SUSCEPTIBILITY TO EMOTIONAL CONTAGION IN HEALTH ORGANIZATIONS: IMPACT ON ORGANIZATIONAL COMMITMENT AND INTENTION TO STAY

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Impact on Organizational Commitment and Intention to Stay

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ABSTRACT

Susceptibility to Emotional Contagion in Health Organizations:

Impact on Organizational Commitment and Intention to Stay

Health organizations include varying emotions experienced due to frequent interactions with colleagues and customers. It was thus of interest to investigate which stressors affect organizational outcomes for employees and patients in these organizations. Of particular interest were stressors and their outcomes at workplaces for doctors. For that purpose, drawing from Job Demands-Resources Model and Social Exchange Theory, the study evaluated the influences of workload and emotional labor on organizational commitment, especially affective commitment, and intention to stay. The moderating role of susceptibility to emotional contagion on the relationship between stressors and commitment, and mediating role of commitment on the relationship between stressors and intention to stay were also investigated. The participants included 270 doctors (137 male, 133 female) from six hospitals in the Marmara region in Turkey. Survey methodology was used for data collection. The results indicated that commitment was positively associated with intention to stay. Higher affective and normative commitment were positively related to intentions to stay. Workload was not related to commitment. Emotional labor and deep acting were positively related with organizational commitment. Commitment did not act as a mediator on the relationships between stressors and intention to stay. Susceptibility to emotional contagion and negative affect factor had moderating roles between workload, and affective and organizational commitment, respectively. Though these relationships may exist in various contexts, the focus of the research was on doctors working in hospitals in Turkey. Research including different

variables, sample groups, analysis methods and geographical regions may be conducted to further investigate these relationships.

ÖZET

Sağlık Örgütlerinde Duygusal Bulaşıcılığa Duyarlılık: Kurumsal Bağlılık ve Kalma Niyeti'ne Etkisi

Sağlık kuruluşları akran ve müşterilerle yoğun ilişkiler sebebiyle deneyimlenen farklı duyguları içermektedir. Bu yüzden bu kuruluşlarda çalışanlar için hangi stres faktörlerinin örgütsel sonuçları nasıl etkilediğini incelemek gerekmektedir. Özellikle çalışma alanlarında stres faktörleri ve sonuçlarına odaklanılmalıdır. Araştırma, bu sebeple, iş yükü ve duygusal yükün kurumsal ve özellikle afektif bağlılık ve kalma niyeti üstündeki etkilerini incelemektedir. Araştırma aynı zamanda duygusal bulaşıcılığa duyarlılığın stres faktörleri ve bağlılık ilişkisi üzerindeki moderasyon etkisine, ve kurumsal bağlılığın stres faktörleri ve kalma niyeti ilişkisi üzerindeki dolayım etkisine de bakmaktadır. Araştırma katılımcıları Türkiye'nin Marmara Bölgesi'ndeki altı hastaneden 270 doktordur (137 erkek, 133 kadın). Sonuçlar bağlılığın kalma niyetiyle pozitif olarak ilişkili olduğunu göstermektedir. Afektif ve normatif bağlılıkları yüksek doktorların kalma niyetlerinin de yüksek olduğu görülmüştür. İş yükü ise bağlılığa ilgili bulunmamıştır. Duygusal yük ve derin oynamanın kurumsal bağlılığa pozitif ilişkili olduğu bulunmuştur. Bağlılığın stres faktörleri ve kalma niyeti ilişkisi üzerinde dolayım etkisi görülmemiştir. Duygusal bulaşıcılığa ve negatif duygulara duyarlılığın, iş yükü, ve afektif ve kurumsal bağlılık ile ilişkisi üzerinde moderasyon etkisi bulunmuştur. Bu ilişkiler farklı içeriklerle incelenebilse de, araştırmanın odağı Türkiye'de hastanede çalışan doktorlardır. Bu ilişkileri ileri seviyede incelemek için bilişsel değişkenler, farklı örneklem grupları, değişik analiz yöntemleri ve başka coğrafi bölgeler içeren araştırmalar da yapılabilir.

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This dissertation is dedicated to

my mother Aysel Aydemir,

father Prof. Ertuğrul Hasbi Aydemir,

and brother Ozan Aydemir

for without them, none of this would be possible;

and my late grandparents, aunt and uncle,

who watch over me still.

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CHAPTER 1

INTRODUCTION

In organizations, there are different kinds of people that can be categorized according to various biological, social, cultural or psychological traits. Researchers spend a long time trying to come up with the best definitions for these categorizations as to understand better what makes certain kind of people tick and what hinders others in organizations. Naturally, as in any situation where the human factor is involved, emotions and affects play important roles in organizational settings. As such, emotions are being acknowledged as potent parts of interpersonal interactions and tools to secure successful relationships (Guillemette, 2011). As a result, recent trends in relevant literature shift their focus towards the consideration of contextual constructs with interpersonal and emotional underpinnings (Scott & Barnes, 2011). This is because contextual factors can also result in emotional consequences and behavioral responses (Kandolin, 1993; Janssen, Bakker, & de Jong, 2001). Therefore the emphasis of emotions in the workplace leads to a significant growth in related literature in terms of research conducted on emotional experiences at work (Weiss & Beal, 2005).

The aim of the current study is gaining insights into emotional experiences at work by examining a stressor-strain model in health organizations and investigating the role of susceptibility to emotional contagion, which involves catching of emotions of others. Employees working with others in organizations react emotionally to experiences, and contextual and interpersonal stimuli, both positive and negative, occurring at work. These emotional reactions are sometimes instigated

by stressors (Lee et al., 2010) and affect employee behavior accordingly in terms of organizational outcomes (Weiss & Cropanzano, 1996). Considering work environments and related experiences in health organizations, workload and emotional labor are regarded as two contextual and interpersonal facets of organizational stressors, respectively (Brotheridge & Lee, 2003; Grandey, 2000; Kiely & Sevastos, 2008; Mann, 2005; Miller, Ellis, Zook, & Lyles, 1990; Montgomery, Panagopolou, de Wildt, & Meenks, 2006; Zapf, 2002). They represent the physiological and psychological burdens employees carry throughout their work lives. They influence employee emotions, psychological and physiological states, attitudes and behavior in organizations (Le Blanc et al., 2001). Workload refers to excessive organizational demands that exceed people's resources (Leiter & Maslach, 2004). Emotional labor is the expectation of the expression of certain organizationally requested emotions by employees during their interpersonal transactions at work (Hoschild, 1983). Management literature considers both individual and contextual factors as relevant to employee wellbeing and performance. This results in workload and emotional labor being important potential determinants of employee actions (Kahn & Byosiere, 1992).

Regarding work experiences and relevant outcomes, workload and emotional labor are found to be associated with organizational commitment (Wright & Cropanzano, 1998) and intention to stay (Glaser, Tatum, Nebeker, Sorenson, & Aiello, 1999). This is because these stressors, and the resulting related experiences, make it more difficult for employees to be committed to and intent on staying in the organizations in which they face these stressors. The stress model of Job Demands-Resources (JD-R) argues that high demands and low resources lead to emotional exhaustion, depersonalization, burnout and relevant attitudinal consequences

(Demerouti, Bakker, Nachreiner & Schaufeli, 2001). In this regard, it is discussed that high workload and emotional labor, as contextual and interpersonal demands, respectively, potentially result in decreased organizational commitment and turnover intentions for employees (Cole & Bedeian, 2007; Demerouti, Bakker, Nachreiner & Schaufeli, 2001; Lee et al., 2010; Wright & Cropanzano, 1998).

The current research examines the relationships between the organizational stressors of workload and emotional labor, and organizational outcomes via two angles. The first point of focus is people's commitments, emotional or obligatory (Allen & Meyer, 1990), to the organizations they work in, and how this commitment mediates the relationship between organizational stressors and outcomes. Organizational commitment refers to the intensity of an individual's affinity with and participation in an organization or employer (Meyer, Allen, & Smith, 1993). In order to better comprehend the concept of commitment, it is important to focus on its contextual and interpersonal antecedents, such as workload and emotional labor. It is also crucial to investigate the consequences of organizational commitment, such as intention to stay, that are experienced by employees in organizations (Allen and Meyer, 1990). In terms of the consequences of organizational commitment, its most commonly observed behavioral outcome is intention to stay in the organization, or turnover intentions. (Cotton & Tuttle, 1986; Jaros, Jermier, Koehler, & Sincich, 1993; Meyer et al., 1993; Mowday et al., 1982; Somers, 1995; Tett & Meyer, 1993). Intention to stay refers to an employee's interest in continuing to work for and willingness to remain in an organization (Lyons, 1981). Only few studies investigated the links between stressors, organizational commitment and intention to stay for doctors in health organizations.

Organizational commitment reflects employees' level of attachments, emotional, calculative or obligatory (Meyer et al., 1993), towards their organizations, while and intention to stay represent decisions to continue to remain with their organizations which they are committed to (Lyons, 1981). The current study adheres to the notion that the more the employees are affected by workload and emotional labor in their organizations, the less likely they are to be committed towards and so intent to remain with them. This is due to the fact that organizations themselves are the settings in which these physical and emotional work stressors are faced and demands are made, and so influence employees' emotions, commitments and behavior.

According to Social Exchange Theory, an employee's commitment towards an employer is initiated as a result of an exchange association between the two parties (Gouldner, 1960; Shore & Terrick, 1991). In other words, organizational commitment develops by employees towards their organizations as a result of desirable working environments the organizations provide (Liu, 2005). In this type of reciprocal interdependent transaction, as an organization provides benefits to its employees, the employees become more attached to their organizations, thus creating a cycle of continuous reinforcement (Cropanzano & Mitchell, 2005). For employees, this likely results in increased commitment towards, and so intention to stay in their organizations (Bishop, Scott, & Burroughs, 2000; Howes, Cropanzano, Grandey, & Mohler, 2000; Rhodes, Eisenberger, & Armeli, 2001). As such, the current study utilizes Social Exchange Theory (Emerson, 1976; Gouldner, 1960) to examine the relationships between workload, emotional labor, organizational commitment and intention to stay.

The relationships between organizational experiences, resulting attitudes and behavior are likely to be moderated by dispositions of the individuals going through these experiences (Bono & Wey, 2005; Weiss & Beal, 2005). These dispositional factors affect the range, intensity, frequency and duration of the emotional reactions shown by employees (Morris & Feldman, 1996). The current study looks at one such dispositional factor, susceptibility to emotional contagion, which is considered to be a potential influence that effects employees' organizational commitments (Hatfield et al., 1994). Emotional contagion refers to the process where people influence and are influenced by others' emotions. Susceptibility to emotional contagion implicates people's propensity to be affected by the emotions of those around them (Doherty, 1997). Thus, the second focal point of the study is examining the effect of susceptibility to emotional contagion on the relationship between the organizational stressors of workload and emotional labor, and organizational commitment. The current research expects that the more the employees are prone to be affected by the emotions around them, the more likely they are to intensely experience the physiological and psychological strains resulting from workload and emotional labor in organizations (Lee et al., 2010). As a result, the less likely they are to be committed to their institutions. In other words, the more susceptible employees are to emotional contagion, the more they will likely feel the effects of workload and emotional labor in their organizations. Accordingly, the less likely their organizational commitments towards these organizations in which they come to experience these negative consequences will be.

Emotional experiences people go through likely depend on the environment in which their emotional transactions take place as well (Doherty et al., 1995; Hatfield et al., 1994). Interactions that occur in an office setting differ from those that

do so in a pub, and even more so from those that occur in a hospital. This study focuses on health organizations, where, due to their context and nature, they are argued to be places that include high frequency and levels of stressors within (Lee et al., 2010; Miller, Ellis, Zook, & Lyles, 1990; Ramirez et al., 1995; Xiaoming et al., 2014). Therefore, employers face problems of turnover relatively more to other types of organizations. Hospitals, especially, are stated as typical environments in terms of these burdens of frequent and emotionally loaded experiences (Hillmer, Hillmer, & McRoberts, 2004; Houlihan, 2004). Moreover, it is stated that due to the strong association between emotions and health, the examination of emotional contagion and the susceptibility to it in health organizational settings would be beneficial to relevant literature (Lundqvist, 2006). In such organizations, enough attention is not being paid to the relationship between emotional issues and organizational ones, such as organizational commitment (Wright & Bonnet, 1997). As such, the current study focuses on the relationship between emotional occurrences in health organizations, their effects on organizational outcomes, and the roles of organizational commitment and susceptibility to emotional contagion on these relationships.

Current literature also mentions that there is a need to examine the mediating role of organizational commitment on the relationship between interpersonal stressors and organizational outcomes, such as intention to stay, in service and health organizations (Rehman, Karim, Rafiq, & Mansoor, 2012). Accordingly, the current study aims to examine the relationship between workload, emotional labor and intention to stay, with the potential consideration that organizational commitment plays a mediating role in this relationship. This way, the study aims to contribute into better understanding the link between emotional and organizational factors, which

are likely to be both affect and cognitive driven (Weiss & Beal, 2005), in organizations.

Current literature also argues that emotional labor in organizations is a difficult concept to understand. This is mostly due to difficulties in its definition, measurement and formulation (Fisher & Ashkanasy, 2000). As such, it requires the execution of further relevant studies to be more thoroughly understood. This study hopefully contributes to the understanding of emotional labor by considering it with related variables. It is also mentioned in current literature that there is a need to consider the spread of emotions, and how much people are affected by this dissemination of emotions, in organizational settings. This is because emotions are argued to be investigated more in theoretical settings than organizational ones (Vijayalakshmi and Bhattacharyya, 2012). The current study, by considering the role of emotional labor and emotional contagion in organizational settings, aims to contribute to related literature in the investigation of these variables beyond theoretical settings as well. This way, organizations can have one more reference point in terms of putting related emotional theories into practice within themselves and the sectors they are functioning in.

