use their family connections with senior management of the hospital to get their leave requests prioritised and approved... I feel stressed when I am declined my leave or told to monetise it as an alternative."</i> (Participant 49)

4.5 Chapter Summary

In summary, the findings of this thesis comprised concrete results and key discoveries from the study that directly answered the research questions presented in chapter one. Hence, the findings revealed contextual definitions of work stress experienced in the nursing profession. There were also emerging themes on the notions of WLB and the actual experiences of nurses in KSA. Furthermore, novel but nuanced evidence emerged to suggest nurses found it difficult to separate work from family obligation which necessitated a new order of work-home boundary violations. The incongruence between the nurses and their working environment, labour-reward disparity, managerial ignorance of family-friendly policies, perceptions of career damage, masculine hegemony, ingrained religious beliefs as well as preferential treatment and favouritism further nuanced experiences of broader contextual challenges hindering work-life boundary management beyond the micro features challenging WLB and job stress within the context of KSA.

The following chapter will discuss these findings in relation to the existing theoretical and empirical literature, with a view to advancing a nuanced, contextually grounded understanding of occupational stress and work-life boundary management within the unique sociocultural context of the KSA.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 Chapter Overview

This chapter presents a detailed discussion of the study's findings in direct relation to the research objectives and questions established in the opening chapter. By engaging critically with the existing body of literature, the findings are contextualised, interrogated, and interpreted through the lens of relevant theoretical frameworks and prior empirical scholarship, thereby illuminating both points of convergence and departure from established knowledge. Recall that in the first chapter of the study, three objectives were stated: to conceptualise wider perceptions and definitions of work stress and WLB outside those existing in work-life scholarships; apply the border theory to systematise and explain empirical data revealing factors causing work-life boundary management problems in the nursing profession at Saudi Arabia; identify wider contextual issues rarely considered in stress and WLB literature that shapes experiences of work stress, work-life imbalance and boundary management practices of nurses working in the KSA; present the implications of this study findings for the development of theory and practice in the nursing profession existing in the Middle East. The chapter begins the discussion with the understanding the perception of participants about work stress and WLB. Thereafter, factors that are making it challenging for nurses to transition, manage and/or negotiate their work responsibilities, family obligations and other private life affairs are discussed. In conclusion, the theoretical and research implications underscoring broader contextual issues affecting nursing profession in the KSA are discussed. The chapter closes by proposing an empirically informed

model that integrates the study's conceptual framework with the findings, before summarising the key points of discussion in relation to each research objective.

5.2 Objective One: Conceptualising Work Stress and Work-Life Balance

5.2.1 Perceptions of Work Stress and Work-Life Balance

From the findings, participants defined occupational stress from the divergent perspectives based on their personal experiences of the nature of stress encountered in the nursing profession. Hence, a common challenge with conceptualising stress has been the varied perspectives of the term (Ackfeldt and Malhotra, 2013). Although work stress is a universal phenomenon that has been proven to cause adversarial health and performance outcomes at both personal and organisational levels (Kozusznik et al., 2012), it has almost become a tradition in most stress research to reveal the lack of a precise and singular definition of work stress in the literature (Mo et al., 2020). In other words, despite the widespread use of the terminology, stress is still a fairly vague concept that is difficult to define with precision (Ganster and Rosen, 2013). So, stress researchers and scholars have had difficulty at agreeing on an acceptable definition of stress. Hence, the nurses of the present study working in the KSA conceived work stress from different perspectives that portrays as a stimulus, response and stimulus-response interface of stress operationalised within the context of the nursing profession. The current findings of this study attest to the dynamic nature of defining work stress. This resonates with the idea of Javaid et al. (2023) describing stress as one of the most creatively ambiguous in the English language because of its chameleon characteristics with many meanings as there are individuals who use the word to describe adversarial work experiences depending on the conversation's context.

From the findings, the first approach is termed the 'engineering perspective' (Cox and Griffiths, 1995). This perspective is conceptualising stress as a threatening or demanding situation or event (e.g., a high-stress job, overcrowding, long commutes to work etc.). According to the findings, conceptualising stress from this standpoint meant it is a stimulus which nurses in the KSA averred arises from the external aversive nature and working conditions in the hospitals that nurses encounter as essential care providers (Lim et al., 2010). Thus, stimulus-based definitions characterise stress as a stimulus that are caused by environmental conditions and externalities (Kivimäki and Kawachi, 2015).

These findings confirm McGrath et al. (2003) that suggests the nursing profession is, by its very nature, an occupation subject to a high degree of stress arising from patient care, working environment and job demands. Indeed, recent evidence confirms that workplace stress among nurses remains a pervasive and structurally embedded problem in contemporary healthcare settings globally (Bahlman-van Ooijen et al., 2023). On a daily basis, nurses encounter stark suffering, grief, and even death of patients as few other people in the medical profession do (Ameri et al., 2021). Many nursing tasks are mundane and unrewarding while many are, by normal standards, distasteful, unpleasant, others are often degrading; some are simply frightening (Happell et al., 2013). To this end, the findings revealed role stress and in particular, work overload, are reported as main sources of occupational stress experiences within the context of the present study. As such, role stress in the nursing occupation in the KSA, conceptualised from the stimulus perspective continues to be an area of great interest to the profession, particularly as stress is found to affect the physical and mental health of nurses (Schneiderman et al., 2005). This is further corroborated by Alghamdi (2020), whose review of the literature on occupational stress in nursing highlights work overload, understaffing, and hazardous working conditions as

dominant structural stressors in the profession. However, there exist conceptual arguments that the stimulus-based definition of stress is problematic because the perspective fails to recognise that people differ in how they view and react to challenging life events and situations (Schwabe and Wolf, 2010).

Hence, further findings of the current study revealed others conceptualising stress in ways that emphasises the physiological responses that occur when faced with demanding or threatening work situations of the nursing profession in the KSA. Thus, narratives from participants resonates with Han Selye, a famous stress researcher who once defined stress as responses of the human body to any demand whether it is caused by, or results in, pleasant or unpleasant conditions or environmental situations (Selye, 1956). Selye's definition of stress is categorised as response-based in that it conceptualises stress mainly in terms of the body's physiological reactions to any demand placed on it (Selye, 1976).

As such, this approach in theory is referred to as response-based definition since these sets of participants working in hospitals at the KSA described stress in relation to their responses to working environment as nurses. From this perspective, it is intriguing to note that while most participants perceive stress as a real threat to the quality of life; provoking adversarial mental and physical health conditions when an individual's adaptive capabilities are overextended, some participants view stress as a positive phenomenon that allows them to thrive on the job, irrespective of the unfavourable working conditions making the nursing profession categorised as one of the stressful occupations in the world. For instance, some participants from the findings in chapter four attested to this. Thus, narratives from these nurses suggest that although stress is often portrayed as pervasive and debilitating, on the contrary, findings of the present study suggest that improving one's response to stress may be a matter of shifting one's mindset on as

described by participants (4 & 6). Within the context of stress here, one's mentality is conceptualised as the extent to which one holds the belief that stress has enhancing consequences for various stress-related outcomes such as productivity and performance (Crum et al., 2013).

From this standpoint, stress responses improve mental and physiological functioning to meet imminent demands and enable survival (Torres and Nowson, 2007). This occurrence is referred to eustress, known as 'good stress' which yield benefits (Le Ferve et al., 2003). Conceptually, stress as a response happens here when the body encounters adversity, then physiological arousal is raised and attention is narrowed, leading it to focus resources on dealing with the obligation at hand positively (Harma, 2006). This is evident in the narratives of participant 4 who claims to maintain a 'positive attitude' in the midst of patient aggression which is normally a stressor in the nursing profession and participant 6 who also claims to keep her emotions in check and not allow the various hospital cases she deals with on a daily basis negatively affect her mental health. Therefore, the response-based definition of stress takes into consideration individual differences given the fact people do not react to stressors the same way. Thus, the demand stimulus may be perceived as pleasant or unpleasant (Atkinson, 2000). Consequently, the findings of the present study confirm the conceptualisation of Hans Selye's theory of stress into categories: distress and eustress. Both categories, though distinct and different from each other, are subsumed within the broader definition of stress in the literature as a response (Koolhaas et al., 2011). Distress is stress that negatively affects an individual when demands placed on the body (whether in the mental or physical aspect) exceeds its capacity to expend in enduring stressors (Hwu and Kuo, 2007). Some nurses in the present study attest to this experience. On the contrary, eustress is stress that has a positive effect on the individual. Eustress is conceived to energise individuals and motivates them to make a change or gives positive outlook and makes people capable of

overcoming obstacles and sickness which were highlights of the lived-experiences of some nurses working in the KSA. As such, Le Ferve et al. (2003) argues that the differentiation leads to the ideas that under- and over-stimulation of the body by stressors may lead to distress while stress that is perceived with some positivity results in eustress.

However, neither the stimulus-based nor response-based definitions provided a complete definition of stress in the literature. Hence, majority of the participants conceived work stress as a combination of both stimulus and response. In short, job stress experienced in the nursing profession was not perceived as mere stimulus or responses as the case may be, but as an interface between stressors and personal susceptibilities (Fink, 2010). In other words, it is suggested that the linear nature of both separate definitions of stress as a stimulus or response led to a broader and generally accepted dynamic definition of the stimulus-response relationship. In theory, the consolidation of both stimulus and responses perspectives emerged from knowledge development in the field of stress research portrays the construct – 'stress' as not merely adversities that causes stress or individual differences to it, but stress is a dynamic and evolving interactions between people and sources of pressured demands that causes physical and psychological reactions (Kelloway et al., 2008).

From the study findings, stress experiences are conceptualised as a process whereby nurses appraise and respond to patients' care services and other job demands they appraise as overwhelming or threatening to their well-being (Gaidica and Dantzer, 2020). A critical element of this definition is that it emphasises the importance of how nurses appraise, that is, judge demanding or threatening work demands (often referred to as stressors) while appraisals, in turn, influence their responses to such work conditions. This is evident in the way participants 4, 11

and 5 defined occupational stress they experience as nurses. From the narratives of these particular nurses, two types of appraisals of a stressor are especially important in this regard.

