INTRODUCTION

Healthcare is one of the most inherently stressful sectors in India and worldwide, where the professionals are demanded to communicate empathetically, competently, and ethically to maintain a professional demeanor and foster a healthy work environment. In the process of caring for the terminally ill patients and dealing with their emotional sufferings, the healthcare professionals are fatigued and consequently deplete their emotional resources, which subsequently results in stress and burnout. In this competitive era, occupational stress has become an unavoidable consequence globally, that affects almost everyone at times and to variable extents. In recent years, the human service industry, especially healthcare sector, is growing rapidly and hence is the competition, resulting into increased demands on the individuals employed. To fulfill those increased demands, pressure, and deadlines, individuals spend their maximum time at job, making workplace as their second home.

Accumulating research evidences reveals that the workplace tends to be a significantly important source of occupational stress owing to the reason that employees spend long working hours at work (Erkutlu & Chafra, 2006). Prolonged exposure to occupational stress can have negative consequences on the physical and psychological health of the employees, which in turn deteriorate their working capacity. In positive terms, work stress can be a source of motivation, excitement, and achievement, whereas in negative terms it can seriously hamper the quality of work life resulting in reduced personal and job effectiveness (Kumar & Pragadeeswaran, 2011). When the occupational stress goes intolerable there is a strong probability that the employees may even develop burnout.

Moreover, with the adoption of unhealthy lifestyle, today nations are facing increased health issues making healthcare as one of the prime sectors
of each and every country. Consequently, healthcare sector is growing multifold and new hospitals are coming up with better facilities, opportunities, and services for patients as well as healthcare professionals. Resultantly, the employees too have an option that they can move from one hospital to another for better pay scale and growth. This process swipes away the creamy layer of experienced doctors, nursing, and support staff from one hospital to the other leading to staff shortage issues. Consequently, staff shortage and work overload becomes a major reason for increase in the levels of occupational stress in the healthcare industry. A persistent exposure to high occupational stress calls for a significant risk of burnout as well. Research suggests that workers in human service organizations such as nurses, police officers, social workers, and teachers are more vulnerable to high degrees of burnout (Coffey & Coleman, 2001) and also that stress is a serious problem in health sector (Ornelas & Kleiner, 2003).

It has been a point of common observation that organizational factors like regular audits, competition with other hospitals, staff shortage, workload, attracting the foreign clientele as well patient related factors like critical patients, handling the families of the patients, code blue (term used for emergency in case of cardiac arrest), death and dying results in immense stress and pressure among the individuals employed in the healthcare industry. It has been observed that lack of recognition and positive feedback at workplace (Maslach, 1982), as well as unchallenging and unrewarding work leads to burnout. This situation is often aggravated through aspects such as inadequate salaries, staff shortages, interpersonal conflicts, and intolerable working environments (Weisberg, 1994). More than that, the healthcare professionals deal with the physical and emotional needs of the patients the whole day continuously with almost no rest intervals. Adding to the stress of healthcare professionals are the patients who are not only concerned about their diagnosis and treatment but demand a quality service with individual attention.
It is believed that healthcare professionals encounter the pain of others so intimately that they ignore their own well-being. They are primarily devoted to the needs of their patients. A doctor may get a call to attend the emergency patient in the middle of lunch or dinner and even in the midnight. A nursing staff may be asked to constantly observe the ICU patient with no rest intervals and sometimes skip the meals too. A front office employee attends the queries of all visitors with a ‘ready to help’ face, ignoring his or her own state of mind. Housekeeping staff is expected to clean the ward of patients even if they get needle prick injury while serving in the hospital. All this may have disastrous consequences in terms of the efficiency of staff and organization as a whole. It has been observed that exposure to tremendous occupational stress over long periods of time, without the necessary and relevant coping mechanisms, might lead to higher incidences of burnout (Duquette, Kerouac et al., 1995; Lauzon, 1991).

Irony of a healthcare professionals’ life is that instead of being there in the hospital, they cannot attend to their own health issues and well being because they are taking care of needs and requirement of their patients. Although various stress management programs have been introduced in healthcare setup, but these programs are either limited to the higher professionals or they focus on the stress management once it occurs instead of knowing the reasons and the root cause of stress at work. Research indicates that the effectiveness of wellness programs have been questioned considering their target being the individual workers and their unique ways of coping in stressful situations, instead of the causes responsible for occupational stress that are inherent to the work environment or the type of work individuals do (Plattner & Mberengwa, 2010).

Moreover, literature suggests that individuals high on emotional intelligence adopt better coping strategies. Emotional intelligence has been recognized as important for success in the workplace (Goleman, 1998; Rozell, Pettijohn, & Parker, 2002), and it is essential for a productive
workplace (Smigla & Pastoria, 2000). Slaski and Cartwright (2003) argued that emotional intelligence could serve as a moderator in the stress burnout process. Nurses with higher emotional intelligence scores reported lower levels of burnout and somatic complaints in response to their stressful occupation than nurses with lower scores on emotional intelligence (Mikolajczak, Menil, & Luminet, 2007). While dealing with the emotional needs of the patients, high emotional intelligence of the staff and professionals is not only important but it is an essential requirement of the healthcare industry.

Emotional intelligence has a major role to play not only while attending the patients but it helps opening a better channel to communicate with seniors, co-workers, and juniors. Abraham (2005) argued that individuals who are high on emotional intelligence have more harmonious relationships at the workplace. Cherniss (2001) contends that emotional intelligence contributes to organizational effectiveness though increased commitment, improved morale, and better health of individuals. An emotionally intelligent individual can effectively handle the time imbalance between job and family and can efficiently deal with the modern day pressures.

In healthcare sector, studies have been conducted on physicians and nursing, but the support staff like dieticians, pharmacists, front office staff, security staff, and housekeeping employees who are in direct contact with the patients have been ignored in the research. The support staff is equally involved in the care of patients and hold equal responsibility towards the healthcare, thereby there is high probability of occupational stress and burnout. Lots of research work has been done on occupational stress among various professions like doctors, police officers, nurses, teachers, and teachers (Plattner & Mberengwa, 2010), however, there is lack of research on the occupational stress of lower level employees.
OCCUPATIONAL STRESS

Stress in general and occupational stress in particular has become a global phenomenon affecting all nations, all types of work, and occupational groups. There is no sector which has not been affected by occupational stress and has not been struggling with its deleterious consequences. Stress can evoke feelings of frustration, conflict, hurt, fear, pressure, sadness, guilt, anger, confusion, inadequacy, and confusion (Cavanagh, 1988). The word stress has been derived from a Latin word ‘strinere’, meaning to draw light. The concept of stress was first used by Hans Selye in 1936. He described stress as an unspecific response to all kinds of stimuli and demands. Later, he discriminated between eustress, distress, hyperstress, and hypostress. Hellriegel, Slocum, and Woodman (1983) described stress as the result of a reaction against an action, an event or physical and psychological pressure. Individuals are under a lot of tension, pressure, and frustration when their physical and mental needs are blocked and there is a demand to adjust to it.

The term stress is not an easy concept to define, different definitions of stress use different terms to define it, but generally it is observed that stress is a result of environmental demands placed on the individual and the resultant response to it. Occupational stress has become a buzz word today and various attempts have been made to accurately define it, but yet it is not possible for the researchers to agree on a single definition of stress because of the complex nature of the variable (Salami, Ojokuku & Ilesanmi, 2010). Four approaches have been adopted to define stress, namely, stimulus based, response based, interactive based, and transactional based.

According to the stimulus based definition, stress is a stimulus (stressors) that creates tension and finally a need to readjust (Goodell, Wolf, & Rogers, 1986). The individual differences in terms of tolerance level and expectations have not been considered by this approach, which is a major limitation. However, response based definition (Cooper, Dewe, & O'Driscoll,
2001; Stinchcomb, 2004) says that stress is the manner in which the body responds when trying to adjust to these stressful stimuli. The manner in which the body responds can be physiological, psychological or behavioral. Stimulus based approach views stress as independent variable, whereas stress is viewed as a dependent variable (i.e., a response to threatening stimuli) in response based approach.

The work of Hans Selye marked the beginning of this approach when he suggested stress as a non-specific response of the body to demand made on it while introducing stress related illness in terms of the General Adaptation Syndrome (GAS). This approach has also been criticized for not considering environmental factors in the process of stress (Cooper, Dewe, & O'Driscoll, 2001). From the interactive approach, stress is the imbalance between environmental demands and individual resources (Cherniss, 1980). According to this approach, stress occurs when demands placed on the individual exceeds the capacity of individual to deal with it. This approach is static (cause and effect), in contrast transactional model consider stress as a dynamic cognitive state. In other words, the interactional perspective focuses on the structural features of the person’s interaction with his environment and transactional perspective is concerned with the dynamics of the psychological mechanisms of cognitive appraisal and coping that underpin the stressful encounter (Lazarus, 1966). The term transaction implies that stress is neither in the environment nor in the person but in the relationship between the two (Lazarus, 1990).

Stress can be acute or chronic (Aldwin, 1994). Chronic stress results from the constant emotional pressure the individual cannot control and acute stress is individual’s response to imminent danger. Crampton, Hodge et al. (2000) asserted that chronic stress is more harmful than acute because it takes a toll on the overall well being of a person. Burnout is the extreme case of chronic stress. Short term and moderate stress facilitates an individual to meet the job demands. However, prolonged stress may have
detrimental consequences and this might adversely affect the physiological and psychological health of the individual.