Considering healthcare personnel, relevant literature argues that a clear understanding of factors influencing intention to stay in health organizations is needed (Cavanagh, 1989; Tai, Bame, & Robinson, 1998). As such, the current study aims to be contributory by providing analyses and discussions on what factors likely affect healthcare employees' intentions to stay in their organizations. This way, a better understanding of intention to stay can be reached for service and healthcare sectors. As a result, proactive applications and implementations can be developed by

these organizations to increase their employees' intentions to stay with them (Flinkman, Leino-Kilpi, & Salanterä, 2010).

Researchers state that the assessment of emotional stressors and moderators among health professionals are also needed (Kevrekidis, Skapinakis, Damigos, & Mavreas, 2008). It is stated that in terms of health organizational considerations, doctors are the least studied members of such organizations. This creates a lack of knowledge based on how doctors experience stressors and respond to them. Doctors are those employees who attend frequently to patients and spend time with them. As a result, they are expected to be among the most affected personnel in health organizations (Lee, Lovell, & Brotheridge, 2010). This notion stems from the fact that more exposure to patients, in terms of frequency, intensity and time, will result in more exchanges of emotions between these patients and health professionals (Xiaoming et al., 2014). This study thus aims to provide adequate analyses and discussions that shed light on the role of stressors affecting doctors in related organizational issues and relationships. In this way, their emotional and psychological states in their organizations can be better understood.

It is also argued in relevant literature that there is a need to consider organizational stressors and incentives in terms of how they affect attitudes and behavior of professional employees in relation to their values. Moreover, the same line of literature also states that variability in personal dispositions should also be taken into account in this relationship (Young, Beckman, & Baker, 2012). It is also discussed that these issues be investigated for professionals not only in advanced career stages, but also at the beginnings of their professional careers (Bucher & Stelling, 1969). The current study, by including professional employees, both early and late in their careers, contributes to the literature via considering doctors with

regard to how they are affected by organizational stressors, how this effect changes their attitudes and behavior, and whether the dispositional factor of susceptibility to emotional contagion plays a role in this relationship.

Countries and cultures can differ in terms of their organizational norms, values and climates. As such, organizations' focus on employees' wellbeing, and the nature of interpersonal relationships within employees and with clients might differ between various regions of the world (Hülsheger & Schewe, 2011). Therefore, there is an apparent need to increase the number and depth of researches conducted in different parts of the world. In that way, the validity of the theories and notions developed based on Western samples and cultures can be confirmed in different parts of the world. If not confirmed, new theories and applications can also be initiated to better at explain the relationships between various antecedents and outcomes in regions other than the United States (Meyer, 1997). Previous research also suggests that analyses, findings and discussions for health organizations and their personnel need testing and confirmation for international generalizability (Tourangeau, Cummings, Cranley, Ferron & Harvey, 2010). In addition, more research is needed in order to expand the coverage of relevant literature for Turkish organizations and employees (Zeytinoğlu et al., 2010). Emotional contagion and the susceptibility to it are considered to be global occurrences (Hatfield, Bensman, Thornton, & Rapson, 2014). However, a confirmation for their generalizability does not exist in current literature for Turkey. Lastly, the number of studies for organizational commitment conducted outside of the United States is in need of expansion. There is thus a necessity to conduct studies in regions outside of the United States (Meyer, Stanley, Herscovitch, & Topolnytsky, 2002). The cross-cultural generalizability of organizational commitment, and especially its affective component, is found to be

confirmed for Turkey (Wasti, 2002, 2003a, 2003b; Wasti & Özge, 2008). Its association with the research variables of workload, emotional labor, susceptibility to emotional contagion and intention to stay in service and health organization in Turkey, however, still warrants conducting further studies. This is because Turkey has unique properties and distinctive dynamics that make it differ from other developing and developed countries (Wasti, 1998; Wasti, 2002). The current research thus aims to study what factors account for the concepts of organizational commitment and intention to stay for doctors working in health organizations in Turkey.

One contribution of the current study is that, as it investigates the factors that affect doctors in health organizations in Turkey, it will provide information as to what experiences organizations should focus on in order to make their employees more committed towards and so intent on staying with them. Organizations may thus develop and tailor applications and interventions accordingly. One other aim of the current study is to conduct a research which provides a new perspective to and suggests a different direction for relevant literature by differentiating itself via focusing on contextual and interpersonal influences that doctors experience in health organizations. For this purpose, the effects of stressors on related outcomes, and the role of the relatively uncharted concept of susceptibility to emotional contagion in relation to workload, emotional labor and organizational commitment is considered. The current research also aims to contribute to relevant literature by providing pertinent information regarding doctors in Turkish organizations. This is so that the properties of being employed as doctors in health organizations in Turkey can be better observed and understood. Furthermore, by the inclusion of this data, comparisons relative to parallel global findings in related literature can also be made.

The current study includes eight chapters. Chapter 1 contains the introductory remarks. Chapter 2 includes the literature review for workload, emotional labor, organizational commitment, intention to stay, susceptibility to emotional contagion, discussions on Social Exchange Theory, and evaluations of these variables in service and health organizations. Chapter 3 entails a look at the theoretical framework, model and hypotheses of the current study. Chapter 4 presents the research design and methodology of the current research, including sample characteristics, scales used in measurement and data collection procedures. Chapter 5 includes data analysis methods, arguments for choosing these analysis methods, hypothesis testing, additional analyses, results and the revised model developed in relation to the findings of the current study. Chapter 6 consists of the discussions relevant to research findings. Chapter 7 talks about the contributions, limitations and implications of the current research. Lastly, Chapter 8 presents the concluding remarks.

CHAPTER 2

LITERATURE REVIEW

The literature review part of the current study firstly covers the literature on the antecedents of workload and emotional labor. They are treated as contextual and interpersonal stressors, respectively. Then, the role of organizational stressors in service and health organizations is discussed. Next, intention to stay is investigated as an outcome related to these stressors. Intention to stay is also examined in special consideration to service and health organizations. Then, organizational commitment is evaluated in detail and Social Exchange Theory is described. Finally, information on emotional contagion and the susceptibility to it is be presented.

2.1 Organizational stressors

Contextual and interpersonal stressors are regarded as important areas of investigation in management and organizational behavior literature in recent years (Bowling, Alarcon, Bragg, & Hartman, 2015). Stress can be defined as a condition or feeling perceived by the individual as environmental demands exceeding one's personal, emotional and social resources (Lazarus & Folkman, 1984). It refers to a disruption of one's equilibrium in terms of cognitive and emotional systems by external factors (McGrath, 1976). These external factors are referred to as stressors (Demerouti et al., 2001). In line with this definition, stressors refer to the demands made by the internal and external environment that disturb people's mental balances and so influence their physical and psychological wellbeing (Lazarus & Folkman, 1984). The person suffering from these stressors, then, needs to act and form an adaptive response in order to overcome the resulting mental imbalance and cope with

these stressors. This coping process likely requires sustained physical and mental effort (Jex, Beehr, & Roberts, 1992).

Current literature mainly focuses on the relationships between organizational stressors, both contextual and interpersonal, and personal and organizational wellbeing (Bowling et al., 2015). It is observed in these researches that organizational stressors are associated with psychological and physiological states of employees (Le Blanc et al., 2001; Nixon, Mazzola, Bauer, Krueger, & Spector, 2011), job attitudes (Spector & Jex, 1998), organizational deviance (Bowling & Eschleman, 2010) and withdrawal tendencies and behavior (intention to stay, absenteeism etc.; Chen & Spector, 1992).

Job Demands-Resources Model (JD-R), as a stress model, may be adhered to in understanding stressors and their influences in organizations (Demerouti, et al., 2001). The model argues that high demands and low resources in jobs or organizations may result in physical and emotional exhaustion, depersonalization, burnout and decreased motivation. Workload and emotional labor are considered to be contextual and interpersonal workplace stressors, respectively (Brotheridge & Lee, 2003; Grandey, 2000; Kiely & Sevastos, 2008; Mann, 2005; Miller, Ellis, Zook, & Lyles, 1990; Zapf, 2002). They both affect employee emotions, psychological and physiological states, and so relevant outcomes and behavior in organizations (Jex et al., 1992; Le Blanc et al., 2001; Nixon et al., 2011). Workload is considered to be a contextual stressor that is frequently observed and also stated by employees to be present in various organizations (Keenan & Newton, 1985). Emotional labor, on the other hand, is regarded as an interpersonal stressor which is stumbled upon in any organization or job including interpersonal interactions (Hülsheger & Schewe, 2011; Kiely & Sevastos). As such, they are regarded as contextual and interpersonal

demands, respectively, that potentially result in the formation of strain for employees in organizations.

The literature on management and organizations more and more considers both contextual and interpersonal factors as relevant to employee wellbeing and performance, which makes workload and emotional labor, important potential determinants of employee actions (Kahn & Byosiere, 1992). Workload and emotional labor are also regarded as stressors that are mainly investigated in service and health organizations (Brotheridge & Lee, 2003; Grandey, 2000; Mann, 2005; Miller, Ellis, Zook, & Lyles, 1990; Xiaoming et al., 2014; Zapf, 2002).

The current study thus considers workload and emotional labor to be two major stressors, commonly stumbled upon in service and health organizations. To deal with these stressors, an employee will likely have to use both cognitive and emotional skills, and spend both physical and emotional stamina. As such, the relationships of these stressors, with relevant mediators, moderators and outcomes are investigated in the context of the current study conducted with doctors in health organizations.

2.2 Workload

Workload can be used to describe to any variable or factor that reflects the difficulty or amount of work of an individual's job (Bowling & Kirkendall; 2012). It refers to organizational demands that surpass people's resources and limits, where employees are assigned to do too much in too little time with too few resources (Allard, Haas, & Hwang, 2011; French & Caplan, 1972; Ippolito, Hines, Mahmood, & Cordova, 2010).

Workload is a multidimensional construct which can be conceptualized in two types: quantitative and qualitative (Parasuman & Purohit, 2000). Quantitative

workload implies the amount of work required in a job, while qualitative workload refers to the complexity of tasks within the required amount of work (Shaw & Weekley, 1985). In other words, quantitative workload refers to the number of hours worked per day / week / month, or number of tasks to be completed in a given job. Qualitative workload, on the other hand, entails the difficulty or complicatedness of demands and tasks a job requires the completion of (Spector & Jex, 1998). It is argued that the majority of literature on workload focuses on the quantitative type (Caplan & Jones, 1975; French & Caplan, 1972).

Workload can be evaluated as either an objective job characteristic or subjective perception by an individual (Gangster, Fox, & Dweyer, 2001) as well. In other words, it can be considered to be a property of one's job or work role, or an employee's assessment of the amount and difficulty of one's work (Spector & Jex, 1998). The subjective dimension of workload can also be referred to as perceived workload.

Workload is an inescapable factor in any job. Regardless of an employee's position or status, he or she will have differentiating workloads throughout the continuance of his or her job. At times, the workload will likely be tight, demanding and suffocating, and at others, lighter and more manageable. The critical point here is whether the job allows an employee to recover from his or her depleted state of physiology and psychology (Shinn, Rosario, Morch, & Chestnut, 1984). If the workload is continuous, and chronically demanding and tiring, this may lead to a deterioration in the performance of the employees experiencing this heavy workload (Leiter, Harvie, & Frizzel, 1998; Shafiezadeh, 2011), disturbance in organizational relationships, and problems in the quality of the work done and service provided (Marina, 2012). It is argued that an ideal organization's workload should neither be

too demanding nor too relaxed. The optimal amount of workload must be sustainable and manageable so that it allows for opportunities for learning and development, and challenges for growth (Chen, Lee, & Chang, 2010; Kahn & Byosiere, 1992; Warr, 1994). The same workload should also give employees enough chances to rest and recover their energy and stamina, both emotional and physical, for dealing with further organizational demands and coping with various work stressors (Landsbergis, 1988).

Workload is considered to be one of the six key organizational domains of research identified in the Areas of Worklife (AWS) model concerning job stress and burnout, along with control, reward, community, fairness and values (Leiter & Maslach, 2004). Control refers to the perception of employees' capacity to affect occupational decisions, have autonomy at work and access to sufficient resources to do their jobs. It implies the wish of the workers to have a say in the decisions they make which they may be held accountable for in the future (Maslach, Schaufeli, & Leiter, 2001). This perspective is based on the Demand-Control theory, regarding the relationship between demands and decision power. The theory states that high demands and low control leads to discrepancies in the wellbeing of employees (Karasek, 1979; Leiter & Shaughnessy, 2006). The reward aspect of work life encompasses the extent to which monetary, social and intrinsic rewards are in line with or differ from employees' expectations (Leiter, 1992). Community implies the overall quality of organizational social interaction including interpersonal support, team effectiveness, communication and conflict resolution (Greco, Laschinger, & Wong, 2006). Fairness, the perception of the justness of work decisions and consequences, communicates respect towards employees, confirms their self-worth and inspires them to create a workplace with a shared sense of socialization and

community (Leiter & Harvie, 1997). Values entail the original motivations and ideals that attract people to their jobs and organizations. They go beyond the exchange of time for money and promotions, and connect employees to their organizations, making them potentially more motivated to work in and committed towards their institutions (Leiter & Maslach, 1999). These six Areas of Worklife are considered to be the areas in which a mismatch between the employee and the job or the environment can occur (Leiter & Shaughnessy, 2006). In other words, if optimal conditions for each area are not met, a misfit between the individual and organization comes to exist. This mismatch, or misalignment, creates a gap between the expectations of the person and the demands of the organization. The greater this gap is, the greater the stress and burnout, and lesser the engagement and commitment of the employee facing this mismatch towards the organization (Leiter & Maslach, 2004). Thus, in terms of workload, when an employee faces more workload, actual or perceived, than he or she expects from a certain job, that employee will likely face a misfit in the relationship with his or her employer.

