CHAPTER-II

REVIEW OF LITERATURE

The present review of literature was considered for the conceptual phenomena as well as the variables under study assess empirical implications. Any research needs support, verification and clarification by having through critical evaluation of the literature available to the researcher to investigate the prescribed objectives of the study.

It has been a tradition to consult and review the earlier work on the related topics before analysing and investigating the problem on hand. The process of accumulation of scientific knowledge is slow, steady and gradual. One investigator builds on the work of the other and in turn, contributes his own share and which sometimes acts as a precursor to future researches. Some times the previous work throws a challenge or leads to disagreement on some derived theories. In some cases either an examination of specialized theory may leave many problem unresolved or may give rise to new applications, which may not be revolutionary in form but are meaningful from the point of view of gradual accumulation of scientific knowledge.

One of the simplest ways of economising effect in an inquiry is to review and build upon the work done by others investigations. A comprehensive review of literature is must in any research endeavour and requires a thorough consideration and efforts on parts of
investigator. The investigator made a survey of literature by reviewing pertinent research related to the area. An in-depth literature review facilitates in knowing trend of thought and researches already done in the specific area of interest and in streamlining the present plan of work. This chapter attempts to give an overview of the literature reviewed by the investigator to tie the theoretical and empirical aspects of the study more securely.

2.1 Mental Health

Mental health is the state of mind, which adjusts with the present situation. A person who is mentally unhealthy does not mean that he is mentally ill.

Martin P. Bakker, Johan Ormel, Frank C. Verhulst and Albertine J. Oldehinkel (2009) also found difference in male and female on their level of mental health.

Indian cooperative banking has passed through hundred years of its existence. At the same time, poor image of cooperative bank employees in the society affects their morale is also exist. The challenges faced in recruitment and retention of efficient personnel for managing the complex affairs of cooperative banks. World over, the technology driven channels such as, ATM, net banking and mobile banking have reduced walk-in-customers at the bank branches. the staff is also confronted with various regulatory norms to mitigate risks in operations. This clearly establishes that employees of cooperative
banks play a vital role in managing not only the ‘transaction’ of a customer but also future long-term relationship with them with various organisational problems like infrastructural problems with growth in the bank and over staffing, the increasing competitive pressure in cooperative banking had led to greater attention to controlling labour costs and increasing labour productivity and the nature of change had moved the emphasis towards being a market-driven rather than an administratively driven organization. These problems directly indirectly affect their mental status. Dr.N.Ramu (2008)

VOGT YUAN (2008) used the National Longitudinal Study of Adolescent Health to test these effects for Black-White differences in adolescent mental health. He found that Black adolescents have more coping resources than White adolescents as indicated by them having greater social support from family, more social ties to neighbors, greater involvement in religious activities, and higher self-esteem. White adolescents are higher on only one coping resource compared to Black adolescents – they receive more social support from friends. These additional coping resources explain why Black adolescents have similar depression and positive well-being to White adolescents and partially explain why they have lower alcohol abuse compared to White adolescents.

Tomas Hemmingsson, David Kriebel, Per Tynelius, Finn Rasmussen and Ingvar Lundberg (2007) revealed in their study that men who
would subsequently be successful at smoking cessation reported better mental health and a lower prevalence of childhood mental health indicators at age 18 than persistent heavy smokers.

Martin P. Bakker, Johan Ormel, Frank C. Verhulst and Albertine J. Oldehinkel (2009) in which they concluded that different mental health problems are associated with male and female which are gender specific.

Cottle, Jeremy (2005) found that psychological abuse is negatively associated with mental health. Such abuse can damage mental health.


Emslie C, Hunt K, Macintyre S.(2004) compared men and women's perceptions of the extent to which paid work interferes with family life, and examines associations between work-home conflict and mental health in their research. Data were collected from 2,176 full-time white-collar employees of a British bank. They did not find any significant gender differences in perceptions of work-home conflict. However, predictors of work-home conflict did vary by gender; having children and being in a senior position were more strongly related to work-home conflict for women than for men, while working unsociable
hours was more important for men than for women. Work-home conflict was strongly associated with reporting fair or poor self-assessed health, a high number of reported physical symptoms and minor psychological morbidity (GHQ-12). These associations were equally strong for men and women.

