Chapter-II

CONCEPTUAL FRAMEWORK

2.1. Stress: Concept and Assessment

Stress has become a globally known phenomenon affecting all countries, professions and all countries of workers (Warner, 1996; Kaushal, 1998). It is an inevitable part of human life (Pestonjee and Mishra, 1998). It is too common a part of life some thing which few can really avoid. Everyone in today’s life, experiences a fair share of stress, irrespective of personal characteristics, environmental and social conditions. The concept of stress is quiet significant in social and behavioral sciences fascinated researchers long ago (Dang and Gupta, 1994).

Stress is considered a phenomenon to be fought, investigated and ‘managed’. The term is generally used in physical or psychological resources and to refer to the emotional response of the person to such situations that tax a person’s physical and psychological resources. Stress is a fact of life; it is a state of total organism under exhausting circumstances, produced by a great variety of environmental conditions. Stress exists when the demands on a person are perceived as taxing or exceeding that person’s adjustive capacity (Lazarus, 1966). Stress is widespread and increasing problem taking a heavy human toll. It is estimated that 75 to 95 percent visits to doctors are stress related (Pareek, 1988).

Stress research is sprawling field characterized by definitional and conceptual problems, methodological complexities and general unevenness of quality, and lack of co-ordinationary efforts (Brenznitz and Goldberger, 1982). There are many components that make up stress and there are a variety of definitions of stress According to Hinkle (1973) “the seventeenth century the word stress was used to describe hardship or affliction” and “during the late 18th century stress, denoted force, pressure, and strain or stress effort, referring primarily to an individual’s organ or mental powers”. According to Kyriacou and Sutcliffe (1978) stress is conceptualized as a response syndrome of negative affect that is developed when there are prolonged and increased pressures cannot be controlled by the coping
strategies that the individual's have. Job stress refers to a situation where in job related factors interact with the workers to change that is, disrupt or enhances his or her psychological and/or physiological condition such that the person is forced to deviate from normal functioning (Dhar, 1991).

Stress reaction depends on what an individual considers dangerous or threatening, people vary greatly in general vulnerability to stress. If a person is marginally adjusted, the slightest frustrations or pressure may be highly stressful. Lack of external support either personal or material makes a given stress more severe and weakens an individual's capacity to cope with it (Dhar, 1991). Hence, stress is the result of an individual's perception that they do not have the resources to cope with a perceived situation from the past, present, or future. It is caused by fear and the reaction to fear is the instinctive and automatic preparation for fight or flight. In basic terms stress is an aspect of living that can be beneficial when it motivates, encourages change or inspires, but can be opposite when it does not (Pestonjee and Mishra, 1998). Stress manifests itself in the form of many psychological and physical problems. Researchers have found that stress is associated with anxiety, depression, hopelessness, anger and helplessness (Pestonjee and Mishra, 1998). Stress that continues over a prolonged period of time shows a variety of consequences or stress results. Prolonged stress may lead to a breakdown of both physical and psychological health for e.g. stress results include ulcers, psychotic behaviour, and burnout (Berry, 1998). Sometimes prolonged stress leads to behaviour and emotional disturbance with or without obvious somatic associations. Depression and anxiety are experiences as are irritability, anger and insomnia, other behaviour stress outcomes are poor work performance problems, such as low productivity and burnout (Berry, 1998).

Technological and information revolution fast and materialistic life, innovations and growing competition have generated in man a feeling of powerlessness, helplessness, meaninglessness and in turn a source of consequent stress (Kaushal, 1998). The increasing complexities, competitions and the hardened struggle of existence have compelled almost all section of people to experience stress in their everyday life events (Banerjee and Gupta, 1996). Stress has become an inevitable part of the psychological life of individual and occupational life is not exception to it. Stress may be experienced in any occupation. It is not the occupation
perse, which is responsible for stress experiences rather; it is the transaction between the job environment and personal characteristics (Handy, 1988).

Work stress exists when people perceive that they have difficulty in coping with both work that there sense of well-being is threatened (Boey, 1998). It is empirically established fact that high and persistent organizational/job stress has detrimental effects on the behaviour, work motivation, job attitude, and physical and psychological well-being of the employees, costing serious consequences to the organization as well as to the individual employee. Stress is being labeled as the major factors of lagging productivity and performance of individuals and organizations. Stress within the elasticity range is positively related to job satisfaction and adjustment, but high level of stress is found to be responsible for poor performance (John and Michael, 1980), physical (Lipowski, 1977), and psychophysiological disorders (Friedman and Rosenman, 1974). Stress is an important and dominating factor for burnout. Stress is a combination of factor within the individual, the organization and wider society which lead to lowering the feeling of personal self worth, achievement, effectiveness and coping with in one's personal role (Trendall, 1987).

Many Indian Researchers have found out significant relationship of job stress to host of organizational variables, such as organizational climate, organizational effectiveness, work motivation and job satisfaction (Mishra, 1987; Mishra, Pattnayak and Das, 1989; Helode, 1989; Gangopadhyaya, 1991). Occupational stress has been extensively studied in form of occupational demands, occupational role stress, and its impact on job dissatisfaction (Bharathi, Nagarathinam and Vishwanath, 1991; Thakaran, 1992), burnout (Sekhar and Chandra, 1996; Pradhan and Misra, 1995), negative mental health (Mishra and Somani, 1993), anxiety and role efficiency (Singh and Mohanty, 1995). Research and practice focusing on occupational stress has steadily increased during the last decades and a half. Researches and orientations including, medical, engineering, psychological, clinical and organizational psychology (Beehr and Franz, 1987).

By occupational/job stress is meant negative environmental factors (e.g. role erosion, workload, inter role distance, role stagnation and role conflict, etc.), associated with a particular job (Cooper, 1983). Job related stress is receiving
an increasing amount of public attention and several studies have indicated that stress related conditions are among the most important health problems of 1990’s for people at work and outside of work (Miller, 1990). There is growing body of evidence from studies in various organizational settings implicated in the etiology of poor mental health and psychosomatic disease for e.g. gastric ulcers, coronary heart disease (Sharma, Ghosh and Spielberger, 1995).