This are the primary and secondary appraisals initially conceptualised by Lazarus and Folkman (1984). The primary appraisal includes judgment about the extent of potential threat or harm to wellness that a stressor might endanger. A stressor would likely be appraised as a threat if an individual anticipates that it could lead to some kind of loss, harm, or other negative consequences. Alternatively, a stressor could also be appraised as a challenge if the person believes that it carries the potential for gain or personal growth (Labrague et al., 2017; Hsu and Li, 2026). Once an initial assessment (i.e. primary appraisal) is done, it then informs the processes that frames an individual's development of coping strategies (i.e. secondary appraisal) used to either accommodate, reduce or remove impending stressors (Pierceall and Keim, 2007). Therefore, within the context of work stress found in the nursing profession, the transactional approach examines the relationship between the nurses and their work environment through the personal assessments that they make of their work environment or working conditions evaluated as potential health hazards (Ickes et al., 2015; Bruza-Augatis et al., 2026).

In general, the contributions of findings from this study were that at the first level of analysis, the definition of work stress of nurses working in the KSA do not differ remarkably from the established definitions in the literature in terms of the way stress is classified into three categories as a stimulus, response and interface between stimulus and responses. However, as the analysis progressed, the findings revealed contextual peculiarities in which the three different interpretations of work stress occur within the nursing profession. On a whole, the stimulus refers to aspects of the work environment (e.g. workload) that can potentially harm the wellness of nurses. These conditions are known as stressors (Jex and Yankelevich, 2008; Gmayinaam et

al., 2024). On the contrary, the response definition depicts an individual's reactions to occupational stressors. Moreso, an employee's reactions to adversarial working conditions are also termed as strain (Westman, 2013). Finally, work stress is also conceptualised as an interaction between stimulus (work stressors) and responses (individual strain reactions) which presents a more robust definition in the literature.

5.2.2 Difficulties Surrounding Stress Definitions

Hence, La Torre et al. (2019) argued that the difficulties surrounding the various definitions of stress possibly foregrounds the reasons for the multiplicity of models and theoretical frameworks of workplace stress which have been important in guiding stress research and practice over the years. Many of these models already reviewed in chapter two of this doctoral thesis are known to have been influential in the field of work stress research although all these models vary in popularity and empirical support (Schwabe and Wolf, 2010). In other words, the number of stress frameworks and theories demonstrates how many different perspectives there are of work stress, and also reveals how complex these processes may be.

Despite the more relational viewpoint (i.e. stimulus-response approach), there has been no serious attempt in research and practice to harmonise what stress actually is from a singular standpoint (Yu et al., 2021). As such, the present study's unique contribution to knowledge is to show how the already existing three conceptual categories of stress definitions are subjectively perceived in the nursing profession of an under-researched country – the KSA. On this part, this work elects not to make direct contribution to theory, but more to apply exiting theory (i.e. stimulus, response and stimulus-response interactions of stress definitions) to a phenomenon (i.e. nursing profession existing from the Eastern part of the continent) that has yet to be adequately understood and explained theoretically from such a context (Aedh et al., 2015). Therefore, the

findings show the diverse ways that nurses working in different hospitals in the KSA defined stress within the context of their profession. Critically, occupational stress among nurses in the KSA must be understood not merely as an individual health outcome but as a systemic challenge embedded in the structural and organisational conditions of healthcare delivery (Almutairi et al., 2024). Since nurses form the largest group of health professionals in KSA and are essential for health care, reform in policies that mitigate the difficulties of work stress is critical to the success of transforming the health care in KSA where nursing services are less stressful (Alluhandan et al., 2020). This urgency is reinforced by the WHO's (2025) State of the World's Nursing report, which underscores persistent shortfalls in nurse staffing, welfare provisions, and occupational health protections across the region, demanding urgent policy attention.

5.2.3 Interpretation of WLB

Additionally, as the analysis progressed, interview questions were also asked on how participants defined WLB. Similar to the multiplicity of work stress definitions, nurses in the study also defined it from different dimensions. From the findings, the first notion of WLB was defined as having time for family. Since this social role plays an integral role in the lives of working adults, within the non-work domain, a major subdomain of social aspects is the family to some participants of the study. These findings indicate that the family system ranked significantly important and far higher than personal careers in the Arabian region (Al-Khraif et al., 2019). More so, families in the KSA constitute the elementary societal unit, fundamentally responsible for economic support, reproduction, protection, social relationships, and well-being such as physical and mental stability (Al-Khraif et al., 2020). In Islamic countries such as Saudi Arabia, the sociocultural fabric of the kingdom is its collectivist nature and the emphasis on the extended family. Within the family setting, people develop strongly knitted social ties and feel a

sense of obligation to support the goals, aspirations and needs of their kith and kin as well as their nuclear and extended families (Almalki and Ganong, 2018). As such, having time to prioritise family needs regardless of work for some nurses reflects achieving a balance between their home life and work commitment. In this sense, Al-Khraif et al. (2020), suggests that families serve as pillars of care, values, and culture in the Arab society acting as reservoirs of traditions, culture, religion, and values, thus playing a role in social, cultural and familial stability. This finding is consistent with more recent work by Alotaibi and Aldossry (2024), whose study of nurse-mothers in Riyadh found that work-family conflict was significantly influenced by the centrality of family roles in Saudi culture, reinforcing the view that family-related WLB challenges are structurally distinct in the KSA context compared to western settings.

Secondly, another set of participants of the current study defined WLB as creating time to deal with health-related issues. These findings resonate with studies (e.g. Chittenden and Ritchie, 2011; Jones et al., 2013; Gragnano et al., 2020) whose findings reveal that WLB is defined in terms of health concerns. For instance, Laal and Aliramaie (2010), found that there was a high level of work stress experienced in the nursing profession because the occupation involves extremely high demands of care activities and interpersonal relationships with patients, hospital senior management, peers and subordinates which can often be strenuous. In nursing specific stressors, it is found that patients experiencing pain, disability and death with all the consequent psychological trauma involved make the work of nurses more harrowing than if it was some other form of care professions (Chatzigianni et al., 2018). This is why some of the nurses in the present study held the notion that being in good health is a condition pre-requisite in achieving WLB. The findings are in tandem with the vision 2030 of Saudi Arabia where the government of

the kingdom intends to build a vibrant society for the future that is based on living according to Islamic principles of moderation, national identity, and cultural heritage which is meant to live a good life in a beautiful environment, that can develop caring families through a social and functional health care system (Abuhammad et al., 2025).

Despite the fact that the overarching of WLB as predominantly being a work-family affair in the literature, other participants went beyond this restrictive notion to define WLB having time for personal leisure activities and religious worship. Conceptually, the more encompassing term "work-life" as distinct from "work-family" has gained widespread recognition and has paved the way for the universal adoption of more inclusive terminology that takes into consideration all other of non-work matters other than family affairs (Shockey et al., 2018). The framing of 'Life' in most WLB literature generates a restrictive discourse to the domestic domains that portrays traditional family settings only (Sirgy and Lee, 2018). Hence, the definition of WLB by nurses to include other aspects of life beyond the mundane family life/matrimonial household structures depicts a wider coverage of non-work activities. This aligns with recent scholarship by Zaitouni et al. (2024), whose comprehensive mapping of two decades of WLB research reveals an increasing tendency in contemporary literature to define WLB beyond the binary work-family dichotomy, encompassing personal health, leisure, spirituality, and community engagement. Furthermore, these findings support studies such as Mullen (2015) which reveal that achieving a balance between social life and work life is becoming increasingly important for nurses to be happy and healthy. The significance of such an inclusive conception of WLB is also underscored by Widayana et al. (2025), whose scoping review of factors associated with WLB among hospital nurses identified a diverse socio-ecological array of life domains including personal,

social, and occupational dimensions that simultaneously shape nurses' capacity to achieve meaningful balance.

In addition, another nurse defined WLB in terms of having time for religious activities. Given that Saudi Arabia is the 'home' of Islam, it becomes apparent that achieving WLB in this society will involve dedication to Muslim worship. Alotaibi et al. (2023) affirmed that people living in the KSA are often very religious and Islam shapes the majority of individuals' way of life. In this regard, Tahir (2025) offers important theoretical grounding, arguing that Islamic work ethics and gender role expectations fundamentally shape the meaning of WLB in Muslim-majority contexts in ways that western theoretical frameworks have systematically overlooked. This supports the present study's position that context-sensitive conceptualisations of WLB are necessary to adequately capture the lived experiences of nurses in the KSA. Further definition of WLB was keenly lined with flexible working arrangements. The discussion on WLB is fundamentally linked to concerns about design of jobs and working arrangements (Shifrin and Michel, 2022). In the literature, labour flexibility has been a topic of considerable interest to researchers, practitioners, and public policy advocates as a tool to help adults manage work and family roles (Kattenback et al., 2010). While availability of flexibility practices can help reduce employee work-family conflict, the findings of the present thesis show that patterns of long shifts in the nursing profession makes it difficult for participants of the study to have greater control over their family matters. As such, there were difficulties in their working patterns that provide them with more freedom and flexibility in determining the timing, location, and manner in which they perform their nursing tasks (Kossek et al., 2011).

Despite the fact that flexible working practices are alternative job options that allow work to be accomplished outside of the traditional temporal and/or spatial boundaries of a standard workday

(Smith et al., 2023), one of the nurses (i.e. participant 34) claimed that they rarely enjoy flexible work arrangements which is one of the root causes of work-life conflict experienced. In addition, there were also claims that nurses do not enjoy flexible arrangements such as part-time, job share, compressed hours, flexitime, annualised leave and so on. This is not the case in developed countries such as the United Kingdom, where flexible is often protected by legislation and made available to employees. It is often utilised by employers of labour as a medium to motivate or way to demonstrate that employers are socially responsible (Chung, 2020). More so, flexible working arrangements have been cited constantly in research and practice as integral to helping employees manage competing work and family domains (Boyar et al., 2024).

