REVIEW OF LITERATURE
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OCCUPATIONAL STRESS

At a given time stress on the body is a fact of life. We are under stress from "womb to tomb". Stress is an individual's physical, mental and emotional reaction to conditions that disturb normal equilibrium. Life Stress does not have a uniform effect on the individual. Whether a given individual is adversely affected by life changes or stressful life events depends on how much impact that event has on the individual.

Stress refers to a state of the organism resulting from some interaction with the environment (Ghosh, 2000). Different people view stress in different ways. Schuler (1980) took a somewhat different approach to Stress in work organization. He outlined three types of Stress (constraint stress, opportunity stress and demand Stress) which are related to organizational qualities. These stresses are seen as being related to a variety of negative physiological, psychological and behavioural symptoms.

Definitions

Lazarus and Folkman (1984) defined Stress as a "relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well being".

"Stress" or "Stressor" refers to any environmental, social, or internal demand which requires the individual to
readjust his/her usual behaviour pattern (Holmes & Rahe, 1967).

The most researchers have defined Occupational Stress in terms of negative characteristics of the individual-organizational interface, using Stressors such as overload, role conflict, role ambiguity and role boundary (French, 1976; Beehr & Newman, 1978; House, 1983; Srivastava and Sinha, 1983; Bhatnagar & Bose, 1985).

Beehr and Newman (1978) defined job stress as "a condition arising from the interaction of people and their jobs characterized by changes within the people that force them to deviate from their normal functioning.

Pestonjee (1987) had identified three important sectors of life in which stress originates. These are: (a) Jobs and organizations, (b) the social sector, and (c) intrapsychic sector. The first namely, job and organization refers to the totality of the work environment (task, atmosphere, colleagues, compensation, policies etc.).

Models of Stress

Sadri and Marcoulides (1994) proposed model of Occupational Stress in which personality (Type A behaviour and locus of control) and Coping strategies were predicted to precede and determine the perception of job stressors which, in turn, were proposed to have an impact on the mental and physical well-being of the individual and his/her job satisfaction.
Carson and Kuipers (1998) have proposed a model of the stress process, which incorporates the idea of stressors, moderators, and stress outcomes. Stressors are seen as arising from three main sources: those relating to one’s occupation, major life events and hassles and uplifts. The critical factor in the model are the mediating or buffering factors which individuals can call upon to help them. These stressors will only lead to negative stress outcomes if the individual has insufficient resources to manage them.

Sources of Occupational Stress

Cooper and Marshall (1976) proposed the following sources of Occupational Stress, which negatively effect employee’s physical and mental health:

1. Intrinsic to job: Poor physical conditions, work overload, time pressure, and physical danger.
2. Role in organization: Role ambiguity and conflict, responsibility for people.
3. Organizational structure and climate: Lack of effective conditions, restrictions on behaviour, office politics.
4. Relationships within the organization: Poor relation with colleagues and subordinates, difficulties in delegating responsibilities.
5. Extra organizational source: Company versus family demands, company versus own interest etc. and.
6. The individual himself: Personality tolerance for ambiguity, ability to cope with the change, motivational and behavioural patterns.
Hingley and Harris (1986) identified five main areas of stress, namely intrinsic to the job, e.g. coping with death, and workload; relationships at work e.g. lack of support from peer; the individual's role within the organization, e.g. lack of job clarity; career development, e.g. limited career prospects; the home/work interface, e.g. taking problems home.

Byers (1989) reported that stressors at work place, stress from job demands, organizational structure and information flow, job roles, informal relationships, perceived opportunity for career development and external commitments. The consequences of stress have individual, physical, psychological and behavioural effects that affect organizational functioning.

According to Holt (1982) Occupational Stress may originate from physical, properties of the work environment (e.g. physical hazards, pollution, noise, extreme heat, cold, humid conditions etc.), change in working hours, time pressure, work and responsibilities, overload, monotony, demotion, change in shift pattern, qualitative changes in job, job complexity, ambiguity about future, inequality of pay and under utilization of abilities etc. He said that marital disharmony, disturbed life events and stressful life events may be some of the job stressor.

Nursing is widely assumed to be a stressful occupation (Marshal, 1980). There is substantial evidence for higher rates of mortality, including deaths from suicide and stress-related disease, burnout and absenteeism, psychiatric admission and physical illness in nurses.
Sources of stress in nurses

1) Academic sources of stress include examinations, long hours of study assignments and grades; lack of free time, faculty response and lack of timely feedback (Beck and Srivastava, 1991). Specific elements of the academic programme e.g. palliative care, experimental workshops (Lawrence et al, 1985), produce stress reactions in nurses.