2.2.1 Antecedents and outcomes of workload

In terms of its antecedents, workload is found to be affected by social support of colleagues and supervisors (Cohen & Wills, 1985). When employees are supported by other employees, they experience a decrease in both actual and perceived workload (Beehr, Jex, Stacy, & Murray; 2000). This happens due to two reasons. The first reason is that one's colleagues can actually help him or her in tangible ways by providing alternative, more effective ways of completing a task. They can also directly help in the execution of this task by taking part in its completion, thus decreasing the actual overall workload per person (Viswevaran, Sanchez, & Fisher,

1990). The second reason is that employees can help each other reduce one another's workloads by providing psychological and emotional support. This will allow the helped employee be more motivated and feel safer towards the completion of his or her tasks and duties, and so decrease his or her perceived workload accordingly (Cohen & Wills, 1985).

Other types of work stressors, such as role conflict, role ambiguity, work-family conflict and lack of control can also act as correlates to workload for employees in organizations (Spector & Jex, 1998). A variable can be considered to be a correlate when there is no consensus in relevant literature regarding its casual ordering. In other words, the same variable can act as an antecedent and also an outcome depending on the context, research purpose and relevant relationships (Meyer, Stanley, Herscovitch, & Topolnytsky; 2002). The correlate role of different stressors may happen in two ways. On one hand, excessive workload may consume most of the resources of an employee due to limited physical, mental and emotional resources (Sideman, Goldberg, & Grandey, 2007; Zyphur Warren, Landis, & Thoresen; 2007). Therefore, employees may experience other stressors more pronounced. On the other hand, empoyees may perceive higher workload in the presence of stressors and feel overwhelmed. They will be also less capable of doing much actual work.

Considering its outcomes, workload affects both employee and organizational wellbeing (Bowling et al., 2015). In terms of employees, this wellbeing includes both physiological and psychological aspects (Bowling & Kirkendall; 2012). Conservation of Resources (COR) Theory can be used to evaluate this relationship between workload and wellbeing (Hobfoll, 1989). The theory states that individuals can rely on various resources, such as physical and emotional stamina, transferrable

and non-transferrable skills, social networks, time and money to cope with various contextual and interpersonal stressors (Wang, 2007). When an individual faces a potential or actual loss of one's resources, or when these resources are not enough to acquire new ones, his or her wellbeing is likely to be compromised (Hobfoll, 1989). In such cases, excessive workload may deprive a person from the capacity to maintain one's current resources or inhibit obtaining new ones. This occurs via heavy workload depleting one's resources by occupying a significant amount of time. This results in physical and emotional exhaustion, and leaves little resources fostering social and organizational networks to gain help, or acquiring new skills to deal with current contextual and interpersonal stressors (Bowling et al., 2015). This depletion, then, results in a decrease in the physical and psychological wellbeing of employees having to deal with heavy workload (Spector & Jex, 1998).

In situations of heavy workload, it is also found that workload has the potential to lead to low performance. This is due to the inability of an individual to perform his or her duty fully as a result of not having enough time for each separate task (Leiter et al., 1998; Shafiezadeh, 2011). This timelessness, then, may result in damaged relationships and reduced work and service quality. This occurs as a result of trying to accomplish more work with less resources (Marina, 2012). These problems are likely to lead to emotional exhaustion (Dyrbye et al., 2011; Ramires et al., 1995) and so burnout (Lee & Ashforth, 1996).

Excessive workload is also found to result in decreased organizational commitment (Deepak, 2013; Wright & Cropanzano, 1998) and increased turnover intentions (Brannon, Barry, Kemper, Schreiner, & Vasey, 2007; Glaser, Tatum, Nebeker, Sorenson, & Aiello, 1999; Houlihan, 2004; Lesage et al., 2013; Xiaoming, Ma, Chang, & Shieh, 2014) for employees. Heavy workload makes it more difficult

for people to be committed to and intent on staying in the organizations in which they continuously face this relevant workload. This is because employees are inclined to minimize and even avoid environments or institutions which provide unpleasant work experiences (Hanisch & Hulin, 1991). In line with the Areas of Worklife Model, this mismatch between an employee's expectation of workload and the actual workload he or she faces in the job will potentially result in decreased commitment and engagement towards the organization (Leiter & Maslach, 1999). This argument is in line with Social Exchange Theory in that organizations that do not provide positive work experiences but instead present negative ones, such as excessive workload, will also likely not be contributed to or committed towards by their employees in the long run (Emerson, 1976; Gouldner, 1960).

2.3 Emotional labor

Emotional labor is one of the most popular research areas in current management literature Fisher & Ashkanasy, 2000). This is due to the fact that employees, as routine parts of their jobs, depending on their organizational roles, are expected to frequently interact with customers, clients, patients, students, colleagues and supervisors (Hülsheger & Schewe, 2011). Emotional labor is the necessity to display specific emotions while hiding others required by organizations (Côté, 2005; Hochschild, 1983). It is the expectation of the expression of certain emotions by the employees during their interpersonal interactions and transactions at work (Morris & Feldman, 1996). Thus, emotional labor is a form of emotional regulation determined and enforced by organizations (Pugh, 2001). Jobs that have the potential to include emotional labor are those that involve personal interactions, require the employee to evoke an emotional state in the customer and allow the organization to exercise a

certain amount of control over the emotional moods of the employees (Hochschild, 1983). Health organization and their personnel can be considered as such (Zhang & Feng, 2011). Regardless of the sector or institution, though, a significant part of an employee's job is in managing his or her emotions in social and organizational interactions. This is due to the fact that in spite of how a person feels or wants to behave, organizational norms restrain an employee's options of emotional display by dictating certain norms in terms of how one must act and what feelings he or she must keep inside and not reflect to those around him or her. Emotional labor, then, entails the behavior of expressing socially desirable emotions and not displaying undesirable ones (Ashforth & Humphrey, 1993). During organizational interactions, employees are expected to regulate the emotions they show to meet the organizational norms specific to their jobs and institutions. These expectations include the content, range, intensity, frequency and duration of the emotions to be exhibited or restrained (Morris & Feldman, 1996). These shown emotions, though, are not always parallel to those actually felt by the employees who display or feign them (Robbins & Judge, 2011).

Emotional labor is conceptualized as an influential interpersonal stressor which requires emotion regulation by individuals (Adelmann, 1995; Duke, Goodman, Treadway, & Breland, 2009; Hill, Darling, & Raimondi, 2003; Kiely & Sevastos, 2008; Montgomery, Panagopolou, de Wildt, & Meenks, 2006; Ngo, Foley, & Loi, 2005; Sonnentag, Kuttler, & Fritz, 2010; Wharton, 1999; Zapf, Seifert, Schmutte, Mertini, & Holz, 2001). This regulation entails two components: deep acting and surface acting (Hochschild, 1983; Rubin, Tardino, Daus, & Munz, 2005). These components of emotional labor both include the expenditure of psychological, physical and emotional effort for realization (Hülsheger & Schewe, 2011). Deep

acting entails pumping up one's emotions by trying to align what is appropriate be felt in an organizational context and what is actually felt by oneself (Brotheridge & Lee, 2003; Grandey, 2000; Gross, 1998). To engage in deep acting, individuals can use two strategies. The first method is attentional development, which refers to the directing of one's emotions towards positive thoughts and experiences to get oneself in a positive mood. The second strategy is cognitive change, in which individuals reappraise their circumstances and situations in order to produce the necessary emotions (Grandey, 2000). Surface acting, on the other hand, involves pushing down one's own emotions in order to don an emotional mask of different feelings to present. It refers to the management of one's emotional expressions to display the required ones (Brotheridge & Lee, 2003; Grandey, 2000; Gross, 1998). It includes hiding feelings and faking emotions as its sub dimensions (Lee et al., 2010). Deep acting and hiding feelings occur before the display or expression of organizationally required emotions, be they genuine or fake. Deep acting alters inner feelings, while surface acting suppresses them by hiding them. As such, in the case of surface acting, the initial original feeling remains intact within the individual (Gross & John, 2003). Accordingly, deep acting results in the display of genuine emotions, while hiding feelings leads to faking emotions (Hülsheger & Schewe, 2011). In other words, expressed emotions by employees are either genuine or fake depending on the acting type adopted in organizations. There are also argued to be cases where an individual's emotions might be in line with those requested by the organization. This is referred to as automatic regulation or passive deep acting (Ashforth & Humphrey, 1993; Zapf, 2002). Automatic regulation can be defined as changes to one's emotions without a decision, attention or engagement to do so (Mauss, Bunge, & Gross, 2008). Unlike surface acting or deep acting, automatic regulation does not

require effort from an individual to be adopted (Diefendorff, Croyle, & Gosserand, 2005; Mikolajczak, Tran, Brotheridge, & Gross, 2009).

There are two main determinants of displayed or expressed emotions in foe employees in organizations. The first factors are the personal characteristics of the employees, including their dispositions. The second factors are the societal and occupational norms (Rafaeli & Sutton, 1989). Emotional expressiveness and inner feelings make up the personal characteristics facet, while transaction busyness forms the occupational norms dimension. Emotional expressiveness is defined as the amount of the use of facial expressions, body language and vocal variations in transmitting emotions (Friedman et al., 1980; Hatfield et al., 1994). Inner feelings, on the other hand, refer to the experienced emotions by the employees, as opposed to their expressed emotions. Inner feelings, in the organizational context, can also be referred to as employee affect (Pugh, 2001). Lastly, transaction busyness refers to the busyness at the time of interaction between the included parties, specifically in organizational environments. It is a contextual factor that includes proponents such as crowdedness and long waiting lines (Pugh, 2001).

The majority of studies on emotional labor focus on its occurrence in the relationships between employees and customers (Hülsheger & Schewe, 2011). Emotional labor, though, can take place in the associations between different parties in organizations. It might come to occur within the employees themselves, as well as between supervisors and subordinates, and leaders and followers (Bono, Foldes, Vinson, & Muros, 2007; Gardner, Fischer, & Hunt, 2009).

2.3.1 Antecedents and outcomes of emotional labor

Emotional labor is affected by occupational norms and characteristics of role occupants (Pugh, 2001). When considering emotional labor within occupational norms, surface acting is considered to be positively related to emotional exhaustion, depersonalization, expressive behavior regulation and negative affectivity. It is found to be negatively associated with perceived achievement and role identification (Kruml & Geddes, 1998). In terms of characteristics, certain individuals may be more prone to suffer from the negative consequences of emotional labor than others, such as those more susceptible to emotional contagion (Lee et al., 2010). Burnt out individuals are also more likely to engage in surface acting, which prospers a sense of inauthenticity (Sheldon, Ryan, Rawsthorne, & Ilardi, 1997). This results in diminished wellbeing in terms of employee emotions and psychology (Brotheridge & Lee, 2003).

It could be argued that when a person is required to display or actually displays emotions he or she doesn't feel, emotional dissonance can occur as a result (Robbins & Judge, 2011; Zerbe, 2000). Emotional dissonance entails the discrepancy between expressed emotions, actual or expected, and felt emotions in the workplace (Robbins & Judge, 2011). In fact, emotional dissonance is argued to play a major role in settings including emotional labor (Côté, 2005; Morris & Feldman, 1996; Rubin et al., 2015; Van Dijk & Brown, 2006). As such, emotional dissonance can act both as an antecedent (Rubin et al., 2005) and outcome (Robbins & Judge, 2001) of emotional labor. In other words, it can be referred to as a correlate (Meyer et al., 2002) of emotional labor. Thus, employees come to face, and deal with emotional dissonance either by suppressing what they feel and changing their expressed feelings (surface acting) or trying to match what they feel to the emotions that are

meant to be displayed in organizational interactions (deep acting; Brotheridge & Lee, 2003; Grandey, 2000). They can also deal with emotional dissonance via displaying what they feel inside and disregarding the emotional requirements of the organization. This can be referred to as emotional deviance (Rafaeli & Sutton, 1987). During situations of emotional dissonance, where an employee engages in surface acting, careful observers can detect cues hinting at the actually experienced emotions, even if the expressed emotions seem to imply otherwise. This is because it is difficult to fake unfelt emotions for long amounts of time (Pugh, 2001; Schwartz, 2012).

As a crucial factor potentially affected by emotional labor, wellbeing can be considered in two dimensions. Personal wellbeing can refer to one's energy and resources, and the authenticity of his or her feelings. Organizational wellbeing, on the other hand, can be said to include one's job satisfaction and organizational commitment towards the organization he or she is employed in (Hülsheger & Schewe, 2011).

Considering personal wellbeing, emotional labor can lead to ego depletion. This is because conscious and continuous control and regulation of emotions by individuals tends to require effort. As such, this constant effort to regulate ones emotions depletes his or her physiological and psychological resources (Baumeister, Bratlavsky, Muraven, Tice, 1998; Muraven, Tice, & Baumeister, 1998). In terms of emotion regulation, this is likely especially the case for surface acting. Surface acting entails the constant monitoring of felt and displayed emotions, actual or expected. As such, an individual has to spend considerable effort to display the organizationally required emotions by surface acting. This results in drained resources, increased strain and diminished personal wellbeing (Côté, 2005; Grandey, 2003). It is also

argued that an individual's physical, mental and emotional resources may be limited (Sideman, Goldberg, & Grandey, 2007; Zyphur Warren, Landis, & Thoresen; 2007). As surface acting depletes a significant amount of one's resources, the individual may, as a result, be left with little energy to spend time on and execute other tasks in an organization. So, the surface acting facet of emotional labor may play a detrimental role on organizational performance as well (Hülsheger & Schewe, 2011).