Margaret Denton, Steven Prus and Vivienne Walters (2003) examine the extent to which these inequalities reflect the different social experiences and conditions of men’s and women’s lives. They address four specific questions. Are there gender differences in mental and physical health? What is the relative importance of the structural, behavioural and psychosocial determinants of health? Are the gender differences in health attributable to the differing structural (socio-economic, age, social support, family arrangement) context in which women and men live, and to their differential exposure to lifestyle (smoking, drinking, exercise, diet) and psychosocial (critical life events, stress, psychological resources) factors? Are gender differences in health also attributable to gender differences in vulnerability to these structural, behavioural and psychosocial determinants of health? Multivariate analyses of Canadian National Population Health Survey data show gender differences in health (measured by self-rated health, functional health, chronic illness and distress). Social structural and psychosocial determinants of health are generally more important for women and behavioural determinants are generally more important for men. Gender differences in exposure to these
forces contribute to inequalities in health between men and women; however, statistically significant inequalities remain after controlling for exposure. Gender-based health inequalities are further explained by differential vulnerabilities to social forces between men and women.

Jennifer Warner and Brunilda Nazario, M (2003) also revealed that working under difficult job conditions can take its toll on workers’ mental and physical health. Jennifer Warner studied the impact of the fear of job loss on health and the findings suggest that job insecurity can have potent health effects, both alone and in combination with other types of job stress. "The results raise concerns about the adverse health effects in people who might be experiencing both high job strain and high job insecurity," in this regard Rennie M. D’Souza of the National Centre for Epidemiology and Population Health at The Australian National University, and colleagues write. "As the labor market becomes more globalized and competitive, employees are more likely to encounter these two work conditions simultaneously." When Jennifer Warner and Brunilda Nazario looked at how these types of job stress (job loss and insecurity) related to workers' mental and physical health, they found job strain and insecure employment had a major impact. They found passive and high-strain jobs were linked to depression, anxiety, and lower self-reported health. Even after adjusting for other factors such as gender, marital status, education, employment status, and major life events, the negative association between job strain and mental health remained significant. Overall
they revealed that Job insecurity was strongly associated with all four mental and physical health measures, regardless of the other risk factors. The effect was most pronounced on depression and self-reported health. For example, workers with high job insecurity were four times as likely to suffer from depression.

Carol Emslie, Rebecca Fuhrer, Kate Hunt, Sally Macintyre, Martin Shipley and Stephen Stansfeld (2002) examined the distribution of minor psychiatric morbidity (measured by the 12 item General Health Questionnaire) amongst men and women working in similar jobs within three white-collar organisations in Britain, after controlling for domestic and socioeconomic circumstances. Data from self-completion questionnaires were collected in a Bank (n=2176), a University (n=1641) and the Civil Service (n=6171). In all three organisations women had higher levels of minor psychiatric morbidity than men, but the differences were not great; in only the Civil Service sample did this reach statistical significance.

Nicolas, Mario George (2002) micro worries and self-report measures of positive and negative affect general mental health status and life satisfaction.

Peter. H. Van, Ness and David B. Larson (2002) found that religious persons reported generally higher levels of well-being. The review also found fairly consistent inverse associations of religiousness with rates
of depression and suicide. Religion’s effects on mental health are generally protective in direction but modest in strength.

Karen Ammann Talerico, Lois K. Evans and Neville E. Strumpf (2001) studied that impaired communication is associated with all forms of aggression, depression with physical aggression and disorientation with verbal aggression.

Ruta K. Valaitis (2000) found that most youth perceived that using computers and the internet reduced their anxiety concerning communication with adults, increased their control when dealing with adults, raised their perception of their social status, increased participation within the community, supported reflective thought, increased efficiency and improved their access to resources.

Hilton Davis, Crispin Day and others (2000) have done study on Child and Adolescent Mental Health in which a random sample of 253 parents and young people were interviewed to elicit: (i) the number, type and severity of psychosocial problems in children/young people; and (ii) the number and type of risk factors for mental health in a very deprived inner city locality. The results suggested that high levels of need for mental health services, with, for example, 37% of children having three or more problems, and over 51% having three or more risk factors. From subjective case-by-case analysis, preliminary criteria were derived for judging the level of required service response and the numbers likely to present appropriate to the various tiers of
service. Of the 25% of the sample expressing a need for help, 6% were judged to be manageable by community staff (e.g. health visitors) with support from child mental health specialists, 4% by specially trained community staff (e.g. parent advisers), 8% by solo child and adolescent mental health specialists and 7% by generic or specialist child mental health teams.