Job stress can have a significant negative effect on physical and emotional health (Williams and Huber, 1986). It is also related to job dissatisfaction and mental and physical ill health (Cooper and Marshall, 1976; Wall, Clergy and Jackson, 1978; Warr, 1990). Occupational stress causes major problem for both individual employees and organizations. It has been estimated that the financial lose by organization as a result of stress related illness is around $ 60 billion (Matteson and Ivancevich, 1987).

A number of instruments or scales have been developed to assess occupational/job stress. Brantly and Jones (1989) developed a psychometric instrument designed to monitor and evaluate the frequency and impact of daily stressors.

The Occupational Stress Index (OSI) developed and standardized by Srivastva and Singh (1981). The OSI consists of 46 items with 5 alternative responses namely: strongly agree, uncertain, disagree and strongly disagree. This index assesses employee’s perceived stress arising from the 12 dimensions of job life. These are role overload, role conflict, role ambiguity, unreasonable group and political pressure under participation, responsibility for the persons, powerlessness, and poor peer relations at work, intrinsic improvement, low status, strenuous working conditions and unpredictability.

Index of homogeneity and internal validity of individual items has been determined by computing point-biserial coefficient of correlations (rpb). The values of rpb ranged from 36 to 59. The internal consistency of the test was determined by odd even method which was found to be .935. The index of reliability was also ascertained by computing Cronbach’s Alpha Coefficient which was found to be .90.
Osipow and Spokane (1981) developed a promising generic measure to assess job stress and psychological strain across different occupational levels and work environment. It consists of 6 scales which are: Role overload, Role efficiency, Role-ambiguity, Role boundary, Responsibility, and Physical environment.

The Generic Job Stress Questionnaire (GJSQ) was developed by researchers at the US National Institute of Occupational Safety and Health (NIOSH) on the basis of a comprehensive review of the job stress literature (Hurrell and McLaney, 1988). The 13 GJSQ scales were either adapted from their job stress measures with demonstrated reliability and validity or constructed to assess job stress dimensions for which no valid measures were available (Hurrell, Nelson, and Simmons, 1998). Influence primarily by PE-Fit and Demand-Control theory, the GJSQ evaluates role conflict and ambiguity, job responsibilities, work load, skill use, and job demands and control. Job dissatisfaction, somatic problems, depression and other sources of distress in workplace are also assessed by the GJSQ.

A Nursing Stress Scale developed by Gray-Toft and Anderson (1981a), consisted of 37 potentially stressful situations encountered by healthcare workers. Respondents used a 4-point Likert scale to indicate the frequency with which they encountered them. Test-retest reliability has been reported as .81.

A scale developed by Rizzo, House and Lirtzman (1970), measures 2 types of role stressors that is, role ambiguity, and role conflict. Earlier, Johnson and Stinson (1975) developed a revised version of this scale. Another measure of role ambiguity is a 14 item questionnaire constructed by Rogers and Molnar (1976).

The Teacher Stress Inventory (TSI) (Fimian, 1984; 1985) is a 49 items measure of 10 stress-related problems for teachers. Teachers rate the strength of different stressors on a 1-5 scale, from no strength, not noticeable to major strength, extremely noticeable. Fimian and Fastenau (1990) reported a n alpha coefficient of internal consistency for the TSI of .097.

In the present study Job Stress Survey (JSS) (Spielberger, 1994; Spielberger and Vagg, 1999) has been used. The Job Stress Survey (JSS) psychometric instrument comprised of 30 items that describe specific sources of stress that are commonly encountered in workplace. Items describing a number of general sources of stress commonly experienced by managerial, professional, and
clerical employer in a variety of occupational settings were selected to form a job stress measure. The JSS was designed to assess the perceived intensity (severity) and frequency of occurrence of working conditions that are likely to adversely affect the psychological well-being of employees who are exposed to them (Spielberger, 1994). The format for responding to the JSS severity scale is similar to the procedure employed for rating stressful life events with Social Readjustment Rating Scale (Holmes and Rahe, 1967). Subjects first rate on a "9-Point" scale, the relative amount (severity) of stress that they perceive to be associated with each of the 30 job stressors (example, "excessive paperwork", "inadequate support from supervisor", "working overtime"), as compared to a standard stressor event, "assignment of disagreeable duties", which was assigned value of "5". The Job Stress takes into account the state-trait distinction that proved important in the assessment of anxiety (Spielberger, 1972; 1983) by requiring respondents to indicate how frequently a stressor event was experienced during the past 6 months. After rating the perceived severity of each stressor as compared to the standard, respondents are asked to report, on a 10-point scale ranging from 0 to 9+, the number of days on which each workplace stressor was experienced during the preceding 6 months. Thus the two ratings for each of the 30 JSS items provide useful information in regard to the perceived severity of each stressor, and how often the stressor event was experienced. Alpha Coefficient for the Job Stress Survey Index (JSS) was reported by Spielberger and Reheiser (1994b) to be very high for the total sample of females and males (.90 and .89) and sub-samples of females and males managerial/professional personnel (.88 and .87) and clerical/maintenance personnel (.91 and .92). Turnage and Spielberger (1991) reported significant relationship of JSS with locus of control (r=.18, P<.001) and the validity of the JSS.

2.2. Anger: Concept and Assessment

In the psychological and psychiatric literature, the concept of anger usually refers to an emotional state that consists of feelings that vary in intensity, from mild irritation or annoyance to intense fury and rage. Anger can be seen as a transitory state or a stable and general disposition to experience this emotion that is, trait anger. Individuals high in trait anger experience the transitory state of anger
more frequently and more intensely than do individuals low in trait anger (Spielberger, Johnson, Russell, Crane, Jacobs and Worden, 1985).

Anger is viewed as having two defining features: cognitive appraisal and action tendency. Ortony, Clore and Collins (1988) propose that anger is a compound emotion combining attributions about the action of an agent with the well being of oneself, more specifically, it is related to disapproving of someone else's blameworthy action (reproach) and being displeased about the related undesirable event (distress). Frijda (1986) emphasized the unique action tendencies associated with anger. These include antagonistic or aggressive tendencies designed to restore control, seek redress, or remove obstruction (Frijda, 1986; Frijda, Kuipers and ter Schure, 1989).