The discussions in terms of the energy spent and preserved by individuals are more contradictory when considering the deep acting dimension of emotional labor. On the one hand, it is argued that deep acting may require less of an individual's resources to be engaged in (Totterdell & Holman, 2003). This is because the amount of attention, drive and resilience demanded to align feelings is argued to be less than those for hiding emotions (Sideman et al., 2007). On the other hand, an alternative argument is also presented in terms of deep acting and its relation to resource depletion and conservation. It is stated that the alignment of one's emotions with those required by the organization demands significant amounts of motivation, internalization and engagement. As such, the physiological and psychological resources needed for the execution of deep acting may be even more than those for surface acting (Liu, Prati, Perrewe, & Ferris, 2008). The current literature does not contain a consensus on the surface vs. deep acting argument in terms of energy usage (Hülsheger & Schewe, 2011). It can still be said, though, that deep acting, like surface acting, requires mental and emotional effort, and drains one's resources to be engaged in (Liu et al., 2008).

Conservation of Resources (COR) Theory can be used here to evaluate the relationship between emotional labor and wellbeing (Hobfoll, 1989) as well. This means that as an individual's resources become depleted due to emotional labor, be it

from deep or surface acting, he or she has less physical and emotional stamina to maintain one's remaining resources or acquire new ones. As a result, one's wellbeing as well as performance in an organization is likely to be detrimentally influenced (Hülsheger & Schewe, 2011).

Regarding individual's personal wellbeing, emotional labor can also have effects on the authenticity of one's feelings. This happens when an individual's emotional expressions and felt emotions are in conflict with each other (Brotheridge & Lee, 2002). The authenticity of an individual's feelings are argued to decrease especially when one engages in surface acting (Erickson & Ritter, 2001; Simpson & Stroth, 2004). This decrease potentially leads to inauthenticity. This inauthenticity of feelings, then, likely results in stress and depression for individuals (Erickson & Wharton, 2007; Sheldon, Ryan, Rawsthorne, & Ilardi, 1997). Deep acting, on the other hand is argued not to lead to inauthenticity. This is because, arguably, no discrepancy occurs as a result of deep acting between one's felt and displayed emotions (Lee et al., 2010). In consideration of personal wellbeing, emotional labor may also result in emotional exhaustion and depersonalization for individuals (Hülsheger & Schewe, 2011).

In terms of organizational wellbeing, job satisfaction refers to the extent to which an employee is content with his or her job (Weiss, 2002). Organizational commitment, on the other hand, refers to the level of an employee's attachment to and involvement in an organization (Mowday et al., 1982). Affective Events Theory (AET) can be adhered to in order to understand the relationship between emotional labor and organizational wellbeing. The theory argues that affective events in organizations can affect employees' judgements about and evaluations of their jobs and organizations (Weiss & Cropanzano, 1996). As such, emotional labor, as it

depletes an individual's mental, emotional and physical resources, becomes a source of negative affective events in organizations. The continuous experiencing of such events, then, likely decreases the job satisfaction and organizational commitment of the employees going through these events (Hülsheger & Schewe, 2011). Social Exchange Theory (SET; Gouldner, 1960; Emerson, 1976) can also be referred to in that as organizations provide their employees constant negative experiences with high emotional labor requirements (Choi & Kim, 2015; Gergen, 1969; Li & Liang, 2015; Kumar Lawler & Thye, 2006; Mishra, 2014; Tang, 2013), employees' commitments towards these organizations are likely to decrease (Hülsheger & Schewe, 2011).

In terms of relationships between employees and customers, expressed emotions occurring as a result of emotional labor are eventually reflected to customers and clients (Pugh, 2001). Emotions that are felt in customers as a result of the reflection of employee affect towards them can be referred to as customer affect. The process of the transfer of employee affect to customer affect occurs via emotional contagion. In this process, employees' expressions of emotions, positive or negative, produce a corresponding emotional change in customers (Hatfield et al., 1994). In this context, transaction busyness is assumed to be negatively related to positive emotional contagion (Pugh, 2001). The appropriateness and authenticity of the displays of emotions by the employees, on the other hand, are found to be positively correlated with evaluations of the service quality by the customers. This is because individuals can differentiate between genuine and fake emotional expressions (Ekman, Friesen, & O'Sullivan, 1988). In fact, positive displays of emotions are found to result in positive customer reactions only when they are perceived as genuine and authentic (Hennig-Thurau, Groth, Paul, & Gremler, 2006;

Pugh, 2001). The personal traits of the customers are also important in these evaluations. The more agreeable customers are, the more likely the transaction will go smoothly between customers and employees, and the more the received service will be perceived in a better manner and positive light (Vijayalakshmi & Bhattacharyya, 2012). As a result, this positive evaluation by customers will likely lead to customer satisfaction and loyalty towards the employees and organizations (Bagozzi, Gopinath, & Nyer, 1999; Grandey, 2003; Hennig-Thurau et al., 2006; Pugh, 2001).

In situations of negative emotional relationships with customers, such events may lead to emotional conflict or emotional harmony. Emotional conflict entails situations where employees feel emotions contrary to those of their customers. Emotional harmony, on the other hand, includes harmonious emotions that are felt too deeply (Lee et al., 2010). Both of these emotional issues can result in the suppression of undesirable emotions and their replacement with more appropriate ones. This then leads to decreased self-esteem and increased cynicism due to the occurrence of emotional dissonance associated with these processes (Hülsheger & Schewe, 2011). This resulting emotional labor may lead to situations of burnout for employees (Brotheridge & Lee, 2003), and also to decreased intention to stay as a result (Çelik & Öz, 2011).

The employee – customer relationship, in terms of emotional labor and its effects on wellbeing, can be explained by the social interaction model (Côté, 2005). The model argues that employee emotional expressions affect customer evaluations, and customer evaluations in return re-affect the employee. This results in a mutual interaction between the interaction partners (Pugh, 2001). Combining this model with Conservation of Resources (COR) Theory, it can be said that experiencing

reciprocal positive feedback within this interaction can be considered as a beneficial resource in dealing with other stressors at work (Hobfoll, 1989). In other words, positive evaluations of customers reflected to employees can act as energy resources. On the contrary, a mutually detrimental relationship will likely result in the depletion of one's physiological and psychological resources. As such, it will be disadvantageous for the wellbeing and performance of employees within this negative reciprocal relationship (Hülsheger & Schewe, 2011).

2.4 Job Demands-Resources Model

As a stress model, the Job Demands-Resources Model (JD-R) can be used to explain the influence of workload and emotional labor in organizations (Demerouti, et al., 2001). The model argues that jobs or organizations that require high demands and provide low resources in return result in the formation of physical and emotional exhaustion, depersonalization, job related depression and as a result burnout and decreased motivation in their employees (Demerouti, et al., 2001). Emotional exhaustion refers to an overextension by emotional requirements. It is found to be related to workload and emotional labor, and may potentially affect people's intentions to stay in their organizations (Lee & Ashforth, 1996). Depersonalization, on the other hand, implies detached reactions or responses to one's customers (Maslah, Jackson, & Leiter, 1996).

Job demands refer to any aspect of a job or organization that requires sustained physical, mental and emotional effort to be dealt with. They are argued to result in physiological and psychological costs for employees experiencing them (Demerouti et al., 2001). Job resources, on the other hand, imply any property of a job or organization which helps employees achieve their goals, reduce organizational

demands and initiate personal development. They can either be external (organizational, social) or internal (personal; Richter & Hacker, 1998). It is argued that high job demands result in overtaxing and exhaustion, while low job resources may end in depersonalization, disengagement and turnover intentions (Demerouti et al., 2001). The model argues that both high job demands and low job resources may lead to burnout, decreased performance (Mojsa-Kaja et al., 2015), decreased organizational commitment (Lee et al., 2010; Omdahl & O'Donnell, 1999; Siebert et al., 2007) and turnover intentions (Le Blanc et al., 2001; Leiter & Shaughnessy, 2006; Xiaming et al., 2014).

An important aspect of the JD-R model is that the model can account for the relationship between demands and exhaustion, and resources and depersonalization separately. This means that the interaction of demands and resources is neither a necessity nor a significant factor for the model (De Jonge & Kompier, 1997; Hockey, 1993). As such, with regard to the current study, the model can be adhered to in explaining the effect of demands on organizational attitudes and outcomes.

2.4.1 Job Demands-Resources Model, workload and emotional labor

Workload and emotional labor can be taken into consideration by the stress model of Job Demands-Resources Model as contextual demands (Cordes & Dougherty, 1993; Janssen, Bakker, & de Jong, 2001; Lee & Ashforth, 1996) and interpersonal demands (Barrick & Ryan, 2004; Brotheridge & Grandey, 2002; Wilk & Moynihan, 2005), respectively.

The physical and emotional overload resulting from high contextual and interpersonal demands results in increased physical and emotional exhaustion and so decreased motivation in the employees (Demerouti et al., 2001; Lee et al., 2010).

These high job demands, then, lead to burnout (Demerouti et al., 2001; Lee et al., 2010), decreased organizational commitment (Miller et al., 1995; Omdahl & O'Donnell, 1999; Siebert et al., 2007) and turnover intentions (Le Blanc et al., 2001; Leiter & Shaughnessy, 2006; Xiaming et al., 2014).

The current study argues that workload and emotional labor, as job demands with important consequences, can effect employee's attitudes towards their organizations. Though employees may also be constrained in terms of job resources such as control, task variety and coworker support (Demerouti et al., 2001), the current research's main focus in on job demands and relevant outcomes. In this process, dispositional factors may play moderating roles as well (Weiss & Beal, 2005). As part of emotional contagion process, the more susceptible people are to emotional contagion, the more likely they will be affected by the negative consequences of demands around them (Lee et al., 2010). In other words, the less resilient people are to being affected by the emotions around them, the more they will be influenced by organizational demands. This is because the relationship between external demands and resulting attitudes can be moderated by employee dispositions (Bono & Wey, 2005; Weiss & Beal, 2005).

2.4.2 Workload and emotional labor in service and health organizations

In recent years, competitiveness within and among organizations is in a trend of dramatic and continuous increase. As a result, employees are more frequently required to display consumer friendly attitudes and behavior. The attitudes that people adopt, though, may be in conflict with their emotions in such situations. As a result, people become victims of emotional labor (Hochschild, 1983; Le Blanc et al., 2001). The service demands in various sectors, including healthcare, are also rising

due to this competition. As a result employees are forced to produce more with less resources (Le Blanc et al., 2001). This increases their workload and creates settings in which they are employed under time pressures (Xiaoming et al., 2014). This is due to the fact that service organizations have unique settings in terms of demographics, job groups, technology, structure, processes, interdependence between colleagues and close relationships with customers (Batt, 2002). These arguments are likely to hold especially for health organizations, where employees work and interact with numerous people on a frequent basis (Cordes & Dougherty, 1993). These employees, in varying time periods, have to continuously and consistently adopt an understanding, empathetic and problem solving manner, and behave accordingly (Hochschild, 1983). This holds despite the emotional and physical problems which they themselves face. Moreover, some healthcare employees might have administrative roles as well. This adds even more to their already heavy workloads (Xiaoming et al., 2014). In other words, both contextual (workload) and interpersonal demands (emotional labor) are quite high in service and health organizations (Houlihan, 2004). As such, these demands are likely to effect employees working in these organizations (Le Blanc, Bakker, Peeters, van Heesch, and Schaufeli, 2001).

In terms of demands and resources relevant to health organizations, long, intense and frequent patient interactions, role conflict and ambiguity resulting from ambiguous information form the job related demands dimension for health personnel (Ramirez et al., 1995). On the other hand, felt autonomy and patient support make up job related resources for them (McCue, 1982). They are also related with each other in that they reinforce one another. This means that demands take from resources, and resources are used to meet demands (Schaufeli & Bakker, 2004). Considering health organizational demands, workload and work-family conflict are found to be

predictors of emotional exhaustion and physical symptoms. On the other hand, in terms of resources, sense of autonomy is found to be positively associated with perceived accomplishment and negatively linked to physical symptoms (Bakker et al., 2005; Lee & Ashforth, 1996; Leiter, 1993; Ramirez et al., 1995). Moreover, predictability is considered to be positively related to perceived accomplishment and negatively correlated with emotional exhaustion and depersonalization (Lee et al., 2010; Schaufeli & Bakker, 2004).

Considering workload, it can be especially heavy for healthcare practitioners (Miller, Ellis, Zook, & Lyles, 1990; Xiaoming et al., 2014). Health personnel are likely to face long, intense shifts, and unexpected critical situations requiring immediate attention, even on weekends and holidays. On top of that, some healthcare personnel have combined shifts and timetables where they may have to take over one another's responsibilities and duties when necessary. As expected, this adds even more to their already tight schedules (Bakker, Schaufeli, Sixma, & Bosveld, 2001). Moreover, others health personnel may come to have all day caretaker positions depending on the medical situation of their patients (Xiaoming et al., 2014). As such, health organizations come to be those which are generally likely to include tight and heavy workloads.