Pamela K. Schraedley, Ian H. Gotlib and Chris Hayward (1999) also study to determine: (a) what demographic and psychosocial factors are associated with elevated levels of depressive symptoms in adolescence; (b) whether male and female show different profiles of correlates and probable risk factors for depressive symptoms. Results revealed that depressive symptoms were differing by gender, age, socioeconomic status, and ethnicity. In addition, life stress, social support, and coping were associated with depressive symptoms. Importantly, stress and social support appear to be particularly salient aspects of depression among females. Finally, high levels of depressive symptoms were associated with increased use of both mental and physical health care resources among male and females. They further concluded that the correlates of depression in this sample closely resemble those seen in other samples, including demographic and psychosocial variables. Some psychosocial variables, such as stress and social support, may have a greater impact on depressive symptoms for female than for males.
Much research has shown that Blacks have similar or better mental health compared to Whites once. Although it has been speculated that Blacks have similar mental health due to their additional coping resources offsetting disadvantages due to race, no research has documented these offsetting effects. (Williams and Harris-Reid 1999; Williams et al. 1997; Kessler et al. 1994; Robins and Regier 1991)

Anoopsingh et al. (1991) rightly indicates that healthy climate in the workplace is strongly associated with greater feeling of well-being or less stressed whereas any undermining from their part put the employee under stressed, irritability, anxiety, depression, and somatic disorders.” Inadequate climate contribute considerable stress for employees in non-nationalized bank.

The previous research regarding gender difference on mental health like National Longitudinal Study of Adolescent Health (1999) in which the gender disparity in mental health explain by examining how experiences within four domains – physical development, school, psychological resources, and interpersonal relationships – impact adolescents’ perceived self worth and depressive symptoms. Findings suggest that experiences in all of these realms have consequences for adolescents’ psychological well being, and differences in these experiences help to explain some of the gender difference in mental health.
In reference of gender difference on mental health Weisman and Klerman (1977) argue, women are more likely than men to be depressed.

Tarvis (1992) and Gilligan (1982) argue that it is not certain whether this is because women really are more depressed or because of a gender bias in the way depression is measured. It may well be that depression measures are only sensitive to the way in which women express depression.

Australian Institute of Family Studies (2002) explain three important things about gender and the risk of mental disorders. First, there seem to be “female disorders” and “male disorders”. Women are more prone than men to mood and anxiety disorders while men are more prone to alcohol and drug disorders. Second, for each disorder the gender difference is statistically significant. Women are almost twice as likely as men to suffer mood and anxiety disorders while men are roughly twice as likely as women to suffer substance use disorders. Third, men and women are equally at risk of having a disorder. Although men and women have different types of disorders they are just as likely as each other to have at least one disorder – 16.6 per cent of men and 16 per cent of women had all the symptoms of at least one classified disorder.
2.2 Life Satisfaction

Yonas Alem and Peter Martinsson (2010) studied the determinants of life satisfaction in urban Ethiopia. People in general report a lower level of satisfaction and many of the determinants of life satisfaction in urban Ethiopia were found to be similar to those found important in studies in other countries. Results from estimated happiness functions using an ordered probit model show that marital status, health, governance, relative position and social networks all affect happiness. In addition to standard economic variables such as income and wealth, inflation affects happiness strongly and negatively. Results also show that clean environment has a positive and significant effect on happiness in urban Ethiopia.

Michael O. Samuel1, Helen O. Osinowo2 and Crispen Chipunza (2009). They assessed the impact of financial distress in the Nigerian banking industry as it affected job satisfaction, perceived stress and psychological well-being of employees and depositors. The research adopted case study as a strategy and employed independent groups design in order to get a balanced assessment of the subject. Variables of interest were not manipulated in order to allow for accuracy of judgment and results. Self administered questionnaire - perceived stress scale by Blaus (1965); psychological well-being scale by Goldberg (1978); job satisfaction scale by Ugwuegbu (1985) and a self-developed questionnaire by the researchers to solicit information from bank employees and depositors - was administered to 105
respondents comprising of 61 bank employees and 44 bank customers. The questionnaire had a Cronbach alpha coefficient of 0.88 thus confirming the reliability of the data collecting instrument. A total of 5 hypotheses were formulated and tested. The results showed that employees in healthy banks were more satisfied with their jobs than those in distressed banks; but the difference between their mean scores did not reach a significant level thus suggesting that employees in distressed banks equally enjoyed their jobs like their colleagues in healthy banks. Curiously, depositors in healthy banks experienced higher level of stress than depositors in distressed banks; while employees in healthy banks experienced higher job satisfaction than those in distressed banks. Finally, the results also showed that employees in distressed banks did not experience higher stress level than those in healthy banks.