From definitional perspective, the findings of this thesis uncovered how occupational stress and work-life imbalances were found to impugne on boundary management of nurses working in the KSA. More specifically, themes emerged on factors making it difficult for these nurses to transition, manage and/or negotiate their work responsibilities, family obligations and other private life affairs. The first theme that emerged is work-home boundary violation. Since the boundary theory used as a theoretical framework of this study focuses on ways that people create, maintain, and/or change boundaries in order to negotiate between work and non-work demands, the present novel study findings revealing nurses experiencing boundary violations which refers to instances in which boundaries are not treated in the way that nurses prefer. For example, Kreiner et al. (2006), conceptualised boundary violation to include boundary intrusion consisting of one's boundaries being breached to the extent that the person finds it difficult to separate their work from non-work as expected. The researcher of this study found a similar pattern of boundary violation in our sample, but with specific regard to work-home boundary. Hence, study results present the ongoing state of work-home conflict and stories from

participants of events and episodes in some particular way to their care roles. It is worthy to also note that since KSA is now home to migrant nurses, the healthcare sector should implement friendly-family policies that will improve the quality of life of both local and foreign nurses since the KSA is now highly dependent on expatriate nurses (Davies and Yallow, 2025).

5.3 Objective Two: Institutional Factors Causing Work-Life Boundary Management Problems

The findings thereby introduced the concept – work-home boundary violation which is defined from the study as perceptions of nurses about how behaviours, episodes or events either breaches or neglects important facets of their desired work-home boundary (Kerman et al., 2021). More precisely, this study contributes to a better understanding of border theory by incorporating it as a conceptual framework. It applies the theory to a distinctive socio-cultural environment such as the KSA, which significantly enhances understanding of readers. Border theory, is fundamentally concerned with how individuals define the boundaries between their professional and personal lives, gains new significance in the context of the KSA. It is obvious from the findings that boundaries are not only more complex but also intricately entangled with cultural and societal factors in the KSA. Hence, the current doctoral thesis utilises the border theory to adhere to, but also broaden, traditional approaches to WLB challenges encountered in the nursing profession peculiar to a region in the Middle-East (Jabeen and Faisal, 2018). This application resonates with the evolving direction of WLB scholarship, where Kossek et al. (2023) argue for examining work-life flexibility policies from a boundary control and implementation perspective that considers how contextual features shape whether and how boundary preferences are realised in practice.

As applied in this definition, it is found that this violation is intrusive which manifests when a nurse desires segmentation but the violation forces an integration (Lapierre et al., 2016). This type of violation deflates the boundary, although temporarily. Examples from the study data reveal one of the nurses (i.e. participant 30) being emotionally drained from the overwhelming nature of her work that disallows her to attend to pressing non-work emergencies when the need arises because she is not given permission at work. Another nurse (participant 31) claims to feel stressed because she to use her mobile at work to check her children's well-being and settle conflicts over the phone with them. Boundary violations occur when working adults are simply unable to prevent unplanned spillover from one into another (Allen et al., 2020). This can take any form, including negative feelings and psychological exhaustion as seen in the findings of the present study. The relationship between such boundary violations and broader nursing workforce outcomes is increasingly evidenced; as the International Council of Nurses (2023) reports in its landmark workforce analysis, persistent work-life boundary pressures contribute significantly to burnout, turnover intent, and declining care quality across global nursing populations, including in under-studied Middle Eastern contexts. Thus, the study findings contribute an enhanced holistic and detailed picture of work-life boundary management that integrates the antecedents, and pertinent work-home outcomes from the perspective of the nursing profession. In doing this, it is demonstrated that the construct of work-home boundary violation is particularly promising. Observably, most WLB studies and occupational stress research have focused on examining the problems on the construct of work-life conflict. Whereas work-life conflict is a generalised and fairly consistent state when individuals struggle to harmonise both domains, the present study introduce and conceptualised boundary violations as events and episodes that violate the work-home boundary preferences of nurses in the KSA.

The second theme that emerged from the study is a factor causing difficulty for nurses to manage their work-life boundaries are experiences of incongruence between them and their work environment. Work stress was found to become apparent in this situation. These experiences were found to occur when individual capabilities of nurses do not match well with characteristics of the hospital environment. The person-environment (P-E) misfit analysis of the study findings provides an excellent framework for understanding boundary conflicts because it sets the stage for seeing boundaries as sites of ongoing negotiation (Kreiner et al., 2009). Examples of the nurses-environment incongruence helps us appreciate the interaction between individual work-life preferences and the person's subjective interpretation of his or her environment (Houlihan and Bourdeau, 2016). While much research on the (P-E) fit or misfit has focussed on the structural interaction between characteristics of the individual and the physical environment. This is similar to the stimulus-based definition of stress where environmental stressors are the main reasons for negative outcomes of strain and conflict experienced by individuals. This occurs when an individual's characteristics and values do not match the environment in which they operate. The (P-E) fit concept appears to assess the misfit from a singular environment which seems not to take into consideration dual environments such as workplace and home spaces where individuals have to manage and/or negotiate between both environments on a daily basis. Hence, it seems little research has been done on the dimensions of incongruence for work-home boundaries (Kossek et al., 2011). Thus, the present thesis provided detailed and nuanced views of nurses about difficulties they face in managing and negotiating boundaries between two different environments (i.e. work and home). Therefore, the findings show incongruences between nurses and environmental conditions that makes the nursing profession

highly stressful and the root cause of nurses' inability to match the caring specificities of their work environment with responsibilities encountered at their non-work environment.

The third factor revealed by the study findings as reasons some nurses struggle to satisfactorily manage their work and non-work boundaries is because of the high demands of the nursing profession which is not commensurate to the reward system (i.e. salaries and work-life benefits). This was conceptualised as labour-reward disparity. In other words, insights from the interviews uncovered a disparity between the quality-of-care service rendered to patients and perceived reward systems. The effort-reward imbalance was said to elicit strong negative behaviour and stress reactions with adverse effects on work-home boundary management of nurses. For instance, participant 4 narrated that she works extremely long hours as a nurse and does not receive in return flexible shift benefits to ameliorate her work-home affairs in such a way that it mitigates stress and work-home conflict. In addition, another interviewee narrated that the outcome of labour-reward disparity is the negative spillover built up at work through high occupational demands and a poor reward system which is transferred to the home front as reasons for financial difficulties and an inability to adequately support family demands. This process is well understood from Siegrist's (1996) effort-reward imbalance model, which focuses on the effects of social reciprocity and how psychosocial stress occurs in individuals as a result of a sustained unfair trade-off between effort and reward. Furthermore, empirical support for this dynamic within the KSA context specifically has been evidenced by Siraj et al. (2023), whose national cross-sectional survey of Saudi healthcare professionals found that perceptions of inadequate recognition and reward were significantly associated with burnout and reduced wellbeing. Therefore, expressions (such as "long night shift frequency and high-intensity work responsibilities that are not equivalent to the salary and night duty allowance: or "we are made to

invest so much energy in clinical practices which is not comparable to the flexible working benefits we should be granted") elicit a process that might result in a spillover of work stress into home affairs arising from disparities between the energy exerted at work and the perceived low reward for labour. Therefore, the quality of satisfactorily integrating the professional and private lives of nurses is considered a fundamental element for further development of the healthcare sector in the KSA (Al-Otaibi and Kerari, 2025).

The fourth theme from the study findings portrays managerial ignorance of family-friendly policies as a reason why nurses find it very difficult to manage boundary between their work and non-work domains. Since the boundary theory conceptualises family and work as two different, but interactive environments that employees have associated with different emotions, rules, values, behaviours and thought patterns, it is argued that a person's satisfactory and good functioning at work and at home with a minimum of role conflict can be fostered by the implementation of organisational WLB initiatives aimed at supporting deserving employees (Kelly et al., 2010). However, managerial ignorance of the importance of implementing friendly-family considering the role of line managers in implementing these policies appropriately was said to be a problem for how nurses effectively manage boundaries between their work and non-work affairs.

The study findings revealed evidence of discrimination based on gender when a request is made to utilise 'compressed working hours' as a family-friendly employment policy. For example, Participant 19 who is a male nurse expressed how his application was turned down simply because his manager feels a deserving employee of this nature of application should be a female nurse. Yeandle et al. (2003), argues that the need for organisations to become more family-friendly and to support WLB is on the agenda for those on the managerial cadre and

institutional policy makers that values the well-being of employees. Yet this study reveals that line managers of these nurses showing insensitivity in handling how to respond to their employees' needs and requests for flexible working arrangements. This was particularly worrisome for female nurses with parental and caring responsibilities. Work-life research has constantly highlighted the connection between gender and WLB (Chandrasekar et al., 2013), showing that women are more likely to consider WLB initiatives such as part-time work, casual leave for family obligations, compressed working hours (Buddeberg-Fischer et al., 2010), and various parental leave packages (Connor and Wright, 2013). Therefore, achieving WLB is an increasingly important issue that requires giving urgent awareness to managers on the importance of day-to-day issues that may arise, as managers are made to ensure prompt responses to those employees that request to use friendly-family policies in these regions (Belwal et al., 2020).