2) Clinical sources of stress include working with dying patients, interpersonal conflict with other nurses, insecurity about personal clinical competence, fear of failure, interpersonal problems with patients, work overload and concerns about nursing care given to patients (Parkes, 1985). Administering injections (Speck, 1990) and performing female catheterization (Bell, 1991) have been associated with high levels of anxiety. The atmosphere created by the clinical faculty, patient care responsibilities, working with HIV/AIDS patients (Mueller et al, 1992) are all clinical sources of stress. Changes in ward allocation have also been shown to be a source of stress for nurses (Jack, 1992)

3) Other sources of Stress are increasing workload, increasing administration and lack of resources (Edwards et al, 2000).

Foxall & Standley (1990) compared the frequency and sources of nursing job stress perceived by 35 intensive care, 30 hospice and 73 medical surgical nurses. Job stress was measured through the Nursing Stress Scale (Gray-Toft and Anderson, 1981). Findings revealed that death and
dying situations were found to be the most stressful to ICU and hospice nurses. Whereas, work load/shifting rotations were the most stressful to medical surgical nurses.

Bamber (1988) described the sources of stress from which nurses suffer. Conflicting role demands can result in considerable stress. Insufficient stimulation is also a source of stress. Factors contributing to stress are rooted in the wider economic, political and social structure of the society.

Munley (1985) divided stressors into two major types as exogenous and endogenous.

**Exogenous Stressors are**

1) Scheduling and workload stressors.
2) Aspects of patient care that cannot be controlled.
3) Strains related to terminal illness and sufferings of the patient.

**Endogenous stressors are**

1) Self-imposed pressures related to exaggerated expectations.
2) Disappointment encountered in day-to-day experiences of teamwork.

Cavanagh and Snape (1993) explored the stressful aspects of neurosurgical nursing that were perceived as stressful by staff. Findings revealed that being exposed to life and death situations among young children, shortage of staff/patient ratio and dealing with aggressive relatives were the major stressful events.
Fornes et al (1998) identified factors in work stress among 85 nurses working in orthopaedic, medical and gynae wards. Findings revealed that staff shortage, poor management and organization and little free time were particularly main factors of work stress.

Lauter an Chaves (1999) carried out a study on 207 nurses at a University hospital Brazil. A questionnaire was distributed to collect data on stress sources and symptoms. Results revealed that 48% of participants were found to be under stress. Stress related to administrative tasks in nursing may trigger changes in nurse’s health. Most commonly reported stress symptoms were cardiovascular changes.

Brown and Edelmann (2000) conducted a study aimed to identify initially perceived Stressors and Coping resources subsequently to compare these with actually reported stressors and available resources, during a critical period in nurses careers. Results showed that both student and staff nurse groups reported fewer stressors and more resources than they had predicted. Students anticipated difficulties with competence and financial difficulties. They experienced support from mentors and newly qualified staff nurses experienced fewer difficulties with meeting personal expectations of the role than they had anticipated. The staff nurses reported more use of emotion -focused coping and less professional support than the student group.

Muscroft and Hicks (1998) carried out a study on a comparison of psychiatric nurses and general nurses' reported stress and counseling needs. A stratified random
sample of 50 psychiatric and 50 general nurses was selected from the cognate units and a questionnaire was distributed. It was found that general nurses reported stress levels that were significantly higher than those of psychiatric nurses.

Larocco et al (1980) reported that perceived job stress arises from many objectives, work situations or conditions that are potentially stressful because of incongruence or lack of fit between the person and the environment. Perceived job stress e.g. perceptions of excessive work load or role conflict, may lead to job related strain (e.g. job dissatisfaction). Both perceived job stress and job related strain may affect physical and mental health outcomes. Caldwell and Weiner (1981) noted major categories of work related stressors like environment and work load, dealing with death and severe illness, interpersonal relationships among nurses, physicians and administrators and responsibility for life and death decisions.

Karen et al (1987) reported the results of an empirical study of psychological stress in nurses in a large hospital. Total 349 nurses participated. A positive correlation was found between higher administrative demands and psychological distress.

Healy & Mckay (1999) conducted a study on Occupational Stress of 12 Victoria nurses. Stress was measured by using Gray-Toft and Anderson’s Nursing stress scale. Findings revealed that higher levels of nursing stress was reported with lower levels of job satisfaction. Nurses rated their workload as highly stressful in terms of
both frequency of its occurrence and its perceived effect upon themselves.

