INTRODUCTION

Over the past years stress at work has become an inevitable part of people’s life and readily acknowledged to be the most prominent and pervading feature of modern organization attracting the attention of many psychologists and management scientists (Lazarus, 1995; Sud and Malik, 1999; Netmeyer, Maxham and Pullig, 2005). As organizations become more complex, the potential for, and the amount of stress increases. Urbanization, industrialization and the increase in scale of operations in the society are some reasons for rising stress (Pareek, 1993). Job stress refers to the harmful physical and emotional responses of the worker, when the requirements of the job do not match his/her capabilities, resources or needs (Niu, 2000). Researchers have suggested that job stress poses a multidimensional effect on professional life of a working person as well as on his/her health, wellbeing and effectiveness (Karasek and Theorell, 1990; Jamal, 2005). Investigators have pointed out that job stress is by no means a new phenomenon, it is becoming increasingly globalized and affects all countries, all professions and all categories of workers, including both blue-collar and white-collar. Handy (1988) highlighted that it is not the occupation perse, which is responsible for stress experiences rather; it is a transaction between job environment and personal characteristics. However, a great deal of research attention has been devoted to investigate job stress in particular, among human service professionals such as managers, bank employees, officers and teachers (Bogg and Cooper, 1995; Rishi, Upadhayay and Solanki, 2004; Buckingham, 2004; Rodriguez-Calcao and Brewer, 2005; Griffin, 2006). The findings of these studies indicated stress prevalence among these professionals.

Other groups of investigators have also examined gender differences in terms of stress experience (Vrgrecha and Mishra, 1990; Koch, Boone, Cohn and Mansfield, 1991; Gardiner and Tiggemann, 1999; Cohen and Patten, 2005; Wells, Colbert and Slate, 2006). Majority of these studies indicated that women experience disproportionately additional stress than their male counterparts due to conflicts arising between work and family responsibilities. However, contrary to above studies an Indian study reported that male executive experienced higher stress than their
female counterparts (Aditya and Sen, 1993). A vast number of studies in relevant literature indicate that healthcare professionals working in health and medical services experience stress due to nature of their work (Gellis, 2001; Postle, 2002; Linzer, Gerrity, Douglas, Mc Murray, Eric, Williams and Konrad, 2002; Niaz, Hassan and Ali, 2003; Sharma, 2005). Taken together findings of these studies have shown that working conditions contribute to stress among these professionals.

There is growing body of research about nursing and there are some general indications of the stressful nature of the job (Tang and Lau, 1996; Virk, Chhabra and Kumar, 2001; Bianchi and Regina, 2004; Glazer, 2005; Tankha, 2006). In a comprehensive review on stress in nursing profession, Marshall (1980) emphasized that nursing can be stressful on two counts: (i) because competence as a skilled worker is constantly on trial; and (ii) constant awareness of vulnerability as a human being to the disabilities the nurse is caring for. Several groups of investigators has documented that amount of stress experienced by hospital nurses depending on the different areas of nursing such as geriatric, psychiatry, critical care and type of care given (Stolley, Buckwalter and Shannon, 1991; Kerasiatis and Motta, 2004; Kennedy, 2005). It has been suggested that these different kinds of nursing may also impose particular additional stresses due to variation in the sources of occupational stress. However, few studies have reported an association between shift work and high level of stress experienced among nurses (Hoffman and Scott, 2003; Parikh, Taukari and Bhattacharya, 2004; Glazer, 2005). Further, another group of studies have shown a positive relationship between personality type of nurses and their experiences of stress (Motowidlo, Packard and Manning, 1986; Glazer, Stetz and Izsso, 2004). However, commonly identified major sources of stress within nursing profession were as follows: workload (both in quality and quantity), death and dying, conflict between work and family, interpersonal relationship with doctors, colleagues and subordinate; lack of support, coping with change in technology and professional development (Gray-Toft and Anderson, 1981a; Tyler, Carroll and Cunningham, 1991; Xianyu and Lambert, 2006).