At least two terms have frequently been used in relation to or even interchangeably with the concept of anger: hostility and aggression (Fernandez and Turk 1995). Anger hostility and aggression generally refer to different though relative phenomena, but these terms are often used interchangeably (Buss, 1961; Berkowitz, 1962). While anger and hostility refers to feelings and attitudes, the concept of aggression generally implies destructive or punitive behaviors directed towards other person or object in the environment.

Hostility is an attitudinal bias that predisposes the individual to view others as untrustworthy, undeserving and immoral (Barefoot, 1962) and likely source of provocation and mistreatment (Smith and Christensen, 1992). When the anger expressed in aggressive behavior is motivated by animosity and hateful destructive attitudes, it may properly be labeled as hostility. Aggression is a behavioral reaction often involving various motoric responses in which the goal is to inflict damage (Bandura, 1977; Baron 1977). Aggression is the actualization of an action tendency proceeding from angry feelings.

Given substantial overlap in the prevailing conceptual definition of anger, hostility and aggression, were collectively termed/referred to as the AHA! syndrome (Spielberger, Johnson, Russell, Crane, Jacobs and Worden, 1985). A useful convention for distinguishing between the concepts is the distinction between hostile and instrumental aggression. Whereas hostile aggression refers to behavior motivated by anger, instrumental aggression refers to aggressive behavior directed towards
removing or circumventing an obstacle that stands between an aggressor and a goal, when such behavior is not motivated by angry feelings.

In the assessment of anger it is imperative to distinguish conceptually and empirically between the intensity of the experience of anger as an emotional state (S-Anger) and individual differences in anger proneness as a personality trait (T-Anger). Following a review of research, Spielberger, Jacobs, Russell and Crane (1983) distinguished between state anger (S-Anger) and trait anger (T-Anger). State anger is a transitory emotional phase, whereas trait anger pertains to a relatively stable personality attributes. They defined State Anger (S-Anger) as an emotional state or conditions that consists of subjective feelings of tension, annoyance, irritation, fury and rage and by activation or arousal of the autonomic nervous system. Trait Anger (T-Anger) is defined as a personality trait in terms of individual differences in the frequency of experiencing state anger overtime persons high in T-Anger are more likely to perceive a wide range of situations as anger provoking than individuals low in T-Anger, and to respond to such situations with elevations in S-Anger.

In order to measure the fundamental properties of anger it is essential to assess the intensity of angry feelings that are experienced at a particular time, the frequency that anger is experienced, and whether anger is held in (suppressed) or expressed in aggressive behavior directed towards other person or objects in the environment. Spielberger, Johnson, Russell, Crane, Jacobs and Worden (1985) have distinguished between experience and expression of angry feelings. There are individual differences in styles of anger-expression or anger management. Researchers observed that individuals manage their anger in either of three forms that is, Anger-in (Ax/In), Anger-out (Ax/Out), and Anger-control (Ax/Con). Anger-in means the frequency with which angry feelings are held in or suppressed. The psychoanalytic conception of anger turned inward toward the ego or self (Alexander, 1948) implies that feelings of guilt and depression will be experienced, though thoughts and memories relating to the anger provoking situations, and even the feelings of anger themselves may be repressed and, thus not directly expressed (Anger-in). Anger-out is defined in terms of how often an individual expressed anger
toward other people or objects in the environment. Anger-control refers to attempts to control and suppress or mitigate the expression of anger.

A number of instruments or scales have also been developed to measure anger. In the early 1970s three anger scales were developed to distinguish between anger and hostility. One was the Reaction Inventory (RI) developed by Evans and Stangeland (1971) which measured the degree to which anger was evoked in a number of specific situations. A high internal consistency was reported (Chronbach alpha = .96). Another scale was Novaco’s (1975) Anger Inventory (AI) consisting of 90 statements that describe anger provoking incident and the third one was the Anger-Self-Report (ASR) which was designed by Zelin, Adler and Meyerson (1972). This scale measured both the experience and expression of anger. The ASR scores of psychiatric patients correlated significantly with psychiatrists rating of anger. These scale had a number of limitations.

The State-Trait Anger Scale (STAS) was designed to assess the intensity of anger as an emotional state and individual differences in anger proneness as a personality trait (Spielberger, 1980; Spielberger, Jacobs, Russell and Crane, 1983). Siegel (1986) has standardized the Multidimensional Anger Inventory. Its test-retest reliability is 0.75 and alpha reliability co-efficient ranges from 0.84 and 0.89.

The “Anger Expression Scale” (AX/Scale) was developed by Spielberger, Johnson, Russell, Crane, Jacobs and Worden (1985). It is a self-report rating scale that assesses anger expression as a personality trait. AX scale assesses how often subjects respond in a particular manner, rather then how they respond to a particular situation. It is a 24 item scale yielding four different scores. The AX subscales assess individual differences in the tendency to express anger towards other people or objects in the environment (Ax/Out), tendency to hold in (suppress) angry feelings (Ax/In), control the expression or experience of anger (Ax/Con) and the total score (Ax/Ex). The convergent and divergent validity of the AX and its subscales was found (Johnson-Saylor, 1984) which reported its correlation with other anger and personality measures.

The State-Trait Anger Expression Inventory (STAXI) developed by Spielberger and his associates (Spielberger, 1988; Spielberger, Johnson, Russell, Crane, Jacobs and Worden, 1985; Spielberger, Jacobs, Russell and Crane, 1983)
provides concise measures of the experience and expression of anger. Anger is conceptualized as having two major components: state and trait. In addition, to these components, scores on Ax/Out, and Ax/Con are also provided by 44 items of STAXI. Individuals rate themselves on a 4-point scale. The Hindi version of Anger Expression Scale (Ax/In, Ax/Out, and Ax/Con) and the total STAXI has been developed by Krishna (1988) and Rana (1990) respectively. The alpha reliability of this scale in respect to total Ax, Ax/In, Ax/Out, Ax/Con are .89, .88, .62, .82 (females) and .96, .92, .92 and .82 (males) respectively. These highly significant alpha co-efficient also establish the internal consistency of STAXI and Anger Expression Scales.

