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Ceren Hancı

Burnout and Engagement: The Moderating Role of Self-Compassion

Master thesis

Supervisor: Liina Randmann (Ph.D)

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Declaration

I hereby declare, that this thesis is entirely the result of my own work and submitted for the Degree of Master of Science in Tallinn University of Technology. For the present thesis no degree has been conferred on me before either in this or in any other university.

Author: Ceren Hancı
“ ..... “ 2018

The work meets the stated requirements for master thesis

Supervisor: Liina Randmann, Ph.D
“ ..... “ 2018

Approved “ ..... “ 2018

Master's theses defense committee chairman in the Department of Business Administration

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ABSTRACT

The aim of this study is to examine the relationship between burnout and work engagement under the influence of self-compassion. The results of Hayes' moderation process model 1 show that self-compassion interacts with this relation and moderates it. Sample of 43 health care personnel (33 doctors and nine nurses) from two hospitals in Turkey participated in this study. Majority of the participants have work experience more than 11 years. Copenhagen Burnout Inventory, Self-Compassion Scale, Utrecht Work Engagement Scale and Perceived Stress Scale were used in the study. Kristen Neff's short-term self-compassion training was applied, however, after 2 weeks training no significant improvement found on participants' scores. Results of moderation also indicate that employees with low (less than 40) and moderate self-compassion, get more affected of burnout. No significant relationship was found for employees with high self-compassion. Two facets of burnout were found significant to predict work engagement. Specifically, client-related burnout and personal burnout are statistically significant predictors of work engagement. Major limitations of the study are high dropout rate (37.2%), low participation and self-accomplished training.

Keywords: Burnout, work engagement, self-compassion, health service, doctors, nurses, moderation.

1. Introduction

Burnout and stress can be seen as the widespread 'impairments' since 1970s (Schaufeli, Leiter & Maslach, 2009), which threaten employees' physical and emotional wellbeing (Montero-Marin & Garcia Campayo, 2010; Montero-Marin et al., 2014) due to fluctuating structure of work demands and the burden of high-competitive work system in contemporary world (Kaschka, Korczak & Broich, 2011). Stress processes are not stable interactions; both environmental variables (organizational structure, social support and the physical environment) and individual differences affect the causal relationships (Parkes, 1994). Major individual differences consist of demographics, personality variables, coping, work expectations, preferences and commitment, health related factors such as smoking or binge eating, exercise, abilities and skills, including job skills, and social and organizational skills which are influential in occupational context.

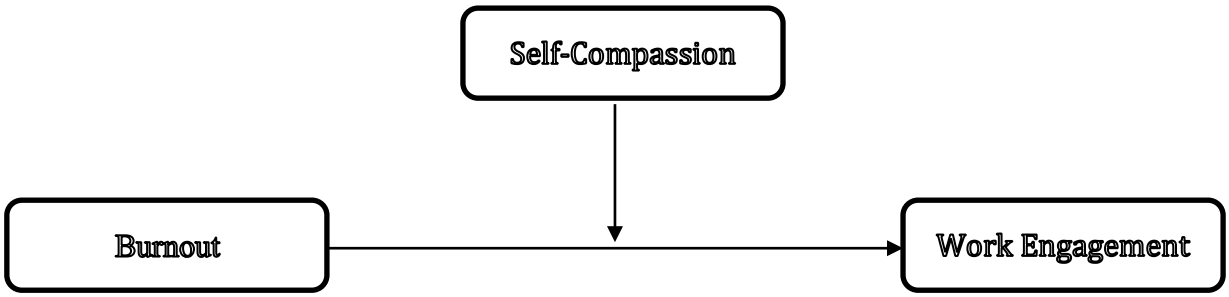
Burnout is accepted as a medical condition. In other words, physicians and other medical workers are trained to assess and treat it as a disorder (Schaufeli, Leiter & Maslach, 2009). It is also described in Diagnostic and Statistical Manual of Mental Disorders (DSM) under adjustment disorders category and International Classification of Diseases (ICD). High workload and prolonged exposure to high levels of stress at work cause burnout (Köverová & Ráczová, 2017). Burnout is a popular well-studied topic – due to published over 6,000 books, chapters, dissertations and journal articles. However, focus of examined professions has not included helping professions such as doctors, nurses, psychologists and psychiatrists (Schaufeli, Leiter & Maslach, 2009), although twenty-five to sixty percent of physicians report burnout across all specialties (Gazelle, Liebschutz & Riess, 2014). According to a recent research, 26.3% of nurses scored at clinical levels for anxiety (11 or more in Hospital Anxiety and Depression Scale) and 5.9% of nurses scored above the clinical cut-off point for depression (Mark & Smith, 2012). Nevertheless, 44.8% of nurses reported "they believe that they had suffered an illness in the past year that had been caused or made worse by stress at work". Gert Van Humbeeck, Chantal Van Audenhove and Anja Declercq listed potential reasons of burnout antecedents - disappointment, dissatisfaction, frustration, discouragement - and even burnout among psychiatrists as (1) physical and verbal aggression of psychiatric client, (2) crisis situations in one-to-one interactions with client and (3) caseload of professional caregivers (2004).

According to recent research, violence among health care personnel is increasing (Estryn-Behar et al., 2008). Workplace violence includes verbal abuse, aggression, harassment, bullying, physical violence, and it may include various types of perpetrators. Violence against health workers is a worldwide problem (Sun et al., 2017; Ferri et al., 2016; Zafar et al., 2013).

Report of Health and Social Workers Union Turkey (Sağlık ve Sosyal Hizmet Çalışanları Sendikası) showed the rates of violence exposure among health care workers as following; 10% never, 31% 1-3 times, 17% 4-6 times, 9% 7-10 times and 31% 11 or more times while 85% of health personnel reported that they feel anxious about exposing violence on their duty whereas this rate among other occupations was 50,4% (2013). In last five years, 46,361 health personnel experienced physical violence in Turkey ("Beş yılda 46 bin 361 sağlık çalışanı şiddete uğradı", 2017). However, On the other hand, nurses are the major target of aggression exposure of all clinical workers, due to the type and amount of patient contact (Iennaco et al., 2013)..

Nevertheless, verbal and physical violence influence employees' psychological wellbeing in terms of changing workplace climate. Expected and exposed violence lead to create fearfulness, increase in sick leave, burnout level (Estryn-Behar et al., 2008), absenteeism and turnover whereas they cause low morale and productivity (Iennaco et al., 2013). In order to prevent and/or protect by law the employees, hospitals provide basic trainings about legal acts and self-protection. However, these precautions are mostly about physical health and legal procedures to secure employees from future violent actions, threatening mannered verbal aggression may cause greater psychological effects on workers than physical aggression (Iennaco et al., 2013). Violence and effects of it not only injure body but also negatively influence psychological wellbeing through stress due to fear and potential recurrent exposure. Jeffrey Brentley illustrates it with the words of "Stress is the response to demands placed on body and mind" (2005). Hence, addition to governmental precautions the goal of self-compassion training is to teach the concept and positively intervene health workers' self-compassion state, in order to improve their psychological wellbeing through reducing stress and burnout effects.

H1: Self-compassion levels of health-care workers will improve after self-compassion training.
H2: Self-compassion moderates the relationship between burnout and engagement.
H3: Client-related burnout affects health personnel more than other two sub-types.



According to past researches, self-compassion has been found correlated with positive outcomes of affect, cognitive patterns, achievement, social connectedness (Barnard & Curry, 2011; Neff, 2003), greater motivation, taking greater self-responsibility, optimism, better coping skills and making healthier lifestyle choices whereas negatively related with anxiety, depression, stress, substance use, perfectionism, body shame and fear of failure (Neff, 2003; Neff, in press).
The aim of this paper is the examination and reduction of burnout and to improve engagement of doctors and nurses in Turkey through self-compassion training.

2. Theoretical Background

2.1 Occupational Stress

As a well-known fact, stress has crucial impacts on psychological and physical wellbeing. Richard S. Lazarus (1995) explains the concept with "In a cognitive-motivational-relational theory, stress depends on the balance of power, as judged subjectively, between the environmental demands, constraints, and resources and the ability of the person to manage them" (p. 5). Job demands, social support, decision latitude and personal development opportunities, effort, over-commitment, rewards and ways of coping are the predictors of occupational stress (Mark & Smith, 2012). There are two major models used generally for studying occupational stress.

Firstly, Karasek (1979) examined the interactions between job demands (high and low) and decision latitude (high and low) to predict potential strain in workplace. Job demands are the factors such as interruption rate, time pressures, conflicting demands, reaction time required, pace of work, proportion of work performed under pressure, workload, degree of concentration required, and the interdependency such as slowing down of work caused by the other employees.

They represent the psychological stressors in workplace. Decision latitude refers to employees' control over their tasks and how those tasks are executed. It consists of both skill discretion and decision authority. Skill discretion describes the degree to which the job involves a variety of tasks, low levels of repetitiveness, occasions for creativity and opportunities to learn new things and develop special abilities. Decision authority describes both the employee's ability to make decisions about their own job, and their ability to influence their own work team and more general company policies.

According to Demands Control Support (DCS) model, stress is a consequence of how demanding a person's job is and how much control (discretion, authority or decision latitude) the person has over it. Karasek categorized jobs in four sub-types: passive (low demand, low latitude), active (high latitude, high demands), low strain (high latitude, low demands) and high strain (low latitude, high demands). Some researchers examined the relationship between four types of jobs and job strain effect on employees' health. On one hand, from the high strain/demands aspect, the major difference between active and high strain jobs stems from one's autonomy, which is the key idea behind the model. It proposes that latitude operates as the buffer effect of high demands and can help to improve employees' job satisfaction via the self-development opportunities – engaging challenging tasks and learning new skills. High strain workers experience job dissatisfaction, emotional exhaustion (Landsbergis, 1988) and anxiety (Mark & Smith, 2012) more than other three quadrants. On the other hand, although active jobs do not differ from the passive jobs on strain scales, active employees report higher personal accomplishment and greater emotional exhaustion compared to passive employees (Landsbergis, 1988) while the anxiety levels are similar regardless of level of latitude (Mark & Smith, 2012). DCS model has proposed as appropriate for nursing samples due to common social support lack, excessive demands and the variability of control mechanism (Mark & Smith, 2012).

Secondly, Effort Reward Imbalance (ERI) Model had been structured on social reciprocity or with other words social exchange concept. Social reciprocity is " characterized by mutual cooperative investments based on the norm of return expectancy where efforts are equalized by respective rewards" (Siegrist, 2012, p.2). Reciprocity fails when this norm is violated and it causes strong negative emotions and sustained stress responses. Mechanism works similar in occupational life. Rewards involves three distribution categories namely; money, esteem and career opportunities. ERI claims that when employees spend high efforts (external demands or

internal motivations) and in exchange they receive low rewards (economic, recognition, promotion or job security), they will experience negative emotions and stress (Siegrist, 2012; Mark & Smith, 2012). Specifically, job demands, extrinsic effort and over-commitment (as the most important predictor) lead to higher levels of anxiety and depression (Mark & Smith, 2012). Similar to DCS model, high levels of reward buffer high levels of effort (Peter & Siegrist, 1999). However, unlikely to Herzberg's 2-Factor Theory, J. Siegrist's model claims that appropriate social rewards not only evoke positive emotions but also promote wellbeing, health and "survival". Mark & Smith (2012) also found that social support, rewards and skill discretion are negatively correlated with mental health problems.