Anger is one of the most important emotional vital signs which is pervasive in today's workplace (Kiewitz, 2002). Anger occurs in response to real or imagined frustration, threat or injustice and the desire to terminate the negative
stimulus (Fine and Olson, 1997). Anger, aggression and hostility have frequently been used in relation to each other interchangeably (Fernandez and Turk, 1995). While anger and hostility both refer to feelings and attitudes, the concept of aggression is generally used to describe destructive and punitive behaviour and is regarded as behavioural reaction to provocation (Spielberger, 1988). Researchers have documented that there are individual differences in styles of anger expression or anger management. Individual’s manage their anger by suppressing (anger-in, ax/in), expressing (anger-out, ax/out) and attempts to control (anger-con, ax/con) the expression of their feelings of anger (Spielberger, Johnson, Russell, Crane, Jacobs and Worden, 1985; Spielberger, 1988). Over the past years, Western culture has considered anger as undesirable emotion symptomatic of irrationality and has considered the use of will to control its expression (Kemp and Strongman, 1994). There is growing body of evidence within organizational psychology on the expression and regulation of emotions in different contexts, such as between service providers and customers. However, little is also known about the perception of anger expression in different occupational roles. It has been suggested that people in different occupational work roles may have different expectations on the emotional expression of anger that is required for that role (Glomb and Hulin, 1997; Fitness, 2000).

Emotion of anger, hostility and aggression has been investigated by several researchers among human service professionals as well as other professions such as teachers, police officers and emergency workers (Mearns, 1998; Anderson, 2002; Monnier, Cameron, Hobfoll and Gribble, 2002; Smith, Roman, Dollard, Winefield and Siegrist, 2005). It has been documented that these emotions are apparent in all occupational sectors. All these researches indicated that employees experience these emotions at their workplace due to numerous reasons such as poor working conditions, inadequate salary, interpersonal conflicts, worker alienation, work harassment by supervisors and coworkers, lack of social support, unfair treatment (Hargreaves, 1994; Rawat, 1996; Bensimon, 1997; Narayanan, Menon and Spector, 1999; Watson, 2000; Kiewitz, 2002; Sharma, 2003). Two studies reported that experience and expression of anger was associated with extensive interaction, and occupational status of an employee at work (Fitness, 2000; Sloan, 2004).
Although there are more women in the workforce than formerly, few studies have examined whether gender might influence a workers experience with work-related anger. Historical review by Kemp and Strongman (1994) have found that alleged gender difference in the anger are a recent phenomenon arising from socialization practices, in which males were taught to express anger and females were taught to suppress it. Some contemporary research indicates that gender differences in an anger expression was due to differential socialization process, and found that girls and women scored higher on anger suppression and control, whereas boys and men scored significantly higher on expressing anger expression (McConatha, Leone and Armstrong, 1997; Cox, Stabb and Hulges, 2000). However, other studies found no gender differences in anger (Averill, 1983; Fine and Olson, 1997; Ferguson, Eyre and Ashbaker, 2000; Gianakos, 2002). Although scant in number, empirical studies indicated that gender roles have significant influences on both anger related behaviour and anger proneness.

Researchers consistently report anger prevalence among professionals working in the health care delivery environment including physicians, technicians, physiotherapist, childcare workers (Bartlett, 2002; Kassinove and Tafrate, 2003; Skjorshammer, 2003; Satar, Cenkseven, Karchioglu, Topal and Sebe, 2005; Li Calzi, Farinelli, Ercolani, Alianti, Manigrasso and Taroni, 2006). Taken together all these studies confirm that these professionals experience anger although at different levels, however the expression of anger also varied in terms of anger-in, anger-out, and anger-control.