Cochran and Ganong (1989) compared the environmental stress of 23 ICU nurses and their 20 ICU patients at the University of Missouri - Columbia Hospital and clinics. A series of one-way ANOVAS were done to compare patients and nurses’ responses. Nurses reported significantly more stress related to physical stressors as compared to nurses who rated psychosocial stressors as more stressful.

Cheryl (1987) found causes of stress among nurses working in general hospital. The findings showed that 65% of nurses feel staff shortage, 48% perceive heavy work load and working with faulty equipment as stressor and 31% nurses perceive lack of equipment as cause of stress. Other stressors include hospital policies, relationship with seniors and colleagues, rude and aggressive relatives.

**Effects of Stress**

It was widely believed that stress could result in wide spectrum of effects (Pestonjee, 1992). These could be biochemical, physiological and psychological. The levels of hormones ACTH, TSH, FSH and Cortisone were found to be increased with stress.

Margolis et al (1974) had observed that occupational stress was a casual factor in causing diseases. Stress was found responsible for the precipitation of different disorders such as bronchial asthma, rheumatoid arthritis and peptic ulcer (Mcfadden et
al. 1988). The adverse effects of stress on coronary heart disease and hypertension have also been documented (Rozanshi et al 1988).

Constable and Russell (1986) studied about the stress experienced by nurses employed in critical cases setting and found that nurses under high level of stress are prone to mistakes, impaired problem solving and lessened effectiveness, physical symptoms like tachycardia, somatic reactions etc. are more common in these nurses.

John (2001) carried out a comparative study to identify the job related stressors and stress among nurses working in critical and Non-critical care units of a selected Hospital. Findings revealed that Non-critical care units have higher stressor score as compared to the critical care units. In both the units work load and managerial staff are highest stressors for critical care unit nurses whereas managerial staff and patient care are major stressors for non-critical care unit nurses. Other findings revealed that job related stress reactions are found more in non-critical care unit nurses; older nurses of critical care unit have more stress.

Herald (1997) did a study to identify and correlate the work related stress and stress reactions among staff nurses working in intensive care unit. Findings revealed that five highest work related stress-provoking items were: difficulty in obtaining leave, equipment failure, lack of supplies, doctor is not available when an emergency arises and criticism by supervisor.
Kipping (2000) studied mental health nursing. The data were obtained via questionnaires from mental health nurses. Open-ended questions were asked about the nurses' experience of stress. Findings revealed that a wide range of stresses were identified as Exams/Written work, physical environments, patient care, staff attitude, lack of support/supervision etc.

Sisk (2000) carried out a study to investigate whether the perception of burden was related to the health-promoting behaviours of Caregivers of the elderly. One hundred twenty one predominantly female caregivers, with mean age 61.1 years were taken as sample. Findings revealed that those who perceived lower subjective burden scores, practiced more health-promoting behaviours than those who perceived higher subjective burden scores.

Thara (1997) assessed the extent of burden among mental health nurses. Sample of 21 nurses were taken and findings showed that over half the sample felt frustrated and nearly 60% felt more tired after they finished their day’s work. The entire group lies between mild to moderate degree of burden.

Mohan (1995a, 1995d and 1996) have done similar studies on stress in different populations.

**BURNOUT**

Burnout is a negative experience and results from the interaction between the individual and the environment. Although a subjective phenomenon, burnout has a clear
relationship with the organizational setting in which it occurs.

Freudenberger (1989) citing Jackson (1982) suggested that there is a general agreement that burnout occurs at an individual level, that is an internal experience that is usually psychological in nature.

**Definitions**

Burnout is a strain caused by chronic stressors (Freudenberger, 1974).

According to Maslach et al (1996), burnout is "a crisis in one’s relationship with work, not necessarily a crisis in one’s relationships with people at work". According to Webster’s New World Dictionary (1975) burnout means “to fail, wear out or become exhausted” by making excessive demands on energy strength or resources. This definition suggests that burnout is the state of emotional exhaustion related to overload.

Maslach et al (1996) authors of the world’s most widely used measure of burnout, have described that burnout is a syndrome consisting of three discrete dimensions viz. emotional exhaustion, depersonalization and reduced personal accomplishment. The first of these dimensions refers to the inability of individuals to ‘give of themselves at a psychological level’. This occurs as a result of feelings of being emotionally overextended and exhausted by one’s work. Depersonalization, in contrast, refers to the development of cold, negative attitudes towards whose who use public services. Finally, reduced
personal accomplishment refers to a negative response toward one self and one's personal accomplishment, also described as depression, low morale, withdrawal, reduced productivity or capability, and inability to cope.