2.3. Depression: Concept and Assessment

Depression haunts the life of many. It exists in many forms, takes various guises and has been recognized for many centuries. Over two thousand years ago Greek physician Hippocrates labeled it melancholia. The Greeks believed that depression arose from a disturbance of humors, specifically black bile (Gilbert, 1992).

We all feel depressed at times, although we may call the feelings something else, like “sad”, or “blue” or “unhappy”. These feelings are normal part of life for children and adults (Rosenhan and Seligman, 1984; Quay and LaGreca, 1986). Depression is usually associated with the perception of lose, events that occurred in the past, and decreased autonomic activity (Feldman, 1993). The term depression has been used to refer to a mood, a symptom, and a syndrome (Romano and Turner, 1985).

During the last few decades impressive progress has been made in the quality and quantity of research on depression. The construct is not only theoretically challenging it is also diagnostically complex. The literature regarding possible symptoms and correlates of depression is extensive and sometimes conflicting (Upmanyu and Reen, 1991). Pestonjee (1992) define depression as the emotional state of dejection, feeling of worthlessness and guilt and usually apprehension. Depressive draw illogical conclusions in evaluation of there immediate world and
Depressed individuals possess stable and enduring negative schema that serve as conceptual filters for coding, screening and several evaluation of impinging stimuli. These negative schemes are the faulty processing strategies, they engender (for example, dichotomous thinking) lead to pervasive negative themes in the depressed individuals cognition about self and future (Beck, Rush, Shaw and Emery, 1979).

Depression is usually the consequence of feelings of powerlessness of life out of one's control. According to Gilbert (1995) depression affects us in many different ways and symptoms are spread over different aspects of functioning:

**Motivation** : Apathy, loss of energy and interest, pointless, hopeless.

**Emotions** : Depressed mood, plus emptiness, anger or resentment, anxiety, shame, anger

**Cognitive** : Poor concentration, negative ideas about the self, the world and the future.

**Biological** : Sleep disturbance, loss of apathy, changes in hormones and brain chemicals.

Depression can vary in items of the relative degree and severity of these symptoms, their duration and their frequency. Hence, individuals can vary as to whether their depression is mild, moderate or severe and they may have an episode or many episodes (Gilbert, 1995). The most typical feature of the behaviour of depressed patients is a marked decrease in the rate of behaviour. The depressed patient withdraws from participation in most of the activities. In the most serious cases, the patient may end up avoiding almost any activity at all, including efforts to escape from situations that are even physically painful (Guidano and Liotti, 1983).

Depression can have an acute onset (within days or weeks) or come on gradually (over months or years). Depression can be chronic (for example, lasting over two years), or short lived (recovery coming in week or months). The difference between normal depression and depression as a serious disorder is a matter of degree. Depression becomes a psychological disorder when it is severe, frequent and long-lasting. People with this disorder tend to have a generally unhappy mood, feel hopeless about the future, appear listless and passive, show disrupted eating and
sleeping habits, have low self-esteem, often blaming themselves for the troubles that afflict them (Gilbert, 1995).

Depression has also been addressed through psychodynamic explications. Abraham (1968) reported anxiety and depression having a relationship analogous to that between fear and grief. He emphasized that depressed patients often have very ambivalent feelings towards their loved ones. The hostile side of this ambivalence is often repressed from consciousness and then that leads to feelings of guilt and depression. Freud (1947) differentiated melancholia (depression) from mourning (grief).

There has been a long-standing notion in psychodynamic theory that depression is anger turned inwards (Freud, 1934; Friedman, 1970; Arieti and Bempord, 1978). Depression has also been viewed as a disorder of cognition. Beck (1967, 1976) argued that certain individual are vulnerable to depression because from an early age, they have possessed negatively biased cognitive schemes of them selves and their experience. This negative thought pattern may lead to symptoms of depression.

Depression is most often characterized by a set of psychologically expressed affect states, it may be important to differentiate among the diverse cluster of psychological phenomena associated with depression. Depression is considered to be an unadaptive response to psychological stress rather then an illness. There are four components to the development and maintenance of depression process: i) antecedents, ii) precipitant psychological stressors, iii) the depression response, and iv) consequences. The antecedents are predisposing factors that interact with psychological stressors resulting from unavoidable stress, events or inadequate coping skills, to produce a state of depression that tends to be maintained primarily by environmental factors (McLean, 1976).

For assessing depression, many researchers have developed various tools. First one to start work in this area was Hildreth (1969). He developed a feeling and Attitude Scale for the measurement of current feeling and attitudes of the individual.
Hathaway and McKinley (1951) in order to assess global personality developed Minnesota Multiphasic Personality Inventory (MMPI). Apart from other scales, the MMPI has the D-Scale which measure depression. Considering depression as a disorder of affect, Weissman, Klerman and Paykel (1961) designed 10 phrases for the measurement of affective state, where subjects have to use these phrases in order to explain their depressive state.

Few adjective checklists have also been developed for measuring depression like the Lubin's Adjective Checklist (Lubin, 1965). Zeally and Aitken (1969) developed a scale of visual analogues.

Hamilton (1967) developed Rating Scale for Depression on the assumption that depressives generally under estimate and at times over estimate their depressive state. A high correlation (0.84) between this scale and global judgment has been reported. The inter-rater reliability of the scale is 0.91. Zung (1965) developed a self rating scale called the Zung Self Rating Depression Scale. Snaitth, Ahmed, Mehta and Hamilton (1971) developed the Wafefield Scale. This scale was further modified by the Leed Scale (Snaitth, Bridge and Hamilton, 1976). Montgomery and Asberg (1979) developed a scale in which the ratings were based on the observations of the clinicians. Zigmond and Snaitth (1983) devised another scale for screening the patients. It differentiates the depressives from the anxiety neurotics.

For the Indian setting, keeping in view the cultural factors, Singh, Verma, Verma and Kaur (1975) developed Amritsar Depressive Inventory. The validity of this inventory was 0.75 when scores were correlated with that of the clinician's diagnosis. Its split-half-reliability was 0.82.