Jiunn-Woei Lian, Dalin Chia-Yi, Tzu-Ming Lin (2007) studied the relationships among three variables that have potential impact on the well-being of individual employees: (a) job stress, (b) job satisfaction, and (3) life satisfaction. Then, we compared these three variables perceived by managerial and technical IS staff respectively. Using samples of IS personnel in Taiwan, we found that managerial IS employees tend to have significantly higher degrees of job and life satisfaction than there is technical counterparts. On the other hand, technical employees tend to have higher degrees of job stress than managerial employees. We also found that job stress has negative
effects on life satisfaction whereas job satisfaction has positive effects on life satisfaction. Furthermore, job stress has negative effects on job satisfaction of IS employees.

Uma Sekaran (2006) Using a sample of 267 bank employees and results revealed that personal, job, and organizational climate factors influenced the ego investment or job involvement of people in their jobs, which in turn influenced the intrapsychic reward of sense of competence that they experienced, which then directly influenced employees' life satisfaction.

Kari Kjeldstadli, Reidar Tyssen, Arnstein Finset, Erlend Hem, Tore Gude, Nina T Gronvold, Oivind Ekeberg and Per Vaglum (2006) examined the relationship between life satisfaction among medical students and a basic model of personality, stress and coping. Previous studies have shown relatively high levels of distress, such as symptoms of depression and suicidal thoughts in medical undergraduates. However despite the increased focus on positive psychological health and well-being during the past decades, only a few studies have focused on life satisfaction. This longitudinal, nationwide questionnaire study examined the course of life satisfaction during medical school, compared the level of satisfaction of medical students with that of other university students, and identified resilience factors. T-tests were used to compare means of life satisfaction between and within the population groups. K-means cluster analyses were applied to identify subgroups among the
medical students. Analysis of Variance (ANOVA) and logistic regression analyses were used to compare the subgroups. Results revealed that life satisfaction decreased during medical school. Medical students were as satisfied as other students in the first year of study, but reported less satisfaction in their graduation year. Medical students who sustained high levels of life satisfaction perceived medical school as interfering less with their social and personal life, and were less likely to use emotion focused coping, such as wishful thinking, than their peers.

Heli Koivumaa-Honkanen, Risto Honkanen, Heimo Viinamäki, Kauko Heikkilä, Jaakko Kaprio and Markku Koskenvuo (2001) investigated whether self-reported life satisfaction predicted suicide over a period of 20 years (1976–1995) in adults unselected for mental health status. A nationwide sample of adults aged 18–64 years (N=29,173) from the Finnish Twin Cohort responded to a health questionnaire that included a life satisfaction scale (score range=4–20, with higher scores indicating greater dissatisfaction) that covered four items: interest in life, happiness, general ease of living, and feeling of loneliness. "Dissatisfied" subjects (life satisfaction score=12–20) were compared to "satisfied" subjects (score=4–6). Mortality data were derived from the national registry and analyzed with Cox regression. Result revealed that Dissatisfaction at baseline (life satisfaction score=12–20) was associated with a higher risk of suicide throughout the 20-year follow-up period (age-adjusted hazard ratio=3.02, 95% confidence interval
[CI] = 1.83–4.98). The association was somewhat stronger in the first decade (hazard ratio = 4.46, 95% CI = 1.95–10.20) than in the second (hazard ratio = 2.34, 95% CI = 1.24–4.45). A dose-response relationship was also found. Men with the highest degrees of dissatisfaction (life satisfaction score = 19–20) were 24.85 times as prone to commit suicide as satisfied men during the first 10 years of the follow-up period. Throughout the entire follow-up, life dissatisfaction still predicted suicide after adjusting for age, sex, baseline health status, alcohol consumption, smoking status, and physical activity (hazard ratio = 1.74, 95% CI = 1.02–2.97). Subjects who reported dissatisfaction at baseline and again 6 years later showed a high suicide risk (hazard ratio = 6.84, 95% CI = 1.99–23.50) compared to those who repeatedly reported satisfaction. Life dissatisfaction has a long-term effect on the risk of suicide, and this seems to be partly mediated through poor health behavior. Life satisfaction seems to be a composite health indicator.