2.2 Emotional Labor

Societal norms frame the appropriate emotions and roles in different occupations. In service sector, agents are obliged to display expected emotions during the work hours. Arlie Russell Hochschild (1983) defined emotional labor as "the management of feeling to create a publicly observable facial and bodily display" (p.7). Displayed emotions may be and often are different from the emotions are actually felt. Emotional labor can be performed in one of two ways; surface acting or deep acting (Hochschild, 1983). First, surface acting involves verbal and nonverbal cues, such as voice tone, facial expression and gestures, which enable employee to pretend expected emotions that are different from the genuine ones. Since display rules consist of behaviors rather than internal states, employee should simulate carefully to accomplish emotional labor. Second, deep acting is the attempts to experience or feel the emotions comply with the desired ones. Employee may accomplish deep acting in two ways: (1) reinforcing the feeling by actively attempting to evoke or suppress an emotion and (2) trained imagination/visualization by actively invoking memories, images and thoughts to induce desired emotion (Hochschild, 1983). Ashforth and Humphrey (1993) exemplified it with " In much the same way that actors 'psyche themselves' for a role, a service agent psyches himself or herself into experiencing the desired emotion" (p.93). Since, feelings are actively induced, suppressed, or shaped.

Organizational factors (explicitness of display norms, closeness of employee monitoring), job characteristics (form of interaction, task routineness) and individual differences (affectivity, gender) are the antecedents of emotional labor (Morris & Feldman, 1996).

Emotional labor has four dimensions; frequency of emotional display, attentiveness to display rules, variety of emotions to be displayed, and emotional dissonance (Morris & Feldman, 1996). They found that for occupations or roles require appropriate emotional display more *frequent*, work demands will be higher.

Employees expose the demand of more psychological energy and physical effort in service jobs due to higher attentiveness rules. *Attentiveness to display rules* consists of both the duration of emotional display and the intensity of emotional display. There are two reasons why duration may have an impact on the effort required to express organizationally desired emotion. First, the longer emotional displays go on, the more likely employees will become less scripted and more improvised; consequently, longer emotional displays require greater emotional endurance and attention (Hochschild, 1983). Second, in a prolonged interaction, more information about the customer may become available. The more getting acquainted, employees tend to show their own personal feelings and violate the organizational or occupational norms (Smith, 1992).

Emotional intensity refers to how strongly or with what magnitude an emotion is experienced or expressed (Morris & Feldman, 1996). Because deep acting focuses on one's inner feelings whereas surface acting focuses on one's observable behavior, Ashforth and Humphrey (1993) suggested that deep acting requires more effort due to the role occupant must actively exert to invoke memories, images and thoughts to prevail upon the associated emotion. Since emotional intensity is difficult to pretend, Morris and Feldman (1996) argued that occupational roles with intense emotion display requirement cause more deep acting and greater effort.

Occupations that require more *variety of emotions* – especially for intimate and complex human interaction tasks -, labor of role occupants will be greater (Morris & Feldman, 1996). Service providers (i.e. health care personnel) whose roles have to fit specific situational contexts, must alter emotions by more active planning and self-monitoring for their behaviors. Therefore, they have to spend greater psychological energy, thus, emotional labor. Morris and Feldman (1996) gave the example of university professors due to their roles in "positive emotions to build enthusiasm, negative emotions to support discipline, and neutrality of emotions to demonstrate fairness and professionalism" (p. 991).

Emotional dissonance is the conflict between organizationally demanded emotions and genuinely felt emotions (Morris & Feldman, 1996). Employees may experience emotional dissonance in case of displayed emotions clashes with what they actually feel. This conflict makes regulation of emotional expression more difficult and more labor intensive. Particularly for nurses, it is much more labor to display neutral expressions when a long-term patient strongly bonded with them is dying.

The amount of emotional labor is related with stress and consequently with the wellbeing of the employees. In helping industries, burnout is a common stress outcome (Grandey, 2000). Burnout occurs when customer interactions require over emotional involvement and employee struggles to replenish the spent emotional resources. The symptoms of burnout are emotional exhaustion, depersonalization and reduced personal accomplishment. Emotional labor may cause emotive dissonance, self-alienation and lower job satisfaction due to priming irredeemable customer expectations (Ashforth & Humphrey, 1993; Morris & Feldman, 1996). On the contrary, flexibility for self-expression in the customer interactions has been found positively correlated with personal wellbeing (Ashforth & Humphrey, 1993). However, Alicia Grandey (2000) emphasized that contradictions of the literature on the relationship between managing emotions at work and job satisfaction needs more examination in her review.

Ashforth and Fried (1988) assumed that service providers might develop habitual routines for surface and deep acting due to repetitive nature of service roles, which would make emotional labor relatively effortless. However, even if employee's feelings are congruent with the organizationally expected ones, s/he still must exert some effort to express oneself in desirable forms (Morris & Feldman, 1996), which may lead to emotional exhaustion.

In service sector, employees carry the burden of emotional labor on their shoulders in order to please and meet the expectations of customers. Morris and Feldman (1996) found that frequency of emotional display, attentiveness to display rules, variety of emotions to be displayed, and emotional dissonance lead to greater emotional exhaustion. Cynthia L. Cordes and Thomas W. Dougherty (1993) mention emotional exhaustion in other words as "compassion fatigue" with the explanation of "…may coexist with feelings of frustration and tension as workers realize they cannot continue to give themselves or be as responsible of clients as they have been in the past"

(p.623). Moreover, stress is another well-known antecedent of emotional exhaustion in health care personnel, which lead to negative feelings toward patients (Zyga et al., 2016). Mc Vicar (2003) stated that most of the situations confronted by nurses at work have a high cost in emotional labor.

2.3 Coping Strategies

Coping is defined as "cognitive and behavioural efforts to manage specific internal and/or external demands that are appraised as taxing or exceeding the person's resources" (Folkman et al., 1986a). It is the implementation of strategies in order to enable individuals to handle stressful events more efficiently and actively due to buffer effect (Koeske, Kirk & Koeske, 1993; Latack & Havlovic, 1992). Carver, Scheier and Weintraub (1989) developed an instrument to measure coping with the following facets; active coping, planning, suppression of competing activities, restraint coping, seeking social support for instrumental reasons, focusing on and venting of emotions, behavioral disengagement/helplessness, positive reinterpretation and growth, denial, acceptance and turning to religion. They used two theoretical models as guidelines; Lazarus model of stress and a model of behavioral self-regulation that has guided Carver and Scheir's researches for some time (1981-1988).

Active coping refers to the process of taking actions for removing or preventing the stressor source or to ameliorate the effects of it. Planning is developing an action draft in mind which, involves forming action strategies, thinking about what steps to take and how best to deal with the problem. Suppression of competing activities is the consciously ignoring other distractors to prioritization of handling the stressor. Restraint coping means is waiting for the first action on the right time to optimize the coping process. Seeking social support for instrumental reasons is seeking for information, assistance or advice. Focusing on and venting of emotions is the tendency to channel on the stressor to find a solution or adopt the best available coping strategy instead of flowing with the negative emotions about it. Behavioral disengagement or helplessness refers to reduced effort to deal with the stressor or even give up due to the expectation of poor coping outcomes. Positive reinterpretation and growth facet means managing distress emotions rather than dealing with the stressor. Denial or in other words, to avoid facing

with the stressor may cause even more important problems or more difficult to cope with. Acceptance, the opposite of denial, is the acquirement of information that indicates the stressor in primary appraisal. Therefore, that is a positive factor of the acceptance to keep going for the solution or facing with stressor. Although they had dilemmas for proposing the turning to religion facet, they clarified their reasons as following;

"One might turn to religion when under stress for widely varying reasons: religion might serve as a source of emotional support, as a vehicle for positive reinterpretation and growth, or as a tactic of active coping with a stressor" (Carver, Scheier & Weintraub, 1989, p.270).

2.3.1 Process-Oriented Approach

On the other hand, Lazarus proposed Transactional Model of Stress and Coping as the process through which the person assesses particular interactions with the environment whether is related with one's wellbeing and if so, potential effects of the exposure (Folkman et al., 1986a). In primary appraisal – the first step of cognitive appraisal – individual evaluates the probable harm or benefit with respect to one's "values, goals or commitments, jeopardy on a beloved one or potential threat for one's self-esteem". In secondary appraisal – the second step – person evaluates 1) the liable solutions for handling or preventing the harm 2) or to enhance the prospects for benefits. Primary and secondary appraisals co-function to determine whether person-environment transaction is significant and if so, assessing the potential threat (harm or loss) or challenge (inhibiting benefits or mastering). Thus, individual can adopt suitable coping strategy/strategies through perceptions and assessments in two-step appraisal system. In general, people cope with more than one strategy with an encounter due to fluctuating nature of stressors and changeability of appraisals. For instance, Folkman et al. (1986b) found that participants of their research used an average of 6.5 forms of coping in each stressful encounter.

Although appraisal system is illustrated as a linear unbreakable chain, this evaluative process is dynamic and fluctuant. Nature of stimulus varies with the combination of retrieving new data from the changing environment and unexpected information about one's own responses to the threat. Reappraisal process may be initiated as a result of the feedback or the unstable status of stimuli. According to conditions, perceived threat may not be jeopardy anymore while harmless

factors may become threats. Unless person finds the suitable coping or any change in situation, one can reappraise it in order to begin afresh from any step.

Transactional Model emphasizes coping based on process-oriented and context-focused actions. Process-oriented approach focuses on person's actual thoughts and behaviors in a stressful environment or event and the changes in these thoughts and actions as the encounter unfolds (Folkman et al., 1986a). They see coping as contextual, that is, affected by one's evaluation of the actual demands in the encounter and personal resources to meet the demands. In other words, "The emphasis on context means that particular person and situation variables together shape coping efforts" (p.993).

2.3.2 Trait-Oriented Approach

On the other hand, although Folkman and her colleagues (1986a) supported contextual and process-oriented coping approach, Carver et al. (1989) stressed the influence of personality and it's features on determining viable coping style. In trait-oriented approach coping is seen as a constant primary characteristic of individual that is slightly affected from variations in stressful situations. Past researches examined the correlation of coping styles and several aspects of personality. They mostly highlighted dispositional optimism, hardiness (composition of control beliefs, high commitment, challenge), Type A behavior (characterized by impatience, hostility, irritability, job involvement, competitiveness, achievement striving), neuroticism and trait anxiety.

According to Carver et al. (1989), optimists prefer active coping and do their best of encountered situation due to their favorable expectations for future, whereas pessimism is related with focus on emotional distress, thus, disengagement. Denial and behavioral disengagement positively correlate with anxiety and negatively correlate with optimism, self-esteem, hardiness, self-belief of being generally able to handle stressful situations and Type A (for behavioral disengagement) (Carver, Scheier & Weintraub, 1989). Moreover, active coping and planning are positively correlated with self-esteem, hardiness and Type A behavior while correlate negatively with trait anxiety (Carver, Scheier & Weintraub, 1989; Parkes, 1994). They also found that hardiness and self-esteem have similar patterns with reinterpretation and growth. The possible explanation for excluding Type As is that they differ from optimistic, hardy and high self-esteem individuals in

terms of their irritable and hostile personality features. Another research with moderately high scored nurses on Type A behavior showed, the most popular coping strategies were seeking social support for both instrumental and emotional reasons and problem-solving while the least popular coping strategies were avoidance and blame (Rout, 2000). Furthermore, optimism was also found positively correlated with problem-focused coping - especially when person has control over the situation - and positive reappraisal (Scheir, Weintraub & Carver, 1986). However, according to Folkman et al. (1986b), personality characteristics are more helpful to the stressed person under unchangeable events or low control over the situations such as in work context (low latitude jobs or positions) whereas coping is more helpful when one's efforts can change the consequences or process, such as in the context of marriage.