Another widely used scale is called the Beck Depression Inventory (Beck, Ward, Mendelson, Mock and Erbaugh, 1961). It is a 22-item scale measuring attitudes and symptoms associated with depression. BDI is reported to possess adequate internal consistency (Upmanyu and Reen, 1990, 1991; Vrendenburg, Krames and Flett, 1985). In the present investigation, Hindi version of Beck Depression Inventory developed by Kaur (1994) has been used. It is also a 21-item scale. The alpha co-efficient of the BDI was 88. The psychometric characteristics of this scale have been well documented in the Indian setting (Upmanyu and Reen, 1990, 1991; Kumar, 1990, Upmanyu, Upmanyu and Dhingra, 1993).
2.4. Organizational Support: Concept and Assessment

Social support is usually defined as the existence or availability of people on whom we can rely, people who let us know that they care about, value and love us. Someone who believes that he or she belongs to social network of communication and mutual obligations experiences social support (Sarason, Levine, Basham and Sarason, 1983). Social support is one of the most widely studied resistance resource in the area of stress and stress-outcomes research. In coping with stress, many of us find it helpful to talk over our problems with family members, friends, and people at work. Social support is an exchange of resources that takes place between at least two people, often members of the same social networks (Shumaker and Brownell, 1984). The perception/belief that someone is ready to extend help or provide assistance either in emotional, informational or in practical terms generally help to reduce stress experience and may also enhance the psychological and physical well-being (Pandey and Tripathi, 2002).

Work support refers to the social relationships involving free expression of ideas, friendship, encouragement, as well as the emotional and instrumental help person give to each other in the work environment (Moos, 1986). A variety of definitions have been offered for social support primarily within work stress literature. It has been defined in various ways, for e.g. as "resources provided by others (Cohen and Syme, 1985), as coping assistance (Thoits, 1986), or as an exchange of resources "perceived by the provider or the recipient to be intended to enhance the well-being of the recipient" (Shumaker and Brownell, 1984). According to Wills (1991) social support is the perception or experience that one is loved and cared for, esteemed and valued, and part of a social network of mental assistance and obligations. Cobb (1976) defined social support as the exchange of information leading person to believe that he/she is cared for, valued, or part of a network having mutual obligations. Kahn and Antonucci (1980) consider social support as an interpersonal transaction including one or more of the following key elements: affect, affirmation and emotional help. House and Wells (1978) describe social support as consisting of frequent interactions, strong and positive feelings and the availability of emotional and instrumental support needed.
Thus there are several definitions and models of social support proposed by social scientists, varying in terms of the dimensions on which attention is focused, but in the organizational field a frequently used conceptualization of support is that advanced by House (1985) in his study, he defined social support as a flow of one or more of four things between people: (a) emotional concern; (b) instrumental; and (c) informational; (d) appraisal. House (1981) differentiated between four kinds of support: (i) Instrumental support (giving direct help often of a practical nature or assist with a problem). (ii) Emotional support (showing interest in understanding of caring for, and sympathy with a person's difficulties or reassurance). (iii) Informational support (giving the persons information that may help him or her deal with problems or give advice) (iv) Appraisal support (providing feedback about the person's functioning that may enhance his or her self-esteem). According to House, support can come from many sources for e.g. from one's supervisor, co-workers and or one's spouse, friends, family or psychotherapists. Caplan (1975) suggested that there are two types of social support (i) Tangible help; and (ii) Emotional support, such as love, affection, sympathy, understanding, friendship, intimacy etc. provided by another person or group.

Social support refers to the positive functions and nature of social relationships with various people, such as spouse, boss, friend or relatives. It includes social support and other contents such as social regulation and control, and social demands and conflicts. Deleterious effects due to negative content or lack of support may be greater than beneficial effects caused by helpful actions. Lack of supervisor support, for e.g. has been shown to be a precursor of teacher burnout (Burke and Greenglass 1993; 1995; Greenglass, Fiksenbaum and Burke, 1994).

Most studies of the role of social support in the stress-coping process tap the individual's perceptions of support available or received rather than more objective index of support (Cooper, Dewe and DrisColl, 2001). Within functional perspective, perceived availability of support must be distinguished from the activation of support. When social support is viewed as a general sense of being loved and valued, it may reflect a personality variable rather than social interaction or resources provided by others. Perceived social support can be equated to a stable individual difference variable based on a sense of acceptance by others (Sarason,
Sarason and Pierce, 1990). Research has suggested that at least under some circumstances perception of social support that remains unutilized is more beneficial than social support that is actually mobilized (Taylor, Sherman, Kim, Jarcho, Takagi and Dunagan, 2004).

Organizational support theory (Eisenberger, Huntington, Hutchison and Sowa, 1986; Shore and Shore, 1995; Eisenberger, Cummings, Armeli and Lynch, 1997; Rhodes and Eisenberger, 2002) supposes that to meet socio-emotional needs and to determine the organization's readiness to reward increased work efforts, employees develop global beliefs concerning the extent to which the organizational values their contributions and cases about their well-being (Perceived Organizational Support, POS). Accordingly, employees shared a consistent pattern of agreement with various statements concerning the extent to which the organization appreciated their contributions and would treat them favorably or unfavorably in differing circumstances (Eisenberger, Huntington, Hutchison and Sowa, 1986; Eisenberger, Fasolo and Davis-LaMastro, 1990; Shore and Tetrick, 1991; Shore and Wayne, 1993). Employees evidently believe that organization has a general positive or negative orientation toward them that encompasses both recognition of their contributions and concern for their welfare. High perceived organizational support (POS) would (a) meet needs for approval, esteem and social identity and (b) produce the expectation that superior conventional performance and extra role behaviour, carried out for the organization, will be recognized and rewarded (Eisenberger, Huntington, Hutchison and Sowa, 1986).