This is particularly relevant in the Middle-East where regulators and cultural barriers constraints the overall employment of women, especially in more conservative societies where scholars have extensively discussed the macro-level factors affecting WLB of women (Alfarran et al., 2018). Although there are reports on notable efforts to support female participation in the Arab world such as the KSA (Belwal et al., 2020), concerns remain on the impact of women working on their marriage, family, and traditional values which is expected to take priority over occupational life (Elamin and Omair, 2010). Women in Arab countries face cultural constraints that manifest as concerns because culturally, there are unequal distribution of responsibilities between men and women and the heavier burden of family duties that falls more on women, which makes achieving a WLB more challenging for women in nations like Qatar, Saudi Arabia, Iran and Oman (Belwal and Belwal, 2014). Thus, Alfarran et al. (2018) argued that more disheartening is

family-friendly policies that create flexible work conditions and enable employees in these regions to manage their work and family responsibilities are lacking, which may be the reason why those at the managerial level claim to sometimes ignorance of the availability of friendly-family policies that can foster WLB of employees. It is important to note that the central focus of the boundary theory is for borders and bridges between work and family to be appropriately managed in order to create and maintain a desired balance either through satisfactory segmentation or integration of both domains (Karassvidou and Glaveli, 2015). Therefore, important for managers to know how to respond to their employees' needs and requests for flexible working arrangements.

Perceptions of career damage emerged as the fifth theme revealing why nurses in the KSA find it difficult to manage boundaries between their occupation and private life affairs. From the study findings, there were assumptions that those nurses who are frequent users of family-friendly policies are sometimes perceived as less committed to hospital's medical practices that prioritises patients' care above anything else. The consequences of this negative perception according to findings is that such nurses are said to deny themselves the opportunity to ascend the career ladder of the nursing profession. Although it is argued that family-friendly policies appear to be an ideal solution to satisfactorily manage and/or negotiate work and family spheres and the borders between them to attain WLB (Clark, 2000), nevertheless, the unexpected trade-offs between these well-intended human resource management practices and important employee outcomes, such as career damage are not uncommon (Grant et al., 2007; Kaiser et al., 2013). Thus, WLB policies may be one such practice, providing opportunities for people to better balance work and family, but at a potential cost if those who use these policies worry that there will be negative career consequences of

doing so (Kossek et al., 2014). Although these policies are designed to help employees especially women, however, the present study suggests that some nurses are susceptible to stereotype threat, which in turn is associated with more negative views of family-friendly policies.

5.4 Objective Three: Broader Contextual Factors Shaping Boundary Management in the KSA

While the forgoing themes are institutional factors causing boundary management problematic for nurses in the KSA, other broader context was found in the study that shape challenges of work-life boundary management experienced at the workplace. One of them which emerged as the next theme after managerial ignorance of family-friendly policies is the culture of masculine hegemony that broadly shapes the lifestyle of the KSA. According to Soekarba (2018), patriarchy is a feminist construct that is to understand and analyse the systematic organisation of male supremacy and female subordination, or the domination of women by male. Furthermore, Solati (2017) argues that the subordination of women in Saudi Arabia is not intrinsic to Islam but stems from patriarchal interpretations of Islam by religious authorities working in conjunction with autocratic political leaders. This is why progress towards gender equality has been especially difficult in the Middle East (Alharbi, 2015; Siraj et al., 2023). This is the possible reason why nurses, according to the study findings are experiencing occupational stress and work-family boundary management challenges.

Masculine hegemony as a social system in Saudi Arabia in which men hold authority over women, children and property. Thus, patriarchy is a social practice in which women are subject to economic dependence, domestication, violence and the peripherals of decision making. Existing evidence reveal that in the Arab world, this problem is particularly severe; here men are considered as superior at all levels when compared to women and thus behave as such

(Alwedinani, 2017). Among the Arab societies, there are normative specificities which includes rigid cultural structures, patriarchal proclivities and social demands in which women are marginalised and disadvantaged in various aspects of life (Khadhar, 2018). Thus, patriarchy as a traditional and institutionalised system that underrates the social conditions of women's WLB and also exacerbates occupational stress.

The findings indicate some nurses as playing dual roles as income earners to support the family purse as well as home carers while men are portrayed as the absolute head of the home with domineering propensities. This is revealed in participant 27's narrative where she specifically mentioned: 'My husband instructs all his wives to live in harmony with one another. He is a very tough and as the head of the home, we must all, as his wives comply with his directives whether right or wrong. He is the breadwinner but also controls our income and how we spend money to avoid wastage...'. In addition, another nurse (i.e. participant 44) was of the view that: 'WLB is not easy to achieve as a woman in the KSA where the system is extremely patriarchal'. From these narratives, it is evident that gender role ideology which stipulates norms, attitudes, traditions, behaviours and assigns responsibilities to people based on their gender is more prevalent in the KSA than other parts of the world such as in western countries. Based on this societal perception and internalised assumptions of masculine supremacy, concerns were also raised about the lack of spousal support in helping with family responsibilities which exacerbates work-family boundary difficulties and work stress (Khalili, 2014; Almutairi et al., 2024; Alomar et al., 2025).

From a theoretical perspective, work-life border theory conceptualises employees as naturally protagonists who are enactive rather than reactive in constructing preferred borders between work and private life domains and thereby attaining a satisfactory balance (Lewis and

Beauregard, 2018). People naturally adopt strategies to manage work and non-work obligations according to their preferences either for segmentation, where work and family roles and locations are kept separate, or for integration, where work and family overlap (Clark, 2000) especially for women who are often identified as primary caregivers. However, critical scholarships have found that women's aspiration to either to successfully segment or integrate their work with family affairs can be frustrated by patriarchal proclivities which is deeply ingrained in any given society (Adisa and Isaika, 2019).

Therefore, the border theory framework provides an excellent framework for understanding boundary conflicts because it sets the stage for helping one understand the interaction between a person's preferences and their interpretations of the environmental features that could cause incongruence in achieving WLB (Basil and Beauregard, 2021). As such, the findings of present study of this doctoral thesis confirms previous studies (e.g. Al-Saleh, 2012; Al-Rasheed, 2013) that have revealed the extent to which patriarchy undervalues WLB of professional women and increases chronic stress conditions. Although many work-life studies have focused on the effects of negative work-home spillovers, less is known about its contextual antecedents from Saudi Arabia. Nevertheless, some relevant information is made available in this study. Thus, Adisa et al., (2019, p. 25) reveals patriarchal tradition is always targeted at consigning "women's WLB to the mercy of their husbands, partners or fathers" while men are always justified as having absolute power over women and their professional life.

Another theme that emerged from the findings as a broader contextual feature shaping the difficulties that nurses working in the KSA encounter in managing work-life boundaries were views that the national religion which is Islam informs a comprehensive system of values and ethical behaviours that governs all aspects of life, including work-home boundary preferences,

relationship with spouses and social life as a whole (Alyami, 2016). The findings show many nurses believing that being a Muslim involves accepting the five pillars of faith which is acknowledging the power, wisdom and greatness of Allah; accepting the final message given by Allah to the holy Prophet Muhammad; reciting the five daily prayers; zakat—giving a prescribed portion of wealth and assets to charity, in order to create a comprehensive welfare system; fasting for a month during Ramadan; and if health and means allow, making pilgrimage to Mecca. Largely, participants concurred that Saudi Arabia is polychronic in nature in that most women do not clearly separate external work and their social, family and religious life interactions from one another (Chaudhry, 2013). Furthermore, in the case of Saudi Arabia, it is pertinent to examine the peculiarities of Saudi's 'religious nationalism' and the power of the Saudi State to shape both the ideologies pertaining to the position of women in the society and the material conditions of their work-life existence (Burkova, 2017). The peculiarities of Saudi "religious nationalism" and the power of the Saudi State to fashion both ideologies relating to the position of women in Saudi while the material conditions of their existence is based on gender hierarchical dominance and masculine hegemony as earlier discussed. Thus, studies on women's restrictive rights in the KSA have revealed explanations that especially focuses on the nexus between autocratic regimes and gender inequality shaping their WLB (Al-Saleh, 2012). For instance, Khalili (2014) analysed the influence of Islam on female literacy, sex ratio, women's work-life participation, gender equality, and all sphere of life, but specifically noted that the inferior status of women in Muslim-majority countries like Saudi Arabia is more clearly associated with the lack of democracy but rather a monarchical system of governance. However, the nurses in the current study recognise that Islam is a dominant religion which also shapes the work-life boundary management of women regardless of their profession.

The final theme that emerged from the study were the preferential treatment and favouritism experienced by nurses which distorts their work-life boundary management. As discussed earlier, nursing is known as a demanding profession. According to the study findings, some nurses claim that an average working shift could take between 10-12 hours and attending to patients for more extra hours is often expected. In the context of the boundary management theory, the border around nursing work must be strong to withstand any interruptions from the home front, while the border around the nursing occupation from private life affairs while the border around home domains must be permeable enough to accommodate work activities that take place during what would normally be considered leisure or family time and in venues not typically associated with work (Lu et al., 2016). However, evidence of preferential treatment and favouritism was said to mar attaining satisfactory boundary management affairs of some study participants. This was because there were claims of some nurses being treated in manner that is likely to lead to greater WLB benefits, access, rights, opportunities or flexible working status than others. The issues of organisational preferential treatments and favouritism have been found to be a societal problem since the type of networks, connections and relationships an individual can identify with are important elements of the Saudi Arab society (Almostadi, 2020). Hence, when a person is connected to the rich, influential and powerful Saudi class or family, it gives such individual undue advantage over others. Thus, personal networks and family relationships are fundamental to the Arab social context where 'wasta' is the terminology used by Arabs to describe the social connections and familial networks that fuels nepotistic practices (Tlaiss and Kauser, 2011).

Certainly, it is recognised that the availability of family-friendly policies is critical to the well-being of employees while agreeably these policies can also accomplish the dual purpose of improving organisational effectiveness (Hammer et al., 2011). Yet, in retaining the ideals

underlying the business case of a win-win paradigm, it is argued that this perspective largely overlooks the dark side of WLB policies and fail to account for how managers of family-friendly policies discriminate against those who should normally be entitled to family-friendly policies (Koch and Binnewies, 2015). Although Perrigino et al. (2018) argue that some progressive line managers display detailed and up-to-date understanding of family-friendly policies and the need to be fair in administering them to deserving employees, many others are categorised as vague, ignorant, biased or resistant about employment policies for enhancing WLB. This was revealed in the excerpts from participant 49 who said: 'Some of our ward managers are partial when approving annual leave requests which should normally be dealt with based on our needs.'