Francis and Barling (2005) argued that while studying stress, it is important to distinguish the closely related terms: stressors, stress, and strain. Stressors are the external events that contribute to the experience of stress, such as workload. Stress is an individual’s internal response of an individual to stressors which is characterized by arousal and lack of pleasure. Strain is the long term effect of stress and has psychological outcomes like anxiety and depression (Kumar & Pragadeeswaran, 2011). Work stressors are those aspects of the occupational environment which result in strains, poor psychological health of the individual (Beehr, 1995).

Research suggests that the major stressors for surgical nurses are death and dying, whereas for the hematology and oncology nurses, the major stressor is workload (Tyler & Ellison, 1994); for psychiatry nurses the major stressors are violent incidents and potential suicides (Sullivan, 1993). It is not the stressors which are inherently negative, but it is the individual’s perception for the same stressor to be experienced as challenge or as hindrance (Hendel & Horn, 2008). Stress results when the individuals perceive that the environmental demands override the adjustment resources available to them (Lazarus & Folkman, 1984). Typically, strains can be classified as physical (headache, coronary heart disease, upset stomach), psychological (anxiety, depression, job dissatisfaction), and behavioral (poor performance, absenteeism, low turnover). According to De Croon, Sluiter et al. (2004), psychological job strain is aversive and potentially harmful reaction. Stress is the force that puts an individual’s psychological or physical self beyond the limits of stability.

Occupational stress which is also called as job or work stress, has become a hard fact and one of the widely recognized problems of modern day world that seems to be on an increase. Occupational stress results from
an individual’s unique perception and interpretation of his or her situation or condition, hence a subjective phenomenon. This is the reason why all the individuals differ on stress scale when placed in an occupational setting. Occupational stress is the individual’s perception of a wide gap between environmental demands of the job and individual’s own capacities to fulfill those increased demands (Topper, 2007). It is the inability to cope with the job pressures, because of a poor fit between an individual’s abilities and his or her job requirements and conditions (Holmlund-Rytkonen & Strandvik, 2005).

The employees who are able to handle the occupational stressors appropriately can have a better work environment for their own self and for the people around them, which in turn is an advantage to the organization as a whole. Antoniou, Polychroni, and Vlachakis (2006) suggested that there are specific conditions that make occupations stressful can either be exogenous like excessive workload or endogenous like the personality characteristics of employees or workers. Stress management techniques and timely intervention should be the priority to handle stress. Research suggests that the four most important sites of intervention are, at the individual level (Wilder & Plutchik, 1982), workplace (Pines & Maslach, 1980), organizational, and interpersonal level (Golembiewski & Munzenrider, 1988).

On the basis of goal and site of intervention, a wide variety of strategic interventions have been proposed by various theorists to deal with burnout, namely (i) Identification: techniques for the analysis of the incidence, prevalence, and organizations (Maslach, 1978); (ii) Prevention: attempts to prevent the burnout process before it begins (Wilder & Plutchick, 1982); (iii) Mediation: procedures for slowing, halting, or reversing the burnout process (Tubesing & Tubesing, 1982); and (iv) Remediation: techniques for individuals who are already burned out or are rapidly approaching the end stages of this process (Freudenberger, 1980).
Individuals who learn from their experiences have better coping strategies and organizations should also take interest in dealing with stress of the employees to avoid burnout. Organizational plans have the primary goal of preventing psychological disturbances among employees.

Theories of Occupational Stress: Different theories have been developed to explain occupational stress and predict the occurrence of job stress (Dollard, 2001). These models have some empirical support in the literature. There are indications that work stress has strongly been associated with the work environment rather than individual or biographical factors (Maslach & Schaufeli, 1993). Some of these theories thrust on the stressors within the work environment (like the Demand–Control or Support Model; Karasek & Theorell, 1990), some concentrate on the mismatch between organizational requirements and rewards (Effort–Reward Imbalance Model; Siegrist, 1996), some focus on the resources available to cope with demands (the Conservation of Resources Model; Hobfoll & Freedy, 1993), and others focus on appraisal and coping to explain individual differences in reactions to stress at work (Cognitive Phenomenological Theory; Lazarus & Folkman, 1984).

Person-Environment Fit Model by French, Caplan, and Harrison (1982) has its root in the work of Kurt Lewin which states that behavior is an outcome of the interaction between the individual and his environment, and the degree to which the individual fits in the situation (Jex, 1988). When there is lack of fit between the person and the environment it results in strain (French, Caplan, & Harrison, 1982). Theoretically, the Person-Environment fit model predicts that the degree of strain experienced by an individual is proportional to the extent of the misfit between the individual and their occupation (Pithers & Soden, 1999). Research on occupational stress suggests that excessive or conflicting demands widens the gap between the individual and his work environment, resulting into an increase in the lack of fit and hence contribute to issues like work overload and role
conflict. This was also investigated in various other studies (e.g., Fisher & Gitelson, 1983; Kahn & Byosiere, 1992). This model was criticized for not giving adequate consideration to the sources of stress that exist at workplace (Edwards & Cooper, 1988).

**Transactional Model of Stress** by Lazarus and Folkman (1984) proposed that person variables (beliefs, goals, values, commitments) interact with the environmental variables (demands, constraints, resources) through a cognitive process termed primary appraisal. The individual's well-being is endangered when the environment is appraised as demanding and exceeding the individual’s resources. Gardner, Rose et al. (2005) applied this model in a study on cognitive therapy and behavioral coping in the management of work related stress and it was found that cognitive therapy has proved as an effective intervention in managing stress.

**The Demand-Control Model** of Karasek (1979) is an influential model in occupational stress research (Bliese & Castro, 2000). According to this model, work content is a major source of stress. The highest level of occupational stress is expected to occur in situations where job demands are high and job control is low. This model is highly influential, but it has been criticized for being too simple by excluding factors related to strain such as social support (Baker, 1985; Schaubroek & Merritt, 1997). Consequently, in 1980s a support dimension was added to the model, resulting in the Job Demand-Control-Support model (JDCS, Johnson & Hall, 1988; Johnson & Hall, 1989). The Job Demand-Control-Support model (Karasek & Theorell, 1990) predicts that high levels of job demand, low levels of job control, and low levels of social support have negative health outcomes. The moderating effects of control on the demand-strain relationship will only be evident if support is high. This was proved in a study by Johnson and Hall (1988) who found that the interactive relationship between work control and job demands was only evident when social support from colleagues were present. Karasek’s model has been used to address the issues like work
stress, coping resources, and heavy drinking (Kjaerheim, Haldorsen et al., 1997) and moderating effect of active coping on the interaction between job demands and job control (Rijk, Blanc et al., 1998).

The Effort-Reward imbalance Model (ERI; Siegrist, 1996) predicts that high levels of extrinsic and intrinsic effort and low levels of reward will significantly lead to negative emotions and harmful stress. The Role Stress Theory of Kahn, Wolfe et al. (1964), McGrath’s Stress Cycle model (1976), Beehr Newman’s Facet model (1978), Edwards’ Cybernetic Theory (1992) are some other stress models worth mentioning. Kahn and Byosiere (1992) argued that all models follow a basic pattern, wherein a stimulus leads to a psychological response, resulting into a number of complex consequences. Occupational stress has debilitating and harmful effects for the employer and the employee both.

Implications of Occupational Stress: Stress has become a normal part of occupational or personal life of an individual. The only difference lies in the severity of the situation and the individual’s own perception to cope with that situation. Some individuals manage to attain peak success under highly stressful conditions because they take that stress positively and as a source of motivation to attain some specific goal. However, in case of others even little or moderate stress can be destructive when it is perceived in negative sense and the individuals fail to adopt appropriate coping skills. Thus, stress is generally thought to be subjective in nature, rather than objective (Lazarus & Folkman, 1984). According to Cooper, Clarke, and Rowbottom (1999), the experience of occupational stress occurs with a person’s appraisal of their ability to cope with exposure to psychological and physical conditions in the workplace.

Zero or no stress leads to lethargy, moderate amount of stress is required for the routine work but excessive or negative stress has unfavorable consequences. According to Fisher (1994) and Keiper and
Buselle (1996), eustress is the positive dimension of stress and it acts as a motivating agent for achievement and productivity. Moderate levels of stress may induce improved effort to work and stimulate creativity (Schermernhorn, Hunt, & Osborn, 2000). Distress is the negative or destructive dimension of stress and it can cause serious ailments or discomforts and leads to negative consequences for the individual as well as the organization (Keiper & Buselle, 1996). Distress could result in reduced performance, dissatisfaction, accidents, errors, illnesses, absenteeism, job losses and unethical behavior (Schermernhorn, Hunt, & Osborn, 2000). It leads to deterioration in performance and stress induced disorders like hypertension, diabetes, acidity, peptic ulcer, irritable bowel syndrome or psychosomatic diseases. Excessive stress may even lead to burnout, a condition that has been associated with significantly disastrous consequences.

Hans Selye in 1930s gave the concept of general adaptation syndrome that occurs due to the continuous exposure to stress. General adaptation syndrome includes three successive physiological stages, namely (a) the alarm reaction: which is the shock phase, degenerative in nature and prepares the individual to cope with stressors; (b) the stage of resistance: when the body resists the effects of continuous stress and at this stage certain hormones, like adrenocorticotropic, are released which helps the individuals to fight stress; and (c) the stage of exhaustion: when the serious physical damage occurs in the brain that has a potential to effect health and even leads to death in some cases. Hemorrhages, seizures, and arteriosclerosis occur during this stage.