Nature of stressful conditions determines potential responses of dominant strategy, although individuals usually adopt both problem-and-emotion-focused-coping. Carver et al. (1989) explained the potential responses in terms of people tend to apply active coping strategies when they have control over the situation, however, they have tendency for strategies as denial and disengagement when the situation is not changeable or they have slight control over it. From a different perspective, Folkman and Lazarus (1980) explained the conditions, as when people perceive that circumstance can lead to a constructive consequence, they prefer problem-focused coping whereas when they feel that stressor is something that should be borne, emotion-focused coping is the dominant option. These strategies can be classified under two main schemes, namely method of coping and focus of coping.

2.3.3 Method of Coping

Firstly, methods of coping are active attempts on stressful events to solve them through cognitive and behavioral strategies and by excluding to avoid from the problem and reducing emotional tension reactions (Billings & Moos, 1981). Active cognitive coping is the attempts to alter one's perception of stressfulness level of the event, such as "tried to see the positive side of the situation" and "drew on my past experiences in similar situations" (Billings & Moos, 1981, p.141). Active behavioral coping involves direct actions to solve the problems and it's impacts, such as "tried to find out more about the situation" and "took some positive action." Avoidance coping refers to refrain from confrontations with the stressful event or to reduce emotional tension through indirect actions such as eating or smoking more than usual.

Frequent avoidance coping individuals deal with more threatening and negative life experiences, which may lead the risk for general or occupational negative consequences (Koeske, Kirk & Koeske, 1993) and depression symptoms in future (Holahan et al., 2005). However, several researchers proposed avoidance/escape from the problem as a potential advantage, even as a necessary component of coping (Latack & Havlovic, 1992; Lazarus & Folkman, 1984). When the individual has not prepared oneself to deal efficiently with the issue or if in the situation cannot been altered (Lazarus & Folkman, 1984).

Positive reappraisal, a form of meaning-based/cognitive coping, is the adaptive process by which stressful events are re-interpreted as benign, valuable, or beneficial (Folkman, 1997) which is often adopted as the first step of an efficient re-engagement with the stressor (Garland, Gaylord & Fredrickson, 2011). It's a widely used (Nelson & Sutton, 1990) active coping strategy instead of a defense mechanism for repressing or denying (Garland, Gaylord & Park, 2009). This cognitive strategy is negatively correlated with stress and positively correlated with mental health outcomes (Garland, Gaylord & Frederickson, 2011).

2.3.4 Focus of Coping

Secondly, focus of coping is formulated by problem-focused coping and emotion-focused coping (Lazarus, 1995; Billings & Moos, 1981). Lazarus and Folkman (1984) described problem-focused orientation as a defense mechanism for coping with environmental stressors that is channeled at defining problems, raising new solutions, considering the benefits and costs of alternatives and acting through the chosen best alternative. Problem-focused coping consists of transforming the current relationship due to seek information about required actions to be taken and taking that actions by changing one's behavior or taking action on the environment. According to Carver et al. (1989), adopting problem-focused coping consists of 1) active coping or the attempt to remove the stressor, 2) planning, 3) suppression of competing activities, 4) waiting for the appropriate time or restraint coping or waiting to deal with the problem, and 5) seeking social support for instrumental reasons such as seeking advice, assistance or information.

When coping actions remodel the person-environment relationship in a better state, they obviate or diminish the exposed threat - refers to a harm that has not yet happened - or harm – damage

has already occurred as in loss of job, poor performance evaluation, negative social reactions from supervisor, manager or peers - and other possible negative results in work context. Thus, potential emotional reaction is altered. Problem-focused forms of coping vary between aggressive interpersonal efforts to alter the situation, and cool, rational, deliberate efforts to problem solve (Folkman et al., 1986a). Furthermore, it has been found that task coping is negatively correlated with depression and physical symptoms while it's positively correlated with self-confidence (Nelson & Sutton, 1990).

Emotion-focused coping consists of efforts avoiding the source or changing the meaning of what's happening and what will happen by positive thinking, distancing or denial in order to regulate the emotional distress caused by harm or threat. It involves cognitive or behavioral efforts to manage stressors and their effects in order to regulate emotions (Billings & Moos, 1981). Potential emotion-focused reactions are distancing, self-controlling, seeking social support, escape-avoidance, denial, positive reinterpretation and accepting responsibility (Folkman et al., 1986a; Carver, Scheier & Weintraub, 1989). Expectation of social support arises from the need to feel understanding and sympathy. Efficacy and consequences of emotion-focused coping have contradictory results in literature. On one hand, positive correlation with depression, dysfunctional physical symptoms and anxiety has been found (Nelson & Sutton, 1990). However, on the other hand, Lazarus proposed that if the situation is not suitable to change, emotion-focused coping is the best strategy, while rational problem-solving attempts can be counterproductive and even may lead to chronic distress when they fail (Lazarus, 1993).

Adopting suitable coping style is not only dependent on perception and appraisal of the variables in terms of context, autonomy, dependency on unchangeable factors and priority of the threat or harm but also some gender differences have an influence. Lazarus et al. (1986a) found that when threat to self-esteem is high, individuals use more confrontive coping, self-control and escape-avoidance coping. Addition to that, they accept more responsibility and seek less social support compared to when threat to self-esteem was low. When a person's self-esteem is involved in the encounter, one's internal state has more influence on the potential response to stress source and coping style rather than environmental factors (Folkman et al., 1986b). Also, they noted that self-esteem encounter had the highest autocorrelation of the primary and secondary appraisal variables which means it is one of the most dependent one to internal state compared to other variables such as goal at work, seeking social support, accepting responsibility and distancing.

The other most dependent variable is not surprisingly positive reappraisal with the highest mean autocorrelation. They assumed that personality characteristics might have a stronger influence on positive reappraisal compared to other coping styles due to stable results among different populations. Conversely, problem-focused coping was found strongly affected by the situational context. In general, they found low autocorrelations among primary and secondary appraisals. Thus, they proposed that appraisal variables are sensitively influenced by the conditions in the environment.

2.3.5 Gender Differences

Scope of focus and impact of different coping styles vary between two genders due to their nature. Past research showed that women focus on and vent emotions, and seek social support for both instrumental and emotional reasons more than men whereas men are more prone to use of alcohol or drugs as a coping strategy, which are consistent with sex role stereotypes (Carver, Scheier & Weintraub, 1989). According to another research, women have a tendency to adopt strategies focused on the emotion regulation whereas men often prefer strategies focused on solving the problems (Zyga et al., 2016). They also found a statistically significant relationship that women are more prone to use "Prayer / Daydream", "Prayer", "Searching of divine intervention", "Avoidance / Escape" and "Denial" strategies. From the focus aspect, women are more considerate for a loved one's wellbeing more than men whereas men attach more importance to a goal at work more than women do (Folkman et al., 1986b). Optimism also was found that it is positively associated with the seeking of social support, but only among men when situations perceived as uncontrollable while association could not be found reliable among women (Scheier, Weintraub & Carver, 1986).

2.3.6 Coping in Health Service

Health care workers expose persistent stressful events such as death, pain and grief in their daily life and work tasks, contrary to most of the other occupations. Particularly for health care workers, identified organizational stressors are timetables, work overload, lack of autonomy and authority, demand-load from the patients and their relatives, lack of support from the supervisors and colleagues, contact with death, temporary replacement and lack of knowledge (Landra et al, 2008; Zyga et al., 2016). Timetables' impact on employees is important due to shift work and

night shift influence on biological rhythm, altering the sleep cycle and work-family relations. From the demand-load aspect, health service jobs, especially nursing, require more than making beds, giving medication and doing the basic care. The holistic approach involves providing psychological care and support alongside the physical care too (McNeely, 1995). However, nurses often are not able to provide the requirements of this approach because of staff lack, although it has been accepted and demanded by the patients for decades, which causes stress. Furthermore, nurses reported more stress, 1) when they have to work temporarily in other services owing to staff shortage, 2) when they do not know how to handle and/or operate equipment and 3) when they have problems with colleagues. The main consequences of these are somatic diseases, suicide attempts, alcoholism, exhaustion and absenteeism (Landra et al, 2008). Moreover, coping characteristics such self-blame, escape/avoidance, and wishful thinking, which are labeled as negative coping, cause anxiety and depression whereas problem-focused coping has a small but significant correlation with depression (Mark & Smith, 2012).

Five main stressors influencing the level of satisfaction among nurses are defined as job demands, lack of communication, work environment, problems with patients, personal/professional life imbalance and career development (Rout, 2000; McNeely, 1995). However, four of them – except problems with patients - were found to be the predictive of high levels of job dissatisfaction. Work environment factors were listed namely; lack of staff, exhausting shifts, lack of autonomy and authority, demand-load from the patients and their relatives, lack of support from the supervisors and colleagues, use of technology and frequent exposure to death (Zyga et al., 2016).

Zyga et al. (2016) finically examined health care workers' coping strategy preferences, their antecedents and effects. Ways of Coping Questionnaire were used in their research to detect differences caused by each variable and they found that gender, educational level, job position, nursing department and the number of patients in morning and afternoon shifts have an influence on coping strategies.

- Gender results were aforementioned above.
- Education factor showed that nurses with postgraduate degree had higher scores in *positive approach, positive re-evaluation, assertive problem solving* and *seek social support* than other nurses have not postgraduate degree. Nurses without postgraduate degree had higher scores in *prayer* and *prayer/daydream*.

- Job position factor analysis showed that deputy head nurses in clinical departments had higher scores in *positive approach* and *positive re-evaluation* whereas head nurses had higher scores in *problem solving* and *denial* strategies. Other nurses had lower scores in all kind of coping.
- In nursing department, nurses in laboratory had lower scores in most of the coping strategy – *Prayer, prayer/daydream, avoidance-escape* and *denial* – whereas surgical department had highest scores in three of them except *denial.* Lastly, intensive care unit nurses had the highest score in *denial.*
- Moreover, they found a significant correlation between coping strategies (*positive approach* and *positive re-evaluation)* and shifts (number of patients of morning shift and night shift). Nurses in morning shift tend more to use *problem solving,* however, they use more *assertive problem solving* in afternoon shifts.
- Lastly, working experience in years has been found correlated with *avoidance-escape* and *denial* strategies.
- However, they did not find any significant relationship with age and marital status.

2.4 Self-Compassion

Kristin D. Neff first coined this concept scientifically in 2003 by inspiring from and modifying self-attitude construct derived from Buddhist psychology. She proposed self-compassion as a healthy form of self-acceptance. It represents a friendly, warm and accepting manner towards those aspects of oneself and one's life that are disliked. It involves six main components namely; (a) self-kindness versus self-judgment, (b) common humanity versus isolation, (c) mindfulness versus over identification (Neff, Rude & Kirkpatrick, 2007).

First, it involves being understanding and kind to oneself in occurrence of suffering events or perceived inadequacy, desire to alleviate one's own suffering and actively soothing and comforting oneself. She stresses the importance of adopting the non-judgmental attitude towards oneself like treating to a friend rather than being harshly self-critical. Because people are mostly much judgmental and unkind toward themselves compared to their reactions to others they cared about, or even to strangers (Neff, 2003).

Secondly, it involves a sense of common humanity, being aware of and recognizing that pain and failure are unavoidable aspects of the shared human experience instead of experiencing them isolated. Since, being imperfect, making mistakes and encountering difficulties are the issues of humankind, not for one self to be isolated (Neff, Pisitsungkagarn & Hsieh, 2008).

Lastly, mindfulness is the balanced awareness of one's emotions. In other words, it's the ability to face painful thoughts and feelings instead of avoiding them, but without exaggeration, catastrophizing or self-pity.

Self-compassion is a distinct notion from self-pity by not involving the main characteristics of it. For instance, individuals who pity themselves can be described with the lost of common humanity and being prone to over-identify their feelings, thoughts and experiences. However, self-compassion enables to break self-absorption by relating one's own suffering to others' and positioning pain in mindful awareness (Barnard & Curry, 2011).