Another group of investigators have pointed out that the emotions of anger, aggression and hostility is prominent among nurses (Brooks, Thomas and Droppleman, 1996; Thomas, 1997; Sherlock, 1999; La Duke, 2000; Thomas, 2003; Baskin, 2004; Oweis and Diabat, 2005). Researchers have documented that anger can be a fact of life for nurses due to features of their job (Thomas, 2004; Cosentino, 2005). Group of Western studies highlighted that anger is evident among nurses. Nurse’s experience of being undervalued and their frequent exposure to work related stresses often makes them angry. Nurses tend to express (anger-out) as well as suppress (anger-in) their angry feelings toward self and others at workplace (Blaha, 1995; Jarvis and Daniel, 2005; Manter, Armstrong-Stassen, Harsburgh and Cameron, 2006).
Another group of investigators documented that nurses felt angry and emotionally hurt in response to patient's aggression and assault (O'Connell, Young, Brooks, Hutchings and Lofthouse, 2000; Needham, Abderhalden, Halfens, Fischer and Dassen, 2005). However, other researchers reported that nurses experienced significantly higher levels of anger in dealing with patients who exhibited difficult behavioral characteristics (Hunter and Ross, 1991; Cole and Slocumb, 1993; Smit, 2005; Chase, 2005). A number of studies have also shown that nurses express their angry feelings in a destructive or punitive manner towards others during their work schedule (Muff, 1992; Campbell and Muncer, 1994; Smith, Droppleman and Thomas, 1996; Robert, 2000). This has also been documented that mismanaged anger among nurses in the form of outward expression is most frequently expressed towards others in a destructive way (Gentry, Foster and Forehling, 1972; Pillemer and Hudson, 1993; Thomas, 2003).

Depression is identified as a widespread pervasive problem in the general population and at workplace, and its effects are costly for the employer (Goldberg and Steury, 2001). Depression has been found to affect as much as 10 percent of the worldwide work (Olson, 2000). Depression and depressed mood pervaded in many work settings (Sullivan, LaCroix, Russo, Swords, Sornson and Katon, 1999). Depression is debilitating illness, characterized by profound feelings of sadness, low moods and loss of interest in usual activities that can have severe adverse effects not only on the individual but also on her job and family life (Lennon, Blome and English, 2001). Researchers have documented that the workplace social environment found to be a common factor in predicting depression in different occupational groups (Bromet, Parkinson, Curtis, et al., 1990). Several investigators have reported that depression is prevalent among human service professionals including, psychologists (Gilroy, Carroll and Murra, 2002), teachers (Juradoa, Gurpeguib, Morenoa, Fernandez, Lunac and Galveza, 2005), police officers (Chen, Chou, Chen, Su, Wang, Feng, Chen, Lai, Chao, Yang, Tsai, Tsai, Lin, Lee and Wu, 2006) as well as other professionals (Nyklicek and Pop, 2005; Peele and Tollerud, 2005; Rugulies, Bultmann, Aust and Burr, 2006).

Researchers have consistently reported that women experience higher incidence of depression than do men at workplace (Kessler, McGonagle, Swartz,
Blazer and Nelson, 1993; Bray, Sanchez, Ornstein, Lentine, Vincus, Baird, Walker, Wheeless, Guess, Kroutli and Iannacchione, 1998; Surmann, 1999; Wieclaw, Agerbo, Mortensen, Burr, Tüchsen and Bonde, 2006). Taken together all these studies have documented that several factors such as work overload, work-related threats, role conflict and harassment contribute to higher rates of depression among women compared to their male counterparts.

A large number of studies indicated that overall medical community including, physicians, general and medical practitioners, dentists, hospital doctors exhibited a relatively higher level of depression than other professional groups (Gallery, Whitley, Anzinger and Revicki, 1992; Firth-Cozens, 1999; Tyssen and Vaglum, 2002; Dahlin, Joneborg and Runeson, 2005; Mathias, Koerber, Fadavi and Punwani, 2005).