"Burnout is a disorder of professional individuals engaged in helping others, characterized by impaired performance, loss of concern, poor morale, emotional problems and drug abuse, burnout is presumed to be the result of prolonged high levels of demand and stress suffered by the victim" (Maslach et al, 1996).

Maslach (1982) reported that according to some critics, burnout is simply old wine in a new bottle - a trendy name for a problem that has been around a long time. They used to call it depression, but now its known as "burnout".

According to Brezniak and Ben-Yair (1989) burnout might be defined as a mismatch between an individual's resource, values and expectations and the demands of the environment. This negative psychological experience which involves feelings, attitudes, expectations and motivations is expressed in exhaustion and passive regressive behaviour. Burnout is a psychological strain, which is marked by symptoms such as physical depletion, emotional and mental exhaustion, chronic fatigue and feelings of disillusionment and hopelessness, accompanied often by negative attitudes towards oneself and others.

Wallace and Brinkerhoff (1991) described burnout as referring to individual workers' inability to respond adequately to perceived demands, and to their accompanying
anticipation of negative consequences for such inadequate responses.

Maslach and Pines (1977) defined Burnout as the loss of concerns for the people with whom one is working. In addition to physical exhaustion (and sometimes even illness) burnout is characterized by emotional exhaustion in which professional no longer has any positive feelings, sympathy, and respect for clients or patients. A very cynical and dehumanized views of these people often develops, in which they are labeled in derogatory ways and treated accordingly. The professional who burns out is unable to deal successfully with the overwhelming emotional distress of the job, and this failure to cope can be manifested in a number of ways, ranging from impaired performance and absenteeism to various types of personal problems (such as alcohol and drug abuse, marital conflict and mental illness).
STRUCTURAL MODEL OF BURNOUT

Demands

Lack of Resources

Diminished
*Control Coping
*Social Support
*Autonomy
*Decision involvement

Burnout

Cynicism

Exhaustion → Depersonalization

Diminished
Accomplishment & Efficacy

Costs

Diminished
Turnover &
Organizational
Commitment
Physical
Absenteism
Illness

Structural Model of Burnout by Maslach et al (1996)
Edelwich and Brodsky (1980) has identified a number of structural factors associated with work, which contribute to high stress levels and may lead to burnout. "Too many work hours, career dead-end, too much paperwork, not sufficiently training for job, not appreciated by clients, not appreciated by supervisor, not paid enough money, no support for important decisions powerlessness, system not responsive to client's needs, bad office politics, sexism, too much travel isolation from peer and no social life", result into burnout.

Edelwich and Brodsky (1980) added that people who seek a career in the helping professions are particularly vulnerable to burnout as many enter this field with unrealistic expectations. Such expectations include the belief that:

a) The services they provide will decisively improve the lives of practically all their clients,
b) They will be highly appreciated by the employing agency and practically all clients,
c) They will be able to substantially change bureaucracies to be more responsive to clients' need and

d) There will be many opportunities for rapid advancement and high status.

Demerouti et al (2000) carried out a study among 109 German nurses to test a theoretically derived model of burnout and overall life satisfaction. Findings revealed that the resulting conceptual model of burnout and life satisfaction proposes that job demands were most strongly
related to feelings of exhaustion, and job resources were most strongly related to disengagement. In addition, results showed that the impact of job demands and job resources on life satisfaction was mediator of burnout.

**Factors affecting burnout**

1) Job characteristics
2) Individual characteristics

1) Several job characteristics like time pressure, autonomy, skill variety and task significance are important. Time pressure increases feelings of burnout, whereas autonomy, skill variety and task significance decreases burnout (Jansen et al., 1996)

2) All the individual characteristics except preference for career and a passive approach to coping with problems, decrease feelings of burnout. The social support received at work in particular is important in decreasing burnout (Jansen et al., 1996).