The nurses who are properly connected use their family connections with senior management of the hospital to get their leave requests prioritised and approved while those on the queue maybe turned down if the management thinks nurses are not enough to cover shifts for the periods when such applications are high'. In addition, participant 65 further reiterates that: 'The reason why I experience work-life imbalance is because I am deprived of the right to use flexible shifts and alternate workweeks [...]. Our HR office in the hospital keeps informing me that the policies are always utilised on a first come, first served basis, but I noticed that flexible work patterns and job sharing are reserved exclusively for female nurses with children'. These findings confirm evidence from Wilkinson et al.'s (2017) study, which reveals the extent to which organisational flexible working schedules focus on the needs of those with nuclear families. As referred to the aforementioned, the participants reported instances of differential treatment in responding to their employees' needs and requests for flexible working arrangements. Although it is said that preferential treatments and favouritism are broadly accepted societal practices in the Arab world (Tlaiss and Kauser, 2011), however, it should be noted that such sharp practices evoke a

spectrum of reactions and outcomes ranging from work-family backlash to organisational counterproductive behaviours (Judge and Colquitt, 2004).

5.5 Towards an Empirically Informed Model of Occupational Stress and Work-Life Boundary Management among Nurses in the KSA

Having discussed the study findings in relation to each of the three research objectives, this section proposes an empirically informed model that draws together the conceptual framework developed in Chapter Two with the patterns generated from the fieldwork. Rather than treating border theory, the stimulus-response conceptualisations of stress, person-environment misfit, and the effort-reward imbalance model as separate explanatory devices, the model synthesises these constructs into a single integrative account of how occupational stress and work-life boundary management unfold among nurses in the KSA.

As depicted in Figure 5.1, the model is organised into three interrelated layers. The first layer, antecedent conditions, comprises the stimulus-, response-, and interface-based stressors identified under Objective One (Cox and Griffiths, 1995; Selye, 1956), together with the effort-reward imbalance (Siegrist, 1996) and person-environment misfit (Kreiner et al., 2009) documented under Objective Two. These antecedents feed into the second layer, the boundary management process itself, in which nurses draw on their preferences for segmentation or integration (Clark, 2000; Lewis and Beauregard, 2018) and appraise the demands placed upon them (Lazarus and Folkman, 1984) in order to negotiate the border between their professional and private lives.

The third layer, outcomes, captures the consequences of this negotiation as they emerged from the findings: work-home boundary violations, work-life imbalance, and either distress or eustress depending on how the demand is appraised (Selye, 1976), together with the perception of career

damage associated with the use of family-friendly policies. As indicated by the dotted feedback arrow in Figure 5.1, these outcomes are not terminal; sustained strain reshapes the resources nurses bring to subsequent rounds of boundary negotiation, producing the cumulative and often worsening pattern of imbalance described by several participants.

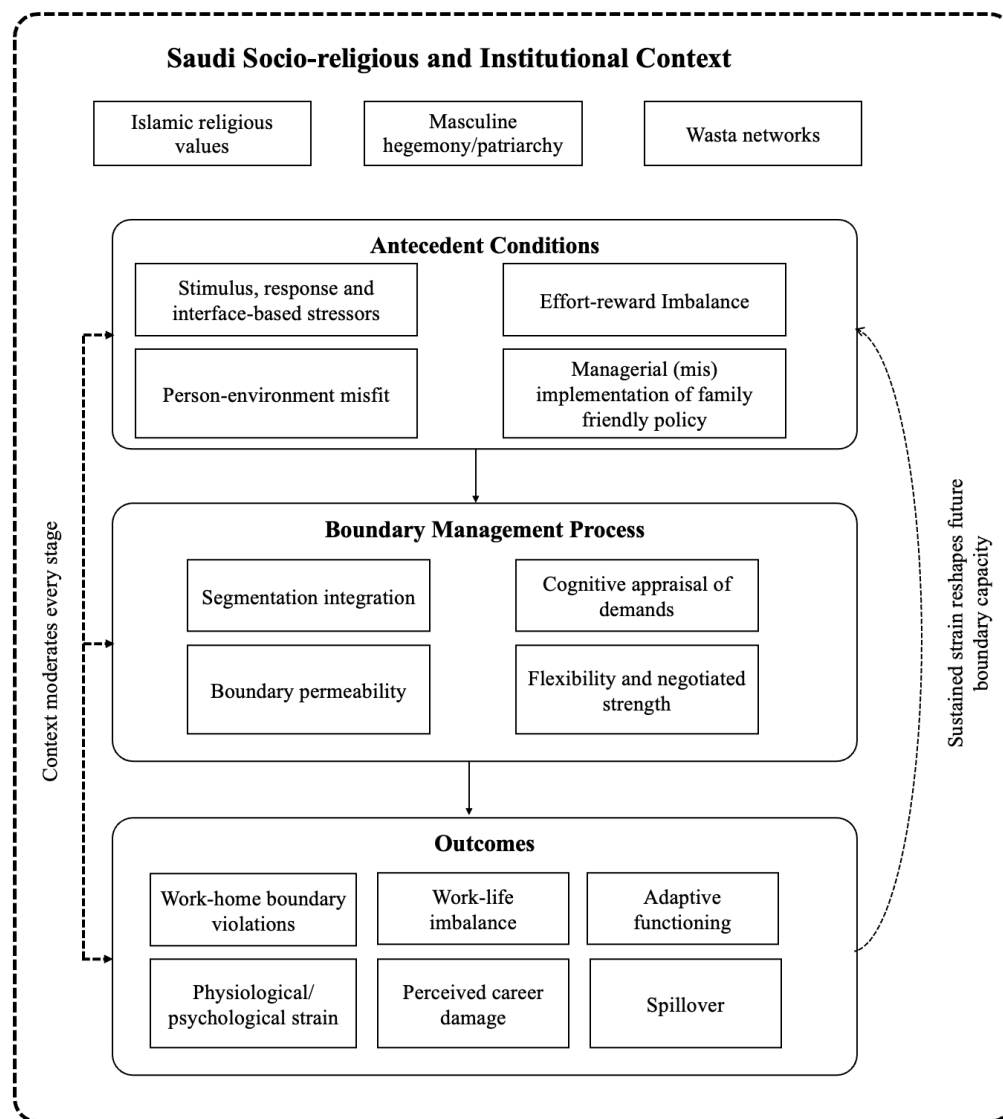


Figure 5.1: Model of Occupational Stress and Work-Life Boundary Management among Nurses in the KSA

Source: Author's own construct

Encasing all three layers is the moderating influence of the Saudi socio-religious and institutional context. As the discussion of Objective Three established, this context is not a peripheral backdrop but an active shaper of every stage of the process depicted: the Islamic values that inform boundary preferences (Alyami, 2016), the masculine hegemony that structures whose boundary preferences are permitted to prevail (Soekarba, 2018; Solati, 2017), and the wasta networks that determine whose requests for flexibility are honoured (Tlaiss and Kauser, 2011) all condition how antecedents are experienced, how the boundary management process unfolds, and which outcomes result. The model's principal theoretical contribution, therefore, is to render this contextual moderation explicit rather than assumed, extending border theory beyond the predominantly Western settings in which it was originally developed.

5.6 Chapter Summary

In relation to Objective One, the discussion has shown that nurses in the KSA conceptualise work stress through three interrelated lenses, as a stimulus, a response, and an interface between the two, and define WLB across four dimensions: time for family, time for health, time for personal leisure and religious worship, and access to flexible working arrangements. These conceptualisations broadly correspond to established categories in the literature but are inflected throughout by the material and cultural conditions particular to nursing practice in Saudi Arabia.

In relation to Objective Two, the application of border theory identified five institutional factors that make work-life boundary management problematic for nurses: work-home boundary violations, incongruence between nurses and their work environment, labour-reward disparity, managerial ignorance of family-friendly policies, and perceptions of career damage associated with using those policies. Together, these factors depict a boundary management process that is persistently disrupted by the operational and administrative conditions of hospital work.

In relation to Objective Three, the discussion identified masculine hegemony, the pervasive influence of Islam, and the practice of *wasta* as broader contextual factors that shape, and frequently constrain, how nurses in the KSA are able to manage their work-life boundaries. These factors extend the discussion beyond the institutional level to reveal the wider societal conditions within which boundary management takes place.

In summary, the discussion of the study findings, interprets the contributions of the results, explains their significance and places them with context of the literature and broader theoretical framework of study. Hence, the findings illustrate wider perceptions and definitions of work stress and WLB outside those existing in western work-life scholarships. This is because it was observed that majority of stress and WLB research has focused on western countries with scarce number of similar studies from regions such as the Middle-East. In essence, one of the main contributions of this thesis is examining the applicability of these theories to and find out if findings are valid in less comparable settings. Thus, the novel information from the study is that the concepts of WLB and work stress were constructed within a particular time and context and thus, may be culture and context sensitive. This observation is increasingly being acknowledged in contemporary scholarship; Atkinson (2025), for instance, offers a theoretical outline that situates the WLB concept within a multiplicity of social fields, arguing that the family-employment-leisure nexus is structured by institutional, occupational, and cultural forces that vary significantly across societal contexts. Similarly, Vydrová (2026) advances the argument that dominant conceptions of WLB are undergoing a paradigm shift from a balance-focused ideal towards a more dynamic notion of work-life fit which may better capture the fluid boundary negotiations documented in the present study among nurses in the KSA.

6 CHAPTER SIX

SUMMARY, CONTRIBUTIONS, LIMITATIONS AND FUTURE RESEARCH

6.1 Chapter Overview

This chapter brings together the entire doctoral thesis. It is divided into three main sections. The first section one provides a summary of the study, including the findings. The second section presents the study's theoretical contributions and their practical implications for policy and practice. The next section discusses some of the limitations of the study and advance avenues for further research.