Investigators have observed the significant prevalence of depression among nurses (McLeod, 1999; Scalzi, 1990; Gallaghere, 2003; Tselebis, Moulou and Ilias, 2001; Laschinger and Leiter, 2006). Although all these studies reported depression among nurses, however levels of depression varied in terms of job specifications. Researchers have also reported that rates of depression in nurses were higher than in general population (Carter, 2002). Several other investigators have shown that environmental conditions of nurses resulted in depression (Pelosi, Caironi, Vecchione, Trudu, Malaarida and Tomamichel, 1999; Barney, 2002; Kimura, 2003; Chan and Huak, 2004). However, few studies indicated that patterns of work and work schedule (e.g. shift-work) was associated with depression feelings among nurses (Ruggiero, 2002; Farahmand and Nasiri, 2004; Ruggiero, 2005). Contrary to these studies, Skipper, Jung and Coffey (1990) have failed to find relationship between shift work and depression. A group of studies have reported that different job specificities (e.g. psychiatry, critical care) was also associated with depression experience in nurses (Nouf, Nael and Aber, 2004; Ozgencil, Unal, Okyavuz, Alanglu and Tulunag, 2004). However, other studies indicated that personal and professional factors were found to be a source of depression feelings among nurses (McCleave, 1993; Lee, Eo, Park and Lee, 2002). Researchers have reported that greater workload contributed to depression among nurses (Thomas, 1997; Greenglass and Burke, 2000).
Social support is a product of interpersonal relationships within the workplace that facilitates individual adaptation (Guglielmi and Tatrow, 1998). Supportive interactions and the presence of supportive relationship in people's lives have been shown to play a major role in physical health, emotional well-being and work performance (Sarason, Sarason and Pierce, 1990). Researchers suggest that social resource factors may serve either as a buffer in the coping process or may directly improve well-being (Cohen and Wills, 1985; Hobfoll, 1988).

The role of social support at work has been the subject of interest for researchers and extensively studied among human service professionals including teachers, police officers, and health caregivers in relation to stress, burnout and emotional vital signs (Sisney, 1993; Banerjee and Gupta, 1996; Lee and Henderson, 1996; Anuradha, 2001; Young, 2004; Lingard and Francis, 2006). Several studies reported moderating-buffering effect of social support (Noor, 1995; Lim, 1996; Sud and Malik, 1999; Wong and Cheuk, 2005; Luszczynska and Cieslak, 2005) while others have obtained its main/direct effect on stress as well as on stress outcomes (Russell, Altamaier and Van Velzen, 1987; Leung and Lee, 2006). However, other studies reported that lack of social support contribute to stress (Linzer, Gerrity, Douglas, Mc Murray, Eric, Williams and Konrad, 2002; Baba, Galperin and Lituchy, 1999). Few studies reported that social support reduces stress level among nurses (Abu-Al-Rub, 2003; Bartram, Joiner and Stanton, 2004).

Another group of researchers have dealt with the role of social support in protection from burnout syndrome presented mixed findings. Some researchers have obtained moderating-buffering effects of social support on burnout (Greenglass, Fiksenbaum and Burke, 1996; Greenglass, Burke and Konarski, 1998; Kirmeyer and Dougherty, 1988; Peeters and Le Blanc, 2001), while others failed to obtain the same (Russell, Altamaier and Van Velzen, 1987) among a variety of occupations in different settings such as schools, hospitals, banks and sales organizations. Empirical studies on different professionals indicated a negative relationship between burnout and social support (Sand, 1997; Baruch-Feldman, Brondolo, Ben-Dayan and Schwartz, 2002; Talmor, Reiter and Feigin, 2005). Several other investigators also confirm similar findings among nurses working in diverse settings (Ogus, 1990; Oehler, Davidson, Starr and Lee, 1991; Plante, 1993; Saulnier, 1993; Janssen, De Jonge and Bakker, 1999).
An association between social support and anger has been observed by several investigators (Greenglass, Burke and Konarski, 1997; Bansal, Monnier, Hoball and Stone, 2000; Marjanovic, Greenglass and Coffey, 2006). Majority of these studies reported a negative relationship between social support and anger. It has been documented that social network allows the individual to control the anger feelings by discussing the source of anger and frustration with others, which enable them to modify annoying obstacles, thus potentially lowering the anger (Greenglass, 1996). Studies have shown that a low level of social support was associated with increased work related anger (Brooks, Thomas and Droppleman, 1996; Schutzwohl and Maercker, 1997; Fitzgerald, Haythomthwaite, Suchday and Ewart, 2003).