Considering specific health personnel, intensive care employees tend to have even tighter schedules with broader and more critical responsibilities. They take care of unstable patients, deal with treatments and procedures, and take initiative in urgent matters (Erlen & Sereika, 1997). Their decision latitude and control, on the other hand, is limited and somewhat lacking in that they may be unable to satisfy these demands due to the authority restraints (Bakker, Le Blanc, & Schaufeli, 2005; Sawatzky, 1996). Relying on the Areas of Worklife model, this situation leads to the

creation of a mismatch in terms of the control dimension for intensive care personnel. In other words, health personnel come to realize that they have less control over and within their jobs then they expect to have. This results in increased stress decreased wellbeing for them (Leiter & Maslach, 2004).

In terms of emotional labor, during interactions with their patients, doctors are supposed to display appropriate emotions and empathic concern (Lee et al., 2010). This requires them to induce or suppress their feelings in order to display different ones through deep acting or surface acting, respectively (Brotheridge & Lee, 2003; Grandey, 2000). Doctors have vital roles as both treatment providers and messengers in the health sector (Xiaoming et al., 2014). As such, they may need to fake their emotions so that they can elicit desirable responses from their patients (Mann, 2005; Zapf, 2002). This is because during interactions or consultations with their patients, the less negative emotions doctors display, the better responses they are likely to get from their patients (Persaud, 2004). This is due to the fact that regardless of how direly ill or terminal a patient is, doctors in health organizations are required to keep their cool, motivate and guide their patients (Xiaoming et al., 2014). This is so that their patients' treatments can go as effectively as possible in terms of patient psychology and emotions, allowing them be motivated enough to get the necessary treatment from their doctors (Lee et al., 2010).

Especially in health organizations, emotional labor can have serious effects on the wellbeing and performance of employees who are in conflict in terms of how they feel and what emotions they should show within their organizations. The effort spent for emotional labor to push down or pump up one's feelings can produce serious psychological strains and may result in the loss of control of emotions (Grandey, 2000). This loss of emotional control is likely to increase people's

susceptibility to emotional contagion (Hatfield et al., 1994). This is due to the fact that as they lose control of their emotions, health employees are likely to become less able to manage their own emotions and more prone to being influenced by those of others (Lee et al., 2010). This loss of control of employees' emotions also results in feelings of inefficacy and underachievement in their organizational roles. The emotional strain and exhaustion that occur as a result of the significant effort spent to align one's felt emotions with those required to be displayed by the organization depletes the emotional resources and energy of the employees (Baumeister et al., 1998; Muraven et al., 1998). As a result, these employees face depersonalization or estrangement to seek emotional distance from those around them. They do this in order to cope with the detrimental effects of emotional labor (Brotheridge & Lee, 2003).

The quality of the interactions between patients and health personnel, where employees are expected to be understanding of and responsive to sociocultural sensitivities and needs, is found to be associated with emotional labor in health organization as well (McCue, 1982). This in turn affects the personal efficacy, emotional exhaustion and physical symptoms of personnel in health organizations, and so ultimately their wellbeing (Lee et al., 2010). As the emotional resources of caretakers are depleted, they go through emotional exhaustion. As a result, they feel unable to provide more to their patients, become cynical, and so form detached feelings towards these patients, resulting in depersonalization (Brotheridge & Lee, 2003). This process causes them to see and appraise themselves in a relatively negative light, leading to anxieties regarding the sufficiency of their competencies and dissatisfaction with their personal accomplishments (Schaufeli, van Dierendonck, & van Gorp, 1996). Moreover, the combined effects of

depersonalization, reduced self-efficacy and cynicism lead the health personnel to experience emotional strains in their organizations. These strains become more detrimental in cases where patients have significantly dire health issues and / or when they react negatively to the treatments of these personnel (Lee et al., 2010).

The common denominator of stressor outcomes in service and healthcare sectors is that their antecedents tend to be contextual and interpersonal stressors (Le Blanc et al., 2001). These antecedents have been categorized in two groups in related health literature. The first are the situational ones, referring to job characteristics of quantitative job demands, such as time pressures, overload (Lau, 2010), medical practice uncertainty (Frankel, 1995) and high patient volumes (Lee & Ashforth, 1996). Qualitative job demands like role clarity / ambiguity, role conflict, lack of job resources such as control (Williams et al., 2002), autonomy and support of peers (Schaufeli, 2007), occupational characteristics of the requirement to display or withhold emotions at work (Zapf, Isic, Bechtoldt, & Blau, 2003) and organizational characteristics like value and ethics conflicts between employees and employers can also be considered as contextual stressors. Interpersonal stressors, on the other hand, imply demographics and job attitudes like expectations (Mojsa-Kaja et al., 2015). Specifically for doctors, managing and dealing with their patients' feelings while at the same time struggling to regulate their own affective states can be considered an interpersonal stressor as well (Coulehan, 1995; Gerrity, DeVellis, & Earp, 1990). As such, not only job stressors but also interpersonal stressors can be investigated in order to better understand the factors that affect doctors' emotional and psychological situations. These stressors potentially lead to burnout, health problems and so turnover intentions (Lee et al., 2010). Also, they not only affect performance and job satisfaction of doctors, but also create work-family conflicts (Ramirez et al.,

1995). As such, they potentially undermine the wellbeing of doctors (Wallace & Lemaire, 2007).

Job demands-resources theory can also be used to explain the consequences of workload and emotional labor in health organizations. Especially in health organizations, emotional labor and workload are frequently associated with burnout (Cordes & Dougherty, 1993; Lee & Ashforth, 1996; Sheldon et al., 1997; Pugh, 2001; Robbins & Judge, 2011),which represents a major misalignment between the individual and his or her institution (Mojsa-Kaja, Golonka, and Marej, 2015). Therefore, high contextual demands like workload and interpersonal demands as emotional labor, as they increase in an organization, ultimately lead to physical and emotional exhaustion, burnout, and so decreased organizational commitment (Demerouti et al., 2001; Lee et al., 2010).

Social Exchange Theory can also be considered for workload and emotional labor (Guy, Newman, & Mastracci, 2014; Lawler 1999, 2001; Kruml & Geddes, 2000) in health organizations (Gouldner, 1960; Emerson, 1976). It can be argued that as institutions provide their employees negative experiences consisting of exposure to heavy workload and emotional labor, these employees are likely to become less attached to, committed towards and intent to stay in their organizations. This is because employees are likely to experience decreased wellbeing due to the negative effects of workload and emotional labor (Wallace & Lemaire, 2007). As such, they may be prone to removing themselves from environments which include negative experiences and stimuli that detrimentally affect their wellbeing (Hanisch & Hulin, 1991).

One aspect to keep in mind in terms of interactions with clients in service and health organizations is the difference between service encounters and service

relationships (Grandey & Diamond, 2010). Service encounters refer to interactions between employees and customers that occur only once or a few times. Service relationships, on the other hand, imply a history of shared interactions between employees and their clients. As such, the interacting parties in service relationships are likely to form emotional bonds between them. However, such bonds are not likely to be initiated in service encounters (Gutek, 1999; Gutek, Bhappu, & Liao-Troth, 1999). This implies that the intensity of the effects of emotional labor on individuals' wellbeing might depend on the relationships within which they engage in surface or deep acting (Hülsheger & Schewe, 2011). This means that, potentially, in terms of employee wellbeing, emotional labor may be more detrimental to adopt in service encounters than in service relationships. This is because it might be easier for employees to align with and express their emotions towards customers with whom they have personal relationships with. It must be noted here that service and health organizations are likely to include both service encounters and service relationships depending on the length and frequency of the service requested by their clients (Grandey & Diamond, 2010).

2.5 Intention to stay

In terms of examining the context for organizational outcomes, job stressors are mentioned as critical contextual and interpersonal factors that can have significant effects on employee health, behavior and performance (Kahn & Byosiere, 1992). These behavıoral outcomes, though, tend to be complex in nature because they are affected by various environmental and systematic stimuli (Anderson, Corazzini, & McDaniel, 2004; Barry, Brannon, & Mor, 2005). The employee's internal stress experience also likely plays an important role in the relationship between impacts of

job demands on organizational outcomes. In other words, organizational conditions tend to influence an employee's experience of stressor outcomes. This in turn determines relevant contextual consequences for them (Maslach & Leiter, 2008). In terms of these outcomes of organizational stressors, behavioral intentions are examined in utmost regard during the recent years in relevant literature (Steel & Ovalle, 1984). This is due to the fact that they are argued to be the most observable and immediate antecedents of related behavioral outcomes. The Theory of Reasoned Action (TRA) can be adhered to in this context. It argues that the most effective predictors of people's behavior are intentions to execute those behavior (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975). This implies that attitudes influence behavior through their immediate effects on relevant behavioral intentions (Steel & Ovalle, 1984).

One common outcome of organizational stressors in related literature is turnover (Steel & Ovalle, 1984). In fact, it is argued that turnover is one of the most frequently investigated consequence in related literature for employees and organizations (Cotton & Tuttle, 1986). Turnover is defined as the separation of an individual from an organization (Naumann, 1992). For employees, leaving is the final decision preceded by intention and thoughts of parting ways with the organization (Alexander, Lichtenstein, Oh, & Ullman, 1998; Steel, 2002). As such turnover intentions, also referred to as intention to leave or intention to quit, are considered to precede actual turnover actions (Tett & Meyer, 1993; Zhang & Feng, 2011).

Another related and frequently observed outcome of organizational stressors in relevant literature is employees choosing to stay or remain in their organizations. Here, similar to turnover intentions and turnover, intention to stay precedes the final

behavior of staying or remaining employed in an organization (Steel & Ovalle, 1984). Intention to stay refers to personal preferences, subjective estimations and resulting attitudes regarding employees' probability to continue to remain with their employers (Chen et al., 2010; Mowday, Porter, & Steers, 1982). It reflects emotional states of employees that accumulate over time. Intention to stay can also be referred to as intention to remain employed (Tourangeau et al., 2010).

It must be noted here that intention to stay and intention to leave are considered to be opposites of each other (Black & Stephens, 1989; Filipova, 2007; Kim, Price, Mueller & Watson, 1996; Matthias & Benjamin, 2005; Mustapha, Ahmad, Uli, & Iis, 2010; Zeytinoğlu, Denton, Davies, & Plenderleith Millen, 2009). In fact, they are even used interchangeably as intention to leave / stay or intention to quit / stay in relevant studies (Cho & Guchait, 2009; Ito, Eisen, Sederer, & Tachimori, 2001; Lee & Maurer, 1999; Johnsrud & Rosser, 2002; McCarthy, Tyrrell, Lehane, 2007; Steel & Ovalle, 1984).

The Theory of Reasoned Action (TRA; Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975) can again be referred to here for explaining the workings of turnover intention and intention to stay. Here, they are respectively mentioned to be the best predictors of employees leaving or remaining in an organization (Kraut, 1975). It is stated in related literature that when cognitive and affective events leading to turnover or staying decisions in organizations are considered, turnover intentions and intention to stay, respectively, are found to be the terminal factors in decision making processes resulting in related behavior (Mobley, Griffeth, Hand, & Meglino, 1979). Intentions of turnover and staying are considered to be a culmination of these decision making processes. As such, they are regarded to represent a crucial, transitional link between perception, affective and cognitive processes and variables,

and resulting overt behavior (Kim & Kao, 2014; Steel & Ovalle, 1984). Thus, it can be argued that employees' attitudes about work influence their intentions to stay in their organizations, and accordingly their resulting actions.

2.5.1 Antecedents and outcomes of intention to stay

Intention to stay is found to play different roles within various contexts in related literature. It is found to be positively affected by job satisfaction and organizational commitment (Steel & Ovalle, 1984). This implies that if an employee is satisfied with his or her job and is committed to the organization, then he or she is less likely to leave his or her employer (Mitchell, Holtom, Lee, & Erez, 2001; Zeytinoğlu et al., 2009). Due to this relationship, satisfied workers become committed workers. As a result their intentions to stay with their organizations increase (Mobley, 1977; Mobley, Griffeth, Hand, & Meglino, 1979). In fact, job satisfaction and organizational commitment are considered to be two of the major antecedents of intention to stay (Meyer, 1997; Van Dick et al., 2004; Zhang & Li, 2001). However, among job satisfaction and organizational commitment, it is argued that organizational commitment is a stronger predictor of intention to stay relative to job satisfaction (Griffeth, Hom, & Gaertner, 2000; Ingersoll et al., 2002).

It is also seen in different intention to stay models that job satisfaction can have an indirect effect on employee's turnover or remaining decisions through their intentions to stay (Mobley et al., 1979). In such cases, intention to stay is found to mediate the relationship between job satisfaction and actual behavior of staying (Bluedorn, 1982; Price & Muller, 1981). Organizational commitment, on the other hand, can potentially play a mediating role between job satisfaction and intention to stay (Bluedorn, 1982; Kraut, 1975; Porter & Steers, 1973; Steers, 1977), and job

security and intention to stay (Chirumbolo & Hellgren, 2003; Zeytinoğlu, 2010). Organizational commitment, by itself, can also have both an indirect and direct effect on intention to stay (Arnold & Feldman, 1982). Occupational commitment, and its three subcomponents, are also argued to be positively related to intention to stay (Chang, Du, & Huang, 2006; Lu, Lin, Wu, Hsieh, & Chang, 2002; Nogueras, 2006; Zeytinoğlu et al., 2006).