6.2 Study Summary

The study investigates WLB challenges and occupational stress of nurses in Saudi Arabia. The study specifically explores this topic from perspectives of work-life border management challenges that nurses experiences as they engaged in one of the professions that is categorised as one most stressful occupation in the world (Alomari et al., 2021). The experiences of boundary management of nurses have been largely overlooked in the work–life literature, where priority has been given to other medical professionals such as doctors (Akanji et al., 2020). Situated in the Arabian context (Kingdom of Saudi Arabia) that has been neglected in favour of Western-based research (Bader et al., 2018), the study has focused on exploring the work-life boundary management problems that nurses working in the KSA. Hence, the study answered three research questions which were: (1) How do nurses in Saudi Arabian hospitals understand and experience occupational stress and WLB challenges? (2) What are the agency-related factors that contribute to work-life boundary management problems among nurses in the KSA? and (3)

Why do cultural and regional peculiarities exacerbate occupational stress, work-life imbalance, and boundary management difficulties among nurses in the KSA?

The objectives for formulating the foregoing research questions were to: (1) examine how nurses working in hospitals understand and experience occupational stress and WLB challenges in the KSA; (2) identify and analyse the agency-related factors contributing to work-life boundary management problems within the nursing profession in the KSA; and (3) explore how cultural and regional peculiarities exacerbate work stress, work-life imbalance, and boundary management difficulties among nurses in the KSA. The research objectives flowed from the research questions which were rooted in the statement of problem.

The second chapter contained a comprehensive review of literature. This detailed literature review was done to gain a deeper understanding of various aspects of understudied phenomena. The review started a brief discussion on the historical antecedents of the concept of WLB. This was followed by a review of prior studies on labour flexibility which is often closely linked with WLB debates in the literature. Thereafter, the definition of WLB as a social construct and explanations of why WLB has become a topical issue in human resource management practices are presented. Further review was done on contemporary WLB popularity which is traced to work-life conflicts or challenges employees experience in trying to find a balance between their work and non-work affairs while WLB theories with particular interest in the border theory and boundary management theory were adopted as underpinning theories to assess the present research. In addition, chapter two also contained a critical review of the multiplicity of the definitions of occupational stress, cost implications of work stress to an organisation, sources of stress in the workplace as well as stress theories in the literature.

The third chapter which was the methodology chapter was designed based on the research questions raised and objectives formulated. The philosophical orientation was interpretivism, while the epistemological, ontological and methodological positions framing this study were discussed. The research approach was inductive and the research method was a qualitative design. Critical reflections on the nature of a qualitative framework and how to judge a good qualitative enquiry were presented. The study collected primary data using a semi-structured interview protocol. A purposive sampling strategy, supplemented by snowball referral, was used, with data saturation forming the basis for determining an adequate number of responses. A total of 70 nurses, drawn from one private specialist hospital and two public general hospitals in Mecca, Kingdom of Saudi Arabia, participated in the study. After the collection of all material data, a thematic analysis was used to analyse the responses of the nurses. The main findings following the analysis are summarised as follows:

1. The study found that multiplicity of perspectives exists when defining work stress within the context of the nursing profession. However, stress as a stimulus, responses and stimulus-response interface were deduced as the major categories of the interpretation of occupational stress irrespective of context.
2. In addition, the study found four prevalent notions of WLB among nurses working in the KSA. These includes having time for family, attending to health concerns, creating pace for leisure and religious time as well as taking opportunity of flexible working arrangements.
3. The study further unveils how WLB challenges and occupational stress impugns on boundary management of these selected nurses of which one of the factors was established to work-home boundary violation. This was found to be abrupt interruptions

as nurses faces challenges trying to transition from one role (i.e. at work) to the other domain (i.e. family concerns), which makes it an increasingly difficult task because of the high work demands.

4. The findings also illustrate incongruences between nurses and their work environment making it difficult for nurses to negotiate their work-home boundaries satisfactorily. The border theory provided an excellent framework for understanding boundary conflicts causing a person-environment misfit in the nursing profession.
5. Evidence also emerged from the study showing the labour-reward disparities creating struggles by study participants to successfully manage work and non-work boundaries as a result of the high caring work demands of nurses that is not commensurate to the rewards received.
6. The study findings revealed detailed and nuanced views about managerial ignorance of family-friendly policies that can foster WLB makes nurses struggle to construct and maintain work-home borders.
7. Report from the study findings also uncovered perceptions of career damage as adduced reasons why few nurses fail to utilise WLB policies resulting in challenges they face in managing their work and home boundary affairs.
8. It was also found that broader contextual and societal features such as masculine hegemony, ingrained religious belief system as well as preferential treatment and favouritism as lessening the margins of discretionary territory which are set by nurses in managing their work and non-work affairs satisfactorily.

6.3 Theoretical Contributions

This study makes five substantive theoretical contributions, summarised below.

First, the study extends WLB and occupational stress scholarship, which has been concentrated overwhelmingly in western contexts (Kotera et al., 2020), to the KSA, a conservative and religiously observant society (Al-Rasheed, 2010) that has been largely neglected in the literature (Idris et al., 2010), broadening the geographic and cultural scope of WLB scholarship.

Second, the study demonstrates that occupational stress and boundary management are not purely individual or organisational phenomena but are embedded in socially constituted, context-specific realities. Masculine hegemony, religious belief systems, and perceptions of favouritism emerged as macro-contextual triggers that existing literature, with its narrow focus on micro-level solutions such as flexible working, tends to overlook (Webster and Archibald, 2022; Feeney and Stritch, 2017).

Third, the study systematically applies border theory (Clark, 2000) to nurses' WLB experiences in the KSA, conceptualising nurses as border-crossers who continuously negotiate the permeability and flexibility of the boundary between work and family (Selvarajan et al., 2013), while accounting for the distinct societal, cultural, and gender-related obstacles particular to this setting.

Fourth, the study introduces boundary violation as a distinct construct within KSA nurses' WLB experiences, capturing specific events in which stressful work demands, shift patterns, and the emotional intensity of patient care breach nurses' preferred work-home boundaries (Brauner et al., 2020), sharpening the analytical focus beyond generalised work-home conflict narratives.

Fifth, the study identifies and theorises work-life boundary incongruence, the mismatch between nurses' preferred boundary arrangements and what their environment affords, across five

dimensions: labour-reward disparity, managerial ignorance of family-friendly policies, perceptions of career damage, masculine hegemony and religious belief systems, and preferential treatment (Park et al., 2011), offering a more contextually sensitive account of WLB challenges than existing frameworks typically provide.

6.4 Practical Implications

The findings of this study carry significant implications for policymakers, hospital management, and HR practitioners in the KSA. Managing the competing demands of work and personal life is a fundamental challenge in the nursing profession, and institutional and attitudinal changes are urgently needed to facilitate positive HR outcomes and support acceptable work-life boundaries for nurses.

A critical starting point is legislative reform. Saudi Arabia currently lacks a working time law comparable to those found in many European countries. The EU Working Time Directive (2003), for example, caps the average working week at 48 hours while regulating rest breaks and holiday entitlements, thereby protecting medical personnel from the harmful effects of excessive working hours. Introducing similar legislation in Saudi Arabia would go a long way toward addressing the work-family boundary challenges faced by nurses, the majority of whom are women, and would contribute to socially sustainable employment outcomes (Chandra, 2012; Valcour, 2007).

Beyond legislative measures, there is a pressing need for feminist citizenship discourse and gender equality advocates in the KSA medical sector to champion an 'ethics of care and social justice' agenda, particularly for nurses who are also working mothers (Lister, 2003). HR practitioners and hospital managers must be adequately trained on the implications of

implementing flexible working arrangements as a primary tool for managing occupational stress. Such organisational training initiatives are foundational to achieving sustainable and green WLB outcomes for nursing staff (Adisa et al., 2014).

Workload management is another area requiring urgent attention. The literature consistently demonstrates that heavy and excessive workloads negatively affect employee performance and organisational productivity (Wong et al., 2020; Al-Otaibi and Kerari, 2025). The consequences of work intensity extend beyond the individual nurse and have broader organisational implications. Hospital management in the KSA must therefore recraft working conditions to better accommodate nurses' WLB values. One practical step would be establishing a dedicated WLB department within the hospital's HR function, staffed by experts responsible for designing and overseeing the implementation of family-friendly policies.

HR practitioners and hospital managers also need deeper understanding of the nature and dynamics of nursing work, its interface with family life, and the critical factors that shape WLB processes (Methot and LePine, 2016; Abdel-Azeem et al., 2024). This knowledge should inform a broader repertoire of strategies addressing the antecedents of work-family balance. For quality care services to be sustained in Saudi hospitals over the long term, a family-friendly orientation must be embedded in hospital culture and values, enabling nurses to integrate or segment their work and home domains more effectively. Open communication and structured discussions on work-family themes can further support nurses' self-management of professional and personal obligations. Importantly, hospital management should also recognise individual differences when addressing work-family boundary issues and tailor interventions accordingly (Michel et al., 2015; Alharbi et al., 2025).

With regard to occupational stress specifically, Saudi hospitals are encouraged to adopt a three-tiered stress management framework comprising primary, secondary, and tertiary interventions (Le Ferve et al., 2006; Asuni, 2026). Primary interventions focus on modifying or eliminating stressful work demands at their source. These include redesigning nursing roles to remove identified stress factors, introducing greater labour flexibility, and cultivating an organisational culture that genuinely prioritises nurses' wellbeing (Ackfeldt and Malhotra, 2013).

Secondary interventions are designed to help nurses cope more effectively with existing work stress. These include organising employee wellness programmes, planned social events, recreational facilities, and delivering stress management training and professional development opportunities (Tetrick and Winslow, 2015). Such measures signal a management commitment to nurse wellbeing and can meaningfully reduce the psychological burden of the role.