Another group of studies have documented an association between social support and depression. There is consistent evidence of a negative relationship between many facets of social support and depression (Billing and Moos, 1981; Bell, Le Roy and Stephenson, 1982; MaloneBeach and Zarit, 1995). Other studies, however reported that lack of social support predicted depressive symptoms (Parkes, 1982; Karasek, 1990; Schaefer and Moos, 1996; Niedhammer, Goldberg, Leclerc, et al., 1998). Another study reported that employees with unsupportive bosses suffered two times more from depression than did their colleagues with supportive bosses (Good Boss, Good Health, 1990).

In recent years the issues of burnout received increasing research attention. Burnout is conceptualized as a work-related syndrome stemming from the individual’s perception of significant gap between expectations of successful professional performance and an observed, far less satisfying reality (Friedman, 2000). Burnout is defined as a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment (Maslach, Schaufeli and Leiter, 2001; Leiter and Maslach, 2004). When burnout is flourishing in the workplace, employees feel emotionally, physically and mentally drained (Maslach and Leiter, 1997). Employee who initially felt enthusiastic, full of energy, and dedicated to their profession, gradually begins to feel burned out, exhausted, cynical and a sense of diminished personal accomplishment (Maslach, 1982; 2000).

Researchers have documented that burnout is a job related hazard for human service employees (Cordes and Dougherty, 1993; Skovholt, 2001; Antoinette,
2005). It has commonly been assumed that there is something unique about health care, social service work, teaching and other "caring" professions that make their occupants more likely to experience burnout (Jackson, Schwab and Schuler, 1986; Leiter and Maslach, 1988; Schaufeli, Maslach and Marek, 1993; Cherniss, 1993). Investigators have demonstrated differences in dimensions of burnout for different service and caring professions (Singh, Goolsby and Rhoads, 1994). Interpersonal demands, such as the intensity and frequency of client interactions and the expectations for positive displays, were expected to be much higher for custom service representatives (Hochschild, 1979; 1983) and for human service workers than for other employees (Rafaeli and Sutton, 1989; Smith; 1991; Hawthorne and Yurkovich, 1994). This has been documented that burnout generates negative emotional responses (e.g. anxiety, fear, anger, depression and alienation) accompanied by cognitive, physiological and behavioural changes, resulting in a deterioration of mental health or psychological well-being (Belcastro, Gold and Hays, 1983; Gupta and Kaman, 1993; Daniel and Schuller, 2000). Burnout continues to create problem for employees, employers and customers in the people helping profession. Some employees remain unaffected from its effect, while others are paralyzed become ineffective (Teska, 2005). A group of recent studies reported evidence of burnout syndrome in human service professionals. Although reported level of burnout varied across studies (Misra and Sahu, 1993; Pandey and Tripathi, 2002; Togia, 2005; Antoinette, 2005; Mabry, 2005; Bauer, Stamm, Virnich, Wissing, Müller, Wirsching and Schaarschmidt, 2006; Johnson, 2006; Borritz, Rugulies, Bjonner, Villadsen, Mikkelsen and Kristensen, 2006).