Occupational stress has become an area of concern for many organizations including healthcare. To paraphrase the “father of stress”, Hans Selye, stress is an unavoidable consequence of life and therefore an unavoidable consequence of organizations. Occupational stress can have its roots in the policies, demands, and environment of the organization and can
affect the individual only when it is appraised as threatening. Outcomes of job stress are not confined to work only. If an individual is stressed at work, it will transfer to the family and friend circle as well and sometimes this stress leads to bitterness of relationships with family members and friends. Repetti (1987) suggested that when negative affect develops in one sphere due to stressors, subsequently it transfers to other life spheres as well. Research suggests debilitating and undesirable consequences like negative spillover effect of occupational stress into family life (Crouter & Bumpus, 2001). Work stress negatively affects marital relations (Robinson, Flowers, & Carroll 2001), and it has negative effect on families and home life (Muchinsky, 2000). Not only this, stress has been seen as an emotional reaction to a situation. Emotions play an important role when an individual deals with a situation and hence emotional intelligence has a significant role to play in stressful situations.

Lazarus (1990) asserts that emotions can have an impact on how the individual recognizes and manages the stressful situations. According to Selye (1956), emotional intelligence could be served as a framework, within which the individuals could learn how to cope with stress and control strong emotions. Also, in a study conducted by Oginska-Bulik (2005), it has been postulated that individuals with higher level of emotional intelligence will perceive their work environment as less stressful. It has been observed that the type of occupation matters when it comes to severity of occupational stress and thereby individuals in some professions face more occupational stress than others. The occupations which involve human service like healthcare are more stressed as it involves investment of not only time and hard work but emotions. Research suggests that some occupations involve emotional elements. Client-centered professions are intrinsically stressful such as police officers (Maslach & Jackson, 1979), school teachers (Schwab, 1986), psychologists (Cushway, 1992), and nursing professionals (Snelgrove, 1998).
It has been observed among healthcare professionals that the job type affected the overall stress levels experienced by individuals in these occupations. Studies show that medical and psychological staff scored significantly higher in emotional intelligence and lower in occupational stress, than other occupations that include paraprofessional and administration personnel (Nikolaou & Tsaousis, 2002). Healthcare industry is one of the most vulnerable areas not only in India but worldwide, where occupational stress is inevitable and the ways to cope are not sufficient.

**BURNOUT**

The phenomenon of burnout was first identified by Bradley (1969) and the term 'burnout' was technically first applied to humans in 1974 by the psychiatrist, Herbert Freudenberger, to characterize the status of overworked volunteers in mental health clinics. Freudenberger originally defined burnout as the progressive loss of idealism, energy, and purpose experienced by people in the helping professions as a result of the condition of their work. The burnout construct explained the process of physical and psychological deterioration in professionals working in areas such as teaching, health care, social work or emergency legal services (Freudenberger, 1974). Freudenberger viewed “burnout syndrome” as a mental disorder which is mainly a result of personal characteristics such as intra-personal conflict, ineffective coping mechanisms, and dysfunctional personality traits (Schaufeli, 2003).

With different focus, a number of definitions of burnout have been presented (Hallsten, Bellaagh, & Gustafsson, 2002; Schaufeli & Enzmann, 1998). One major area of difference is whether burnout to be viewed as a state or a process, although majority of the researchers regard burnout as a process. Another area of difference in opinion is whether burnout is an illness or a disease (Hallsten, Bellaagh, & Gustafsson, 2002). Almost at the same time, in 1980s, social psychologist Christina Maslach explored the loss
of emotional feeling among human services workers. Since that time Christina Maslach had extensively worked on the concept of burnout and became the leading figure in the field of burnout and the author of the most commonly used instrument in burnout research, Maslach Burnout Inventory. Due to the popularity of the Maslach Burnout Inventory (Maslach & Jackson, 1986) as a psychometric measure of the construct, the concept of burnout has mostly been associated with the Maslach definition of burnout (Schaufeli, 2003). According to Maslach and Jackson (1981), burnout is a blanket term that is used to describe a syndrome of emotional exhaustion and cynicism that occurs in response to the stressors and strains of professional life.

Later, this definition was updated stating that burnout is a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with people in some capacity (Maslach, Jackson, & Leiter, 1996). Emotional exhaustion is a feeling when the emotional resources seem inadequate to deal with the situation. It refers to a feeling of excessive emotional stress and being drained by contact with other people (Kowalski, Ommen et al., 2010). Depersonalization refers to the treatment of other individuals as objects rather than people. Patients are viewed negatively and cynically when depersonalization occurs. A diminished feeling of personal accomplishment refers to a tendency to evaluate one’s own behavior and performance in a negative way, resulting in a feeling of incompetence on the job and an inability to achieve performance goals (Cooper, Dewe, & O’Driscoll, 2001). Resultantly, Maslach (2003) described burnout as a prolonged response to chronic, emotional and interpersonal stressors on the job.

Another perspective on burnout describes it as a psychological response to chronic stress at work (Maslach, Schaufeli, & Leiter, 2001). But still, stress and burnout have important distinction. It has been argued that stress can be experienced by anyone but burnout can only be experienced
by the individuals who have high goals and expectations (Pines & Keinan, 2005). Pines and Keinen (2005) questioned the suitability of the recurrence with which burnout is defined within the framework of stress research. They argued that even though burnout and strain are seen as adverse responses to stressors, they seem to have different antecedents, correlates, and consequences. It has also been suggested that interventions in stress and burnout should differ.

Researchers have frequently conceptualized burnout within a stress research framework. Both the terms are familiar and understood but there is a lack of more scientific and precise definition (Pines & Keinan, 2005). Occupational or job stress is the strain due to individual and organizational stressors and if not handled properly and timely job stress leads to ineffectiveness, exhaustion, lack of personal accomplishment, and detachment which is nothing but burnout. There has been a growing research in the area of stress and burnout to predict and identify the factors responsible for both the constructs (Auerbach, Buerhaus, & Staiger, 2007; Ludwick & Silva, 2003).

Stress and burnout can cause the same symptoms, but stress is precipitated by the situational factors, whereas burnout is the outcome of prolonged stress (Maslach, 2003). There has been evidence that burnout does not always develop as a result of stress, it is the result of the perception that their lives are useless (Pines, 2000). Another concept of prolonged fatigue is confused with burnout-related fatigue. Fatigue is due to health-related causes, whereas burnout is the outcome of job-related factors. It is possible that prolonged fatigue can occur simultaneously with burnout, but the overall situation seems complicated for the individual and becomes very difficult to handle (Leone, Huibers et al., 2007). According to Schaufeli and Enzmann (1998), burnout and stress should be viewed as two separate constructs. Stress is seen as a temporary process and demands short-term adjustment and is accompanied by mental and physical symptoms (Brill,
Burnout is a kind of prolonged job stress and is accompanied by chronic malfunctioning at work (Schaufeli & Enzmann, 1998).

**Theories of Burnout:** Considering the increasing research initiatives in the area of burnout there is need to develop the theoretical framework. The models and theories of burnout can theories gives an insight into the better understanding of burnout construct.

**Maslach Burnout Model** (Maslach & Jackson, 1986) is the outcome of extensive interviews with the individuals employed in the human service sector. Literature suggests that the aim of this model was to go beyond the experience of stress (exhaustion), to include a person’s response to the job (cynicism and depersonalization), and the response in the person self (feelings of efficacy and personal accomplishment). The most dominant dimension is emotional exhaustion as it is the basic response to stress and research indicates that this dimension shows a direct and positive correlation with stress related aspects of life. The depersonalization dimension is an individual’s negative feelings felt in response to job is the key feature of burnout. It has been seen that depersonalization and exhaustion manifests as a result of interpersonal conflicts and work overload. Lack of personal accomplishment or the feeling of inefficacy is the third dimension of burnout and most likely it is the result of lack of support and resources (Maslach, 2003).

Maslach, Schaufeli, and Leiter (2001) recently attempted to provide a theoretical framework for burnout and stress research by analyzing the former in terms of six key fields, namely, work overload, lack of control, inefficient reward, breakdown of community, absence of fairness, and conflicting values (Angerer, 2003). This framework is presented as a person-job fit framework where emphasis is placed on the compatibility between the six domains of the job environment and the employee. Studies have confirmed the impact of factors like work overload, lack of support, and
other situational variables on the burnout construct (Schaufeli & Enzmann, 1998). Similar to the Maslach burnout model, Golembiewski and Muzenrider (1988) developed phase model of burnout, where it is proposed that the depersonalization which is the second component in the Maslach burnout model should be at the first phase. According to phase model, depersonalization constitutes the manifestation of burnout which further impairs performance. Consequently, individual’s sense of personal accomplishment is reduced and hence constitutes the second phase in Golembiewski model. It has further been argued that depersonalization and lack of personal accomplishment exceed an individual’s capacity to cope and hence result in emotional exhaustion. The stage of emotional exhaustion is the most powerful stage in the development of burnout (Cooper, Dewe, & O'Driscoll, 2001).

The Phase Model suggests that burnout becomes more evident when individual moves through depersonalization to reduced sense of personal accomplishment to emotional exhaustion. This model constitutes eight phases and individuals in the more advance phases will experience more severe symptoms and consequences than those in the earlier phases. Each individual is not expected to progress through all the eight phases (Golembiewski, Scherb, & Boudreau, 1993). Burke (1989) proposed that instead of eight phases three four phases model would have been more effective. Conservation of resources theory (Hobfoll, 1989) suggests that there are four main resources in the domain of individuals namely objects, conditions, personal characteristics, and forms of money. Individuals are threatened when there is potential loss of these resources or they are inadequate, resulting into stress and hence the burnout. This provides a general perspective of stress in relation to burnout and suggests that burnout develops when there is continuous loss of resources. Hobfoll’s theory is well-matched with the transactional model of stress by Lazarus and Folkman’s (Cooper, Dewe & O'Driscoll, 2001).
Process Model of burnout by Cherniss (1980) suggested that the characteristics of the individual as well as the work environment both are viewed as sources of strain. To deal with strain, individuals choose their own negative ways such as becoming detached from work environment, reducing workload or taking less responsibility. It has been argued that this model of burnout is possibly too broad and does not allow for differentiation between burnout and job strain. The burnout construct is a complex phenomenon that a single theory or viewpoint is not sufficient (Schaufeli & Buunk, 2003). An eclectic approach helps an individual to gain clarity about the construct, its causes, and consequences.