Self-compassion is strongly related to mental wellbeing. Hence it's negatively correlated with depression, anxiety, stress, rumination, thought suppression and neurotic perfectionism while being equally strongly related to positive states such as happiness, social connectedness and life satisfaction (Neff, 2003). It's linked to greater motivation, taking greater self-responsibility and making healthier lifestyle choices. It's also linked to having more sense of connectedness with others and better interpersonal relationships (Neff, 2003). Self-compassion offers the benefits of self-esteem without the pitfalls. It's associated with strong mental health whereas it's not associated with narcissism or constant social comparison or ego-defensive aggression. It also provides a much more stable sense of self-worth then self-esteem does, since it's related with one's perception of self not the set standards compared with others (Barnard & Curry, 2011).

Deci and Ryan (1995) suggested that "true self-esteem" – which is a sense of self-worth is not linked with extrinsic standards or expectations but is assumed as authenticity of being – develops when an individual acts according to his or her inherent nature. In other words, true self-esteem can be gained when person behaves autonomous, self-determined and intrinsic instead of being prone to behave with extrinsic motivation sources such as potential external threats or rewards. Because high self-compassionate individuals have true self-esteem, expected behavior is higher intrinsic motivation to accomplish a goal or learn new skills.

Moreover, self-compassion is positively correlated with mastery orientation (being motivated by curiosity and the hanker to gain new skills) whereas negatively correlated with performance orientation (the motivation to defend or enhance one's self-worth) (Neff, Hsieh & Dejitterat, 2005).

Mark R. Leary and his colleagues (2007) conducted an experiment in order to compare self-compassion and self-esteem by examining self-compassionate people's cognitive and emotional processes to deal with unpleasant life events. Participants responded fictional scenarios, reacted to interpersonal feedback, rated their or others' visual records in awkward and mildly embarassing circumstances.

Results showed that;

- Self-compassion predicted emotional and cognitive reactions to negative events in everyday life,
- Self-compassion buffered people against negative self-feelings when imagining distressing social events.
- Self-compassion moderated negative emotions after receiving ambivalent feedback, particularly for participants who were low in self-esteem.
- Low-self-compassionate people undervalued their videotaped performances relative to observers.
- Self-compassion leads people to acknowledge their role in negative events without feeling overwhelmed with negative emotions.

In general, the results indicated that high-self-compassionate people react to negative life events different from and in some cases more beneficial than low-self-compassionate people. In other words, self-compassion has a moderating effect between the reactions to real and potential failure, by reducing the averseness of self-esteem threatened events.

As it mentioned before, Kristin D. Neff (2003) proposed the self-compassion term as a healthy form of self-acceptance on the contrary to self-esteem. Although self-esteem has shown as a factor in psychological health and is assumed by many psychologists it is a universal and fundamental need (Croker & Park, 2004), it consists of self-judgment – which is not involved in self-compassion. Self-judgment is the comparison to set standards in domains of perceived

importance such as performance, being liked by others or peer's ideals about oneself (Neff, 2003).

Schools across the United States have implemented programs with targeting to boost students' self-esteem in order to reduce problems such as high dropout rates, teenage pregnancy, and drug and alcohol abuse (Crocker & Park, 2004). However, this self-esteem movement in schools has been causing not only an increase on student self-esteem but also on the bullying rates (Neff in press). Culture effect was evaluated among United States, Taiwan and Thailand by measuring self-compassion and self-esteem scores. Results showed that participants in Thailand had the highest self-compassion scores followed by United States and then Taiwan while participants in United States had the highest self-esteem scores compared to Thailand and Taiwan (Barnard & Curry, 2011).

Researchers proposed that self-compassion could be taught by several training methods namely; Compassionate Mind Training, The Compassionate Image, Gestalt Two-Chair, Mindfulness Based Stress Reduction and Mediation, Dialectical Behavior Therapy, and Kristin Neff's long and short-term self-compassion trainings. In this paper, researcher applied Neff's short-term self-compassion training to twenty health workers (20 doctors and a nurse). This training includes writing a one-paragraph compassionate letter to themselves each day for a week. Neff found that letter exercise significantly reduce depression, which lasted up to three months and increased happiness, which endured up to six months (Neff in press).

Compassionate Mind Training (CMT) is a therapy to teach patients with high self-criticism and shame, how to generate self-soothing and self-reassuring thoughts. CMT proposes self-judgmental and self-kind pathways in brain, which inhibits one another. The main mechanism of this treatment is enhancing the self-kind pathway to enable cognitive and affective shift. Patients learn not only how to react with assertiveness instead of submission to their critical voice but also as a prevention for long-term they learn self-compassion as an ability that can be learned whereas judging oneself is only a habit, which can be handled (Gilbert & Procter, 2006). Nowadays, Gilbert's therapy is widely used in United States and United Kingdom to treat shame-based difficulties and self-criticism, anxiety, psychosis, personality disorders, anger management problems, mood disorders, eating disorders, smoking cessation, to build

compassionate management in organizations and in education domain (The Compassionate Mind Foundation).

The Compassionate Image Therapy (CIT), which aroused from Buddhist's visualization technique, involves soothing and calming visions in mind as the perfect nurturer figure offers unquestioning warmth and acceptance without judgment to learn or improve self-compassion (Barnard & Curry, 2011). Gilbert and Irons (2004) applied this technique on depressed and high self-criticizing group to study self-compassion and it's effects on mental health. Participants were asked to create two selves that attributed to one harsh self and the nurturing self – Gestalt Two Chair. They noted that in CIT exercises imagining the nurturer part was more difficult for participants that high in self-criticism while they could easily imagine the attacking part of self with hostile, powerful and controlling characteristics and vice versa for the low in self-criticism. While they were conducting the CIT exercises in second session with the participants, introduction below were used;

> *"When we attack ourselves we stimulate certain pathways in our brain, but when we learn to be compassionate and supportive of our efforts we stimulate different pathways. Sometimes we are so well practiced in stimulating inner attacks that our ability to stimulate inner support and warmth is rather underdeveloped. What we would like to do today is see if we can generate some compassionate images and ways of thinking that you can practice using over the next week and see how this may help you."*

Most of the participants imagined a natural vision such as white bush with comforting arms, floating in warm sea, rainbow, sunset and mountains except one participant who imagined arm round her shoulder.

In Gestalt Two-Chair approach participant vocalizes two conflicting selves – self-critical and "experiencing" that feels criticized - in order to reflect both selves' own values, wants and needs. They are asked to behave and talk for the both selves by moving between two chairs (Neff, Kirkpatrick & Rude, 2007). Principle of this technique is to make the criticizing self feels compassion for the newly discovered one in order to transform the judged and feeling unworthy self to an appreciative one.

Mindfulness-based stress reduction and meditation (MBSR) teach participants to label, tolerate, accept and adopt thoughts and feelings instead of ignoring or reacting them through improving awareness in current moment and disengaging self-judgment (Shapiro et al., 2005). It is a structured 8-10 week, group program with groups mostly varying between 10 and 40 participants (Grossman et al., 2004). Participants can be grouped heterogeneous or homogeneous - related to their disorders or problem areas. Sessions are typically conducted during 2.5 hours per week, and an additional single all-day session per course on a weekend day. Particular exercises and topics that are examined within the context of mindfulness are applied in each session. These consist of different forms of mindfulness meditation practice, mindful-awareness during yoga postures and mindfulness during social interactions and stressful situations. Participants are responsible of carrying out daily 45 minutes homework assignments due to the repetition-need nature of mindfulness development. These assignments include meditation practice, mindful-yoga and applying mindfulness to everyday life situations. It can be applied to a wide range of individuals; ones with pain, cancer, heart diseases, depression or healthy ones whose goal is to improve their abilities to cope with daily life stressors.

Dialectical behavior therapy (DBT) is the combination of eastern mindfulness practices and basic strategies of behavior therapy (Dimeff & Linehan, 2001). DBT involves two main paths, acceptance and change. In acceptance procedures, mindfulness (e.g., focusing on effectiveness attention to the present moment, assuming a non-judgmental stance) and a variety of validation and acceptance-based strategies are included. Change strategies in DBT involve cognitive modification, exposure-based strategies, behavioral analysis of maladaptive behaviors and problem-solving techniques (skills training, contingency management). DBT serves the following five functions; 1) improves behavioral capabilities, 2) augments motivation to change, 3) assures that new capabilities are generalizable to the natural environment, 4) prioritizes client and therapist capabilities in treatment environment structuring, and 5) enhances therapist capabilities and motivation for effective treatment of clients. It can be used for borderline personality disorder, binge eating disorder, suicidal behaviors and drug addiction among both adults and adolescents (Linehan et al., 2006; Linehan et al., 1999; Telch et al., 2001; Miller et al., 1997).

3. Method

3.1 Participants

The study was conducted with 43 health care personnel who work in two Turkish government hospitals (11 participants from Istanbul University Cerrahpaşa Medicine Faculty Hospital, 27 participants from Hamidiye Şişli Etfal Research and Training Hospital and 5 participants from other hospitals in Turkey). Therefore, some of the health care workers in these two hospitals are also responsible of teaching and practice duties. Participants included 33 doctors and 9 nurses from different age ranges. Although 43 health personnel participated to first phase (taking the self-compassion scale), 16 of them drop out of the experiment and did not participate to third phase (re-taking the self-compassion scale). Most of them were 25-34 years old (37.2%) and least were more than 55 years old (9.3%). They reported that 62.8% work between 40 to 50 hours per week (32.6% work more than 55 hours per week while 4.7% work less than 40 hours). Majority of participants (60.4%) have work experience more than 11 years (30.2% 11-20 years, 30.2% more than 20 years). However, most of them (44.2%) have been working at the same organization less than 5 years. Almost all of them are full-time employees (90.7%) with a permanent contract (83.7%). For sick leave, 81.4% of participants had less than 10 days in previous year. They reported that more than half are in a stable relationship (72.1%) and have 1 or more children (51.2%). Lastly, as another indicator of perceived stress, they were asked about economical difficulties they experience in general and results showed that 60.5% *sometimes* have difficulties.

3.2 Procedure

The study was conducted with doctors in Turkish hospitals on April 2018 in order to assess self-compassion moderation between occupational stress (IV) and work engagement (DV). All the participants were informed of study's objective, confidentiality and anonymity on the first page of survey. They were assigned randomly to training and control groups though the determination of lowest self-compassion scores. Questionnaires were sent via Google Survey in the beginning of April. In total, questionnaire consists of 74 questions including demographics. Demographic questions include age, relationship status, number of child, occupation (nurse or physician), organization name, working hours per week, experience in years, working years in current organization, contract type and duration, economic difficulties, days of sick leave in the previous year, smoking habits and diabetes. These questions were about the important domains for

engagement and burnout/stress facets. Years in same organization, contract type (full-time, part-time) and duration (temporary, permanent) were asked for engagement. Economic difficulties, smoking habits ("I do smoke but I do not have an intention to quit", "I do smoke but I am trying to quit", "I do not smoke") and diabetes ("I have diabetes but my blood sugar is stable", "I have diabetes but my blood sugar is not stable", "I do not have diabetes") were asked for perceived stress. Lastly, days of sick leave was asked for burnout.