Researchers have consistently shown an association between burnout and gender roles. Females reported significantly more burnout than their male colleagues (Welsch, 1998). Study reported that women scored higher on emotional exhaustion and lower on personal accomplishment than men (Maslach and Jackson, 1985). However, other data indicate that men experienced higher depersonalization than women (Anderson and Iwanicki, 1984; Greenglass and Burke, 1988; Ogus, 1990; Greenglass, Burke and Ondrack, 1990). Researchers have suggested that this tendency occurs because of gender role socialization or sex role dependent stereotypes (Maslach and Jackson, 1985; Schaufeli and Enzmann, 1998).
More recent studies have shown that healthcare professionals experienced significant higher levels of burnout at their workplace (Esteva, Larraz and Jiménez, 2006; Goehring, Gallacchi, Künzi and Bovier, 2005; Haley, 2003). Researchers have documented that burnout among healthcare workers is a critical issue as organizations seek to provide, high-quality patient-care in an increasingly competitive market (Akroyd, Caison and Adams, 2002).

Burnout has many implications for nursing care as well as for caregivers’ health and costs related to health services (Chemiss, 1980; Jaracz, Görna and Konieczna, 2005; Edwards, Burnard, Hannigan, Cooper, Adams, Juggessur, Fothergill and Coyle, 2006). Nurses are susceptible to burnout because of the very stressful nature of their work (Malach-Pines, 2000). However, another group of studies indicated that there are personal and environmental factors which contributed to nursing burnout (Papadatou, Anagnostopoulos and Monos, 1994; Ueno and Yamamoto, 1996; Sumi and Nagae, 1998; Higashiguchi, Morikawa, Miura, Nishijo, Tabata, Ishizuka and Nakagawa, 1999; Fujino, Hayashi, Maeda and Fukugawa, 1999). Investigators have also observed that there was a diversity in the level of burnout depending on the specialization at work among nurses such as geriatric (Duquette, Kerouac, Sandhu, Ducharme and Saulnier, 1995), psychiatric (Foster, 2003), forensic (Happell, Pinkahana and Martin, 2003), oncology (Quattrin, Zanini, Nascig, Annunziata, Calligaris and Brusaferro, 2006), community (Prosser, Johnson, Kuipers, et al., 1996). However, one study indicated that burnout is contagious and it may cross over from one nurse to another nurse (Bakker, Le Blanc and Schaufeli, 2005).

A number of studies have been conducted to understand burnout as a consequence of occupational stress among human service professionals (Sonnentag, Brodbeck, Heinbokel and Stolte, 1994; Bussing and Schmitt, 1998; Sekhar and Chandra, 1996; Friedman, 2000; McManus, Winder and Gordon, 2002). Taken together findings of all these studies indicated a significant relationship between occupational stress and burnout. Burnout has been found to be a psychological strain that develops after an extended period of peculiar job stress arising from regular interpersonal interaction, particularly with people in need such as clients, patients, students etc, often making heavy emotional demands, which overtime can be very
tiring and can induce different levels of stress which in turn may lead to burnout (Maslach, 1982; Cordes and Dougherty, 1993; Cherniss, 1995; Pandey and Tripathi, 2002).

Burnout vis-à-vis anger has not been extensively studied among human service professionals. There is paucity of related studies on the relationship between burnout and anger; however few studies reported an association between burnout and anger (Keller, 1990; Lee and Ashforth, 1996; Riddle, 1999; Zoccali, Campolo, Carroccio, Cedar, Muscatello, Pandolfo, Rosa and Meduri, 1999; Morgan, Cho, Hazlett, Coric and Morgan, 2002).

There is considerable amount of research dealing with the relationship between burnout and depression among human service professionals (Glass, McKnight and Valdimarsdottir, 1993; Bellani, Furlani, Gnechi, Pezzotta, Trottì and Bellotti, 1996; Schaufeli and Enzmann, 1998; Baba, Galperin and Lituchy, 1999; Shanafelt, Bradley, Wipf and Back, 2002; Dorz, Novaro, Sica and Sanavio, 2004; Toker, Shirom, Shapira, Berliner and Melamed, 2005; Nyklicek and Pop, 2005). Findings of these researches indicated that there is a close association between burnout and depression. Burnout and depression has been found to co-occur.