Thomas Li-Ping Tang, Jwa K. Kim, Theresa Li-Na Tang, (2002) investigated the money ethic scale among full-time employees, part-time employed students, and non-employed university students. Confirmatory factor analyses results showed that there was a good fit between the three-factor model and research data for full-time employees and non-employed students and a weaker fit for part-time employees and the whole sample. Further, factors success and evil were predictors of income for full-time employees. Money attitudes
were not related to pay satisfaction. Factor budget was associated with life satisfaction for full-time employees and non-employed students. Full-time employees in this sample tended to be older, male, and have higher education than part-time employees and students. Non-employed students tended to have higher life satisfaction, lower protestant work ethic, less type A behavior pattern, and think more strongly that money does not represent their success, that they budget money carefully, and that money is not evil than part-time employees.

Benjamin Palmer, Catherine Donaldson and Con Stough 2002. examined the relationship between emotional intelligence and life satisfaction. To determine the nature of this relationship, personality constructs known to predict life satisfaction were also assessed (positive and negative affect). Emotional intelligence was assessed in 107 participants using a modified version of the Trait Meta-Mood Scale [TMMS; Salovey, P, Mayer, J., Goldman, S., Turvey, C. & Palfai, T.1995. Emotional attention, clarity and repair: exploring emotional intelligence using the Trait Meta-Mood Scale. In J. W. Pennebaker (Ed), pp. 125–154. Washington, DC: American Psychological Association] and the Twenty-Item Toronto Alexithymia Scale [TAS-20; J. Psychosom Res, 38 (1994) 26]. Life satisfaction was assessed using the Satisfaction With Life Scale [SWLS; J. Pers. Social Psycol., 69 (1985) 71]. Only the Clarity sub-scale of the TMMS (which indexes perceived ability to understand and discriminate between moods and
emotions), and the Difficulty Identifying Feelings sub-scale of the TAS-20 were found to significantly correlate with life satisfaction. Subsequent analyses revealed that only the Clarity sub-scale accounted for further variance in life satisfaction not accounted for by positive and negative affect. This finding provides further evidence that components of the EI construct account for variance in this important human value not accounted for by personality. Implications and directions for further research are discussed.

H. Koivumaa-Honkanen, R. Honkanen, H. Viinamäki, K. Heikkilä, J. Kaprio and M. Koskenvuo (2000) investigated the role of self-reported life satisfaction in mortality with a prospective cohort study (1976–1995). A nationwide sample of healthy adults (18–64 years, n = 22,461) from the Finnish Twin Cohort responded to a questionnaire about life satisfaction and known predictors of mortality in 1975. A summary score for life satisfaction (LS), defined as interest in life, happiness, loneliness, and general ease of living (scale range, 4–20), was determined and used as a three-category variable: the satisfied (LS, 4–6) (21%), the intermediate group (LS, 7–11) (65%), and the dissatisfied (LS, 12–20) (14%). Mortality data were analyzed with Cox regression. Dissatisfaction was linearly associated with increased mortality. The age-adjusted hazard ratios of all-cause, disease, or injury mortality among dissatisfied versus satisfied men were 2.11 (95% confidence interval (CI): 1.68, 2.64), 1.83 (95% CI: 1.40, 2.39), and 3.01 (95% CI: 1.94, 4.69), respectively. Adjusting for marital
status, social class, smoking, alcohol use, and physical activity diminished these risks to 1.49 (95% CI: 1.16, 1.92), 1.35 (95% CI: 1.01, 1.82), and 1.93 (95% CI: 1.19, 3.12), respectively. Dissatisfaction was associated with increased disease mortality, particularly in men with heavy alcohol use (hazard ratio = 3.76, 95% CI: 1.61, 8.80). Women did not show similar associations between life satisfaction and mortality. Life dissatisfaction may predict mortality and serve as a general health risk indicator.