Finally, tertiary interventions serve a therapeutic function, targeting nurses who are already experiencing the adverse health and performance effects of prolonged stress (Hepburn et al., 2021). Counselling services, employee assistance programmes, rehabilitation support, and injury compensation mechanisms fall within this category and provide an essential safety net for nurses whose effectiveness in managing work-life boundaries has already been compromised.

6.5 Limitation of Study and Avenue for Future Research

Despite the study making important contributions to the field by examining WLB challenges and occupational stress among an understudied work group – nurses in the KSA, some limitations of the study have been identified that can be addressed in future research. Firstly, this study is limited to nurses of which majority were females. The medical profession is a highly respected and demanding white-collar job in the KSA that have become inroads for many immigrant

nurses around the world (Hussam and Alnjadat, 2022). Future studies might consider whether different WLB concerns and occupational arise from other medical personnel such as medical doctors in the KSA. The purpose is to widening the scope of study so that policy implications can also apply to medical doctors who also form an integral part of the health sector in the KSA. Secondly, future research should examine the accounts of WLB challenges and work stress from the perspective of a different occupational group within the knowledge-based professions like academics and those in Information and Communication Technology.

Thirdly, the study adopted a qualitative research design, which makes our study exploratory in nature (Saunders et al., 2012). In a sense, the purely qualitative method adopted may make findings only tentative because of the small sample size used. Future quantitative research involving hypothesis testing with larger sample sizes is imperative for the generalisation of the study findings. Fourthly, the present study is a cross-sectional which is an observational research design usually collected from a representative sample from a population at a single point in time, providing a ‘snapshot’ of the data as at the time of collection. Wang and Cheng, (2020) argues that this type of studies are often used to measure the prevalence of health outcomes, understand determinants of health, and describe features of a population. This assumption sits well with the present doctoral thesis. However, unlike other observational studies, cross-sectional research does not follow research subjects up over time; which is why they are usually inexpensive and easy to conduct (Hunziker & Blankenagel, 2024). Although these studies are useful for establishing preliminary evidence in planning a future advanced study, it is often criticised that cross-sectional studies are susceptible to biases such as nonresponse biases and recall biases as well as difficult to measure futuristic incidences (Cvetkovic-Vega et al., 2021). It is therefore recommended that longitudinal studies which involves collecting data from the

nurses over an extended period to observe changes and trends over time can be conducted in the future. This is because stress and WLB experiences are dynamic phenomenon. Hence, conducting longitudinal research of a similar study of this nature will allow the researcher to track the development of complex phenomena, identify patterns, and establish cause-and-effect relationships by observing variables at different points in time (Olsson et al., 2022).

Finally, it would be interesting to engage in cross-cultural research that compares Arabian contexts with western cultures. This is because comparative research gives a broadened perspective, fostering self-reflection and challenging assumptions by comparing different cultural systems (Chen et al., 2023).

6.6 Conclusion

This thesis set out to understand how nurses working in the Kingdom of Saudi Arabia experience, define, and manage occupational stress and the boundary between their professional and personal lives, a question that Western-centric WLB scholarship has left largely unanswered. What the study demonstrates, ultimately, is that these experiences cannot be adequately explained by reference to individual coping strategies or organisational policy alone. They are shaped, at every turn, by a Saudi socio-religious and institutional context, Islamic values, masculine hegemony, and the practice of *wasta*, that determines whose boundary preferences are permitted to prevail. Occupational stress and work-life boundary management are, in this sense, not private struggles to be resolved through individual resilience, but socially and culturally situated phenomena that demand to be understood on their own terms.

In extending border theory into this setting, the thesis has shown that a framework developed to explain boundary negotiation in Western, individualist workplaces can be meaningfully enriched

by attending to the collectivist, religious, and patriarchal structures that govern boundary negotiation elsewhere. The nurses whose accounts inform this study are neither passive victims of an unforgiving system nor entirely free agents able to draw their boundaries as they wish; they are border-crossers (Clark, 2000) negotiating within limits that are as much cultural as they are institutional. If this thesis leaves the reader with a single conclusion, it is that meaningful progress on occupational stress and work-life balance in the Saudi nursing profession, and in comparable contexts across the region, will depend on interventions that take this cultural specificity seriously, rather than importing solutions designed for a different world.

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APPENDICES

Appendix A

PARTICIPANT INFORMATION SHEET

Study title: “Investigating Work-Life Imbalance and Occupational Stress of Nurses in Saudi Arabia”.

Invitation Paragraph

Thank you for your time – You are being asked to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me/us if there is anything that is not clear or if you would like more information.

Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the study?

The study seeks to conceptualize wider perceptions and definitions of work stress and work life balance outside of those existing in work-life scholarships, particularly within the middle east region. By addressing the gap in current literature and through an in-depth exploration, I intend to present the implications of this study findings for the development of theory and practice in the nursing profession in the Middle East. This study would be conducted June – December 2024.

Why have I been invited to participate?

You have been chosen to participate as you have met criteria for inclusion to take part in the study:

1. A nurse working in either government hospital or private specialist hospital in Saudi

Arabia.

2. Minimum age is 18years.

A minimum of 65 other nurses employed in either government hospitals or private specialist hospitals, spanning various specialisations are also expected to participate in the study. Such specialities will include clinical nursing, community health, parent-child nursing, neuroscience, paediatrics, midwifery, ambulatory care, and general nursing practice.

Do I have to take part?

As participation is entirely voluntary, it is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep, and you may be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time up until [September 2024] and without having to give a reason. Also, should you wish to withdraw your data, you can do so after your involvement has ended and at the point at which your data is anonymised.

What will happen to me if I take part?

After gaining consent from yourself, interviews will be conducted. The interviews will be conducted over Microsoft Team, the virtual private video meeting platform, at a set date and time that is convenient for yourself and the researcher. Each interview would be recorded and last a maximum of an hour. You will also be told about your right to withdraw at any stage of your participation if you are feeling distressed or uncomfortable and do not wish to continue participating. Once your participation has ended, you will be given a debriefing sheet to keep. You are allowed to speak about any of your concerns with the researcher. Contact details of the researcher will also be found on the debrief sheet.

Are there any lifestyle restrictions?

The research poses no harm or lifestyle restrictions should you decide to participate. Again, if you decide to take part, you are still free to withdraw at any time up until [September 2024] without giving a reason should you feel any unusual discomfort.

What are the possible disadvantages and risks of taking part?

There are no anticipated disadvantages or risks associated with taking part in this study. However, if you do find any of the questions uncomfortable to answer, then you will always have the right to not answer or discuss anything you do not wish to. Importantly, as a participant you can always answer how you would like to and always have the right to withdraw at any point during the study.

What are the possible benefits of taking part?

There are no intended benefits for participation. As mentioned, the study aims to explore the factors that contribute to work-life imbalance and occupational stress of Nurses in Saudi Arabia's public and private hospitals. By taking part, these findings can help improve our understanding of how individuals can manage stress and ensure work-life balance and how organisations can develop strategies to support their employees, thus enhancing their overall well-being. Please note that these are only prospective significance of the study.

What if something goes wrong?

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action, but you may have to pay for it. Should you have any complaints about your experience, please contact the College of Business, Arts and Social Sciences Research Ethics Committee Chair – Professor Nigar Hashimzade (CBASS-ethics@brunel.ac.uk).

Will my taking part in this study be kept confidential?

All information which is collected about you during the research will be kept strictly confidential. The data will be kept until graduation after which it will be securely destroyed. Any information about you which leaves the University will have all your identifying information removed. With your permission, anonymised data will be stored and may be used in future research – you can indicate whether or not you give permission for this by way of the Consent Form. If during the research, evidence of harm or misconduct come to light, then it may be necessary to break confidentiality. We will tell you at the time if we think we need to do this and let you know what will happen next.

Will I be recorded, and how will the recording be used?

First, you will be briefed. For interviews, this involves being told that your voice will be recorded, made aware you will be given a pseudonym in the write up of the report and asked not to repeat the information spoken about during the interview. The recordings will only be used for research purposes in this study at Brunel Business School. The information is provided in confidence– no information will be disclosed about any individual and all original interviews will be destroyed on completion of study. The data analysis will be anonymous – no names will be used in the data analysis, and all data will be aggregated.

What will happen to the results of the research study?

Only the researcher, I, will have access to the actual raw data. Interviews will be transcribed and analysed, and selected quotations will be used in the results/findings section of the final report and journal article (once published). Anonymised transcripts will also be included in the appendices of the report. All the results and discussion are likely to be completed by the end of the first quarter of 2025. Once fully complete, please do not hesitate to get in contact with myself for a copy of the full report. To reiterate, your identity will not be exposed in the report and so full confidentiality is guaranteed.

Who is organising and funding the research?

The research is funded and being conducted by myself, Talal Al-Anezi in conjunction with Brunel University.

What are the indemnity arrangements?

Brunel University London provides appropriate insurance cover for research which has received ethical approval.

Who has reviewed the study?

The College of Business, Arts and Social Sciences Research Ethics Committee has reviewed the study and granted me as the researcher permission to conduct it.

Research Integrity

Brunel University London is committed to compliance with the Universities UK [Research Integrity Concordat](#). You are entitled to expect the highest level of integrity from the researchers during the course of this research.

Contact for further information and complaints.

Researcher name and details: Talal Al-Anezi, Human Resource Management PhD Researcher, Brunel Business School, Brunel University.

Contact Email: talal.alanezi@brunel.ac.uk

Supervisor name and details: Dr. Chima Mordi, Reader, Human Resource Management, Brunel Business School, Brunel University.

Contact Email: chima.mordi@brunel.ac.uk

For complaints, Chair of the Research Ethics Committee: Professor Nigar Hashimzade, Chair of the College of Business, Arts and Social Sciences Research Ethics Committee, Brunel University London.