Causes of Burnout: Burnout has its root in work environment but the fact that not all the individuals experience burnout working in a single environment emphasizes the role of personal factors as well. Broadly, the causes of burnout have been attributed to the employee, the organization, and the interaction of both. In a study, Hare, Pratt, and Andrews (1988) argued that burnout can be a result of both organizational and personal factors. Cherniss (1980) suggested a process model of burnout where aspects of the work environment and the characteristics of the individual are both viewed as sources of strain. It has been observed that burnout could also develop by non-work stress factors such as maladaptive coping strategies and ineffective social support (Cox, 1993; Muldary, 1983). Research suggests that work environment coupled with demographic variables (such as younger age, lack of life partner or children, being early in career, higher level of education) and personality traits (low self-esteem, intolerance, overachieving, and perfectionism) leads to potential risk factors of burnout.

However, the individual characteristics, coping mechanisms, and levels of emotional intelligence have a moderating effect in the development of burnout. Generally, individuals are motivated when they step in the career of their own choice, but disappointment arises when their
expectations from the job are not met or the work environment is not favorable and supportive. The probability of burnout development is more the individuals step in a job against their interest due to family needs and pressure. If the situation is not timely addressed and resolved, stress accumulates and may lead to the development of burnout. Pines (1993) observed that prolonged exposure to stress leads to burnout. Healthcare professionals invest not only hard work but emotions while attending, interacting, and serving people and hence, they are more prone to occupational stress and burnout. Emotional labour leads to emotional exhaustion and lack of personal accomplishment which are the two dimensions of burnout. Empirical investigation suggests that emotional labour and burnout are positively correlated.

The individual and work environment mismatch is contributed by various factors, but the six major factors as identified by Maslach and Leiter (1997) are workload, lack of control, insufficient reward, the feeling of community, absence of fairness and conflicting values. Workload is a situation when the work is more and resources are limited and not sufficient enough to handle that work, which leads to the development of stress and burnout. Staff shortage and the resultant long working hours to complete that work overload deplete the employees physically and emotionally. Inadequate staffing increases workload in nursing industry and consequently gives rise to burnout (Brewer & Kovner, 2005).

Economy stagnation has an important role to play in the development of burnout when the employees are fired and their salaries get negatively affected. Downsizing leads to workload when the organizations fail to retain the required workforce. Consequently, there is more work and fewer employees who are forced to share the additional work and they are under constant pressure to perform and meet the unrealistic deadline. In addition to workload, reward factor such as insufficient or not enough pay, lack of acknowledgement, praise, and appreciation for the work done and low
satisfaction leads to the person-job disequilibrium. Research indicates that individuals who are being fairly rewarded and recognized for their contribution have lower levels of burnout (Brewer & Kovner, 2005; Graber, Huang, & Drum, 2008). Heavy workload, long working hours, and shift work have been observed as major factors of high attrition rate in nursing staff.

Another factor due to which an individual feels burned-out is fairness in terms of discrimination and favoritism. If there is lack of support system and the employee feels isolated or if there is conflict or disrespect at the workplace, then the chances of burnout development are more. Supportive work environment and healthy relationships at workplace have been related to decreased levels of burnout (Brewer & Kovner, 2005; Jennings, 2008). Meaningless and unpleasant task is another factor that leads to burnout where the individual are not satisfied with what they are doing. Chances of burnout are more when the employees do not have the opportunity for personal expression and their effort in taking initiatives is not praised and rewarded but discouraged. Smith, Jaffe et al. (2007) asserted that there is likelihood of burnout development when the task is unpleasant. The dimension of control which includes accountability without power, lack of influence, poor leadership, and micromanagement also leads to the burnout among employees. In a study of nurse managers, Browning, Ryan et al. (2007) observed that more control leads to lowest rate of burnout, whereas the least control leads to the highest rate of burnout. Excessive performance monitoring is also responsible for the development of burnout. Studies indicate that performance monitoring has a differential impact on the well being of the employees.

Factors like role conflict and role ambiguity leads to job dissatisfaction and burnout. Hazardous working conditions, lack of job security, and working with difficult population also contribute to the development of stress and burnout. Literature suggests that nurses work in a highly stressed environment (Humpel & Caputi, 2001) and often interact
with the patients high on anger and intense emotions (Maslach, Jackson, & Leiter, 1996). Occupations that involve interaction with people are more demanding and hence the probability of burnout development is higher.

Technological advancements and the constantly changing work environment have lead to information overload and performance anxiety. On the job training is necessary for the technology advancement. In addition to that, individual factors include the personal factors such as age, gender, family status, educational status, personality traits, financial stability, chronic health problems, stress management skills, marital status play an important role to how one is affected by job stressors. Burnout prevalence is low in older population as they have a balanced perspective of life and they are more stable (Maslach, 2003). Research indicates that low social status and low educational level has increased the burnout risk among women (Ahola, Honkonen et al., 2006). Setting unrealistic goals (Smith, Jaffe et al., 2007) and lack of control over the service may also result in burnout. Poor and unhealthy interpersonal communication with colleagues and seniors is one of the reasons that aggravate the stressed environment of an organization and leads to the development of burnout.

The mutual accumulation of stressors at work (organizational) and in personal life (individual) of individuals certainly leads to the disastrous consequences of burnout. The consequences of burnout are multidimensional and lead to somatic, interpersonal or social, psychological or psychiatric manifestations. Maslach and Jackson’s (1981) attributional or environmental model focuses on burnout as being the consequence of the interaction between individual and environmental factors.

**Consequences of Burnout:** Literature suggests that burnout has negative impact not only on the professional life of the individual but personal life as well. Cordes and Dougherty (1993) stated that burnout has real physical, emotional, interpersonal, attitudinal, and behavioural implications. It has
been observed that burnout leads to total wear and tear of the sufferer. Consequently, the individual feels physically, mentally, emotionally, and spiritually depleted. In burned out situation, there are chances that the individuals loose confidence in their own potential and capabilities. A competent health professional feels overwhelmed when burned out and there is a lack of confidence in his own capabilities and eventually demands serious interventions to address and prevent these high levels of burnout (Levert, Lucas, & Ortlepp, 2000).

At individual level, the employees develop physical, psychological, emotional and social or behavioral consequences of burnout. Individuals suffering from burnout distance themselves from their own family members, display tiredness, and psychosomatic problems. Physical consequences include elevated blood pressure, coronary heart disease, poor immune system, physical exhaustion, and increased occurrences of illness. Maslach, Jackson, and Leiter (1996) asserted that the burnout leads to depletion of emotional and physical resources of the individual.

Psychologically, an individual develops a negative perspective and attitude towards life in general, suffers from depression and mental exhaustion, make frequent changes in professional goals and feels psychologically withdrawal from work. In relation to the consequences of burnout, depression is the most studied variable (Schaufeli & Enzmann, 1998), where it has been observed that burnout results in depression. It has been observed that burnout increases the risk of absenteeism and overall job dissatisfaction (Aiken, Clarke et al., 2001). At the emotional front, feelings of reduced personal accomplishment, inability to empathize, emotional exhaustion, and detachment are a few uphill battles to count. In a study on burnout among teachers, Dunham and Varma (1998) found that the feelings of disaffection and alienation are the most pervasive implications of burnout.
The social or behavioral consequences of burnout includes excessive mistakes, substance and alcohol abuse, becoming isolated and detached from colleagues, rude and aggressive behavior, excessive sick leaves, irritability and impatience, unwillingness to help, and depersonalization. Pines (1993) observed that burned out individuals have a strong tendency to blame others and are unable to concentrate on the task. Professionals suffering from the problem of burnout develop negative approach towards life and heads towards alcohol consumption, substance abuse, broken relationships, and suicidal tendencies (Balch, Freischlag, & Shanafelt, 2009). Positive relationship exists between the burnout and substance abuse (Maslach & Jackson, 1982; Schaufeli & Enzmann, 1998).

The negative impact of burnout at individual level ultimately influences the organization as a whole. Research indicates that individual burnout has a positive relationship with team-level burnout (Garman, Corrigan, & Morris, 2002). At the organizational level, burnout leads to decreased performance, absenteeism, and low productivity (Schaufeli & Buunk, 2003). There is high attrition rate when the organization fails to retain the employees by not acknowledging and addressing the issues of the staff. It has been reported that decreased level of organizational commitment, job dissatisfaction, and high health related issues are the negative impacts of burnout (Halbesleben & Buckley, 2004; Shirom, 2003). Research indicates that burnout and absenteeism are positively related in an organization (Bakker, Demerouti, & Schaufeli, 2003). Literature suggests that the two dimensions of burnout namely emotional exhaustion and depersonalization are inversely related to organizational commitment (Schaufeli & Enzmann, 1998).

Burnout has been proved detrimental and costly for both the individuals as well as the organization (Morgan, 2008). Disturbed personal and professional life equilibrium is the major consequence of burnout. An individual’s family relations are also disturbed as a consequence of burnout.
The overall perception and attitude of the individual towards family and organization gets affected and deteriorated due to burnout, resulting into unhealthy, disturbed, and conflicting relationships. Identification of the areas of mismatch between the individual and work environment is the first step to fix and handle burnout. Beating burnout is like breaking the uneasy bond between the individuals and their environment, whereby replacing exhaustion with enthusiasm and anxiety with efficacy.