Axel R. Fugl-Meyer; Roland Melin; Kerstin S. Fugl-Meyer (2002) investigated Satisfaction with life as a whole and with 10 domains of life was assessed in a nationally representative Swedish sample of 1207 women and 1326 men aged between 18 and 64 years, using a generic self-report checklist (LiSat-11), with levels of satisfaction ranging along a six-grade ordinal scale from 1 (very dissatisfied) to 6 (very satisfied). The main findings are that, with marginal exceptions, life satisfaction is gender independent, while age is systematically and positively associated with vocational and financial situations. Having no partner and being a first-generation immigrant implies for most LiSat-11 items a relatively low level of satisfaction. Factor analysis of the domain-specific items yields a gender-independent four-factor structure, which is robustly independent of different scaling reductions. Gross levels of satisfaction (dichotomized scales 1-4 vs 5-6) of seven domains were significant classifiers (odds ratio 1.7-3.9) of gross level of satisfaction with life as a whole. This investigation
provides reference values for LiSat-11, which, with its ease of administration may be an adequate instrument for analysing, in terms of subjects' cognitive appraisal of emotions, aspirations-achievement gaps.

Lawrence S. Linn, Joel Yager, Dennis Cope and Barbara Leake (1985) compared academic and clinical faculty affiliated with a major teaching hospital in terms of work characteristics, job stress, conflict between work and personal life, job and life satisfaction, and perceived health. There were no significant differences between the two physician groups on job satisfaction, total stress, anxiety, or depression scores. However, academic faculty reported working longer hours, taking less vacation time, and spending more time in research and teaching, but seeing fewer outpatients. Academic physicians experienced more conflict between work and personal life, were burdened by a variety of time pressures, and were less satisfied with their finances, but experienced fewer recent episodes of physical illness than clinical faculty. However, compared with what is known about the general population, both physician samples seemed equally or more satisfied with their health and their lives.

Sex differences in life satisfaction are a recurrent research issue in the field of social gerontology. However, the evidence concerning the effect of sex on morale is still inconclusive. This may be due to (a) the neglect of other relevant variables, (b) the failure to distinguish between main effects and interaction effects, and (c) the lack of formal
statistical tests in making comparisons. In this study, a causal model of life satisfaction is proposed and evaluated by using four data sets with sample sizes ranging from 961 to 3,996. The proposed structural model fitted both the male and female subsamples reasonably well. The findings were also replicated across these four data sets. No systematic sex difference was found in terms of structural parameters. This indicates that the same causal mechanism is operating among the males as well as the females. Jersey Liang, (1982)

Life satisfaction is one of the indicators of Life satisfaction (component of subjective well-being (Horley J; ;1984). It has been conceptualized as an assessment of life as a whole on the basis of the fit between personal goals and achievements (Andrews FM, Withey SB and others;1976). It has also been viewed as a dimension of mental health ( Headley B-W, Kelley J, Wearing AJ;1996). Indeed, many of its correlates—such as depressive symptoms, self-esteem, anxiety, and psychosomatic symptoms Koivumaa-Honkanen HT ;1996)—are aspects of mental health, but life satisfaction is also associated with diagnosed mental disease and health risk factors, including poor health behavior and poor social support (Koivumaa-Honkanen H;1998). Thus, life satisfaction is a broad and nonspecific subjective perception comparable to self-rated health—another of its correlates. Both have proven to be predictors of mortality Idler EL, Benyamini Y;1997), but level of life satisfaction is a particularly effective predictor of psychiatric morbidity (Koivumaa-Honkanen H-T;1998)). It is not

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surprising that life dissatisfaction is much more common in psychiatric patients than in the general population Koivumaa-Honkanen;2000) regardless of the level of psychopathology Koivumaa-Honkanen HT;1999).

### 2.3 Occupational stress

Occupational stress, in particular, is the inability to cope with the pressures in a job, because of poor fit between someone’s abilities and his/her research requirements and condition which affects an individual’s productivity, effectiveness, personal health and quality of work (Akinleye and Hassan, 2004). Workplace stress can have a wide-ranging and negative impact on the well being and mental health of the individual and his or her day-to-day functioning. This is observable at physical level (e.g., exhaustion, headaches, high blood pressure), at psychological level (e.g., depression, anxiety, low self-esteem), at cognitive level e.g. (absent model for females and males E.M.Hassan(2009)

Martin P. Bakker, Johan Ormel, Frank C. Verhulst and Albertine J. Oldehinkel (2009) in which they tested and concluded that stress is unlikely to be associated with employees gender. Instead, male and female are more likely to be susceptible to different types of peer stressors.