Job security is found to be a crucial factor that might positively affect intention to stay (Chirumbolo & Hellgren, 2003). Job security refers to an employee's evaluation of his or her current working conditions and perception of their possible future in their jobs. Job insecurity, on the other hand, is defined as the perception of helplessness to continue to remain in a current job (Greenhalgh & Rosenblatt, 1984). Job security can be considered with objective and subjective dimensions. Objective dimensions include continuous contract, full-time working and overtime (paid or unpaid). Subjective dimensions, on the other hand, entail the concept of perceived job security. It refers to an employee's perception that he or she feels safe and confident in his or her job, and will continue working in the current organization as long as he or she wants to remain there (Pearce, 1998). Basically, perceived job security refers to an employee's subjective assessment of his or her security in the job rather than an actual contract or agreement that guarantees his or her continuous, safe and voluntary employment (Chirumbolo & Hellgren, 2003; Pearce, 1998). Regarding the relationship between job security and intention to stay, job insecurity is found to be negatively correlated with intention to stay. It is also found to be negatively associated with organizational commitment and job satisfaction (Zeytinoğlu et al., 2009). Perceived job security, on the other hand, is

found to be significantly and positively correlated with intention to stay (Zeytinoğlu et al., 1992).

One other factor that influences intention to stay in organizations is role clarity, or its obverse, role ambiguity. They refer to the clarity or ambiguity, respectively, of tasks associated with an organizational role (Pearce, 1981). They can be thought of in two manners: objective and subjective. The objective approach entails the existence or absence of sufficient information relevant to employee roles based on the quality or restriction of the subject information. The subjective perspective refers to the feeling of owning as much or not as much information related to employee roles as one would ideally like to have (Lyons, 1981). There are three main organizational conditions that affect employees' role clarity and ambiguity: organizational complexity, organizational change and managerial communication philosophy. More complexity in organizational structure, frequent and rapid changes in an institution, and restricted communication policies lead to role ambiguity for employees (Caplan & Jones, 1975). Perceived role clarity is found to be negatively related to propensity to leave, turnover and tension. It is found to be positively related to intention to stay, and also job satisfaction (Lyons, 1971).

Factors of leadership style and position power can also be regarded as important antecedents of intention to stay (Taunton, Boyle, Woods, Hansen, & Bott, 1997). It is argued that a leadership style that seeks contribution from employees and actually values them, promotes a climate of delegation and decision making at all staff levels, enhances effective and open sharing of information, provides necessary support, exerts but does not abuse position power, encourages personal development and advancement opportunities, and increases coordination among employees is positively associated with their intentions to stay with their employers (Boyle, Bott,

Hansen, Wood & Taunton, 1999). Autocratic leadership and management, on the other hand, are found to be negatively related with intention to stay (Ahmad & Riaz, 2011).

Career and personal development possibilities (Camerino et al., 2008; Flinkman, Laine, Leino-Kilpi, Hasselhorn, & Salantera, 2008; Hasselhorn, Tackenberg, & Muller, 2003), organizational support (Kim & Kao, 2014), perceived organizational support (Hirschi & Deller, 2014), autonomy (Boyle et al., 1999), collaboration (Tourangeau & Cranley, 2006) and satisfaction with salary and benefits (Barron & West, 2005; Collins et al., 2000) are also found to be positively associated with intention to stay of employees with their employers. In terms of organizational support, supervisor and coworker support are deemed especially important for their associations with intention to stay (Hinshaw, Smeltzer, & Atwood, 1987; Shader, Broome, Broome, West, & Nash, 2001; Sourdif, 2004; Tourangeau & Cranley, 2006). Listening to people's concerns and helping them in appropriate manners also increases employees' intentions to stay in their organizations (While & Blackman, 1998). As such, work group cohesion (Boyle et al., 1999; Sourdif, 2004) and a positive organizational culture and climate (Kim & Kao, 2014) is found to be positively related with intention to stay. Work-family conflict, on the other hand, is also found to be associated with intention to stay. However, this association is observed to be negative (Flinkman et al., 2010; Simon, Kuemmerling, & Hasselhorn, 2004).

Workload (Brannon et al,, 2007; Glaser et al., 1999; Houlihan, 2004; Lesage et al., 2013; Xiaoming et al., 2014) and emotional labor (Qureshi et al., 2013) are also found to be important negative antecedents of intention to stay. In other words, it is argued in relevant literature that as workload and emotional labor for employees

increase in an organization, their intentions to stay in that institution will likely decrease. This argument is in line with Social Exchange Theory (Gouldner, 1960; Emerson, 1976) in that as organizations present their employees detrimental experiences of high workload and emotional labor, these employees are prone to become less intent to stay in their organizations. As such, they may likely be intent on leaving their organizations consisting of these negative experiences and factors that are likely to negatively influence their wellbeing (Hanisch & Hulin, 1991; Wallace & Lemaire, 2007).

Another factor that is found to negatively affect intention to stay in organizations is burnout (Aslam & Safdar, 2012). It is a complex phenomenon considered to be negatively associated with intention to stay (Aslam & Safdar, 2012; Le Blanc et al., 2001; Pınar, 2010; Shanafelt et al., 2012). Burnout is defined as a fundamental disconnection between the employee and organization. It explains that though a person starts a job with motivation and positive expectations, in time, these feelings come to be replaced by frustration, exhaustion and ultimately a decline in performance and effectiveness (Mojsa-Kaja et al., 2015). Burnout is a cumulative psychological syndrome of exhaustion, cynicism and inefficacy as a result of chronic stressors in the organizational environment. The exhaustion component represents the individual stress experience: a feeling of being drained and depleted of both physiological and psychological resources (Maslach & Schaufeli, 1993). Cynicism is described as the interpersonal context facet of burnout: a state of negativity and detachment towards the job and / or organization. It is a self-defensive state which may result in the loss of motivation, idealism and ultimately dehumanization of others in the organizational environment. It also detrimentally affects interpersonal conflicts in the organization (Leiter, 2005). The inefficacy dimension of burnout

refers to feelings of incompetency and lack of productivity at work. If unaccounted for, it tends to be stable over time, increasing the need for interventional applications and regulations (Leiter & Maslach, 2004).

If the relationship between employees and organizations is to be considered a continuum, while burnout is the negative end of the spectrum, engagement is the positive one (Leiter & Maslach, 2008). Engagement refers to a cumulative psychological state of energy, involvement and effectiveness, which reflect the positive versions of exhaustion, cynicism and inefficacy, respectively. Engagement differs from certain more common related constructs such as organizational commitment, job involvement and job satisfaction. In organizational commitment, the employee's focus is on the organization. It refers to an allegiance to the employer by the employee (Meyer & Allen, 1991). In engagement, on the other hand, the emphasis is on the work itself. Job satisfaction refers to a multidimensional measure of how content and satisfied an employee is with his or her job (Weiss, 2002). However, it does not cover the employee's relationship with the work. Job involvement encompasses being involved, invested and engaged in one's work (Lodahl & Kejner, 1965). It does not include the aspects of energy and effectiveness, though. Thus, engagement offers a more thorough analysis of an employee's relationship with work (Leiter & Maslach, 2004). This implies that while burnout is negatively associated with intention to stay, engagement is positively associated with it (Leiter & Maslach, 2008). The experience of engagement and burnout is likely to be a moderating or mediating factor between organizational factors and job related outcomes. Burnout is found to be related to organizational commitment, perception of organizational change. (Leiter & Maslach, 2004).

The most observable outcome of intention to stay is retention or turnover. Retention refers to an employee deciding to stay in an organization, while turnover refers to the opposite action of leaving the institution (Cotton & Tuttle, 1986; Steel & Ovalle, 1984; Tourangeau, 2009, 2010). Turnover and retention are being extensively studied in relevant literature still, and many factors that affect them can be talked about (Cotton & Tuttle, 1986). In terms of these factors, workload, emotional labor, burnout, value conflict, stress, role ambiguity, role overload, role conflict, task repetitiveness, authoritarian leadership, routinization, alternative job opportunities, withdrawal cognitions, lateness, absenteeism and turnover intentions are found to be negatively associated with retention and positively associated with turnover (Cotton & Tuttle, 1986; Griffeth, Hom, & Gaertner, 2000; Kim & Kao, 2014; Mor Barak, Nissly, & Levin, 2001; Yin & Yang, 2002; Zimmerman & Darnold, 2009). On the other hand, job satisfaction, job involvement, organizational commitment, affective, normative and continuance commitment, occupational commitment, intrinsic work value, role clarity, career commitment, organizational justice, work group cohesion, organizational support, perceived organizational support, instrumental communication, transformational leadership, fairness, tenure, performance, autonomy, physical comfort, satisfaction with salary and benefits, unemployment rate, recognition, growth opportunities, sense of achievement and intention to stay are found to be positively related to retention and negatively related to turnover (Cotton & Tuttle, 1986; Dwyer, Schwarz, & Fox, 1992; Griffeth, Hom, & Gaertner, 2000; Kim & Kao, 2014; McCloskey, 1990; Mor Barak, Nissly, & Levin, 2001; Zimmerman & Darnold, 2009).

2.5.2 Intention to stay in service and health organizations

Throughout the recent years, turnover occurrences extend from the private sector to the public ones. Especially for the healthcare sector, health personnel tend to be more inclined then before to leave their organizations and even professions (Li, Yin, Zhang, Su, & Meng; 2010). This is likely due to the increase of demands in the healthcare sector (Yin & Yang, 2002), especially in Europe, because of the aging population (Dubois, McKee, & Rechel, 2006). The intentions to stay of healthcare personnel are crucial because if these intentions decrease and become turnover intentions, there will likely occur problems in terms of the capacity to care for patients (Clarke & Aiken, 2003) and quality of the healthcare service provided to them (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002). There will also be issues in terms of heavier workloads and decreased morale for the remaining staff (Tourangeau et al., 2009). Turnover intentions are found to predict actual decisions to leave in the health sector as well (Krausz, Koslowsky, Shalom, & Elyakim, 1995). Therefore, if these decreased intentions result in health personnel actually leaving their institutions, associated costs of replacing healthcare employees, orienting new ones and compensating the loss of productivity are likely to occur as potential problems as well (Contino, 2002; Rivers, Tsai, & Munchus, 2005). Similar concerns can also be raised for employees working in the service sector and organizations (Kim & Kao, 2014). It is thus important to consider the effects of and influences on intention to stay for the service and healthcare sectors (Kassebaum & Szenas, 1994; Martini et al., 1994).

Organizational antecedents specific to health organizations play an important role in the development of turnover intentions for health personnel. These antecedents can be considered to be excessive exposure to patients (Tummers et al.,

2002), task and medicinal procedure complexity (Schaufeli, Keijsers & Reis-Miranda, 1995) and time pressures (DeRijk et al., 1998). These factors all contribute to the occurrence of physical and emotional strains, and so may lead to turnover intentions for health personnel (Fong & Mahfar, 2003).

Workload (Brannon et al., 2007; Glaser et al., 1999; Houlihan, 2004; Lesage et al., 2013; Xiaoming et al., 2014) and emotional labor (Qureshi et al., 2013) are also found to have negative relationships with intention to stay and organizational commitment (Deepak, 2013) in health organizations. Heavy workload and time constraints are significantly correlated with higher burnout in health organizations as well (Lee & Ashforth, 1996). This burnout develops due to emotional overload, lack of patient support and emotional contagion in health organizations (Hatfield et al., 1994). When the efforts of health personnel, in their interactions and relationships with their patients, exceed the constructive feedbacks of their patients, an imbalance leading to emotional exhaustion occurs (Lee et al., 2010). Aside from health personnel's interactions with their patients, relationships with their colleagues also influence their emotional states. Health personnel, as they perceive the symptoms of burnout in coworkers they work with, may come to take on these negative feelings on themselves (Hatfield et al., 1994). As a result, they are likely to experience burnout. This occurs as they, while expressing empathic concern, start feeling the negative emotions that those around them most likely unconsciously emit. This leads to reduced emotional health and diminished emotional health for health personnel (Pines, 1982). The excessive job and interpersonal demands deplete the energy of these employees, cause emotional exhaustion, lead to burnout, and so result in the formation of detrimental physical symptoms (Lee et al., 2010). This can also lead to a decrease in the quality and effectiveness of the care caretakers deliver to their

patients (Leiter et al.,1998; Vahey, Aiken, Sloane, Clarke, & Vargas, 2004). As such, burnout for health personnel, which is positively correlated with workload and emotional labor, is also found to be negatively related to intention to stay in health organizations (Collins et al., 2000; Pınar, 2010; Schaufeli & Bakker, 2004; Shanafelt et al., 2012).

Demanding relationships between health personnel and their patients also affect health organizational employees. These interactions are likely to result in the formation of relationships that require personal and emotional demands to be met (McCue, 1982). In this regard, dealing with patients in dire health situations is likely to be both time consuming and emotionally draining (Dyrbye et al., 2011). The reason for this is that the more emotionally charged these relationships are, the more likely they will lead to the development of contextual stress and negative psychological states for health personnel as a result (Bakker, Le Blanc, & Schaufeli, 2005). This is due to the fact that health personnel not only have to provide medical treatment to their patients, but also have to deal with their emotional and psychological requests, and also those of their families and acquaintances. As such, patients and their families tend to develop intense and dependent relationships with their care providers, and place significant amount of trust and faith in them (Frankel, 1995). This dependence by the patients and their families is prone to create physical and emotional burdens on their caretakers. Thus us because patients' and their families' needs may need to be continuously met and dealt with over long periods of time, depending on the severity of the health state of the patient (Le Blanc et al., 2001). This may result in physiological and psychological exhaustion of the personnel taking care of these patients. Thus, the intensity of the relationships and

demands can potentially lead to burnout and so decreases in intention to stay for health personnel (Le Blanc et al., 2001; Xiaming et al., 2014).