**Measurement of Burnout:** Since the time the term ‘burnout’ was first introduced, there have been abundant of research in this area. Maslach Burnout Inventory (MBI; Maslach & Jackson, 1986; Maslach, Jackson, & Leiter, 1996) is the only inventory to measure burnout that dominates and stands out in most of the research till date. Maslach Burnout Inventory is a self assessment tool which got published for the first time in 1981 comprising of three subscales and 22 statements (Maslach & Jackson, 1981) and initially it was developed to measure burnout in human service industry. There are nine statements to measure emotional exhaustion, five statements regarding depersonalization and eight statements measure personal accomplishment. Every statement of the Maslach Burnout Inventory depicts a particular feeling or attitude and the frequency with which an individual experiences that feeling is marked on a scale of 0 (never) to 6 (everyday).

The higher scores on the dimensions of emotional exhaustion and depersonalization characterize higher degrees of burnout. However, on the dimension of personal accomplishment a lower score corresponds to a lower degree of burnout. For each subscale, a separate score is evaluated and for each dimension or subscale a low, average, or high degree of burnout is provided in the scoring key. In a study on teachers, three factors were clearly found, whereas in a study on Computer Company, depersonalization did not found a meaningful sub factor (Evans & Fischer, 1993). Walkey and Green (1992) observed that the dimensions of emotional
exhaustion and depersonalization might collapse into a single factor. No support was found for the three factor model of the MBI (Byrne, 1991; Yadama & Drake, 1995). But, overall, emotional exhaustion seems the strongest of the three MBI factors.

At present the Maslach Burnout Inventory (MBI) is available in three versions, (1) The Human Services Survey (MBI-HSS), (2) The Educators Survey (MBI-ES), and (3) The General Survey (MBI-GS). The MBI-HSS and the MBI-ES both contain the three scales and are virtually identical except for the fact that the word recipient is replaced by student. The MBI-GS is suitable for more generic occupations and include the following subscales: Emotional Exhaustion, Cynicism, and Professional Efficacy. The MBI-HSS was used to assess burnout in the present study on healthcare professionals. Support has been reported for three dimensions of the burnout construct across cultures and occupations (Schutte, Schuettpelz, & Malouff, 2000; Worley, Vassor et al., 2008). Recently, attempts have been made to put forth a four dimensional model of burnout dividing the dimension of depersonalization into depersonalization and cynicism (Salanova, Agut, & Peiro, 2005).

Although the convergent and discriminant validity of the construct have been supported by exploratory factor analysis of the three scales (Burke & Richardson, 1993; Cordes & Dougherty, 1993). But considering the extensive research in the area of burnout using Maslach Burnout Inventory, it is strongly suggested to develop an alternative measure of burnout and investigate more on the cross cultural validity and psychometric properties of the Maslach Burnout Inventory (Maslach & Schaufeli, 1993).

Another Burnout Measure (BM) given by Pines and Aronson (1988) is used in approximately 5% of the burnout studies (Schaufeli & Enzmann, 1998). This instrument is one-dimensional which results in a single composite burnout score. The discriminant validity of the Burnout Measure
in relation to depression, anxiety, and self-esteem has been questioned (Shirom, 2003). The Burnout Measure is a self-report measure and the items are rated on a seven-point frequency scale and access the person's level of physical, emotional, and mental exhaustion. The Burnout Risk Survey by John Henry Pfifferling and Oldberg Burnout Inventory (OLBI; Demerouti, Bakker et al., 2001) are some other burnout measures, but these tests have rarely been used in research.

**Prevention of Burnout:** It is more appropriate to prevent burnout than resolving and addressing it once it has occurred (Maslach & Leiter, 1997). Research indicates that it takes months and years to handle and resolve burnout in later stages (Lyckholm, 2001). The way impact of burnout can majorly be studied under the individual and organizational front, the same way banishing burnout includes two paths, individual and organizational. There have been two approaches to burnout reduction, one is inclined towards change in individual employees and the other focus on the modifying the organization (Ross & Altmaier, 1994; Schaufeli & Buunk, 2003).

It is easier to change the individual than to change the organization as a whole (Maslach & Goldberg, 1998). At the individual level, during strenuous times an employee should find ways to relax physically or mentally so that the severe consequences of burnout can be minimized. Literature indicates that yoga, spirituality, music, relaxation techniques, and hobbies have the potential to effectively manage stress and prevent burnout (Galinsky, 2009). Adopting healthy lifestyle, healthy diet, proper sleep, and regular exercise can help to a great extent in dealing with burnout. To avoid stress and burnout, it is important to maintain a healthy life style (McKee & Ashton, 2004).

Learning to deal with the administrative and technological changes of the workplace and enhancing communication skills to maintain positive
relationships with colleagues, supervisors, and clients is another important step to prevent burnout. It is important to learn how to communicate more effectively across language and cultures with the patients and use of interpreters for better communication and satisfaction of the patient (Flores, 2005). Learning to delegate the responsibilities and sharing the workload may also help. Moreover, an assertive approach and learning to say “no” where the work or responsibility belongs to someone else is also helpful. It is important to create a time budget to help and prevent the negative consequences that may arise due to mismanagement of time.

Healthcare professionals should seek support from family and friends and strengthen the relationships that can help in preventing burnout (Vachon, 2002). Healthcare professionals come across the death and dying cases almost every another day and keep accumulating stress, and hence, have more chances of developing burnout. Research also indicates that in case of healthcare professionals, it is important to grieve well when they come across loss and deaths in hospital settings, instead of masking their emotions (Erickson & Grove, 2007; Lyckholm, 2001).

At the organizational level, it is not only the change or modifications that can help, but the individuals need to be proactive in taking healthy decisions to resolve the conflicting situations and narrow down the person-environment gap. The organizations should implement strategies to involve the employees and enhance efficacy to prevent burnout (Maslach & Leiter, 1997). Regular interventions and training can help in preventing burnout, especially regarding the administrative and technological changes. It has been observed that nurses have dealt more effectively with the peers and physicians after assertiveness training (Smith, 2004).

Organizations can protect the employees from burnout by opening the channels of communications and providing a healthy work environment where the individuals can trust and support each other (Maslach, 2003;
Raiger, 2005). There should be flexible channels to meet the authorities so that employees can discuss their problems without hesitation. Appropriate staffing should be the most important step and priority of organizations to reduce and prevent burnout. Bonus, salary increment and other materialistic and non-materialistic rewards enhance the interest level and satisfaction of the employees and they are more motivated to do what they are doing. Though burnout can occur in any work setting, but it has been extensively studied in human service field ranging from teachers, police to healthcare professionals (Maslach, 2003). The consequences of burnout in the healthcare setup hinder the work and hence proper functioning of the professionals. This situation further affects the efficient treatment of the patients. Thus, it is advisable to use appropriate ways of coping and strategies to avoid occupational stress and hence burnout.

COPING

Coping is a multidimensional process to deal with stressful state and involves emotional, cognitive, and behavioral efforts to deal with stressful events (Carver & Scheier, 1994; Folkman & Lazarus, 1985). Mostert and Joubert (2005) described coping as an adaptive response to stress to eliminate, modify or ameliorate the stress producing factors. In terms of Lazarus and Folkman (1984), coping is the constantly changing cognitive and behavioral efforts to manage specific external and internal demands that are appraised as taxing or exceeding the resources of the person. Pearlin and Schooler (1978) stated that coping refers to the behavior that protects individuals from being psychologically harmed by problematic social experience. However, Schuler (1984) asserted that coping is a process to protect oneself against the adverse stressors. Like stress, coping is dependent on the individual’s perception of the environment and then strategically implementing the selected alternatives after analyzing the situation.
Researchers observed that individual's well-being gets affected not only by the degree of stress experienced but also from the fact that how he copes with that stress (Antonovsky, 1979). Coping shares an inverse relationship with stress. Like stress, coping has been defined differently as a process, as a trait, and as a strategy or effort (Dewe, Cox, & Ferguson, 1993). Generally coping has been seen as a transaction between the individuals and their environment. Coping has two major functions, that is, regulating stressful emotions and altering the person-environment relationship that causes distress (Folkman, Lazarus et al., 1986). The first function is linked with emotional intelligence which involves the process of recognizing, understanding and managing these emotions effectively. Salovey and Mayer (1990) asserted that regulating emotions effectively is one of the abilities of individuals with high emotional intelligence. Thus, it can be concluded that emotional intelligence assists an individual in using appropriate coping strategy to understand and regulate stressful and emotionally demanding situation.

In an organizational setup, where the job demands are too high to cope and exceed the person's adaptive resources, stress reactions are likely to occur (Lazarus & Folkman, 1984). Organizational stress results from the interplay the personality characteristics of an individual, work environment, demands placed upon them, and their ability to cope (Lazarus & Folkman, 1984; Siegrist, 2001). If the imbalance between all these factors continues for a long time, development of burnout is most likely, resulting into exhaustion, irritation, and ineffectiveness. It has been observed that emotional intelligence and coping acts as the moderator to reduce, eliminate, and handle this imbalance. Preventing burnout is easier than than resolving it once it has occurred. Research suggests that a number of moderating factors that can reduce or eliminate the negative effects of organizational stress have been identified including such as coping style (Lazarus, 1999; Lazarus & Folkman, 1984), emotionality (Costa & McCrae,
1992), levels of control (Spector, 1986), and social support (House, 1981). Coping plays a significant role in the stress–burnout relationship (Wiese, Rothmann, & Storm, 2003).