Eunice Modupe Hassan (2009) who have investigated the determinants of occupational stress using gender, self-concept and
occupational status as factors. Survey research design was adopted. Sample comprised 100 Bank workers randomly selected from Lagos state, Nigeria. Job Situation Questionnaire (JSQ) was used. Three hypotheses were tested while the student t-test was used for data analysis. Results tested at 0.05 level of significance indicated no significant difference in occupational stress of male and female bank workers and in the research of workers of different occupational status. However, significant difference exists between workers with high self-concept and those with low self-concept. Conclusively, stress effects are greatest among service staff at the bottom of the hierarchy, with least participation in decision.

Dileep Kumar. M (2006) in which he has studied the significant difference in the level of occupational stress between Nationalised and Non-Nationalised bank employees. as it observed significant difference between the two sectors, in the level of organisational stress. The findings clearly indicate that stress is higher among non-nationalised bank employees compared to nationalise bank employees.

D. G. Byrne; 2003 proposed in his paper that the frustration of competitiveness by structural aspects of the occupational environment contributes to the generation of occupational stress.

A large sample of managers selected from the private and public sectors completed the pressure management indicator (PMI). The PMI is a 120-item self-report questionnaire developed from the
occupational stress indicator (OSI). The PMI provides a global measure as well as differentiated profiles of occupational stress. Outcome measures include work satisfaction, organisational security, organisational satisfaction, and commitment, as well as physical wellbeing (physical symptoms and exhaustion) and psychological health (anxiety depression, worry and resilience). In addition moderator variables are assessed including type A behaviour, internal locus of control and coping strategies. The data from the PMI show that, when compared with British managers, the German managers reported greater job satisfaction and lower levels of resilience. The German managers displayed substantially higher pressure from the home-work interface but less pressure from the need to have their achievements recognised. German managers reported higher levels of impatience (a sub-scale of type A behaviour), coupled with high internal control (extent to which individual feels able to influence and control events) and made more use of coping strategies, especially problem focused measures. (B.D. Kirkcaldy, R.M. Trimpop, S. Williams, 2002).

Pamela K. Schraedley, Ian H. Gotlib and Chris Hayward (1999) also revealed that depressive symptoms were differing by gender, age, socioeconomic status, and ethnicity. In addition, life stress, social support, and coping were associated with depressive symptoms. Importantly, stress and social support appear to be particularly salient aspects of depression among female.
Bury, Peter and Myrna (1992) studied the role of occupational counselling in Czechoslovak enterprises and concludes that counselling organizations resolves the conflicting situations and provide for the different modes of coping with stress.

Smith (1991) in his book "A guide to stress management" gave many methods to cope with stress. One of the methods described is the meditation exercises & relaxation technique. Which gives the strategies for stress management coping and emphasizes upon the cognitive behavioral relaxation theory through concentrating on the behavior change to manage stress.

Duckworth and Douglas (1991) is their article studied the role of professional counsellor in facilitating recovery from disaster work experiences and concluded that counsellor supports the staff at the time and after the disaster and helps them to cope with crisis solutions and come out of it easily.

Beehr and Newman (1978) define occupational stress as "A condition arising from the interaction of people and their jobs and characterised by changes within people that force them to deviate from their normal functioning."

Cobb (1975) has the opinion that, "The responsibility load creates severe stress among workers and managers." If the individual manager cannot cope with the increased responsibilities it may lead to several physical and psychological disorders among them. Brook
(1973) reported that qualitative changes in the job create adjustment problem among employees. The interpersonal relationships within the department and between the departments create qualitative difficulties within the organisation to a great extent.

Miles and Perreault (1976) identify four different types of role conflict: 1. Intra-sender role conflict 2. Inter sender role conflict. 3. Person-role conflict; 4. Role over load. The use of role concepts suggests that job related stress is associated with individual, interpersonal, and structural variables (Katz and Kahn, 1978; Whetten, 1978). The presence of supportive peer groups and supportive relationships with super visors are negatively correlated with R.C. (Caplan et al., 1964).