Excessive demands and diminished resources are associated with physical symptoms of stress, which then are likely to lead to burnout and turnover intentions for employees in health organizations (Leiter et al., 1998). They can also affect the quality and effectiveness of the care they deliver to their patients (Vahey, Aiken, Sloane, Clarke, & Vargas, 2004). In terms of specific healthcare positions, those that include high demands and low authority, such as the roles of ICU personnel, likely lead to physiological and psychological suffering, emotional exhaustion, depersonalization, stress, burnout and so decreased intention to stay for healthcare employees (Karasek, 1979; Leiter & Shaughnessy, 2006). This argument is parallel to the control facet of the Areas of Worklife model in that higher demands combined with lower control over one's job lead to detrimental physical, mental and emotional strains as a result (Leiter & Maslach, 2004).

Personal values and belief systems of health personnel are also found to be associated with intention to stay. This implies that the more doctors rely on their values and beliefs in making decisions, the more likely they are found to be intent on staying in their current organizations. (Xu, Veloski, Hojat, & Fields, 1995).

2.6 Organizational commitment

It is argued that organizational commitment is one of the most commonly investigated factors in relevant literature. It is a multidimensional construct with influences and influencers varying across different research and practice contexts (Meyer et al., 2002). As such, in order to better comprehend the concept of commitment, it is important to focus on the psychological aspects of organizational commitment, antecedents that

lead to its occurrence, and consequences that are experienced by the employees in organizations as a result. Only thus can it be examined from different angles and perspectives (Allen & Meyer, 1990).

Commitment is a psychological state experienced by employees that characterizes their relationships with their employers (Meyer & Allen, 1991). It refers to the intensity of an employee's identification with and involvement in an organization or employer (Gallie, Felstead, & Green, 2001; Mowday et al., 1982). Various conceptualizations for organizational commitment are made throughout the literature, yet they come to reflect one of the three general themes. These themes are affective attachment, perceived costs and obligation (Allen & Meyer, 1990). The affective attachment facet of organizational commitment refers to an employee's strong identification and involvement with, and emotional bond to the organization he or she is employed in (Kanter, 1968). This attachment implies that the employee actually enjoys his or her time in the organization. The perceived costs concept, on the other hand, focuses on an individual's engagement in a continuous line of activity, and the recognition of the costs of leaving this activity. This is because it is assumed by employees that there is a profit linked to continuing with one's job and cost associated with quitting it (Becker, 1960). The recognition of these costs related to leaving the organization is considered to be a conscious psychological state shaped by environmental circumstances (Meyer & Allen, 1991). Lastly, the obligation dimension suggests that employees believe that they have a responsibility towards the organization they work in. They remain to continue to work in their organization since it is the righteous and moral thing to do (Allen & Meyer, 1990; Wiener, 1982).

Another type of conceptualization for organizational commitment includes the difference between attitudinal and behavioral commitment. Attitudinal commitment

puts an emphasis on the processes by which individuals tend to think about their relationships with their employers. There is also an emphasis on the consideration of the extent of the congruence between employees' own goals and values, and those of the organization (Mowday, Steers, & Porter, 1979). Behavioral commitment, on the other hand, focuses on the processes by which people come to be bound to their organizations and how they manage this organizational attachment (Becker, 1960). This distinction between attitudinal and behavioral commitment is also reflected in the literature concerning research methods as well (Meyer & Allen, 1991). For attitudinal commitment, most of the existing research focuses on identifying the antecedents and behavioral consequences of it. For behavioral commitment, research is more focused on under which conditions a once exhibited behavior is repeated and how this behavior affects attitude change (Mowday et al., 1982). In terms of the attitudinal commitment perspective, behavioral results of commitment can be expected to affect circumstances leading to changes in commitment. For the behavioral commitment approach, attitudes that occur as a result of certain behavior are likely to effect the probability of the reoccurrence of that behavior (Mathieu & Zajac, 1990). These differences in attitudinal and behavioral commitment perspectives can be seen in Figure 1:

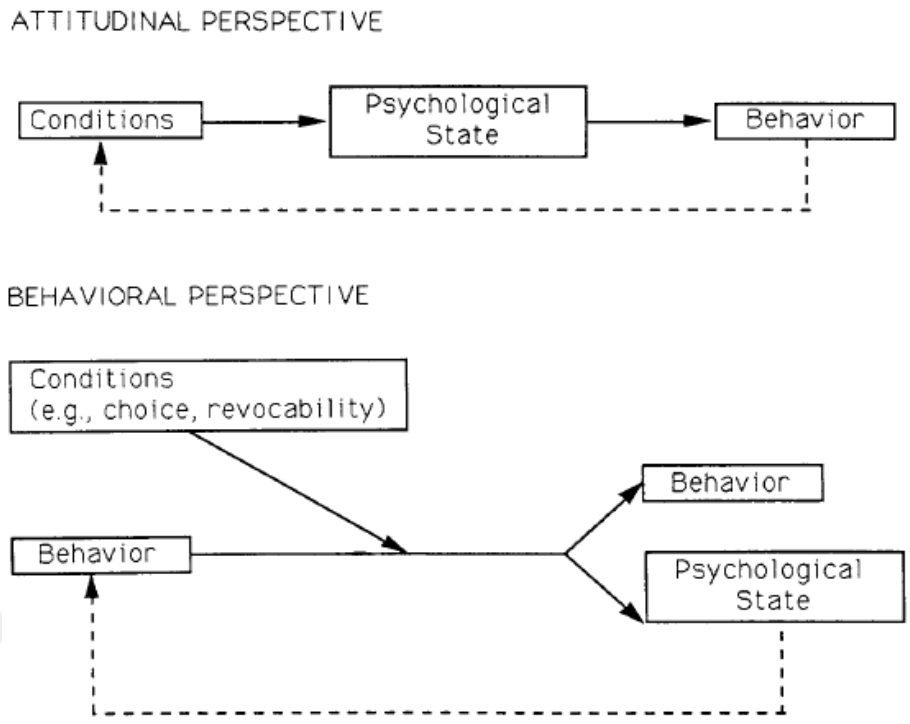


Figure 1. Attitudinal and behavioral perspectives on organizational commitment

Source: Meyer & Allen, 1991

Attitudinal and behavioral approaches to organizational commitment, once combined, provide a better and more thorough understanding of commitment. Attitudes are likely to be instrumental in shaping behavior (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975) when responsibility felt by employees increases in the organization. This results in their subsequent behavior being influenced. Thus, via a reciprocal and continuous influence process, positive work behavior tends to increase behavioral commitment, and as a result attitudinal commitment (Meyer & Allen, 1991).

Based on these general themes, a three-component conceptualization of organizational commitment is formed. It incorporates both the attitudinal and behavioral aspects of commitment, and their related antecedents and consequences (Meyer et al., 2002). This is done in order to expand the notion of organizational

commitment and consider it as a psychological state or mindset. This aim is adopted because organizational commitment can reflect different levels of wants, needs or obligations to remain in an organization for the committed employees (Meyer & Allen, 1991). This occurs as a result of benefits the organization provides to its employees, in alignment with Social Exchange Theory (Emerson, 1976; Gouldner, 1960). The three components of organizational commitment are referred to as affective, continuance and normative commitment, reflecting affective attachment, perceived costs and obligation, respectively (Meyer & Allen, 1991). Thus, organizational commitment comes to include three components. The first is affective commitment, where an employee wants to stay in the organization because of the emotional attachment to it (Meyer et al., 2002). The second is normative commitment, in which the individual working in the organization feels indebted to and obligated to stay in it (Allen & Meyer, 1990). The third is continuance commitment, where the employee considers the costs of leaving the organization and availability of job alternatives (Meyer et al., 1993). It is stated that these three components should not be regarded as separate categories of organizational commitment. Rather, they should be considered as distinguishable but related components reflecting psychological states which employees may come to feel simultaneously with varying degrees towards their organizations throughout their employment periods (Meyer & Allen, 1991).

2.6.1 Antecedents and outcomes of organizational commitment

In terms of the processes of organizational commitment, commitment occurs via the antecedents of organizational commitment producing relevant psychological states. These states are then translated into behavior (Meyer & Allen, 1991). The three components may come to develop somewhat independently of each other, and so are

likely to have diverse antecedents and outcomes that employees in organizations (Meyer et al., 1993). For affective commitment, these antecedents are mentioned as personal characteristics, job characteristics, structural characteristics and work experiences (Mowday et al., 1982). Work experience antecedents prove to be the strongest ones among the four. This is because they satisfy psychological needs of employees by making them feel comfortable in their organizations and competent in their jobs. So, the more employees feel comfortable in their organizations, the more their affective commitment will likely show towards their organizations (Meyer & Allen, 1991).

Personal dispositions such as need for achievement, affiliation and autonomy, and locus of control may be more fruitful to examine as antecedents of affective commitment in terms of their relationships with organizational commitment. This is because employees may be more or less prone to become affectively committed to their organizations depending on these personal dispositions (Griffin & Bateman, 1986). These personal dispositions can also be considered in terms of their interaction with environmental factors. People with work experiences parallel to their personal dispositions are likely to have more positive work attitudes than those with experiences unfitting their dispositions (Hackman & Oldham, 1976).

One other antecedent of affective commitment is the organizational structure of the employer which the employee works for. In terms of organizational characteristics, affective commitment is negatively related to centralization of decision making and policy or procedure formalization (Brook, Russell, & Price, 1988; Morris & Steers, 1980). This relationship, though, may not actually be direct, but rather come to occur by being affected by subjective work experiences of employees relevant to the structural characteristics of the organization. These subjective work experiences

may be role clarity and employee relations (Podsakoff, Williams, & Todor, 1986). Work experience, as the final antecedent of affective commitment is related to affective commitment in that experiences that satisfy needs of employees and are compatible with their values tend to result in an increase in the organizational commitment of these employees towards their employers (Meyer et al., 1993). These experiences can be considered in two categories. The first ones are those experiences that make the employees feel comfortable in their organizations by satisfying their needs, both physically and mentally. These can also be referred to as the hygiene factors (Herzberg, 1968). The second category of experiences that satisfy needs of employees are those that increase employees' perceived competences in their work roles within their employment periods (Meyer & Allen, 1991).

For continuance commitment, the related antecedents are the magnitude and number of investments people make, and perceived lack of job alternatives (Becker, 1960). Both of these antecedents increase perceived costs for employees related to leaving their organizations. The more these perceived costs are, the stronger the employees' continuance commitment towards their employers tends to be (Allen & Meyer, 1990). Regarding the antecedents of continuance commitment for the employees, since it is based on the perceived costs related to leaving their organizations, any event or occurrence that increases these costs can considered as an antecedent. The most recognized of these antecedents are personal investments and availability of job alternatives (Meyer et al., 1993). People's commitments to courses of behavior and actions occur as they make investments which would be lost or wasted if those behavior or actions are interrupted and cease to continue. These investments are likely to be made during an employee's employment period, since one spends a significant amount of his or her time on the job and in the organization. Investments

made by employees can be personal, social and / or organizational (Meyer & Allen, 1991). Since each investment requires certain resources to be spent through a particular period of time, leaving the organization where these investments are made is perceived as a risk that will result in the loss of acquired and learned non-transferable skills, benefits and privileges resulting from seniority, and interpersonal relationships built over the amount of employment time (Allen & Meyer, 1990). Anything that increases the costs related to leaving the organization can be considered a source of continuance commitment. Potential costs develop as a result of employee actions and tend to accumulate over time (Meyer et al., 2002). The gist of this component of commitment is that in order for it to occur, these potential costs must be realized by employees. In other words, if employees are not consciously aware of the costs associated with leaving the organization, they are not likely to develop continuance commitment towards it. This is because continuance commitment is initiated via the recognition of the costs of leaving the organization (Meyer & Allen, 1991).

In terms of the concept of time in relation to investments, over time, the magnitude and number of investments made in organizations are likely to increase. This makes it more difficult for employees to even think of leaving their jobs, let alone realize the thought (Becker, 1960). This discussion is similar to the arguments on the concepts of sunk cost and escalation of commitment. People tend to escalate commitment in response to previous investments because they try to rationalize these investments, do not want to waste them by giving up on them halfway, and consider it more difficult and risky to quit their current courses of action and behavior and start on a set of new ones that lead to new investments (Staw, 1976). The argument on considering quitting an already made investment more risky due to the perception of the difficulty of starting a new one may even cloud people's judgments of their

available potential job alternatives. In other words, they may see these job alternatives as less desirable and unbeneficial, and use this as a rationalization to remain with their current employers. In reality, they simply do not want to leave their comfort zones, in which they already made numerous investments (Heath, 1995). Due to these reasons, people are likely to continue to act in line with their already made investments even if they are no more fruitful, or even harmful (Staw, 1976). As can be deduced, the more time passes, the harder these previous investments are to let go for people due to their perceived costs (Allen & Meyer, 1990). If such is the case, individuals are better off instead accepting these investments and resources spent in making them as sunk costs. Sunk costs are defined as those which have already been suffered and cannot be recovered (Heath, 1995). After considering the prospective costs of continuing with their actions, people are better off changing their attitudes and behavior as necessary in order to avoid even further costs (Meyer & Allen, 1991).