The transactional approach of stress takes coping as a mediating variable (Lazarus & Folkman, 1984). Coping acts as a mediator of the emotional response of a stressful situation. Unlike emotional intelligence, it is not a moderator because the process of coping arises subsequently and not prior to the occurrence of the stressful encounter from the transaction between the person and the environment. Research suggests that the individual’s emotional state at the beginning of a stressful encounter gets changed by the end of the encounter and the coping strategy adopted by the individual decides the direction of this change (Folkman, Lazarus et al., 1986). The individuals who are higher on emotional intelligence manage stress more appropriately by using effective coping strategy at the beginning of the encounter only. Kinicki and Latack (1990) observed that coping acts as an independent variable (cause) and as a dependent variable (effect) of stress related constructs. It has also been argued that choice of coping strategies is influenced by the environmental and personality variables.

Billings and Moos (1981) identified three methods of coping, that is, active-cognitive, active-behavioral and avoidance. First method active-cognitive, is the management of assessing stressful events. The second, active-behavioural, is the individual’s effort towards the management of a problematic situation. The last coping method, avoidance, is refusal to face a stress provoking situation. Maddi and Kobasa (1984) talked about two forms of coping, namely transformational and regressive. Transformational coping involves thinking optimistically and acting decisively to alter and minimize the stressful situation, whereas regressive approach involves thinking pessimistic and acting evasively type of strategy. Another concept of non-coping can be described as failed efforts to cope that involve physical...
or psychosocial disturbances, resulting into stress (Callan, 1993). Non-
coping is also directly correlated with depression and anxiety (Carver,
Sheier, & Weintraub, 1989).

**Theories of Coping:** To gain more insight into the concept of coping various
theories and models have been developed. Research in the area of coping
has been influenced by a mosaic of theoretical frameworks. Transactional
approach on stress and coping corresponds to the well-known research
tradition of Lazarus (1991). Stress experience depends on subjective
judgments of the individual when the transaction between the person and
work environment is evaluated as threatening. Two dimensional coping
efforts are required when the situations are appraised as taxing, namely
problem-focused and emotion-focused. There are some concerns about the
dichotomy (emotion-focused vs. problem-focused) of coping as the
subdivisions of these two have been found (Hepburn, Loughlin, & Barling,
1997).

In spite of that transactional approach has extensively been used in
research, such as job-related coping across multiple stressors and samples
(Smith, 1992), relationships between coping process and the adjustment to
organizational change (Callan, Terry, & Schweitzer, 1994), wellbeing and
coping effectiveness (Patterson, 1997), temporal stability of workplace
stress and coping among female managers (Long, 1998), gender differences
in coping (McDonald & Korabik, 1991), and mediating role of coping in the
work stressors-employee interaction (Harris, Holpin, & Halpin, 1985).
Schwarzer (2000) presented the coping construct in terms of the method or
foci (target of coping effort), which to an extent is in congruent with
Lazarus’ transactional model of stress.

**Proactive theories** as developed by Schwarzer (2000) is a new
theoretical approach on coping, which is based on time-related stress
appraisal and perceived certainty of critical events or demands. He
differentiates four coping mechanism, namely reactive coping, preventive coping, anticipatory coping, and proactive coping. Reactive coping is associated with the harm or loss experienced in the past, whereas preventive coping deals with uncertain threats in the distant future. Coping-related emotions such as a threat that is near in the future are assumed to be associated with anticipatory coping. While proactive coping involves future challenges that are seen as self-promoting. Time and certainty play an important role in proactive approach (Schwarzer & Taubert, 2002).

Aspinwall and Taylor (1997) analyzed the processes through which individuals prevent or mute the impact of potential stressors by anticipating in advance and gave five stages of proactive coping through which an individual “must” pass, namely resource accumulation, recognizing potential stressors, initial appraisal, preliminary coping efforts and elicitation, and use of feedback regarding initial efforts. Proactive coping is a new concept and isolated research has been found, such as proactive coping in HIV gay men (Nicholson & Long, 1990), proactive coping scale development (Greenglass, Schwarzer, & Taubert, 1999), proactive coping with an anticipated academic stressor (Raffety, Smith, & Ptacek, 1997), and theoretical model for proactive coping (Aspinwall, 1997).

Conservation of resource theory was developed in late 1990s and identifies nine types of human coping, namely assertive action, avoidance, seeking social support, cautious action, social joining, instinctive action, aggressive action, antisocial action and indirect action (Hobfoll, 1989). In contrast to transactional approach, stress is not the appraisal process that originates from person-environment interaction but a threat or lost of resources. This theory is practically unknown in research, except a unique study that was conducted by Freedy and Hobfoll (1993).

**Process of Coping:** Coping is a process to master and overcome stress and the individuals keep changing the strategy from one situation to another to
cope efficiently in a stressful or problematic situation. At first stage an individual evaluates the situation and decides whether they need to adapt or not, whereas at the second stage, the individuals decide as to what can be done considering and evaluating his or her resources (Lazarus & Folkman, 1984). Lazarus and Folkman (1984) and others have suggested that the coping process consists of four steps. The first step is appraisal, to determine the meaning and implication of a particular situation or event. The second step is the selection of an appropriate coping strategy after assessing the coping resources at hand. The third step involves carrying out the selected coping strategy. Finally, the fourth step involves evaluating the effectiveness of one's coping efforts in managing, reducing or culminating stress (Smith & Carlson, 1997). Lazarus and Lazarus (1996) asserted that the more information individuals have about the stressful situation or event, the better they cope, because it becomes easy for them to monitor their stress after properly assessing the situation.

Schuler (1984) has explored six steps under the process of coping: (1) the coping trigger; (2) primary appraisal; (3) secondary appraisal and strategy development and selection; (4) strategy implementation; (5) strategy evaluation; and (6) feedback. An individual begins to engage in coping when the situation is perceived as stressful and a response is required. Primary appraisal involves answers to various questions like what is the stressor, where is the uncertainty and if it is really important. For Lazarus (1966), primary appraisal initiates the coping process. If the cause of discomfort is judged as important, then the secondary appraisal begins where the focus is on the factors that have been associated with the stress. This step not only involves if the situation is important or not, but determine why it is important. After getting the answer to why of the situation, strategy implementation or the ways to deal with the situation are developed. After the process of strategy implementation, evaluation is done to understand if the strategy adopted was appropriate to handle the stressful encounter.
Feedback is the last step that completes the process and evaluates the effectiveness of coping strategies.

**Coping Strategies:** Coping strategies are the steps individuals take in order to reduce or alter the impact of stressors. It has been claimed that every person has a specific and unique way to cope and there is no standard coping strategy because each problem is different and calls for a different solution. This indicates that coping strategies change according to the context and play a significantly important role in determining health outcomes (Cooper, Dewe, & O’Driscoll, 2001; Shimazu & Kosugi, 2003). Individuals use both coping resources, coping styles, and coping strategies in dealing with stress to alter or reduce stressors. Coping styles are the stereotypical reactions to stress and Menaghan (1983) has described them as habitual or preferred ways adopted by an individual while approaching a problem or crisis. Coping resources are different from coping strategies, in the sense that coping resources comprise the complex set of relatively stable cognitive, personality, and attitudinal characteristics that provide the psychological context of coping and affect the coping processes (Shaw, 1993).

Emotional intelligence is seen as a coping resource. It has been observed that emotional intelligence moderate both the subjective (deterioration of mood, intensity of emotions, tendencies to take action, and the bodily sensations) and endocrine response to acute stressors (Mikolajczak, Menil, & Luminet, 2007). It is also evident that in order to deal with negative events, emotional intelligence influences the choice of coping strategies. Petrides, Furnham, and Mavroveli (2007) and Saklofske, Austin et al. (2007) asserted that emotional intelligence is positively related with the use of adaptive coping strategies and negatively with the maladaptive coping strategies. Emotions are the product of man-environment interaction in response to stressors and coping is seen as an effort to handle and manage stress by dealing with negative and unpleasant emotions. Leventhal
(1990) identified the significance of emotional states and their relationships with coping ability of individuals by arguing that one must first lower emotional distress before the effective coping takes place. Moreover, it has also been observed that individuals use coping strategies in order to restore a favorable emotional state (Aldwin & Revenson, 1987).

There are two broad coping strategies, problem-focused and emotion-focused. Problem-focused coping is akin to problem solving where an individual takes steps to change the source of the stress to solve or alter the situation, whereas emotion-focused coping involves efforts to change one's emotional response to the stressor which involves escape-avoidance, distancing, selective attention, wishful thinking, and the use of social support (Bunkholdt, 1997; Lazarus & Folkman, 1984). Problem-focused coping means that person them-self tries to solve the problem of the stress reaction. Problem-focused coping is when a chronically ill person tries to find a way to live a satisfactory life (Bunkholdt, 1997). In case of problem solving approach of coping, if an employee is stressed because of another individual at workplace, then the employee might adapt a strategy to change the behavior of that individual to eliminate stress. What often complicate problem-focused coping efforts are touchy attitudes of the others that must be dealt with (Lazarus & Lazarus, 1996).

Emotion-focused coping involves passive avoidance or distraction. Emotion-focused coping means focus on relaxation, substances abuse, defence mechanisms to reduce the effects of stress caused by unpleasant situation, events or experiences (Edwards & Holden, 2001; Rothmann & Van Rensburg, 2002). Denial, alcohol abuse, acting childish in response to an unexpected death is the ways adopted to handle emotions (Bunkholdt, 1997). Making use of available social supports is also emotion-focused coping. Individuals who have caring and supporting relationships who can listen to encourage, comfort, and strengthen them through stressful situations without being hurt. This support can be experienced as
tenderness and love, that is, the feeling of acceptance and appreciation (Kalimo, 1987). It has been observed that love and support of the family helps nurses to cope with the work stress (Maslach, 1985). Social support is one of the three coping strategy domains namely, avoidance, problem solving, and seeking social support. Studies have shown that people should not avoid, bury or close off the situation that promotes the distress, at least not for very long (Lazarus & Lazarus, 1996). This is indicative of the fact that the problem-focused coping strategy is more helpful in coping with stress and burnout.