There is evidence that role incumbents with high levels of role ambiguity also respond to their situation with anxiety, depression, physical symptoms, a sense of futility or lower self esteem, lower levels of job involvement and organisational commitment, and perceptions of lower performance on the part of the organisation, of supervisors, and of themselves (Brief and Aldag, 1976; Greene, 1972).

Ivancevich and Matteson (1950) indicate, "Lack of group cohesiveness may explain various physiological and behavioural outcomes in an employ desiring such sticks together." Workplace interpersonal conflicts and negative interpersonal relations are prevalent sources of stress (Dewe, 1993; Lang, 1984; Long et al., 1992), and are existed
with negative mood depression, and symptoms of ill health (Israel et al., 1989; Karasek, Gardell and Lindell, 1987; Snap, 1992).

Lack of participation in the decision making process, lack of effective consultation and communication, unjustified restrictions on behaviour, office politics and no sense of belonging are identified as potential sources of stressors. Lack of participation in work activity is associated with negative psychological mood and behavioural responses, including escapist drinking and heavy smoking (Caplan et al., 1975).

According to French and Caplan (1975), “Pressure of both qualitative and quantitative overload can result in the need to work excessive hours, which is an additional source of stress.” Having to work under time pressure in order to meet deadlines is an independent source of stress. Studies show that stress levels increase as difficult deadlines draw near.

Stress is often developed when an individual is assigned a major responsibility without proper authority and delegation of power. Interpersonal factors such as group cohesiveness, functional dependence, communication frequency, relative authority and organisational distance between the role sender and the focal persons are important topics in organisational behavior (Vansell, Brief, and Schuler).
Stress develops when an individual feels he is not competent to undertake the role assigned to him effectively. The individual feels that he lacks knowledge, skill and training on performing the role (stress, conflict management and counselling, p.283).

Occupational stress is an increasingly important occupational health problem and a significant cause of economic loss. Occupational stress may produce both overt psychological and physiologic disabilities. However it may also cause subtle manifestation of morbidity that can affect personal well-being and productivity (Quick, Murphy, Hurrel and Orman, 1992). A job stressed individual is likely to have greater job dissatisfaction, increased absenteeism, increased frequency of drinking and smoking, increase in negative psychological symptoms and reduced aspirations and self esteem (Jick and Payne, 1980). The use of role concepts suggests that occupational stress is associated with individual, interpersonal and structural variables (Kutz and Kahn, 1978; Whetten, 1978).

Studies on burnout found that, it is related to exhaustion and work over load factors in various organisations (Green and Walkey, 1988; Chermiss, 1980; Freudenberger, 1977, 1980). Stress on the job is costly for employers, reflected in lower productivity, reduced motivation and job skills, and increased and accidents.
2.4 Stress management

Gold, Dave and Alistair (2003) studied the value of meditation in business workingwomen. Meditation techniques are applied to the small business enterprises. Concerning the view of their involvement in the meditation programme, the results reveals that meditation is of real importance is monitoring the stress and it reduces the stress level also and helps the workingwomen to work efficiently in their business.

John Richard (1998) who studied the effect of meditation on psychological, physiological and organizational variables at the worksite. This study evaluated the effectiveness of a stress reduction intervention offered to employees at one worksite where 80 were employed. 41 volunteers (aged 21-65) participated in meditation and rest did not attend any of the stress reduction programme. An hypothesis that the group that participated in the stress reduction programme will have better mental and physiological health was proved as compared to those who did not participated in the stress reduction programme.

Smith (1991) in his book "A guide to stress management" gave many methods to cope with stress. One of the methods described is the meditation exercises & relaxation technique. Which gives the strategies for stress management coping and emphasizes upon the
cognitive behavioral relaxation theory through concentrating on the behavior change to manage stress.

Cooper et. al. (1991) concluded by their study on the stress counselling in the post office that the impact of stress counselling on sickens, absence and psychosocial measures of job stress for 78 subjects indicated that counselled employees showed significant improvement in anxiety, stress and depression.

Charles, Gerald, Maxwell et-al (1994) presented an article on the effects of the mediation program on stress reduction and health improvement. Measuring the stress and anxiety level before and after the meditation session saw the effect of meditation. It was seen that there was a great reduction in anxiety and stress level after the meditation program was carried out.

Delone and Susan (1987) concluded by their study that meditation has a psychological effect on the stress management. It is the self control strategy for stress management.