Names of questionnaires were written before the each one to facilitate filling process. The questionnaires used are namely with the same order; Neff's Self-Compassion Scale, Kohen's Perceived Stress Scale, Schaufeli's Utrecht Work Engagement Scale and Kristensen's Copenhagen Burnout Scale. They were asked to designate a personal nickname including letters and numbers in order to differentiate the participants' responses to compare first and second results after training. They wrote their nicknames on the first page of survey. First survey collection took one week. After 44 responses received, 23 participants were asked to write themselves daily one-paragraph self-compassionate letters for one-week with the following instructions;

"To start writing your own letter, try to feel what part of you that can be kind and understanding of others. Think about what you would say a friend in your position, or what a friend would say to you in this situation. Try to have understanding for your distress (e.g. I am sad you feel distressed) and realize your distress makes sense. Try to be good to yourself. Make sure this letter provides you with what you think you need to hear in order to feel nurtured and soothed about your stressful situation or event."

Two-weeks later than one-week training session, Google Survey link was sent again via e-mail in order to ask participants to fill the same questionnaire. As the surveys were completed, each was reviewed for completeness and data were entered into the SPSS database.

3.3 Measures

3.3.1 *Self-Compassion Scale (SCS)*

The scale comprised of 12 items, which assesses trait levels of self-compassion. The scale was developed by Kristin Neff (2015) to explicitly represent the thoughts, emotions, and behaviors associated with the six facets of self-compassion. It consists of items that assess how frequent people respond to feelings of suffering or inadequacy with *self-kindness* (e.g., "I try to be loving toward myself when I'm feeling emotional pain"), *self-judgment* (e.g., "I'm disapproving and judgmental about my own flaws and inadequacies"), *common humanity* (e.g., "I try to see my failings as part of the human condition"), *isolation* (e.g., "When I think about my inadequacies it tends to make me feel more separate and cut off from the rest of the world"), *mindfulness* (e.g., "When something painful happens I try to take a balanced view of the situation"), and *over-identification* (e.g., "When I'm feeling down I tend to obsess and fixate on everything that's wrong"). Responses are given on a 5-point likert type scale from "Almost Never" to "Almost Always". Items representing uncompassionate responses to suffering are reverse-coded so that higher scores represent a lower frequency of these responses. Then, means are calculated for each subscale, and a grand mean is calculated that represents an overall measure of self-compassion (Neff, 2015).

Factor loadings of these subscales in Neff's studies were as follows: for *self-kindness*, .71-.77; for *self-judgment*, .65-.80; for *common humanity*, .57-.79; for *isolation*, .63-.78; for *mindfulness,* .62-.80; for *over-identification*, .65-.78. Cronbach's alpha coefficient for the overall scale was .92, and for the subscales .78, .77, .80, .79, .75, .81, respectively. Test-retest reliability coefficient for the overall scale was .93, and for the subscales .88, .88, .80, .85, .85, .88, respectively (Neff, 2003).

SCS was transcribed to Turkish version with three professors fluent in English. The original form and the Turkish version were administered to English Language teachers twice with a two-week interval between the two administrations to check the language equivalence of the scale. A significant positive relationship was found between the scores from the Turkish and English forms of the SCS administered over a two-week period ($r = .96$, $p < .001$). Therefore, the translated version was accepted as equivalent to the original. After the Turkish version of the SCS had been administered twice as described, resulting reliability coefficient was $r = .83$ (Deniz, Kesici & Sümer, 2008).

3.3.2 *Perceived Stress Scale (PSS)*

The PSS is the most widely used psychological instrument for measuring the perception of stress, which was constructed by Sheldon Cohen (1994). It measures the degree of which situations in one's life are perceived as stressful. Items were designed to assess how unpredictable, uncontrollable, and overloaded respondents find their lives. The scale also includes a number of direct questions about present levels of experienced stress. The PSS can be used in community samples with at least a junior high school education. Moreover, the questions are generalizable to population due to the free of content specific nature to any subpopulation group. The questions in the PSS ask about feelings and thoughts during the last month. In each case, respondents are asked how often they felt a particular way (Cohen, 1994).

The 10-item Perceived Stress Scale was used to assess on a five-point likert type scale how often (0=never, 4=very often) in the past month participants found their lives unpredictable, uncontrollable, and overwhelming and includes items like "How often have you felt nervous and 'stressed'?" and "How often have you felt that you were on top of things?" PSS scores are measured with reversed responses to the four positively stated items (items 4, 5, 7, & 8) and then summing across all scale items.

The internal consistency reliability coefficient for the Turkish version of the PSS-10 was 0.82. The test-retest reliability coefficient for the version of the PSS-10 was 0.88. Factor analyses indicated that the items of PSS-10 loaded on two factors namely; "perceived insufficient self-efficacy" and "perceived stress/distress". Results showed the three versions of the PSS to possess highly adequate reliability and validity (Eskin et al., 2013).

3.3.3 *Utrecht Work Engagement Scale (UWES)*

Schaufeli and Bakker constructed UWES after Maslach and Leiter (1997)'s Burnout Inventory (MBI). They stress that examination of burnout and engagement on a continuum as the negative and positive poles is not effective (Schaufeli & Bakker, 2004). MBI assesses the engagement via opposite scoring pattern of exhaustion, cynicism and reduced professional efficacy as the three facets of burnout. In other words, low scores on the exhaustion and cynicism scales and a high score on the professional efficacy scale of the MBI is indicative of engagement.

According to Schauefeli and Bakker (2004), there are two major flaws of opposite scoring (see Schauefeli & Bakker, 2004). For this reason, they define burnout and engagement as distinct concepts that should be measured independently. According to their work engagement definition, dedication and vigor are considered direct opposites of cynicism and exhaustion, respectively. The continuum that is spanned by dedication and cynicism has been labeled identification, whereas the continuum that is spanned by vigor and exhaustion has been labeled energy or activation (Schaufeli & Bakker, 2001). Thus, work engagement is defined by strong identification with one's work and high level of energy. Lastly, they eliminated the professional inefficacy and added absorption as the state of "being immersed and happily engrossed in one's work" (Schaufeli & Bakker, 2004, p.5).

Vigor is assessed by six items (α = .83), that refer to "high levels of energy and resilience, the willingness to invest effort, not being easily fatigued, and persistence in the face of difficulties" (Schaufeli & Bakker, 2004, p.6). Those who score high on vigor usually have much energy, enthusiasm and endurance in work context, whereas those who score low on vigor have less energy, enthusiasm and endurance as far as their work is concerned.

Dedication is assessed by five items (α = .92) that refer to "deriving a sense of significance from one's work, feeling enthusiastic and proud about one's job, and feeling inspired and challenged by it" (Schaufeli & Bakker, 2004, p.6). Those who score high on dedication work is experiences as meaningful, inspiring, and challenging, thus, they are mostly identified with their work. Those who score low do not identify with their work since their experience is neither about meaningfulness, inspiration nor challenges.

Absorption is measured by six items (α = .82) that refer to "being totally and happily immersed in one's work and having difficulties detaching oneself from it so that time passes quickly and one forgets everything else that is around" (Schaufeli & Bakker, 2004, p.7). Those who score high on absorption feel to be engrossed in their work and have difficulties detaching from it whereas those who score low experience the opposite feelings.

The examination of UWES-15 related with different occupational groups showed that physicians had the lowest scores in all three facets of engagement, namely vigor (M= 3.04, SD= 0.92),

dedication (M= 3.29, SD= 0.92) and absorption (M= 3.10, SD= 0.87) compared to total group scores (M= 3.91, SD= 1.10; M= 3.58, SD= 1.18; M= 3.82, SD= 1.10), respectively.

Results of Turkish version indicated that UWES-TR has an adequate level of reliability and validity (Eryılmaz & Doğan, 2012). The factor structure of the Turkish version of the scale was found to be similar to the original version. Reliability of UWES-TR was examined by internal consistency and test-retest reliability methods. According to the results, Croncbach's alpha of UWES-TR was measured as .94. The vigor subscale consisted of 6 items (α = .94), the dedication subscale consisted of 5 items (α = .87), and the absorption subscale consisted of 6 items (α = .84). Scale was given twice with a one-month range to 31 employees in order to evaluate test-retest reliability. Results showed that test-retest coefficient is .89 for total, vigor (α= .89), dedication (α= .80) and absorption (α= .69).

3.3.4 *Copenhagen Burnout Inventory (CBI)*

CBI consists of three sub-dimensions to measure all kinds of participants whether they work, conversely to Maslach Burnout Inventory (MBI). Kristensen et al. (2005) designed CBI to compensate the pitfalls of MBI (see Kristensen et al.'s article for pitfalls). These dimensions are personal burnout, work-related burnout and client-related burnout. The personal burnout subscale was designed for all human beings regardless of their occupational status (e.g. young people, early retired, unemployed or pensioners) even if they do not work. The personal burnout dimension is defined in the following way: ''Personal burnout is the degree of physical and psychological fatigue and exhaustion experienced by the person''. (Kristensen et al., 2005, p. 197). The work-related burnout questions can be used for everyone who has a paid job. They define work-related burnout as "The degree of physical and psychological fatigue and exhaustion that is perceived by the person as related to his/her work" (Kristensen et al., 2005, p.197). Comparing personal burnout scale and work-related burnout scale enables researchers to identify participants who are tired due to non-work factors such as, e.g. health problems or family demands instead of occupational stress. Lastly, the questions on client-related burnout involve the term 'client' – or a similar term when appropriate such as patient, student, inmate, etc. It is defined as "The degree of physical and psychological fatigue and exhaustion that is perceived by the person as related to his/her work with clients" (Kristensen et al., 2005, p.197).

Cronbach's alpha for internal reliatbility was found very high (.85-.87). Predictive validity results showed strong positive associations between burnout and future sickness absence, sleep problems, use of painkillers, and intention to quit. Hospital doctors (39.8), hospital secretaries (37.8), associate nurses (36.1) and nurses (35) had higher scores in work-related burnout compared to mean score (33) in Project on Burnout, Motivation and Job Satisfaction study of Kristensen et al. (2005).

Turkish version of CBI was adapted by Marmara University academics with high reliability and validity (Deliorman et al., 2009). It was transcribed to Turkish by responses of 351 university staff. Cronbach's alpha values are personal burnout (.87), work-related burnout (.87) and client-related burnout (.85) in total CBI (.87).

4. Results

Demographics

The correlation between diabetes and perceived stress was intended to be measured, however, tests could not been run due to low participant number (2) of "I have diabetes but my blood sugar is not stable" level which was found as a factor for higher perceived stress according to literature (Cohen, 1994).

Intention to quit smoking was presented as another factor for higher perceived stress. Point-biserial correlation was run to assess three levels of smoking (non-smoker, smoker, smoker with intention to quit). There was homogeneity of variances for perceived stress scores for three levels of smoking (non-smokers, smokers, smokers with intention to quit), as assessed by Levene's test for equality of variances ($p = .079$). Perceived stress scores for levels of smoking habit except smokers were normally distributed, as assessed by Shapiro-Wilk's test ($p > .05$). "Smokers" level was eliminated in order to run point-biserial correlation test in SPSS. There were only five participants who are "intended to quit smoking". SPSS did not show any results due to few participants. Lastly, non-smoker participants and participants who have the quit intention were assessed together for the correlation with perceived stress but the results were not significant, $p > .05$.

A one-way ANOVA was conducted to determine if the burnout (CBI score) was different for groups with different occupations. Participants were classified into two groups: doctors (n = 33) and nurses (n = 9). There were no outliers, as assessed by boxplot; data was normally distributed for each group, as assessed by Shapiro-Wilk test (p > .05); and there was homogeneity of variances, as assessed by Levene's test of homogeneity of variances (p = .193). There was not a significant difference between group means, nurses (max: 75, min: 45) and doctors (max: 82, min: 29).