From the preceding discussion it is evident that there has been great deal of empirical research on job stress, emotional vital signs (anger and depression), social support and burnout among human services as well as other professions. According to international literature, it has been established that nurses serve one of the most stressful professions. As far as burnout is concerned the most studied professional categories are nurses indicated that nurses are particularly susceptible to burnout. Most of the studies considering emotional vital signs have been conducted in the Western set up. However, in the Indian context very limited number of studies focused on the negative emotions of anger and depression among human service professionals in particular among nurses. Further, it is also clear, that only few studies have attempted to explain the relationship between burnout and emotional vital signs (anger and depression) in India as well as in West. The present study set out to examine the prevalence of job stress, emotional vital signs, perceived organizational support and burnout together among nurses and compared them with comparable group working within the same work environment. Further, study also
explored the relationship between burnout and rest of the study variables among nurses and controls separately.

In view of the above, the present study addressed itself to the following objectives.

**Objectives**

1. Whether the nurses differ from controls on overall job stress and its severity and frequency.
2. Do the nurses differ from controls in terms of levels of trait-anger and modes of anger expression (Ax/In, Ax/Out and Ax/Con).
3. Whether there will be any difference between nurses and controls in terms of depression.
4. To study the difference between nurse and controls in terms of perceived overall support (non-organizational and organizational).
5. Do the nurses differ from controls in terms of burnout (emotional exhaustion, depersonalization and reduced personal accomplishment).
6. Do job stress, emotional vital signs (trait-anger, modes of anger expression (Ax/In, Ax/Out, Ax/Con) and depression) and burnout (emotional exhaustion, depersonalization and reduced personal accomplishment) correlate differentially in terms of direction and magnitude in nurses and controls.
7. Do perceived overall support (non-organizational and organizational) would have a negative relationship with burnout (emotional exhaustion, depersonalization and reduced personal accomplishment) in nurses and controls.
8. Optimal set of variables (overall job stress, trait anger, modes of anger expression, depression, perceived overall support and burnout) which in combination would separate nurses from their control counterparts.

**Definitions of Terms**

The following are the definitions of the terms used in the present study.

**I. Job Stress**

Job stress refers to a situation wherein job related factors interact with the worker to change disrupt or enhance, his/her psychological and physiological condition such that the person is focused to deviate from normal functioning.
Job Stress Severity
Job stress severity refers to the perception of amount or severity/intensity of stress associated with a particular stressor event at workplace.

Job Stress Frequency
Job stress frequency refers to the frequency of occurrence of stressful events in work environment.

II. Trait Anger (T-Anger)
Individual differences in anger proneness that is the tendency to perceive a wide range of situations as annoying or frustrating, and the disposition to respond to such situations with elevations in State-Anger.

Anger-In (Ax/In)
Individual differences in the frequency, with which, angry feelings are held in or suppressed.

Anger-Out (Ax/Out)
Individual differences in the frequency, with which, the state anger is expressed in aggressive behaviour toward other people or objects in the environment.

Anger-Control (Ax/Con)
Individual differences in the frequency, that individuals attempt to control or mitigate the outward expression of angry feelings.

III. Depression
Depression is defined as the emotional state of dejection, feeling of worthlessness and guilt usually apprehension.

IV. Perceived/Non-Organizational and Organizational Support
Support is defined as the availability and quality of an employee’s relationship with supervisors, coworkers, family and friends and the amount of positive consideration and task assistance received from them.
V. Burnout

Burnout is a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment that can occur among individuals who do “people work” of some kind.

**Emotional Exhaustion**

Emotional exhaustion refers to the depletion or draining of emotional resources.

**Depersonalization**

Depersonalization refers to a negative, callous and cynical attitude towards the recipients of one’s care.

**Reduced Personal Accomplishment**

Reduced personal accomplishment refers to the tendency to evaluate oneself negatively, particularly with regard to one’s work with clients.

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