Leiter and Harvie (1996) reviewed research articles over a 10-year period in relation to burnout and mental health workers. This review suggested that burnout occurs as a result of problems arising through excessive demands associated with caseloads or personal conflict that interfere with opportunities to attend thoroughly to the needs of service recipients. These problems are often exacerbated by insufficient support from colleagues, family or the nature of the work itself.
Effects of Burnout on the health care professionals (Bennett et al 1994) are as follows:

1. Members of the high burnout group had higher levels of stress and anxiety.
2. Members of the high burnout group also had higher levels of stigma which also may have affected levels of stress and anxiety.
3. Respondents in the low burnout group had higher scores on social recognition, reward, indicating the possible role that this variable may have in promoting psychological well being and quality of life in staff.
4. Respondents in the low burnout group also had greater social support than respondents in the high burnout group.
5. Respondents in the high burnout group were more likely to record higher tangible support than members of the low burnout group.
6. Respondents with high burnout scores were more likely to use external coping strategies.
7. Respondents in the low burnout group were more likely to use internal coping strategies which are more positive in outlook.

Joseph et al (1986) reported that burnout among nurses appears to be a serious problem affecting delivery of health care from previous empirical research findings; the authors reported that burnout among these nurses results from reactions to adversities inherent in the work environment.
Pelosi & Caironi (1999) carried out a comparative study among nurses working in ICU and in general medicine units and found that nurses working in general medicine have more severe "burnout" syndrome than the ICU nurses.

Maslach & Ayala (2000) conducted a comparative study of 100 Israeli nurses and 30 police officers to investigate the burnout and found that the nurses burnout score was slightly higher than the burnout scores of the police officers and nurses also reported significantly higher levels of emotional exhaustion than the police officers.

Sekhar (1996) explored job stress, job burnout and job related anxiety and helplessness experiences among nursing personnel from three hospitals. Results revealed that University hospital nurses scored lower in all the job stress and job burnout experiences than government hospitals. Further calculations showed that nurses' helplessness, depersonalization experiences and personal accomplishment were significantly affected by the number of patients nursed.

Patil and Borse (2002) carried out a study on the burnout behaviour among the professionals and the political leaders and found that the professionals were having moderate burnout while the political leaders were having low burnout behaviour.
HARDINESS

The attention has been focused on personality variables that may operate as personal resources during encounters with stressful events. (Johnson and Sarason, 1979)

Personality is the organization of internal and external activities. It includes the external appearance qualities, aptitudes and capacities etc. It is not a fixed state but a dynamic totality, which is continuous due to interaction with the environment in his personality.

Definitions

Allport (1961) defined personality as a dynamic organization within the individual, of those psychophysical systems that determine his unique adjustment to the environment.

According to Kobasa (1979) a personality variable which combines several components is the hardiness concept. This construct continues the theme of control and has been incorporated into a number of studies on the relationship between the experience of stress and health according to Taylor and Cooper (1989).

"Hardy" persons are easily committed to what they are doing in their lives, believe that they have some control over the causes and solutions of life problems, and view changes in life and adaptive life demands and challenges as opportunities for growth rather than as threats (Florian et al, 1995)
According to Kobasa, (1988) hardiness is composed of three dimensions: commitment, control and challenge. Hardy persons are more likely to appraise a situation as challenging rather than threatening. They have a higher sense of Commitment to self and feel a greater sense of Control over their lives, viewing stressors as potential opportunities for change.

### Stress and Hardiness

Sinclair & Tetrick (2000) reported that hardy people from sickly families do better under stress, on average than those from healthy families but with fewer inner resources. Hardy people are thought to perceive potentially stressful events differently than non-hardy people and are thought to be more resistant to the potentially harmful affects of stress.

According to Maddi (1990), persons high in Commitment think of themselves and their environments as interesting and worthwhile and thus can find something in whatever they are doing that increases their curiosity and seems meaningful. Persons high in control believe that they can have an influence on what goes on around them. And persons high in challenge believe that what improves their lives is growth through learning rather than easy comfort and security.

According to Kobasa (1979), the effects of hardiness on mental health/stress are mediated by the cognitive appraisal and coping mechanisms of the individual. Research consistent with this view by Florian et al (1995) found Commitment improved mental health by
reducing the appraisal of threat as well as the use of palliative strategies and by increasing secondary appraisal. Further more, control improved mental health by reducing the appraisal of threat and by increasing secondary appraisal and the use of action coping strategies.

Kobasa (1979) in an initial retrospective study identified business executives who reported experiencing an equivalent high level of recent stressful life events, and divided them into two groups according to number of reported illness symptoms. The high stress-low illness group scored higher on measures of personality hardiness than did the high stress-high illness group.