In preliminary analysis of Pearson correlation coefficient, engagement was found correlated only with age in a positive pattern in demographics (r = .305, *p* = .047) and SES in a negative pattern (r = -.317, *p* = .038) whereas burnout total score was positively correlated with only economic difficulties (r = .409, *p* = .007). Pearson correlation coefficient was used again for results of burnout facets. Personal burnout and client-related burnout were found positively related with economic difficulties, r = .423, *p* = .005; r = .306, *p* = .049, respectively. However, work-related burnout was found positively correlated with economic difficulties (r = .377, *p* = .013) and negatively correlated with age (r = -.342, *p* = .025). Lastly, self-compassion was found only negatively correlated with economic difficulties (r = -.382, *p* = .011).

Hypothesis 1 – Differences in Self-Compassion Score After Training

A paired-samples t-test was conducted to compare the scores of self-compassion questionnaire in before and after training conditions. There were no outliers in the data, as assessed by inspection of a boxplot for values greater than 1.5 box-lengths from the edge of the box. The assumption of normality was not violated, as assessed by Shapiro-Wilk's test (p = .623). The difference scores for the self-compassion scores before and after the training were normally distributed. Participants had higher scores in self-compassion questionnaire before compassionate letter training (M = 40.85, SD = 6.59) as opposed to the after training (M = 40.21, SD = 7.10) (Table 1). There was not a significant difference in the scores for self-compassion before training (M=40.85, SD=6.59) and after training (M=40.21, SD=7.10) conditions; t(27)=-.56, p = .578. These results suggest that self-compassion training does not increase self-compassionate behavior. Specifically, results suggest that 1-week self-accomplished training does not have a significant effect in 2-weeks among health care personnel.

Hypothesis 2 – Hayes Process Moderation Effect of Self-Compassion

To test the hypothesis that work engagement is affected by burnout and more specifically whether self-compassion moderates the relationship between burnout symptoms and work engagement, a linear multiple regression analysis was conducted. The overall model was significant, R^2=.54, $F(3,39)$= 15.5, p =.000. Self-compassion was not a direct significant predictor of engagement, β= 1.05, $t(39)$= -1.33, p= .2. Burnout was found as a significant predictor of engagement, β= -1.50, $t(39)$= -3.29, p= .002. Moderation interaction was found significant, R^2= .071, $t(39)$= 2.48, p= .017. For low self-compassion, burnout β= .11, $t(39)$= -4.52, p= .0001, for employees with low self-compassion score (32) there is a significant relationship between burnout and work engagement. Every unit in burnout decreases .11 points in work engagement score. For average self-compassion, burnout β= .12, $t(39)$= -2.05, p= .048, for employees with average self-compassion score (39.63), there is a significant relationship between burnout and work engagement. Every unit in burnout decreases .12 points in work engagement score. For high self-compassion, β= .19, $t(39)$= -.01, p= .99, there is no relationship between burnout and work engagement under the high self-compassion condition. Employees who scored less than 40 in self-compassion questionnaire, their work engagement will be significantly affected by burnout symptoms, $t(39)$= -2.02, p= .05, β= -.24. As self-compassion decreases, the relationship between burnout and work engagement becomes more negative with the lowest self-compassion score (18), β=-.93, $t(39)$= -2.02, $p < .001$. (Table 2-4)

Hypothesis 3 – Different Levels of Burnout

A Pearson's product-moment correlation was run to assess the relationship between work engagement and three sub-scales of burnout (personal burnout, work-related burnout, client-related burnout). There was a moderate negative correlation between work engagement and work-related burnout, $r(41) = -.439$, $p < .0005$, with experience of work-related burnout explaining 19% of the variation in work engagement decrease. There was a small-moderate negative correlation between work engagement and personal-related burnout, $r(41)= -.309$, $p < .05$, with experience of personal-related burnout explaining 9% of the variation in work engagement. Lastly, no significant correlation found between client-related burnout and work engagement (Table 5).

A multiple regression was calculated to predict work engagement from three levels of burnout. Stepwise method was used. Work-related burnout was eliminated from the model due to the non-significant results of first analysis. The multiple regression model statistically significantly predicted work engagement, $F(2, 40) = 11.021$, $p < .0005$, adj. R2 = .323. Model of only client-related burnout model was also significant to predict work engagement, $F(1,41) = 16.523$, $p < .0005$. Results showed that one unit increase in client-related burnout causes 0.567 decrease in work engagement, $p < .0005$, and one unit increase in personal burnout causes 0.992 decrease in work engagement, $p < .05$ There was linearity as assessed by partial regression plots and a plot of studentized residuals against the predicted values. There was independence of residuals, as assessed by a Durbin-Watson statistic of 2.108. There was homoscedasticity, as assessed by visual inspection of a plot of studentized residuals versus unstandardized predicted values. There was no evidence of multicollinearity, as assessed by tolerance values greater than 0.1. There were no studentized deleted residuals greater than ±3 standard deviations, no leverage values greater than 0.2, and values for Cook's distance above 1. The assumption of normality was met, as assessed by a Q-Q Plot. Only two burnout variables added statistically significantly to the prediction, $p < .05$. Regression coefficients and standard errors can be found in Table 6.

A Pearson's product-moment correlation was run to assess the relationship between total burnout score and the scores of three sub-scales of burnout (personal burnout, work-related burnout, client-related burnout) to identify their effects in correlation relationship. The strongest correlation was client-related burnout, $r(40)= .864$, $p < .0005$, followed by work-related burnout and personal burnout, $r(41)= .784$, $p < .0005$ and $r(41)= .606$, $p < .0005$, respectively. Addition to that, another strongest significant correlation was between work-related burnout and personal burnout, $r(41)= .819$, $p < .0005$ (Table 7).

5. Discussion

This research has contributed to the relationship between burnout and work engagement with the moderation of self-compassion among health care personnel. The results of present study demonstrate that burnout and work engagement interaction is affected by self-compassion, although self-compassion has not a direct significant effect on work engagement. This means that higher the health personnel have self-compassion, lower they get affected by burnout factors. However, two-weeks self-compassion training did not have any effect on improving the

self-compassion results. This may conclude from two possible reasons; 1) homework style of training might not be done by the participants regularly and 2) negative correlation of economic difficulties and self-compassion might affect the significance due to majority of sample (60.5%) indicated that they 'sometimes' have economical problems.

Comparing the results with literature is limited for burnout levels due to favoritism of Maslach Burnout Inventory (MBI) in past researches instead of Copenhagen Burnout Inventory (CBI). These two scales measure burnout with different levels, which are personal burnout, client-related burnout and work-related burnout for CBI, and cynicism, depersonalization and professional inefficacy for MBI. It is not possible to compare personal burnout with any facet of MBI, since MBI measures only occupational burnout. Client-related burnout cannot be examined as an independent facet either, even though regression analysis showed client-related burnout is a significant predictor of work engagement. Therefore, only work-related burnout scores will be examined in this paragraph. Present study shows a moderate negative relationship between work-related burnout and work engagement ($r(41) = -.439$, $p < .0005$). Burnout scores were significant to predict work engagement compliance with past researches. Schaufeli, Taris and Rhenen (2008) found that burnout and work engagement are negatively correlated ($r = -.65$) with correlations typically ranging from -.30 to -.65 in terms of MBI facets, which supports the results of burnout prediction for work engagement ($\beta = -1.50$, $t(39) = -3.29$). Past researches indicated that the burnout risk is higher for younger and single employees without kids (Maslach, Schaufeli & Leiter, 2001). However, results didn't show any correlations for total burnout score with any of these factors ($p > .05$). Only work-related burnout facet and age were found negatively correlated ($r = -.342$, $p = .025$).

Another research conducted with Dutch doctors showed that 20.1% of their sample consists of doctors who work in general teaching hospital had diagnosed with burnout while 19.9% of the sample consists of doctors who work in university medical center had diagnosed with burnout (Prins et al., 2010). Although other two types of hospital workers had diagnosed with burnout in higher rates, the reason I chose these two samples is they are the most similar hospital types to the hospitals in present research. Istanbul University Cerrahpaşa Medicine Faculty Hospital may have a similar structure with university medical center and Hamidiye Şişli Etfal Research and Training Hospital may have a similar structure with general teaching hospital. Perceived Stress Scale scores range between 0 to 56 and higher scores indicate higher perceived stress. Present

study showed that health service workers feel more stressed (39.14) than Turkish community sample (28.1) (Eskin et al., 2013). According to Demands Control Support (DCS) model, stress is a consequence of how demanding a person's job is and how much control (discretion, authority or decision latitude) the person has over it (Karasek, 1979). DCS model has proposed as appropriate for nursing samples due to common social support lack, excessive demands and the variability of control mechanism (Mark & Smith, 2012). Addition to that, stressful work environment factors were listed namely; lack of staff, exhausting shifts, lack of autonomy and authority, demand-load from the patients and their relatives, lack of support from the supervisors and colleagues, use of technology and frequent exposure to death (Zyga et al., 2016). According to McNeely's research on stress among nurses, top five occupational stressors were listed; 1) too much work/too little time; 2) inadequate staffing in the unit; 3) inability to meet patients' needs; 4) very difficult/violent patients; 5) inadequate support/understanding from senior staff. Thus, literature supports the findings of present research.

According to Utrecht Work Engagement Scale results, mean score of health care workers were found high (5.36) compared to Schaufeli's UWES database (3.82) (Schaufeli & Bakker, 2004). Scoring of the scale ranges between zero to six and the score was calculated by dividing the total score by item number. Any articles couldn't be found for Turkish population, neither regardless of occupations nor for health care personnel only. Prins et al. (2010) conducted a research among resident doctors in Netherlands and they used UWES to measure work engagement in different hospital types. Doctors work at general teaching hospitals had the highest scores ($M= 4.16 \pm 0.81$) whereas doctors work in rehabilitation center had the lowest scores ($M= 3.66 \pm 0.68$). General teaching hospitals can be seen as the most similar hospital type with Şişli Etfal Training Hospital, however participants in present study had higher scores than Netherlands sample.

5.1 Practical Implications

This research discovered relationship between burnout and work engagement under the influence of self-compassion, and thus offers several practical implications. Burnout is a universal problem in all occupations. However, burnout among health care personnel has not been examined frequently, although they are in high-risk group due to frequent exposure to death and severe emotional exhaustion. Addition to that, anything about burnout-work engagement relationship under the influence of self-compassion could not been found in literature. This research may

help HR departments of hospitals to improve engagement and prevent burnout via self-compassion. Results showed that as self-compassion decreases, the relationship between burnout and work engagement becomes more negative with the lowest self-compassion score (18), β=-.93, $t(39)$= -2.02, $p < .001$ (Table 2-4). Even though self-completed training did not have any significant effect, hospitals have complete access for training groups in the organization without outsourcing for health care employees with psychologists and/or psychiatrists who work in the organization. Improved self-compassion does not only improve work engagement, but also it may increase employee and patient satisfaction.

Stepwise method results showed that only client-related burnout can influence work engagement, addition to client-related and personal burnout model. That shows the importance of intervention, since health care personnel's main duties are related with patients and relatives of patients. High workplace violence rates also stress the crucial impact of intervention need for more engaged and satisfied workers, therefore more satisfied patients.

5.2 Limitations

From the Karasek's Demand-Control-Support (DCS) model aspect, several limitations exist due to the nature of health care occupations and cultural influences. First of all, decision latitude, which means employees' control over their tasks and how those tasks are executed, might not perfectly fit for daily tasks of physicians and nurses. The main supervisory authority is head physician's office of each hospital. Since the tasks are standard for both occupations except surgical complications or emergencies such as emergency room (ER) or severe internal bleeding in surgery, monitoring and supervising functions are low for higher status doctors and nurses. Decisions in operation rooms may urgent calls in case of complications and that leads high decision latitude only for the head surgeon. Decision latitude of health personnel is usually directly proportionate to their successful operations and for university hospitals reputation of doctors is another factor. Higher status physicians are mostly provided the demanded equipment by the hospital management or head physician's office. However, costs and gains are calculated finically in government hospitals due to low appropriation budget. Communication problems between nurses and doctors may cause stress, especially under vital conditions.