EMOTIONAL INTELLIGENCE

The construct of emotional intelligence has given rise to unparalleled interest since the publication of Daniel Goleman's book “Emotional Intelligence” in 1995. Emotional Intelligence has its origin in the concept of social intelligence (Salovey & Mayer, 1990) which was first defined by Thorndike in 1920. Several years later, Gardner (1983) talked about seven different types of intelligence relating to different parts of the brain in his “Theory of Multiple Intelligence”. He did not mention the term emotional intelligence, but his intrapersonal and interpersonal intelligence provided a foundation for later models of emotional intelligence (Schutte, Malouff et al., 1998). Peter Salovey and John Mayer first coined the term "Emotional Intelligence" in 1990 (Salovey & Mayer, 1990) and since then it has been developed, embraced, and adapted by various organizations. Matthews and Zeidner (2000) stated that adaptive coping might be conceptualized as emotional intelligence in action, supporting mastery emotions, emotional growth, and both cognitive and emotional differentiation, allowing us to evolve in an ever-changing world.

According to Mayer, Salovey and Caruso (2004), emotional intelligence is the ability to perceive and express emotions, assimilate emotions in thought, understand and reason with emotion, as well as
regulate emotion in the self and others. In contrast, Goleman (1998) refers to emotional intelligence as the capacity to recognize feelings in oneself and others, as well as the capacity to motivate others and manage emotions within one and subsequent relationships. Bar-On (1997) included adaptability and stress management as the two important components of emotional intelligence. Bar-On in 2001 indicated that trait or ability EI is related to life success. Apart from these, Palmer and Stough (2001) asserted emotional intelligence as the capacity to deal with one's own and other's emotions, which involve the capacity to effectively perceive, express, understand, and manage emotions in a professional and effective manner.

**Models of Emotional Intelligence:** Emotional Intelligence has been a topic of debate, whether it is a true form of intelligence, a cluster of personality traits or simply little more than interpersonal skills repackaged (Woodruffe, 2001). Several attempts have been made to define this construct but the search for a single definition has proved fruitless (Landy, 2005). The different models and theories have been developed to have a better understanding of emotional intelligence.

Yet the two major perspectives in the theoretical explanation of emotional intelligence are the ability and mixed model. Ability model describes emotional intelligence as pure intelligence or a pure form of mental ability. At present, the ability model of emotional intelligence by Salovey and Mayer (1990) is the only ability model. However, mixed models mix the dimension of personality characteristics with mental ability. Reuven Bar-On (Bar-On, 2002) and Daniel Goleman's mixed model are the examples. All these approaches present a different perspective about emotional intelligence and forms the basis for the development for various measurement instruments such as the Multifactor Emotional Intelligence Scale (MEIS, 1997), Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT; Mayer, Caruso, & Salovey, 1999), Schutte Emotional Intelligence
Scale (Schutte, Malouff et al., 1998), Bar-on EQ-I (Bar-on, 1997), and the Swinburne University Emotional Intelligence Test (SUEIT; Palmer & Stough, 2001).

The Ability Model of Salovey and Mayer (1990) shows that the emotional nature of the information is differently processed by individuals and varies in their abilities to relate it to a wider cognition. This model focused on the individual’s ability to process emotional information and uses it to navigate the social environment. This model proposed two areas of emotional intelligence, namely experiential (ability to perceive emotions without understanding) and strategic (ability to understand the emotional information without feeling and experiencing). Each area further divided into two to integrate emotions with cognition. Emotional perception, emotional assimilation, emotional understanding, and emotion management are the four resultant branches, making it a four-branch model (Mayer & Salovey, 1997).

Mixed Model by Reuven Bar-On is one of the first assessment tools of emotional intelligence that used "Emotion Quotient". The Bar-On’s mixed model of emotional intelligence is a process-oriented model rather than outcome-oriented (Bar-On, 2002). It focuses on a wide range of emotional and social abilities, which includes the ability to understand, be aware of and express one self and others and relate to them, the ability to handle strong emotions and the ability to adjust to change and solve problems belonging to social or personal nature (Bar-On, 1997). In Bar-On model, five components of emotional intelligence have been outlined namely, adaptability, general mood, intrapersonal, interpersonal, and stress management. In general, Bar-On asserts that the emotional intelligence and cognitive intelligence have equal share in the general intelligence of an individual, which offers an indication of one’s capability to be successful in life (Bar-On, 2002).
Daniel Goleman got so inspired by the work of Salovey and Mayer that he began to conduct his own research and wrote the landmark book “Emotional Intelligence” in 1995 which familiarized the concept of emotional intelligence in both public and private sectors. The five main constructs of emotional intelligence as outlined by Goleman includes self-awareness, self-regulation, social skills, empathy, and motivation (Goleman, 1998). A set of emotional competencies are imbibed within each construct of emotional intelligence. It was asserted that emotional competencies are learned capabilities rather than being innate talents and to achieve outstanding performance emotional intelligence must be worked on and developed. According to Goleman, individuals are born with a general emotional intelligence and this general emotional intelligence determines their capability to learn emotional competencies.

Trait Model by Konstantinos Vasilis Petrides encompasses behavioral dispositions and self perceived abilities and is measured through self-report. In lay terms, trait EI refers to an individual’s self-perceptions of their emotional abilities. The trait EI shall be investigated within a personality framework. Trait emotional self-efficacy is the alternative label for this construct.

Emotional Competence Model by Saarni (1997) described emotional competence in term of skills consisting of the ability to understand, manage, and express the social and emotional aspects of an individual’s life which support in the successful management of life. It includes self-awareness, emotional regulation, working in cooperation, and caring about one self and others. Saarni proposed eight skills indicating of an emotionally competent person as: (a) Be aware of one’s own complex emotional state, (b) Able to discern other’s emotional state, (c) Able to state and communicate our emotions, (d) Able to feel with and for others, (e) Able to understand that we and others do not always show emotions accurately, (f) Able to cope with different emotional communication when relating to others, (g) Aware of
emotional communications in interpersonal relationship, (h) Aware that one is in charge of one’s feelings and may choose one’s emotional response in a given situation.

Four Cornerstone Model by Sawaf and Cooper (1996) is the result of global survey on Emotional Intelligence. Emotional Literacy, Emotional Fitness, Emotional Depth, and Emotional Alchemy are the four cornerstones of this model. Emotional Literacy is the learning of alphabets, grammar and vocabulary of era and respecting the inherent wisdom of feelings. Emotional Literacy can be improved through self-observation and monitoring thoughts. Emotional Fitness is the flexibility of the body and quality of heart that enables an individual to put the skills of emotional literacy into practice. This assists an individual in expanding the circle of trust for an increased profitability and hence success. Trust is an important characteristic of emotional fitness. Emotional Depth is the core character of an individual. It is the unique potential with respect to accountability and commitment. It can be developed through self-awareness, empathy, and assertiveness. Emotional Alchemy throws light on individual’s hidden range of solutions that acts like a force in discovering creative opportunities and ideas. These models do not necessarily contradict one another but gives a different perspective on the nature of emotional intelligence.

Importance of Emotional Intelligence: Emotions enable human beings to respond appropriately in a variety of situations. The popularity of the emotional intelligence during the past few years has motivated the researchers to assess its potency in different areas of human functioning. Contributions of emotional intelligence have been observed in the physical, psychological, social, and behavioral aspects of the individual and act as a moderating factor in dealing with stress and burnout. Taylor (2001) asserted emotionally intelligent individuals can effectively handle and cope with life’s challenges and can control their emotions more appropriately, which further results in psychological and physical fitness.
Literature suggests that emotional intelligence is related with the positive outcomes and has a significant effect on the work attitude of individuals. Bar-On (1997) argued that emotional intelligence influences an individual’s ability to get success in coping with environmental demands under stressful work conditions. Mayer and Geher (1996) asserted that emotional intelligence involves emotional problem solving. Emotional competencies (learned capabilities) are different from emotional intelligence (a dispositional aptitude). According to Goleman (1998), Individual’s success at workplace is 80% contingent on EQ, our IQ gets us selected and EQ gets us promoted. It is the emotional competencies underlying or nested within emotional intelligence which differentiates successful from unsuccessful executives. Emotional intelligence is the potential of the individual at certain emotional responses and emotional competencies is the learned capabilities based on emotional intelligence that result in outstanding performance at work (Goleman, 2001).

It is the emotional competence that helps an individual on job and has been found to be critical in occupational setup (Weisinger, 1998). Emotional self-awareness, regulation of emotions in self social awareness of emotions and empathy, regulating emotions in others, motivational tendencies, and character are some of the competencies in the 25 listed competencies by Goleman in 1998. Goleman (1996) in his book ‘Emotional Intelligence: why it can matter more than IQ’ gave the world a new meaning of Emotional Intelligence. According to him, IQ accounts for only about 20% of a person’s success in life. Success can be attributed more to Emotional Intelligence or EQ. The most productive and successful individuals are considered to be those who are high on Emotional Intelligence (EQ) and not necessarily those with higher IQ.