**Stress, Burnout and Hardiness**

Schmitz et al (2000) carried out a study and the aim of the study was to evaluate the effects of locus of Control and work-related stress on burnout in hospital staff nurses. A convenience sample of 361 staff nurses from nine units in five German hospitals were surveyed using the Maslach Burnout Inventory, the Locus of Control questionnaire and a Work-Related stress Inventory. Results suggested that greater work related stress and burnout would be associated with poorer locus of control in nurses.

Collins (1996) carried out a study to find out the relation of work stress, hardiness and burnout among its full time hospital staff nurses. It was hypothesized that among hospital staff nurses the greater the personality hardiness, the less job stress and the greater personality hardiness, the less burnout will be. Findings
revealed that low hardiness score and high stress and high burnout scores were there.

SELF-ESTEEM

Definitions

Self-esteem is the way one feels about one-self including the degree to which one possesses self-respect and self-acceptance.

Over the years, researchers have developed a considerable interest in the construct of self-esteem, defined as "the evaluation which the individual makes and customarily maintains with regard to self" (Coopersmith, 1967).

Wells and Marwell (1976), in review of literature on self-esteem, presented a long list of terms used interchangeably with self-esteem; including self-regard, self-acceptance, self worth, and self-image. Most therapists agree that self-esteem is a learned phenomenon, involving a lifelong process (Coopersmith, 1967; Crouch and Straub, 1983). This learning process revolves around the interaction of the individual with the social environment, referring primarily to family of origin, and including significant others as they vary across the individual’s lifespan.

Self-esteem in adulthood is primarily a reflection of social relationships and career development (Stanwyck, 1983).

Ann and Judy (1986) carried out a study to identify relationships among perceived social support, self-esteem and positive health practices among adults.
living in a Southwestern metropolitan area. Findings revealed that both self-esteem and social support are positive indicators of life-style. Further, social support was found to exert influence indirectly through its direct effect on self-esteem.

Srivastava and Sinha (1983) carried out a study among 120 male Indian managers (35-51 years). They completed measures of ego strength, job involvement and occupational stress. Findings revealed that subjects with high ego strength experienced milder stress from role overload, role ambiguity and role conflict relative to that experienced by subjects with low or moderate ego-strength. Similarly, subjects with high job involvement also experienced less stress. High ego strength improved coping responses and led subjects to be psychologically attached to their job and satisfy their need for self-esteem.

Greenberg et al (1992) reported that self-esteem had been found to function as a buffer, which protects against the negative impact of stress and reduces anxiety.

Development of the Concept of Self-Esteem

Before James (1890) addressed the nature of the self, this was considered to be the domain of the philosopher rather than the psychologist. He discriminated the self as known from the self as knower, and divided the former, into three components—Material (body/family/have), Social (“a man has as many social selves as there are individuals who recognize him”), and Spiritual (states of consciousness, psychic faculties, dispositions). The self-concept was seen as being acquired through interaction with
other people rather than being inborn and it was recognized that the self as experienced may differ from the self as presented. James (1890) stressed the vital role of personal values in determining the affective response to self-evaluation, and argued that self-esteem is determined by the interaction between success and pretensions.

The acquisition of self esteem

Coopersmith (1967) has identified what he believes to be clear antecedents of high self-esteem in childhood. These are: unconditional acceptance of children by their parents; clearly defined and enforced limits to behaviour; respect and latitude for individual action and interpretation within the defined limits; and high self-esteem in the parents. He argues that major components of self-esteem are:

- a sense of competence
- a sense of significance
- virtue
- and power

According to Beck (1967), a person acquires his self-concept from personal experience, from the judgments made of him by others and from identification with family and friends.

Brown and Harris (1978) hypothesized that certain vulnerability factors lower self-esteem in certain women. This is supported by results from an important community survey (Ingham et al, 1986). This confirmed that early separation from parents and lack of a personal confidante
were associated with low self-esteem in both normal women and those with psychiatric disorder.

Brown et al (1986) have shown in a prospective community study, that the level of social support correlated quite highly with measures of self-esteem in a large group of working-class women. Negative evaluation of self and lack of social support were associated with a much higher risk of depression in the face of a subsequent stressor.

Maintenance of self-esteem

There is evidence that self-esteem stabilizes as a person progresses into adolescence and the positive correlation with achievement increases in this period (Rubin, 1978). This stability is independent of the level of self-esteem (Padin et al, 1981). In order to defend their self-esteem, individuals evaluate the results of their efforts in such a way as to maintain consistency between objective evidence and protective explanations of outcome (Psycszczynski et al, 1985).