Skill discretion, which refers to the degree to which the job involves a variety of tasks, low levels of repetitiveness, occasions for creativity and opportunities to learn new things and

develop special abilities, cannot be seen as an advantage in health service sector. High level of repetitiveness is favored in order to decrease the surgical risks and mortality rates by becoming a specialist in several operations. Doctors do not prefer to operate high-risk-group patients and/or surgeries, even though they may provide prestige. Instead of that, they refer the patients to other specialized doctors. Tasks of nurses are altered with the department they work, however, they also consist of standardized checklists. Motivation sources for nurses can be mainly listed as strong relationships with long-term hospitalized patients, newborn babies and bonds with colleagues. Besides that, ER and intensive care unit nurses are hang by a thread due to frequent exposure to death, unstable patient profile, workload and lack of socialization. These reasons may cause the feel of helplessness and emotional exhaustion more than other groups.

Effort Reward Imbalance model, which had been structured on social reciprocity or with other words social exchange concept, have some limitations. Although physical workload and emotional burden are much more for health service personnel than other occupations, rewards are not adequate in Turkish government hospitals. Wages are dramatically low for moderate work conditions and extreme numbers of patients. Promotion opportunities such as becoming the head of a department or chief executive are linked with governmental exams and work experience in years. Although promotion opportunities are low, working at a university hospital is an important factor for reputation and high self-esteem. On the other hand, circumstances are completely different for private hospital doctors, even though promotion opportunities are similar. Wages are high, patient appointments per day are low but working hours are much longer including the weekends. General profile of patients also alters from government hospitals to private ones due to low SES and education level. High prices in private hospitals are another reason for patient-load in government hospitals. However, low education level and ethnicity variety cause communication problems between health care personnel and patients, therefore stressful encounters. These differences may assist to deduce that doctors who work in government hospitals are more likely to engage through intrinsic motivation.

Social support, which is a contributor to wellbeing, is provided often in two hospitals of research by special zones for personnel in order to facilitate socialization and to let them for a breathe without challenging tasks and patient demands. Social support for instrumental reasons are provided by weekly patient consultation meeting among doctors to discuss about patient's surgery and/or current health status. Surgeries with complications are discussed in those

meetings to assess surgeon's and the surgery room team's performance to avoid future complications.

6 Conclusion

This research presents the results of a unique study of burnout and work engagement relationship under the influence of self-compassion. The author found that self-compassion is a significant moderator on the relationship between burnout and work engagement, even though self-compassion has not a direct effect on work engagement. Also, results showed that, as self-compassion decreases, the relationship between burnout and work engagement becomes more negative with the lowest self-compassion score. Specifically, employees who scored less than 40 in self-compassion questionnaire, their work engagement will be significantly affected by burnout symptoms whereas no relationship found between burnout and work engagement for the high self-compassionate employees.

Kristen Neff's short-term self-compassion training was conducted to improve participants' compassionate behaviors and thoughts for themselves. However, no significant increase was detected in self-compassion scores.

On the other hand, sub-scales of burnout were examined for their unique influences on engagement. According to results, only client-related burnout and model 1 (personal burnout + client-related burnout) significantly decreases work engagement whereas no effect was found for work-related burnout (Table 6). Correlations of total burnout score and three facets were examined with Pearson's correlation coefficient. The strongest correlation was client-related burnout, followed by work-related burnout and personal burnout. Addition to that, another strongest significant correlation was found between work-related burnout and personal burnout (Table 7).

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8. Appendices

APPENDIX I.

I. Self-Compassion Scale

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

1. When I fail at something important to me I become consumed by feelings of inadequacy.

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

2. I try to be understanding and patient towards those aspects of my personality I don't like.

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

3. When something painful happens I try to take a balanced view of the situation.

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

4. When I'm feeling down, I tend to feel like most other people are probably happier than I am.

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

5. I try to see my failings as part of the human condition.

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

6. When I'm going through a very hard time, I give myself the caring and tenderness I need.

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

7. When something upsets me I try to keep my emotions in balance.

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

8. When I fail at something that's important to me, I tend to feel alone in my failure.

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

9. When I'm feeling down I tend to obsess and fixate on everything that's wrong

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

11. I'm disapproving and judgmental about my own flaws and inadequacies.

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

12. I'm intolerant and impatient towards those aspects of my personality I don't like.

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

II. Perceived Stress Scale

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate by circling how often you felt or thought a certain way.

1. In the last month, how often have you been upset because of something that happened unexpectedly?

Never	Almost Never	Sometimes	Fairly Often	Very Often
0	1	2	3	4

2. In the last month, how often have you felt that you were unable to control important things in your life?

Never	Almost Never	Sometimes	Fairly Often	Very Often
0	1	2	3	4

3. In the last month, how often have you felt nervous and "stressed"?

Never	Almost Never	Sometimes	Fairly Often	Very Often
0	1	2	3	4

4. In the last month, how often have you dealt successfully with irritating life hassles?

Never	Almost Never	Sometimes	Fairly Often	Very Often
0	1	2	3	4

5. In the last month, how often have you felt that you were effectively coping with important changes that were occurring in your life?

Never	Almost Never	Sometimes	Fairly Often	Very Often
0	1	2	3	4

6. In the last month, how often have you felt confident about your ability to handle your personal problems?

Never	Almost Never	Sometimes	Fairly Often	Very Often
0	1	2	3	4

7. In the last month, how often have you felt that things were going your way?

Never	Almost Never	Sometimes	Fairly Often	Very Often
0	1	2	3	4

8. In the last month, how often have you found that you could not cope with all the things that you had to do?

Never	Almost Never	Sometimes	Fairly Often	Very Often
0	1	2	3	4

9. In the last month, how often have you been able to control irritations in your life?

Never	Almost Never	Sometimes	Fairly Often	Very Often
0	1	2	3	4

10. In the last month, how often have you felt that you were on top of things?

Never	Almost Never	Sometimes	Fairly Often	Very Often
0	1	2	3	4

11. In the last month, how often have you been angered because of things that happened that were outside of your control?

Never	Almost Never	Sometimes	Fairly Often	Very Often
0	1	2	3	4

12. In the last month, how often have you found yourself thinking about things that you have to accomplish?

Never	Almost Never	Sometimes	Fairly Often	Very Often

0	1	2	3	4

13. In the last month, how often have you been able to control the way you spend your time?

Never	Almost Never	Sometimes	Fairly Often	Very Often
0	1	2	3	4

14. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

Never	Almost Never	Sometimes	Fairly Often	Very Often
0	1	2	3	4

III. Utrecht Work Engagement Scale

The following 17 statements are about how you feel at work. Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling, cross the '0' (zero) in the space after the statement. If you have had this feeling, indicate how often you feel it by crossing the number (from 1 to 6) that best describes how frequently you feel that way.

1. At my work, I feel bursting with energy*

Never	Almost Never / a few times a year or less	Rarely / once a month or less	Sometimes / a few times a month	Often / once a week	Very Often/ a few times a week	Always/ Everyday
0	1	2	3	4	5	6

2. I find the work that I do full of meaning and purpose

Never	Almost Never / a few times a year or less	Rarely / once a month or less	Sometimes / a few times a month	Often / once a week	Very Often/ a few times a week	Always/ Everyday
0	1	2	3	4	5	6

3. Time flies when I'm working

Never	Almost Never / a few times a year or less	Rarely / once a month or less	Sometimes / a few times a month	Often / once a week	Very Often/ a few times a week	Always/ Everyday
0	1	2	3	4	5	6

4. At my job, I feel strong and vigorous

Never	Almost Never / a few times a year or less	Rarely / once a month or less	Sometimes / a few times a month	Often / once a week	Very Often/ a few times a week	Always/ Everyday
0	1	2	3	4	5	6

5. I am enthusiastic about my job

Never	Almost Never / a few times a year or less	Rarely / once a month or less	Sometimes / a few times a month	Often / once a week	Very Often/ a few times a week	Always/ Everyday
0	1	2	3	4	5	6

6. When I am working, I forget everything else around me

Never	Almost Never / a few times a year or less	Rarely / once a month or less	Sometimes / a few times a month	Often / once a week	Very Often/ a few times a week	Always/ Everyday
0	1	2	3	4	5	6

7. My job inspires me

Never	Almost Never / a few times a	Rarely / once a month or less	Sometimes / a few times a month	Often / once a week	Very Often/ a few times a week	Always/ Everyday

	year or less					
0	1	2	3	4	5	6

8. When I get up in the morning, I feel like going to work

Never	Almost Never / a few times a year or less	Rarely / once a month or less	Sometimes / a few times a month	Often / once a week	Very Often/ a few times a week	Always/ Everyday
0	1	2	3	4	5	6

9. I feel happy when I am working intensely

Never	Almost Never / a few times a year or less	Rarely / once a month or less	Sometimes / a few times a month	Often / once a week	Very Often/ a few times a week	Always/ Everyday
0	1	2	3	4	5	6

10. I am proud on the work that I do

Never	Almost Never / a few times a year or less	Rarely / once a month or less	Sometimes / a few times a month	Often / once a week	Very Often/ a few times a week	Always/ Everyday
0	1	2	3	4	5	6

11. I am immersed in my work

Never	Almost Never / a few	Rarely / once a month or	Sometimes / a few times a	Often / once a week	Very Often/ a few times a week	Always/ Everyday

	times a year or less	less	month			
0	1	2	3	4	5	6

12. I can continue working for very long periods at a time

Never	Almost Never / a few times a year or less	Rarely / once a month or less	Sometimes / a few times a month	Often / once a week	Very Often/ a few times a week	Always/ Everyday
0	1	2	3	4	5	6

13. To me, my job is challenging

Never	Almost Never / a few times a year or less	Rarely / once a month or less	Sometimes / a few times a month	Often / once a week	Very Often/ a few times a week	Always/ Everyday
0	1	2	3	4	5	6

14. I get carried away when I'm working

Never	Almost Never / a few times a year or less	Rarely / once a month or less	Sometimes / a few times a month	Often / once a week	Very Often/ a few times a week	Always/ Everyday
0	1	2	3	4	5	6

15. At my job, I am very resilient, mentally

Never	Almost Never / a	Rarely / once a	Sometimes / a few	Often / once a	Very Often/ a few times a	Always/ Everyday

	few times a year or less	month or less	times a month	week	week	
0	1	2	3	4	5	6

16. It is difficult to detach myself from my job

Never	Almost Never / a few times a year or less	Rarely / once a month or less	Sometimes / a few times a month	Often / once a week	Very Often/ a few times a week	Always/ Everyday
0	1	2	3	4	5	6

17. At my work I always persevere, even when things do not go well

Never	Almost Never / a few times a year or less	Rarely / once a month or less	Sometimes / a few times a month	Often / once a week	Very Often/ a few times a week	Always/ Everyday
0	1	2	3	4	5	6

IV. Copenhagen Burnout Inventory

The following 23 statements are about how you feel at work. Please read each statement carefully and decide if you ever feel this way about your job.