Central to social exchange theory is the norm of reciprocity which obligates people to respond positively to favorable treatment received from others (Gouldner, 1960; Blau, 1964). On the basis of the norm of reciprocity, POS would strengthen affective commitment to the organization and increase efforts made on its behalf (Eisenberger, Huntington, Hutchison and Sowa, 1986; Shore and Shore, 1995). Measure of Organizational Commitment tends to focus on employee's attitude toward the organization, the survey of perception of support focuses on the employee's perception of the organizations attitude toward them. An employee's inferences about the organizations commitment to him/her contributes to the employee's subsequent commitment to the organizations (Eisenberger, Huntington,
Hutchison and Sowa, 1986). By repeated indications that the organization places little value on one's contribution and well-being would reduce POS and lessen the employee's perceived obligations to the employer. Here, employees would decrease their affective organizational commitment and lessen their performances of standard job activities and extra role behaviours. Employees would further decrease organizational involvement by being absent more often and would be more likely to search for employment elsewhere or take early retirement (Eisenberger, Cummings, Armeli and Lynch, 1997).

POS was positively related to following: high quality employee-supervisor relationship, favorable development training experiences, and promotions (Wayne, Shore and Liden, 1997) participation in goal setting and receipt of performance feedback (Hutchison and Garstka, 1996) and low role conflict and ambiguity (Jones, Flynn and Kelloway, 1995). The favorableness of job conditions such as promotion practices reward systems, fringe benefits and training opportunities was found to have a stronger relationship with POS when employees believed that these conditions represents discretionary actions of the organization rather than being the result of external constraints (Eisenberger, Cummings, Armeli and Lynch, 1997).

Perceived organizational support, was positively related to variety of work outcomes including affective organizational commitment (Eisenberger, Fasolo and Davis-LaMastro, 1990; Shore and Tetrick, 1991; Guzzo, Noonan and Erion, 1994; Hutchison and Garstka, 1996; Setton, Bennett and Liden, 1996; Wayne, Shore and Liden, 1997), effort-reward experiments (Eisenberger, Fasolo and Davis-LaMastro, 1990), evaluative and objective measures of in-role job performance (Eisenberger, Huntington, Hutchison and Sowa, 1986; Eisenberger, Fasolo and Davis-LaMastro, 1990), help given co-workers (Witt, 1991; Shore and Shore, 1995; Wayne, Shore and Liden, 1997), constructive suggestions for improving the operations of the organizations (Eisenberger, Fasolo and Davis-LaMastro, 1990), and influence tactics designed by employees to make supervisors aware of their dedication and accomplishments (Shore and Wayne, 1993). Perceived Organizational Support (POS) was negatively related to absenteeism (Eisenberger, Huntington,
Studies have found that people get different kinds of help from different supporters. Supervisors can provide social support that is, instrumentally useful on job, as well as emotionally helpful (Greenglass, 1993; Eastburg, Williamson, Gorsuch and Ridley, 1994). Co-workers often are helpful with objective job problems for which they can provide facts and opinions, and with career development concerns (Burke, Weir and Duncan, 1976). Interviews with supervisors revealed that subordinates also can be important sources of emotional support (Erera, 1992). Apparently, however, women are more capable of making use of social support than men. Greenglass (1993) found that women, but not men, used social support from the work supervision to both solve and prevent stress problems. According to Pinneau (1976), men with high support from either supervisor or co-workers generally reported low role conflict, low role ambiguity and low future ambiguity, high participation, and good utilization of their skills.

Increasing, research has demonstrated the beneficial effects of social support on a person's physical and psychological well-being (Russell, Altamaier and Van Velzen, 1987; Marshall and Barnett, 1992; Greenglass, 1993). Social support has received much attention by researchers studying stress, social relationships, and emotional and physical health. It has been repeatedly found that social support can assist coping and can have beneficial effects on various health outcomes (see review in Cohen and Syme, 1985; House, Umberson and Landis, 1988; Rodin and Salovey, 1989; Sarason, Sarason and Pierce, 1990; Schwarzer and Leppin, 1991; Veiel and Baumann, 1992).

Research suggests that social resource factors may serve either as a buffer in the coping process or may directly improve well-being (Cohen and Wills, 1985; Greenglass, 1993; Hobfoll, 1988). In main effects analyses, an inverse relationship has been found between social support and stress where negative correlations are reported between social support and stress and strain. The buffer argument suggests that stress may affect some individuals adversely, but that those who have social support resources are relatively resistant to the deleterious effects of
stressful events. The evidence for the buffering or moderating effect of social support on occupational stress is controversial (Himle, Jayaratne and Thyness, 1991) as reported in a number of research studies among a variety of occupation in various settings. In one review by LaRacco, House and French (1980), evidence is cited for a buffering effect of social support on problems created by occupational stress. Social support from supervisors and co-workers reduced the psychological strains related to occupational stress and the effects of work-related stressors. However, in other studies no buffering effects of social support on work-related stress have been found (Lin, Simeone, Ensel and Kuo, 1979; Shinn, Rosario, March and Chestnut, 1984; Himle, Jayaratne and Thyness, 1991). These contradictory findings support the contention of Cohen and Wills (1985) that the buffering effect of social support may be limited by differences in occupational tasks, working environments, and by individualistic worker response to job stress. Cohen and Wills further suggested need to study the buffering effects of various types of social support in other human service professions as well.

A number of questionnaire or scales have also been developed to measure social support. Henderson (1980) developed a 50 questions structure scale which assesses the perceived availability and adequacy of people who can be counted on for assistance in problem solving, emotional support and social integration, its availability and adequacy. Sarason, Levine, Basham and Sarason (1983) developed social support questionnaire (SSQ), which yields scores for (i) perceived number of social supports; and (ii) satisfaction with social support that is available.

House and Wells (1978) developed social support questionnaire. This questionnaire focused on the support received from supervisor, coworker, spouse and friends or relatives. The alpha coefficients for reliability range from 0.75 to 0.92. Predictive validity of .92 has been found with physical and mental health in a variety of occupations (House, 1981).