It seems that to maintain a positive self-image, it is necessary to seek out and accept positive information about oneself while avoiding or rejecting negative information. As an example of this process, there is evidence that normal subjects remember pleasant self-descriptive phrases better than unpleasant ones (Bower and Gilligan, 1979). It is also helpful to attribute positive outcomes internally, stably, and globally, and negative consequences externally, unstably and specifically.
Consequences of low self-esteem

Consequences of low self-esteem have been said to include:

- dependency, the need for approval, helplessness, and masked hostility (Storr, 1979)
- depression, anxiety and submissiveness (Luck and Heiss, 1972)
- poor general health (Goldberg & Fitzpatrick, 1980)
- apathy, feelings of powerlessness, isolation, unloveability, withdrawal, passivity and compliance (Coopersmith, 1967)
- the tendency to down grade others (Adler, 1926).
- a tendency to accept unfavourable assessments as accurate (Swanson and Weary, 1982)
- vulnerability to multiple interpersonal problems in adolescence (Kahle et al, 1980)

Pines and Kafry (1978) had found that professionals who had low self-esteem were found to have low performance and tended to express less satisfaction from their jobs.

Consequences of high self-esteem

High self-esteem lessens the tendency to social isolation, exploitative attitudes or hostile dependency.

According to Coopersmith (1967), people with high self esteem are more accepting and are more likely to be leading active lives with a sense of being self-
determining, are better able to tolerate internal or external distress without isolating themselves from inner experiences; are less anxious, less sensitive to criticism, paying greater attention to personal values than group mores. They tend to have better physical health, enjoy better relationships, value independence, welcome competition and anticipate more success (Rosenberg, 1965).

**Self-esteem and affective disorder**

According to Lewinsohn (1974), low self esteem is a consequence of depressive behaviour.

Bagley et al (1979) reported that low self-esteem and anxiety are highly correlated. Manic patients score similarly to normal people on self-esteem scales, but they have much higher social desirability and self-deception ratings (Winters & Neale, 1985).

According to Sarason (1966) and Spiellberger (1972) anxiety trait pointed to sensitivity of the individual to subjects such as self-esteem and anxiety over being a failure.

**Stress and Self Esteem**

Callen (1994) found significant negative associations between self-esteem and levels of stress, anxiety and depression among a sample of attorneys.

Thoits (1995) reported that perceived control over life and high self-esteem were consistently observed to buffer a negative health effects of stress, researchers
have reasoned that those characteristics probably increase the use of effective coping strategies.

**Burnout and Self-Esteem**

Fothergill et al (2000) conducted an All-Wales survey of community mental health nurses to determine their levels of stress, coping and burnout. 103 nurses were surveyed. Findings revealed that nurses with higher self-esteem had lower feeling of depersonalization and had a better sense of personal accomplishment and good coping skills.
COPING

It is difficult to talk about coping, or even define it, without talking about Stress. Definitions of stress typically incorporate some variation on the idea that stress involves trying to meet demands from the environment that approach or exceed the person’s ability to respond effectively. The concept of Coping refers to the various ways in which people respond when confronting the stress situation. According to Rao et al (1989) how people cope with stress may be more important than the frequency or severity of stress. Coping mechanisms are conscious, reality-oriented problem solving activities designed to relieve anxiety.

Definitions

Hamburg and Adams (1967) defined coping as “the seeking and utilization of information”.

Folkman (1984) says that coping can be defined as active or passive attempts to respond to a situation of threat with the aim of controlling the threat or reducing emotional discomfort.

Pearlin and Schoolar (1978) defined coping as behaviours that protect people from being harmed psychologically by problematic social experiences.

Coping Resources

Coping resources are social and personal characteristics upon which people may draw when dealing with stressors (Pearlin and Schoolar 1978). Resources
reflect a latent dimension of Coping because they define a potential for action, but not action itself. In addition to Social Support, the two personal coping resources frequently studied by sociologists are a sense of control or mastery over life and somewhat less commonly self-esteem. These coping resources are presumed to influence the choice and the efficacy of the coping strategies that people use in response to stressors (Folkman, 1984).

**Coping strategies**

Coping strategies consist of behavioural and/or cognitive attempts to manage specific situational demands which are appraised as taxing or exceeding one’s ability to adapt (Lazarus & Folkman, 1984).

Coping efforts may be directed at the demands themselves (problem or task-focused strategies) or at the emotional reactions, which often accompany those demands (emotion-focused strategies).