Contact Email: CBASS-ethics@brunel.ac.uk

Please also note you will be given a copy of this information sheet and consent form for yourself to keep. Thank you once again for taking the time to read this through - please do not hesitate to contact me if you have any further queries. Lastly, please let me know whether or not you would like to participate via email.

Appendix B

PARTICIPANT CONSENT FORM

“Investigating Work-Life Imbalance and Occupational Stress of Nurses in Saudi Arabia”

Talal Al-Anezi

APPROVAL HAS BEEN GRANTED FOR THIS STUDY TO BE CARRIED OUT
BETWEEN 17/06/2024 AND 22/12/2024

The participant (or their legal representative) should complete the whole of this sheet.		
	YES	NO
Have you read the Participant Information Sheet?	☐	☐
Have you had an opportunity to ask questions and discuss this study? (via email/phone for electronic surveys)	☐	☐
Have you received satisfactory answers to all your questions? (via email/phone for electronic surveys)	☐	☐
Who have you spoken to about the study?		
Do you understand that you will not be referred to by name in any report concerning this study?	☐	☐
Do you understand that:		
• You are free to withdraw from this study at any time.	☐	☐
• You don't have to give any reason for withdrawing.	☐	☐
• Choosing not to participate or withdrawing will not affect your rights.	☐	☐
• You can withdraw your data any time up to 30/09/2024.	☐	☐
I agree to my interview being audio recorded.	☐	☐
I agree to the use of non-attributable quotes when the study is written up or published.	☐	☐
The procedures regarding confidentiality have been explained to me.	☐	☐
I agree that my anonymised data can be stored and shared with other researchers for use in future projects.	☐	☐
I agree to take part in this study.	☐	☐

Signature of research participant:

Print name:	Date:
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Appendix C

PARTICIPANT DEBRIEF SHEET

Proposed Study Title: “Investigating Work-Life Imbalance and Occupational Stress of Nurses in Saudi Arabia”.

Purpose/Background to study:

The demand for primary care, community care and community nursing services are on the increase due to world demographic changes (World Health Organization, 2008). Nurses are fundamental in ensuring the delivery of high-quality care to patients in healthcare systems globally. However, work-related stress in the nursing profession is considered a common problem worldwide (McGrath et al., 2003). Clegg, (2001), argues that nursing is one of the many disciplines contributing to a huge body of research in America into the causes and effects of the ill-defined phenomenon that strives as a result of poor organisational culture. Among the various occupations present in the hospital industry, interests of health researchers often lie in the nursing profession, simply because medicine/caring profession such as nursing is ranked as the second most stressful among the various professions (Burgess et al., 2010). For instance, reports indicate that in the UK, NHS nurses work 12-hour shifts. Access to food and drink is often limited during shifts, and nurses are expected to endure high levels of stress without respite or any relief (Farquharson et al., 2013). This experience appears to be similar in other world regions, and this research intends to explore the experiences of work-life imbalance and occupational stress of nurses in Saudi Arabia. Stress experiences of nurses have been linked to reduced psychological and psychological health, poor job satisfaction, increase sickness absence, increased staff turnover, and low job commitment (Khamisa et al., 2015). This research will validate this in our research setting. While stress can be beneficial, too much is always harmful irrespective of the fact that stress is an inevitable occurrence of life. But overwhelmingly, stress is often labelled for a growing number of workplace concerns or negative environmental realities adversarial to human existence especially in the health profession.

The aim of this study is therefore to make scholarly contributions to the literature on occupational stress and work-life research by amplifying the importance context (i.e. societal

peculiarities) as highly significant when considering experiences of work stress and work-life difficulties of occupational groups.

Confidentiality:

Personal information about participants will be kept confidential in the following ways:

- a) Participants asked not to repeat responses to what was said within the interview publicly.
- b) The participant's data is safely stored through the Brunel University password-protected server.

These recordings will be destroyed on a later date upon study completion.

- c) Pseudonyms will also be given to participants, and no actual names or other identifying information will be used in the written report.

Contact:

If you are interested in knowing more information about the study or have any queries about it – please do not hesitate to ask either myself or my authorised supervisor. Below are our contact details:

Researcher: Talal Al-Anezi, Human Resource Management PhD Researcher, Brunel Business School, Brunel University.

Contact Email: talal.alanezi@brunel.ac.uk

Supervisor: Dr. Chima Mordi, Reader, Human Resource Management, Brunel Business School, Brunel University.

Contact Email: chima.mordi@brunel.ac.uk

Thank you for taking part in my study.

Appendix D

INTERVIEW GUIDE

INVESTIGATING WORK-LIFE IMBALANCE AND OCUPATIONAL STRESS OF NURSES IN SAUDI ARABIA

INTERVIEW PROTOCOL

Section 1: Background Information

- Can you share your age range? 18 - 24; 25 - 44; 45 – 64?
- How many years have you been employed?
- What is your gender?
- What is your speciality?

Section 2: Understanding of Occupational Stress and WLB: Perspectives and Experiences

- Given the nature of your job, what do you understand as occupational stress?
- Do you experience stress on your job. If your answer is in the affirmative, tell the nature of work stress you encounter in your daily routine as a nurse?
- In your own understanding, could you share some moments in your job where you have to work intensively or where you worked intensely? Has it always been like this? Do you think this is inevitable?
- What are the circumstances that make you experience time pressure on your job as a nurse?
- Tell me, if you experience periods that you felt you had no control over your daily work routine?
- Reflect and explain to me when you experienced role stress, role conflict and ambiguity on your work as a nurse.

Section 3: Work-Life Balance

- What do you understand as work-life balance?
- As a parent, do you experience work-life balance taken into consideration family life outside work?
- Are there family-friendly policies available in your hospital for nurses. If yes, tell me if these policies are utilised by nurses in your hospital?
- Do you experience work-family conflict? If yes, how and why?
- What are the causes of work-life imbalances within and outside of your workplace?

Section 4: Work-Life Boundary Management

- How do you manage work-family conflict if you experience any?
- How do you manage boundaries to negotiate the demands between your nursing profession and home life?
- Do find it difficult to create boundaries between your work and private life? If so, how? ▪ What are the consequences of creating boundaries between you work and family life?
- Are there interventions like policies to help nurses manage their work and non-work roles effectively? If there are such policies, do you take advantage of them and why?

Appendix E

RESEARCH ETHICS COMMITTEE LETTER OF APPROVAL



College of Business, Arts and Social Sciences Research Ethics
Committee
Brunel University London
Kingston Lane
Uxbridge
UB8 3PH
United Kingdom
www.brunel.ac.uk

6 June 2024

LETTER OF APPROVAL

APPROVAL HAS BEEN GRANTED FOR THIS STUDY TO BE CARRIED OUT
BETWEEN 06/06/2024 AND 22/12/2024

Applicant (s): Mr Talal Al-Anezi

Project Title: Investigating work life imbalance and occupational stress of nurses in Saudi
Arabia

Reference: 47999-MHR-May/2024- 50982-2

Dear Mr Talal Al-Anezi

The Research Ethics Committee has considered the above application recently submitted by
you.

The Chair, acting under delegated authority has agreed that there is no objection on ethical grounds to the proposed study. Approval is given on the understanding that the conditions of approval set out below are followed:

The agreed protocol must be followed. Any changes to the protocol will require prior approval from the Committee by way of an application for an amendment.

Please note that:

Research Participant Information Sheets and (where relevant) flyers, posters, and consent forms should include a clear statement that research ethics approval has been obtained from the relevant Research Ethics Committee.

The Research Participant Information Sheets should include a clear statement that queries should be directed, in the first instance, to the Supervisor (where relevant), or the researcher. Complaints, on the other hand, should be directed, in the first instance, to the Chair of the relevant Research Ethics Committee. Approval to proceed with the study is granted subject to any conditions that may appear above.

The Research Ethics Committee reserves the right to sample and review documentation, including raw data, relevant to the study. If your project has been approved to run for a duration longer than 12 months, you will be required to submit an annual progress report to the Research Ethics Committee. You will be contacted about submission of this report before it becomes due.

You may not undertake any research activity if you are not a registered student of Brunel University or if you cease to become registered, including abeyance or temporary withdrawal. As a deregistered student you would not be insured to undertake research activity. Research activity includes the recruitment of participants, undertaking consent procedures and collection of data. Breach of this requirement constitutes research misconduct and is a disciplinary offence.



Professor Nigar Hashimzade

Chair of the College of Business, Arts and Social
Sciences Research Ethics Committee Brunel
University London

Appendix F

PARTICIPANT INVITATION DOCUMENT

Brunel Business School
Brunel University London
Kingston Lane
Uxbridge
London UB8 3PH

Dear Sir/Madam,

I am a PhD Management Studies Research student at the Brunel Business School, Brunel University London. I am currently working on a research project titled: Investigating Work-Life Balance Challenges and Occupational Stress of Nurses in Saudi Arabia: Perspectives of Border Management Challenges.

The aim of this study is to make scholarly contributions to the literature on occupational stress and work-life research by amplifying the importance context (i.e. societal peculiarities) as highly significant when considering experiences of work stress and work-life difficulties of occupational groups. This is why this doctoral thesis investigates the management of under-researched work-life boundaries by focussing on how conventionally ignored in work-life research manage their nursing role in light of work-life imbalances and work stress encountered in their daily lives.

I am, therefore, through this email requesting your permission to engage you in an interview to explore the Work-Life Balance Challenges and Occupational Stress of Nurses in Saudi Arabia: Perspectives of Border Management Challenges. Should you be able to grant me this request, all the necessary documents will be forwarded to you beforehand to study and know more about your rights as the interviewee, and what to look out for before, during and after the interview process. You will also be given the interview questions beforehand and the participant information sheet which will include the contacts of my supervisor and the Ethics Committee of the Brunel University London should there be any course for concern.

Thank you.

Kind regards,

Talal Alanezi *Doctoral Researcher.*