In the present study, Functional Social Support Questionnaire (Singh and Srivastva, 1997) has been used. This self administered, functional social support questionnaire (FSSQ) consists of an 80 items to measure availability of support from various organizational (work related) and extra-organizational (non-work) sources. These items refer to what other people do (the function they perform), rather than
only the existence of other people in social structure. The first section measures extra-organizational sources of support, which include support from family, friends and spouse. The second section of questionnaire aims to measure organizational sources of support, which include support from co-worker and supervisor/ immediate officer. The reliability and validity indices of the questionnaire have been reported to be quite high and satisfactory.

2.5. Burnout: Concept and Assessment

Burnout has been conceptualized as resulting from the nature of human service work and as a function of organizational context in which professionals provide human services. Both lines of thought emphasize the social context in which burnout develops, when the focus is on the nature of human service work, it is stated that although human service professionals are drawn towards work which gives direct contact with people in need, they are unprepared for the emotional demand of work and are readily overwhelmed by them. The organizational focus emphasizes the manner in which problems endemic in any work context can aggravate symptoms of burnout among human service workers (Leiter, 1992).

Burnout is viewed as a chronic negative psychological process that occurs among workers in occupations requiring substantial interpersonal contact (Shirom, 1989). The term "burnout" was first coined and applied to human beings by Herbert Freudenberger (1974) to denote a state of physical and emotional depletion resulting from conditions of work. He tailored his original concept for human service profession. Since its "discovery" in the early 1970s, burnout has been recognized as a serious threat particularly for human service professionals (Schaufeli, Maslach and Marek, 1993).

Though burnout can be found in all kinds of professions including, military personnel (Leiter and Schaufeli, 1996) and managerial personnel (Perlman and Hartman, 1982). Results of recent studies have shown that it is especially prevalent among human services (Schaufeli and Enzmann, 1998) like physicians (Barnett, Garies and Brennan, 1999), nurses (VanYerpren, Buunk and Schaufeli, 1992; Schaufeli and Janczur, 1994; Pines and Guendelman, 1995; Decker, 1997),
education and health care (e.g. Maslach, 1982; Kahill, 1988; Vandenberghe and Huberman, 1999). Human service workers and professionals appear to be especially vulnerable to burnout because the basic characteristic of the work of human service professionals is their often emotionally charged contacts with the recipients of their care, and these contacts are recipients of their care, and these contacts are considered to play a central role as determinants of burnout (Van Dierendonck, Schaufeli and Buunk, 2001).

Over the past decades, the phenomenon of job burnout has been investigated in a variety of service occupations and settings. The construct has been linked to job stress and is thought to represent a unique response to frequent and intense client/patient interaction (Maslach, 1982; Cordes and Dougherty, 1993). Burnout can be considered as a chronic occupational stress reaction and has been described as an occupational hazard in the helping professions. Health care providers are predisposed to burnout when clients' needs pertaining to intensity or the complexity of the circumstances, surpass the resources of the care providers (Courage and Williams, 1987). Caring for others and care giving environment are generally considered to be the primary cause of burnout syndrome (Van Dierendonck, Schaufeli and Buunk, 2001). Burnout among health care workers is a critical issue as organizations seek to provide high-quality patient care in an increasingly competitive market. Health care workers are especially susceptible to occupational burnout. Their exposure to patient problems (psychological, social and physical) leaves them vulnerable to chronic stress, which can be emotionally draining and, in due course, lead to burnout (Maslach, 1982). The consequences of burnout are potentially very dangerous for the staff, the clients and the larger institutions in which they interact (Maslach and Jackson, 1986).

Authors have varied in the way that they define burnout, but the condition is generally taken to refer to a collection of cognitive (e.g. negative attitudes, concentration difficulties), behavioral (e.g. absenteeism, declining work performance), affective symptoms (e.g. emotional exhaustion, irritability) (McElroy, 1982; Seuntjens, 1982; Maher, 1983) and somatic complaints (Belcastro, 1982;
Belcastro and Hays, 1984) that reflect a chronic stress reaction to the work situation (Maslach and Jackson, 1981; Freudenberger and North, 1985). Gillespie (1991) defined burnout as a "reaction to chronic, job related stress characterized by physical, emotional and defensive coping". Pines, Aronson and Kafry (1981) defined burnout more narrowly as physical, mental and emotional exhaustion, which is often found in those who have involvement with people in emotionally demanding situations.

The multifaceted phenomenon of occupational burnout has been a fertile subject of researchers for the past decade (Akroyd, Caison and Adams, 2002). Considerable progress has been made recently in understanding the nature of burnout. Operationally burnout is defined as a syndrome of emotional exhaustion, depersonalization of others, and a feeling of reduced personal accomplishment (Maslach, 1982). Burnout is a psychological concept, depends upon how an individual fulfills or fails to fulfill their needs, especially those needs which are dependent on interpersonal relationships for their fulfillment. As Maslach, notes, and researchers and theorists usually define burnout in terms of psychological experience of the individual and on the other hand administrators are concerned with possible behavioural consequences of burnout for their agencies, namely employee absenteeism, turnover and poor job performance (Shinn, 1984). The most fundamental tenet of burnout syndrome is that it is an end-stage consequence of a process of deterioration in a person who has been exposed to relentless stress in the work environment (Miller, 1995). When a person works for a long time in stressful working condition with inadequate stress management skills develops burnout feeling (Misra, 1992).

Maslach and Jackson (1986) pointed out that burnout is not an all or none state, but reflects the extreme end of a continuum. Three main aspects of burnout have been investigated in the literature. A key aspect of the burnout syndrome is increased feelings of emotional exhaustion. As a result of high emotional demands in the interpersonal relationships with patients or clients, workers may feel emotionally exhausted; as emotional resources are depleted, workers feel they are no longer able to give of themselves at psychological level (Maslach, 1982). Another
aspect of burnout syndrome is the development of depersonalization. To cope with these feelings of exhaustion workers will try to protect themselves by detachment from their recipients, that is viewing one's client negatively and by treating them in an indifferent and cynical way. This detached attitude towards clients or patients is called depersonalization (Maslach, 1982). A third aspect of burnout syndrome is reduced personal accomplishments, as a result of this attitude, workers are unable to perform adequately and the quality of their care will impair. In turn, this will lead to decline in one's feelings of personal accomplishment, or professional efficiency. Workers develop a tendency to evaluate oneself negatively, particularly with regard to one's work and their clients. Workers may feel unhappy about themselves and dissatisfied with their accomplishments on the job (Maslach and Jackson, 1986).