PART 1 Personal Burnout

1. How often do you feel tired?

Never	Very Rarely	Occasionally	Very Frequently	Always
1	2	3	4	5

2. How often are you physically exhausted?

Never	Very Rarely	Occasionally	Very Frequently	Always
1	2	3	4	5

3. How often are you emotionally exhausted?

Never	Very Rarely	Occasionally	Very Frequently	Always
1	2	3	4	5

4. How often do you think: ”I can’t take it anymore”?

Never	Very Rarely	Occasionally	Very Frequently	Always
1	2	3	4	5

5. How often do you feel worn out?

Never	Very Rarely	Occasionally	Very Frequently	Always
1	2	3	4	5

6. How often do you feel weak and susceptible to illness?

Never	Very Rarely	Occasionally	Very Frequently	Always
1	2	3	4	5

PART 2 Work-Related Burnout

1. Is your work emotionally exhausting?

Never	Very Rarely	Occasionally	Very Frequently	Always
1	2	3	4	5

2. Do you feel burnt out because of your work?

Never	Very Rarely	Occasionally	Very Frequently	Always
1	2	3	4	5

3. Does your work frustrate you?

Never	Very Rarely	Occasionally	Very Frequently	Always
1	2	3	4	5

4. Do you feel worn out at the end of the working day?

Never	Very Rarely	Occasionally	Very Frequently	Always
1	2	3	4	5

5. Are you exhausted in the morning at the thought of another day at work?

Never	Very Rarely	Occasionally	Very Frequently	Always
1	2	3	4	5

6. Do you feel that every working hour is tiring for you?

Never	Very Rarely	Occasionally	Very Frequently	Always
1	2	3	4	5

7. Do you have enough energy for family and friends during leisure time?

Never	Very Rarely	Occasionally	Very Frequently	Always
1	2	3	4	5

PART 3 Client-Related Burnout

1. Do you find it hard to work with clients?

Never	Very Rarely	Occasionally	Very Frequently	Always
1	2	3	4	5

2. Do you find it frustrating to work with clients?

Never	Very Rarely	Occasionally	Very Frequently	Always
1	2	3	4	5

3. Does it drain your energy to work with clients?

Never	Very Rarely	Occasionally	Very Frequently	Always
1	2	3	4	5

4. Do you feel that you give more than you get back when you work with clients?

Never	Very Rarely	Occasionally	Very Frequently	Always
1	2	3	4	5

5. Are you tired of working with clients?

Never	Very Rarely	Occasionally	Very Frequently	Always
1	2	3	4	5

6. Do you sometimes wonder how long you will be able to continue working with clients?

Never	Very Rarely	Occasionally	Very Frequently	Always
1	2	3	4	5

APPENDIX 2.

Table 1

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	SCTTOTAL	40.2143	28	7.10950	1.34357
	SCTotal	40.8571	28	6.59244	1.24585

Table 2

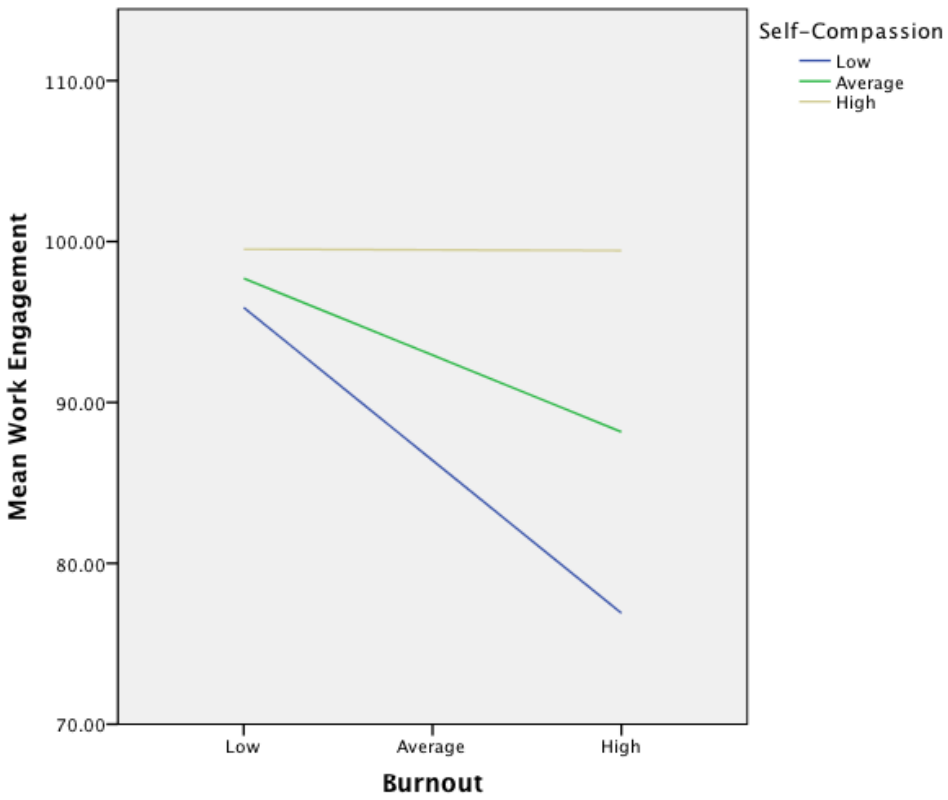
Self-Compassion
Low
Average
High
110.00
100.00
90.00
80.00
70.00
Mean Work Engagement
Low
Average
High
Burnout

Table 3

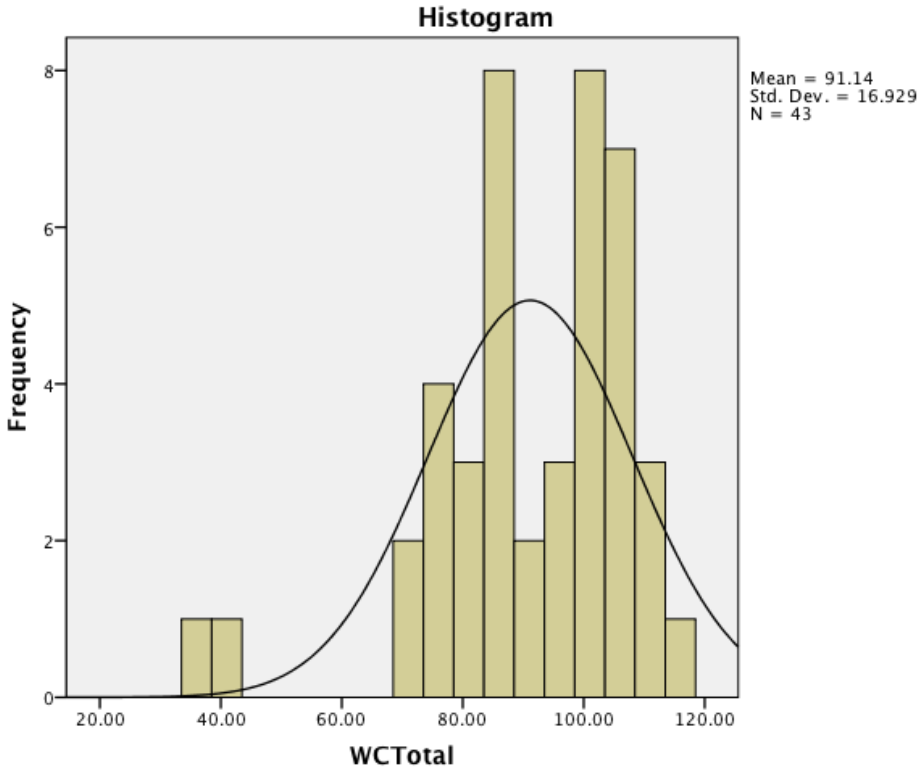
Histogram
Mean = 91.14
Std. Dev. = 16.929
N = 43
Frequency
WCTotal
0
2
4
6
8
20.00
40.00
60.00
80.00
100.00
120.00

Table 4

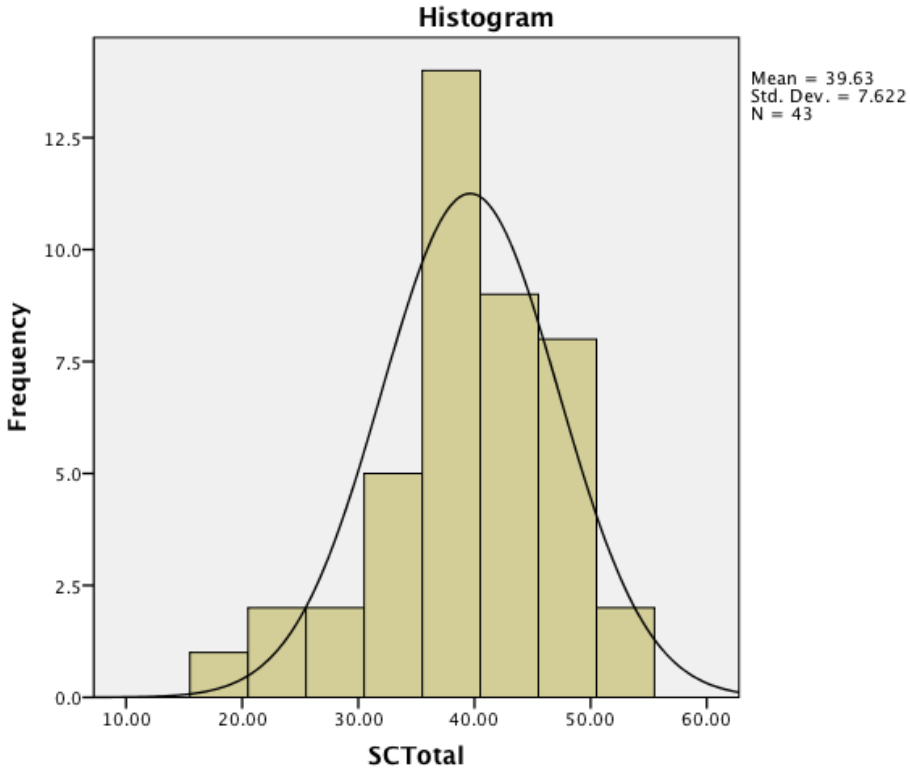
Histogram
Mean = 39.63
Std. Dev. = 7.622
N = 43
Frequency
SCTotal
0.0
2.5
5.0
7.5
10.0
12.5
10.00
20.00
30.00
40.00
50.00
60.00

Table 5

Correlations

		WCTotal	PersonalBO	WorkBO	ClientBO
WCTotal	Pearson Correlation	1	-.309*	-.439**	-.200
	Sig. (2-tailed)		.044	.003	.203
	N	43	43	43	42
PersonalBO	Pearson Correlation	-.309*	1	.819**	.606**
	Sig. (2-tailed)	.044		.000	.000
	N	43	43	43	42
WorkBO	Pearson Correlation	-.439**	.819**	1	.784**
	Sig. (2-tailed)	.003	.000		.000
	N	43	43	43	42
ClientBO	Pearson Correlation	-.200	.606**	.784**	1
	Sig. (2-tailed)	.203	.000	.000	
	N	42	42	42	42

Table 6

Model		Unstandardized Coefficients		Standardized Coefficients
		B	Std. Error	Beta
1	(Constant)	103,330	3,723	
	Client	-,594	,146	-,536
2	(Constant)	120,582	9,131	
	Client	-,567	,141	-,512
	Personal	-,992	,483	-,262

a. Dependent Variable: Work Engagement

Table 7

Correlations

		ClientBO	BOTotal	WorkBO	PersonalBO
ClientBO	Pearson Correlation	1	.864**	.784**	.606**
	Sig. (2-tailed)		.000	.000	.000
	N	42	42	42	42
BOTotal	Pearson Correlation	.864**	1	.726**	.507**
	Sig. (2-tailed)	.000		.000	.001
	N	42	43	43	43
WorkBO	Pearson Correlation	.784**	.726**	1	.819**
	Sig. (2-tailed)	.000	.000		.000
	N	42	43	43	43
PersonalBO	Pearson Correlation	.606**	.507**	.819**	1
	Sig. (2-tailed)	.000	.001	.000	
	N	42	43	43	43

**. Correlation is significant at the 0.01 level (2-tailed).