Most investigators assume that people high in self-esteem or perceived control are more likely to use active, problem focused coping responses; people low in self esteem or perceived control prefer more passive or avoidant emotion focused coping.

**Relationship between coping resources and coping strategies**

Resources such as high self-esteem and an internal locus of control give individuals the confidence or motivation to attempt problem-focused coping in the face of stress (Folkman, 1984). People low in personality
resources should more often perceive problems as uncontrollable and thus engage in emotion-focused coping.

Robert et al. (1987) reported, more adjusted persons use more problem solving coping responses and fewer avoidance responses; perceived availability of social support is positively related to coping effectiveness through the mediating variables of problem and emotion-focused coping.

People use both emotion focused and problem focused coping simultaneously in dealing with daily stressors (Folkman and Lazarus, 1980).

**Stress and Coping**

Healy and Mckay (2000) conducted a study on the relationship between nursing work-related stressors and coping strategies, and their impact upon nurses’ levels of job satisfaction and mood disturbances. It was proposed that higher levels of perceived work stress and use of avoidance coping would increase mood disturbances, while problem focused coping would decrease mood disturbances. Results revealed a significant positive relationship between nursing stress and mood disturbance and a significant negative relationship between nursing stress and job satisfaction. The use of avoidance coping and the perception of work overload were found to be significant predictors of mood disturbances.

Jone and Johnson (1997) carried out a study on levels of affective distress, sources of stress and coping strategies in first year student nurses in Tayside,
Scotland. Findings revealed that around the time of an initial series of hospital placements 50.5% of students in Cohort 1 (n=109, Week=40) and 67.9% of students in Cohort 2 (n=111, week=24) suffered significant affective distress. In both cohorts the use of direct coping was associated with lower levels of distress, and lower total stress scores. The use of fantasy and hostility was associated with high levels of distress and stress in both groups.

Mahat (1998) conducted a study among junior Baccalaureate Nursing students to identify perceived stressors and ways of coping during the clinical component of nursing education. Findings revealed that the following were the frequency stressors perceived by the students:- Initial experience (34.5%), interpersonal relationships (27.1%), ability to perform roles (23.4%), heavy workload (9.3%) and feelings of helplessness (5.6%). The findings also revealed that students used two problem focused coping strategies i.e. problem solving and seeking social support coping strategies more frequently than the two emotion focused coping strategies i.e. tension reduction and avoidance coping.

Ghosh (2000) conducted, a study aimed to find out the pattern of Occupational Stress and strain in two different occupational groups namely, physicians and executives. Occupational stress Inventory was administered to these two groups of individuals which measured three dimensions of Occupational adjustment namely, Occupational Stress, psychological strain and coping resources. Results revealed that the two groups were found to be with in the normal range of Occupational Stress, though executives were
found to possess more Occupational Stress than the physicians. It was observed that the executives differed significantly from the physicians in terms of role insufficiency and responsibility. Coping resources were found to be high in the areas of social support and rational/cognitive coping in both the groups.

**Burnout and Coping**

Carson et al (1999) carried out a study on burnout among mental health nurses. The total sample comprised of 648 ward based mental health nurses. The total sample was divided into a high burnout group and a low burnout group. The high and low burnout groups were compared on the six subscales of questionnaire. Findings revealed that low burnout group utilized three of the six measures significantly more than the high burnout group. These were social support, organization of tasks, and involvement with work aims. They also scored significantly higher on the total coping skills score.

Cronin-Stubbs and Rooks (1985) carried out a study of hospital nurses and found that perceived impact rather than frequency of job stressors contributed to burnout. It was also found that the amount of on-the-job and off-the-job social support were negatively related to burnout.

Rees and Cooper (1992) examined levels of occupational stress in 1176 employees of all occupational groups within one large UK health authority. Findings revealed that health workers reported significantly greater pressure at work but scored lower on measures of Type A
behaviour pattern (personality) and employed coping strategies more frequently than the non-health workers.

**Stress, Burnout and Coping**

Edwards et al (2000) carried out a study to investigate stress, burnout and coping amongst the community mental health nursing work place. The aim of the study was to examine the variety, frequency and severity of stressors, to describe coping strategy used to reduce work-based stress and to determine stress outcomes. Findings revealed that stressful items were trying to maintain a good quality service in the midst of long waiting lists, poor resources, and having too many interruptions while trying to work in the office. The coping strategies were having a stable home life and looking forward to going home at the end of the day, having outside interests and hobbies and talking to people that they got on well with.