Burnout often starts as a feeling of fatigue, mental or emotional which lasts increasingly longer. One may become angry, hostile and depressed. Employees, suffering from burnout become less energetic and less interested in their jobs. They tend to find fault with all aspects of their work environment, including co-workers and react negatively on the suggestions of others. The quality of their work deteriorates but not necessarily the quantity (Bellafiore, 2004). Leiter (1989) suggested that the burnout process can be understood in terms of the stress-strain coping framework (Lazarus and Folkman, 1984). A major strain produced by job stressor is burnout. Burnout has been the most widely studied as a correlate of job stress (Lee and Ashforth, 1993) while emotional exhaustion and depersonalization have been found to be strongly associated with stress. Personal accomplishment was related to employee's perceptions of their job performance and their degree of control and to their level of self efficacy (Lee and Ashforth, 1990).

Emotional exhaustion corresponds with the notion of stress as it has been linked to tension, anxiety, physical fatigue, insomnia, and so on (Maslach and Jackson, 1981; Perlman and Hartman, 1982). Depersonalization corresponds to the individual attempts to staunch the depletion of emotional energy by treating others as objects or numbers rather than as people (Maslach, 1982; Kahill, 1988). Ashforth and Lee (1990) argued that depersonalization constitutes one form of defensive
behaviour, defined as reactive and protective actions intended to avoid an unwanted demand or reduce a perceived threat. Personal accomplishment represents an aspect of self-efficacy and is thus linked to adjustment to demanding situations (Bandura, 1986).

Some personality factors have been found to contribute to burnout. A personality orientation called Type-A has been found to be associated with burnout. Research has shown that two specific elements in Type-A personality contribute to burnout: cynicism (low interpersonal trust) and a sense of loneliness. Other personality factors contributing to burnout are externality (a feeling that the person does not have control over what happens, and external forces or chance or fate determine things), low self-esteem, rigidity, alienation and machiavellism, (manipulative orientation). One research has shown that stress tolerance is higher in individuals with greater impulse control (voluntary delay of gratification of physical and physiological needs), or self control (Pareek, 1988).

The causes of burnout can be grouped into three categories. Job characteristic: These include employee-patient relationship, role conflict, role ambiguity, and role overload. Organizational characteristics: These refer to the extent to which rewards and punishment are linked to job performance. Personal characteristic: These include various socio-demographic variables of the employee, self-efficacy and social support (Cordes and Dougherty, 1993). While the causes of burnout, may be personal, occupational or both (Maslach and Jackson, 1984; McCranie, Lambert and Lambert, 1987; Rich and Rich, 1987; Maslach and Leiter, 1988; Stechmiller and Yarandi, 1992). Majority of these studies research suggests that characteristics of the work setting are more strongly related to burnout than personal factors. A variety of symptoms of burnout have been identified. Studies have shown burnout to be linked to ulcers and to kidney, gallbladder and cardiovascular disorders. But there is a stronger empiric link between behavioral and effective disorders and burnout (Kahill, 1988; Miller, 1995).

A number of instruments or scales have been developed to measure burnout. There are at lest five published burnout scales in the literature. One was the
Staff Burnout Scale (SBS) (Jones, 1980) is based on Maslach's conceptual framework, but includes reported behavioural and physiological items as well as cognitive and emotional ones. In this scale, factors are included. A Job dissatisfaction factor assesses feelings about the workplace and attitude related to turnover. A Psychological and Interpersonal Tension factor measures tension, and interpersonal problems with supervisors, co-workers and clients. The Physical Illness and Distress factor assesses fatigue and physical complaints often found in measures of somatic symptoms (Langner, 1962; Caplan, Cobb, French, Harrison and Pinneau, 1975). The final factor, Unprofessional Patient Relationships, covers some of the same ground as Maslach's depersonalization factor. The instrument is thus quite broad, and it is not yet clear whether the different factors have the same causes and consequences.

The Burnout Index (BI) devised by Pines, Aronson and Kafry (1981). It measures on a 7-point scale that ranges 1 (low frequency of occurrence) to 7 (high frequency of occurrence) how often respondents experience physical (for example, weak, tired), emotional (for example, worthless, rejected) exhaustion. In various studies (Justice, Gold and Klein, 1981; Corcoran, 1986), factor analysis of the BI revealed only one dimension. The BI focuses on exhaustion, whereas the Maslach Burnout Inventory (MBI) measures depersonalization and diminished sense of personal accomplishment as well as exhaustion. Many investigators have used the BI to measure burnout (Etzion, 1984; Geller and Hobfoll, 1994).

Another measure of burnout is provided by the Berkeley Planning Associates (1977). This scale assesses alienation from clients, co-workers, the job, and the opportunities in the job. The scale is highly related to job satisfaction (r=59).

A scale designed by Freudenberger and Richelson (1980) is a self assessment tool. It measures exhaustion, sadness and withdrawal from routine activities. This scales, is unrelated to work settings.

In the present study Maslach Burnout inventory (MBI), (Maslach and Jackson, 1986) has been used The MBI consists of 22 items yielding different subscales that assess the different aspects of burnout that is, emotional exhaustion, depersonalization and personal accomplishment. Each aspect is measured by a
separate subscale. The Emotional Exhaustion subscale assesses feelings of being emotionally overextended and exhausted by one's work. The Depersonalization subscale measures an unfeeling and impersonal response toward recipients of one's service, care, treatment or instructions. The Personal Accomplishment subscale assesses feelings of competence and successful achievement in one's work with people. The three subscales of MBI provide a general index of frequency that is, how often one has these feeling and intensity that is, how strong one has these feelings. Numerous studies have been supported the validity of the burnout scales (Golembiewski and Munzenrider, 1981; Iwanicki and Schwab, 1981; Maslach and Jackson, 1981b; Belcastro, Gold and Hays, 1983). The split half internal reliability co-efficients have been reported at .74 for the combined intensity-subcales (Maslach and Jackson 1981a)

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