Considering the physical aspect, literature asserts that individuals high on emotional intelligence enjoy better physical and psychological health as compared to those with low emotional intelligence. Research
suggests that emotional intelligence is positively correlated with psychological well-being of individuals like satisfaction in life and happiness, while emotional intelligence shares a negative relationship with measures of mental ill-health like stress, loneliness, and even depression (Austin, Saklofske, & Egan, 2005; Tsaousis & Nikolaou, 2005). It has been observed that negative emotional states are connected to unhealthy patterns of physiological functioning, whereas positive emotional states have a strong association with healthier patterns of functioning in both cardiovascular activity and immune system (Herbert & Cohen, 1993).

Psychological well being has also been associated with the emotional intelligence construct. Research suggests that lower levels of emotional intelligence are associated with higher levels of perceived stress (Naidoo & Pau, 2008; Pau & Croucher, 2003; Slaski & Cartwright, 2003). Ciarrochi, Deane, and Anderson (2002) asserted that emotional intelligence acts as a moderating variable in the relationship between stress and psychological health measures among young people like depression, hopelessness, and suicidal tendencies. It has been argued that individuals with high levels of Emotional Intelligence are motivated and self-disciplined (Goleman, 1996; Mayer & Salovey, 1997). Individuals high on emotional intelligence have better coping skills when confronted with conflicting situations in modern work and family life (Heiliger & Hingstman, 2000). This indicates that those who are high on emotional intelligence are in a better position to deal with stress using appropriate coping strategies more effectively.

On social and behavioral front, research revealed that emotional intelligence is associated with reduced tendency to smoke and alcohol intake (Austin, Saklofske, & Egan, 2005; Trinidad & Johnson, 2002; Tsaousis & Nikolaou, 2005). Evidences suggest that emotional intelligence is a significant predictor of an individual's social functioning (Extremera & Fernandez-Berrocal, 2005; Schutte, Malouff et al., 2001). Emotional intelligence has been significantly and positively related to the higher
quality social relationships (Gil-Olarte, Marques et al., 2006; Lopes, Brackett et al., 2004), prosocial behavior (Lopes, Salovey et al., 2005), more satisfaction in life (Extremera & Fernandez-Berrocal, 2005; Palmer, Donaldson, & Stough, 2002; Palomera & Brackett, 2006), and the use of better adapted coping strategies (Extremera & Fernandez-Berrocal, 2005). Mayer, Caruso, and Salovey (1999) called emotional intelligence as a multidimensional construct involving the characteristics of self-awareness, managing emotions, motivating oneself, empathy, and handling relationships among various emotions. Emotional intelligence can help individuals in the process of coping with stressful situations and acts as a moderating variable in the stress burnout relationship.

**Emotional intelligence as the Moderator:** The methodology of the mediating and moderating role of variables has now frequently been used in educational, sociological as well as health research to understand the casual relationship among various variables. Wegener and Fabrigar (2000) stated that there exist three types of causal hypotheses namely, direct causal effect, moderated casual effect, and mediated causal effect. In general, moderators and mediators are the third variables that help in deeper understanding of a casual relationship. The causal nature of mediation and moderation is normally overlooked and often misunderstood leading to misapplication of the moderators or mediators and hence misinterpretation of results in much of applied research (MacKinnon, Lockwood et al., 2002; Rose, Holmbeck et al., 2004).

Moderating variable is a variable that influences, or moderates, the relation between two other variables and thus produces an interaction effect. The embryo of the moderation effect can easily be traced in the concept of “interaction effect” from the analysis of variance (Saunders, 1956). A moderator is a third variable that influences the strength and direction of a causal relationship (Rose, Holmbeck et al., 2004). A moderator is a third variable that modifies a causal effect. A moderation effect is a
causal model that postulates “when” or “for whom” an independent variable causes a dependent variable most strongly or most weakly (Baron & Kenny 1986; Kraemer, Wilson et al., 2002). A moderator modifies the strength and direction in terms of positive and negative in a causal relationship, whereas mediating variable is the synonym for intervening variable that links a cause and effect.

Moderators explain the situations when weak or ambiguous association are caused between two variables where there is expected to have a strong relationship. In contrast, a mediator provides additional and extra information about why and how the two variables are strongly correlated. Mediators and moderators are the third variables that change the association between independent and outcome variables (Baron & Kenny, 1986). It is a confusing situation for the researcher to decide whether a variable is moderator or mediator and this decision is made considering the conceptual and theoretical framework of the study. According to some researchers coping is a mediator as it cannot occur unless a stressor has occurred. Stressor as an independent variable predicts the mediator coping and both independent variable and mediator together predict an outcome or response. Contrarily, for some researchers coping acts as a moderator variable. As a moderator, coping acts as an independent variable that influences the stressor-outcome relationship. When coping skills are high, the stressor-outcome correlation is weak, whereas when coping ability is low, the stressor-outcome association is strong (Holmbeck, 1997).

**RATIONALE OF THE RESEARCH**

The working environment of healthcare professionals, stress induced by the patients and administration, limited resources, as well as the work-family conflict has been researched for many years. It has been indicated that the professionals are at significant risk of occupational stress and
burnout due to workload, leadership styles, management issues, daily crisis, role ambiguity, life-death situations, personal and professional relationships, time pressure, shift working and emotional demands. All this has further resulted into declined performance, less commitment, increased employee conflict, high attrition, increased absenteeism, and staff turnover. Moreover, due to prolonged stress, there are high burnout cases in the healthcare industry, worldwide (Burke & Richardsen, 1993; Chan, 2004; Duran & Extremera, 2004). In has been documented that burnout in nursing has resulted in deterioration of quality service, which may have deleterious consequences not only for the organization but for the patients as well.

Today patients demand not only an efficient doctor and an effective treatment but a personalized care with empathetic approach. Moreover, the emotional needs of the patient’s family and friends are to be taken care of along with the patient. Research suggests that the profitability of business is dependent on the effectiveness of employees (Slaski & Cartwright, 2002). Due to this reason, most of the healthcare organizations have counseling psychologists recruited for wards, Intensive Care Units (ICUs), and Out-Patient Departments (OPDs).

Individuals employed in human service occupations such as nurses, police officers, and teachers experience greater levels of stress and burnout (Brotheridge & Grandey, 2002). Therefore, coping is necessary to understand, handle, and reduce occupational stress as well as burnout. It has been observed that coping strategies play a significantly important role in the well-being of professionals and help in minimizing the negative impact of stress and burnout. It has also been indicated that the successful individuals are the ones who have been able to cope effectively in the stressful encounters, thereby reducing the chances of burnout development. More so, emotions play an important role in reactions to stress and in the development of burnout (Humpel & Caputi, 2001).
Emotional intelligence that refers to the capacity to deal effectively with one’s own and others’ emotions helps in regulating and controlling emotions, which in turn moderate the development of stress and burnout. It has been asserted that emotional intelligence play more important role than general intelligence for success (Goleman, 1995), and more research is expected in this context so that individuals as well as organizations can be benefitted. It is pertinent to mention that stress and burnout is linked to emotional reaction (as is evident that Emotional Exhaustion is one of the dimensions of burnout; Maslach & Jackson, 1986), emotional labour (Brotheridge & Grandey, 2002), and emotional intelligence plays a moderating role in the stress and burnout relationship.

Therefore, the rationale of this study is to explore the relationship between burnout, occupational stress, coping, and emotional intelligence among healthcare professionals and to determine whether emotional intelligence is a moderator in coping with occupational stress and burnout and how coping would appear to be a useful tool in managing occupational stress and burnout, and in enhancing a higher level of emotional and professional competence at work. Therefore, the problem of the present study may be stated as: “COPING WITH OCCUPATIONAL STRESS AND BURNOUT IN HEALTHCARE PROFESSIONALS: MODERATING EFFECT OF EMOTIONAL INTELLIGENCE”.

This study will help the healthcare professionals to become more aware and vigilant about the risks and difficulties prevalent in the healthcare environment, which they may encounter in the near future. This study may also prove to be helpful in providing strategies to lower the levels of Occupational Stress and Burnout in healthcare environment, and how emotional intelligence can be improved by the organizational efforts and individuals themselves in order to choose appropriate coping strategies in stressful encounters.
OBJECTIVES OF THE RESEARCH

The main objectives of the study are:

1. To examine the differences across occupational groups and gender in Occupational Stress, Burnout, Coping, and Emotional Intelligence.

2. To examine the relationship between Coping and Occupational Stress in healthcare professionals.

3. To examine the relationship between Coping and Burnout in healthcare professionals.

4. To examine the relationship between Occupational Stress and different components of Burnout.

5. To examine the relationship between Emotional Intelligence and Occupational Stress.

6. To examine the relationship between Emotional Intelligence and Burnout.

7. To examine the role of Occupational Stress, Coping and Emotional Intelligence in the Burnout in healthcare professionals.

8. To examine the moderating effect of Emotional Intelligence on the role of Coping in Occupational Stress.

9. To examine the moderating effect of Emotional Intelligence on the role of Coping in Burnout.

HYPOTHESES

The main hypotheses of the study are:

1. Different groups of healthcare professionals would not differ on Occupational Stress, Burnout, Coping, and Emotional Intelligence.

2. There would be no gender differences in Occupational Stress, Burnout, Coping, and Emotional Intelligence.
3. Ways of Coping would correlate negatively with Occupational Stress of healthcare professionals.

4. Ways of Coping would correlate negatively with Burnout of healthcare professionals.

5. There would be positive relationship between Occupational Stress and Burnout.

6. There would be negative relationship between Emotional Intelligence and Occupational Stress.

7. There would be negative relationship between Emotional Intelligence and Burnout.

8. Occupational Stress, Ways of Coping and Emotional Intelligence would account substantial proportion of variance in Burnout of healthcare professionals.

9. Emotional Intelligence is likely to moderate Coping with Occupational Stress.

10. Emotional Intelligence is likely to moderate Coping with Burnout.