Finally, for normative commitment, the relevant antecedents are said to be familial / cultural socialization and organizational socialization. They represent an employee's personal and social experiences prior to and following entry into the organization, respectively (Wiener, 1982). If these socializations result in the emphasis of loyalty in individuals' psychological states, then those individuals are likely to have strong normative commitment towards their employers (Allen & Meyer, 1990). The process of socialization experiences leading to the normative commitment start with observation of role models (Meyer & Allen, 1991). Other factors can also act as antecedents to normative commitment, such as rewards, benefits or training provided by the organization. These create an imbalance in the employee - employer relationship and lead employees to feel obligated to reciprocate and compensate the efforts of the organization. Employees do this by increasing their commitment towards

the organization (Tansky & Cohen, 2001), in accordance with Social Exchange Theory (Emerson, 1976, Gouldner, 1960), at least until their perceived debts are repaid (Scholl, 1981). A summary of these arguments can be seen in the three-component model of organizational commitment in Figure 2:

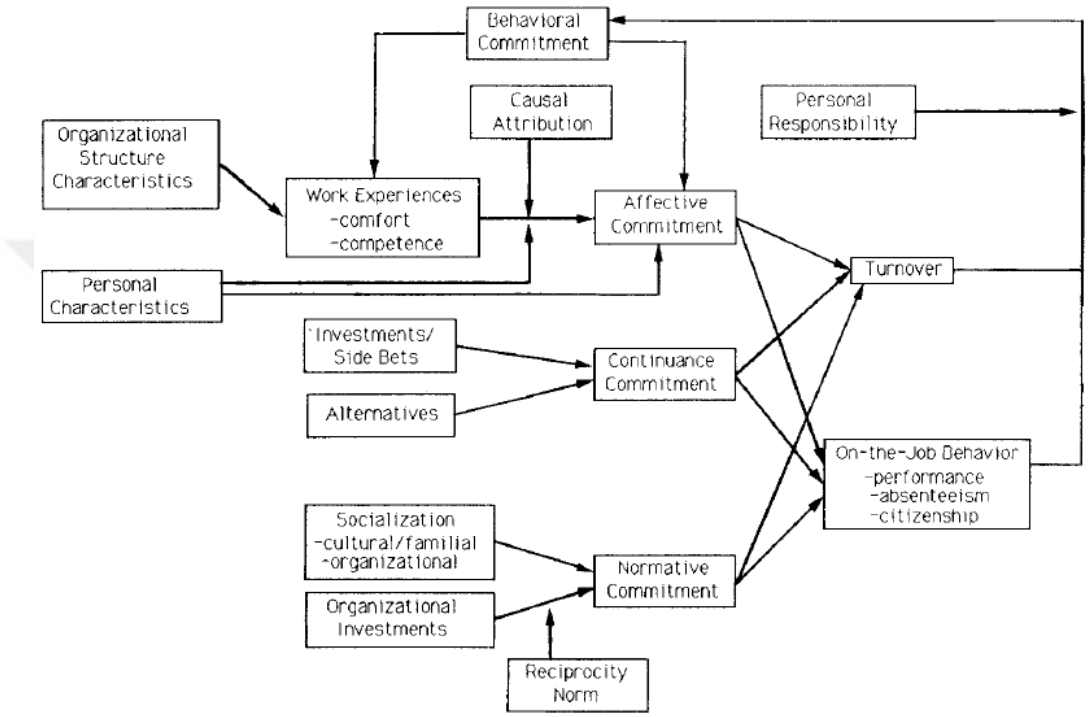


Figure 2. Three-component model of organizational commitment

Source: Meyer & Allen, 1991

Perceived organizational support can also be considered as an antecedent of organizational commitment. Where organizational commitment refers to the attachment of an employee to his or her employer, perceived organizational support can be regarded as an employer's commitment to its employee (Jackson et al., 2004; Shore & Shore, 1995). This implies that individuals working in organizations are likely to exchange their commitments towards their organizations in return for the

support of their institutions. This makes perceived organizational support a likely antecedent of organizational commitment (Rhoades & Eisenberger, 2002). In fact, the strong association between organizational commitment, and especially its affective component, and perceived organizational support is confirmed in relevant literature (Meyer et al., 2002).

In terms of other antecedents of organizational commitment, some which are positively associated can be tenure, self-efficacy, organizational support, transformational leadership, organizational justice and interactional, distributive and procedural justice. Role ambiguity and role conflict, on the other hand, can be considered as negatively related antecedents to organizational commitment (Meyer et al., 2002).

It is argued in relevant literature that a major reason for the popularity of organizational commitment is its relationship to retention / turnover, and their behavioral counterparts: turnover intention / intention to stay (Cohen, 1993). In terms of the consequences of organizational commitment, the most commonly observed behavioral outcome of commitment is intention to stay in the organization, or turnover intention, its obverse. The assumed negative relationship between organizational commitment and turnover intentions / turnover is found in many studies in literature. A similar relationship can also be observed between affective, continuance, normative commitment and intention to stay / retention as well (Carmeli & Gefen, 2005; Cotton & Tuttle, 1986; Jaros, Jermier, Koehler, & Sincich, 1993; Igharia & Greenhaus, 1992; Loi et al., 2006; Meyer et al., 1993; Mohammad, Taylor, & Ahmad, 2006; Mowday et al., 1982; Rehman et al., 2012; Somers, 1995; Suliman & Al-Junabi, 2010; Tett & Meyer, 1993; Udo, Guimares, & Igbaria, 1997; Yousef, 2002; Wong, Ngo, & Wong, 2001).

Commitment, as the common denominator of the three components, reflects a psychological state that relates the individual to his or her employer. Different organizational commitment profiles of employees may imply different results in terms of turnover and other related outcomes (Allen & Meyer, 1990). For example, though high affective, continuance and normative commitment are all indicators of intention to stay for employees, they are likely to differ in terms of their implications as to what employees actually do within the time they remain in the organization. This is because simply being existent and working in an organization does not mean contributing to it (Meyer et al., 1993). From the employer's viewpoint, the least desirable commitment by employees is continuance commitment, since the continuation of the employment due to this commitment type is more a necessity than a desire. As such, employees are prone to exerting effort to satisfy the minimum requirements to remain in their jobs set by their organizations. The more employment is guaranteed for employees, the less their performances are likely to be (Meyer & Allen, 1991). Considering normative commitment, employees' feeling of obligation to stay with their employers stems from the internalization of exerted normative pressures before or after entering the organization (Wiener, 1982). As such, normative commitment is regarded to be more desirable for organizations than continuance commitment (Meyer & Allen, 1991). Affective commitment, on the other hand, among all organizational commitment factors, is considered to be the most crucial one for employers. This is because it entails a heartfelt dedication from the employee to the organization (Meyer et al., 2002). For affective commitment, intention to stay with an employer is mainly a consequence of an employee's work experiences. A person wishes to continue to be a part of an organization since this organization provides him or her with positive work experiences. This results in the formation of expectations by employees to wait for and

continue to receive these positive experiences. Hence their intention to stay with the organization occurs (Meyer & Allen, 1991). Moreover, in order to maintain the equity in their relationship with organizations that provide them these positive experiences, employees are likely to exert effort and contribute to organizational effectiveness as a compensating behavior, parallel to the arguments of Social Exchange Theory (Emerson, 1976; Gouldner, 1960). When an employee's affective commitment increases, his or her normative and continuance commitments likely increase as well. The value of affective commitment, then, comes from the fact that it provides a measurable psychological orientation and, equity and expectancy considerations for organizations regarding their employees, and so is prone to have various implications for multiple organizational behaviors (Allen & Meyer, 1990). Two important components of affective commitment are identification and internalization. Identification implies the acceptance of organizational effects to maintain a fruitful relationship with the organization. Internalization, on the other hand, involves acceptance of the organizational effects in terms of shared values (O'Reilly & Chatman, 1986). These aspects make employees with high affective commitment want to remain in an organization and continue to receive the benefits they derive from their relationships (identification). They also make employees mutually share values with their organizations (internalization). By exerting effort towards contributing more to their organizations, employees come to behave in a manner consistent with their values, which they share with their employers (Meyer & Allen, 1991). Organizational commitment, similar to the discussions on turnover intentions, is also found to be negatively associated with absenteeism and withdrawal cognitions (Meyer et al., 2002).

The reduction of turnover solely is not the only concern for organizations. This is because as the type of organizational commitment leading to intention to stay in the organization differs, so will the context and quality of the duration of employment for the employees (Haifa, 1993). In other words, remaining in an organization is a necessary but not sufficient condition for organizations to increase the motivation, performance and organizational citizenship behavior of their employees (Wiener & Vardi, 1980). An employee can choose to remain with an organization, and do so while contributing his or her bare minimum in the process (Allen & Meyer, 1990). As such, employees who want to remain in an organization (affective commitment) are more likely to exert effort for themselves and their organizations than those who feel obliged to belong (normative commitment), and even more than those who need to stay (continuance commitment; Meyer & Allen, 1991; Meyer et al., 2002).

Job satisfaction can also be regarded as a positively related factor to organizational commitment (Meyer, 1997). It can be considered to be an antecedent or outcome of organizational commitment depending on the context and perspective of the studies As such, it can be regarded as a correlate of organizational commitment (Meyer et al., 2002). In other words, it can be that employees who are satisfied with their jobs become more committed to their organizations, or that individuals more committed to their institutions are more likely to be satisfied with their jobs (Paik, Parboteeah, & Shim,2007). This also implies that organizational commitment may come to play a mediating role on the relationship between job satisfaction and intention to stay, as employees who are satisfied with their jobs and committed to their organizations are prone to be more intent on staying in their institutions (Zeytinoğlu, 2010).

One other relevant correlate of organizational commitment can be job involvement, which is defined as being involved, invested and engaged in one's work (Lodahl & Kejner, 1965). Career commitment and occupational commitment can also be considered as correlates of organizational commitment (Meyer et al., 2002). Considering different types of commitment as correlates of organizational commitment, commitment, as a management concept, is a multifaceted, complex construct which can take different forms (Meyer et al., 2002). One of these forms is organizational commitment, yet there is potentially more to the concept of commitment than just organizational commitment and its components (Meyer at al., 1993).

Occupational commitment relates to one's commitment to his or her profession, and can be felt by both professionals and nonprofessionals (Omdahl & O'Donnell, 1999). The concepts of affective, continuance and normative commitment can also be applicable for occupational commitment. Those who are emotionally connected to their occupations are more likely to keep themselves updated on new developments relevant to their occupations and become members of related associations. Similar statements can be made for people normatively committed to their occupations. Employees who feel a continuance commitment towards their occupations, on the other hand, are prone to accomplish as much as necessary to remain in the occupation, and not more. Hence they are much less likely to engage in active participation to any event or occurrences related to their occupations (Meyer at al., 1993). Unlike career commitment or profession commitment, occupational commitment relates to particular lines of work (Nogueras, 2006).

The mechanisms for the development of the three components of occupational commitment are similar to those of the three components of organizational

commitment as well (Meyer et al., 2003). Affective commitment stems from positive work experiences occurring as a result of active involvement in one's occupation. Continuance commitment develops as a consequence of recognized costs of losing investments made in the name of the occupation. Normative commitment is initiated when employees are effected from the internalization of normative pressures of an obligation to reciprocate within their occupations (Scholl, 1981). The components of organizational and occupational commitment are also related to each other. In other words, affective, normative and continuance dimensions of organizational commitment are positively associated with affective, normative and continuance dimensions of occupational commitment, respectively. They also have similarities in terms of their associations with related antecedents, correlates and outcomes, and so are better considered together as factors making up occupational commitment than separately (Meyer at al., 1993).

Career commitment is the enduring attachment to the internal and subjective career potentially foreseen by the person (Blau, 1985). It differs from organizational commitment in that organizational commitment works more on the organizational level rather than the person. This is because it is concerned with institutional goals (Meyer et al., 2002). Occupational commitment, on the other hand, refers to the commitment to a specific profession rather than a career path or organization (Meyer et al., 2003), whereas career commitment implies strong connections to long term goals and discovery of ways of achieving those goals (Blau, 1985). Career commitment is found to be positively and significantly correlated to professionalism and organizational citizenship behavior, indicating that organizations should provide career support and development opportunities to their employees in order to increase their organizational citizenship behavior, since it is valuable to any organization as it

increases organizational effectiveness without extreme costs and resources (İnelmen et al., 2010). Other types of commitment such as union, employment and profession commitment (Meyer et al., 1993) can be stumbled upon in relevant literature as well.

Another outcome associated with organizational commitment is organizational citizenship behavior (Meyer et al., 1993), which can be defined as discrete and voluntary individual actions performed by the employees that are not formally recognized or rewarded by the organization. It includes five dimensions: altruism: voluntarily helping others, sportsmanship: tolerating inconveniences without complaining, civic virtue: being involved in the strategy and politics of the organization, courtesy: informing people of possible influential changes, and conscientiousness: going beyond normal expectations in terms of attendance and punctuality (Smith, Organ, & Near, 1983). In relation to this relationship, trust, as it leads to cooperation and consensus among employees, can be a predictor of organizational citizenship behavior for organizations, and as such, organizational commitment and trust can be used to explain organizational citizenship behavior (İnelmen et al., 2010; Zeffane & Al Zarooni, 2008). In terms of affective, continuance and normative components of organizational commitment, the more desirable the type of organizational commitment, the more likely it is to be positively related to organizational citizenship behavior (İnelmen et al., 2010).

Organizational commitment is also found to be a predictor of organizational effectiveness (Wiener & Vardi, 1980), job performance (Meyer et al., 2002) and reduced absenteeism (Suliman & Al-Junabi, 2010). This is because individuals committed to their organizations are more likely to strive to achieve organizational goals than those who are not (Suliman, 2002). Moreover, it is found to be negatively related with work-family conflict, implying that the more conflict a person goes

through between one's organization and family, the less likely one will be committed to the organization (Meyer et al., 2002).

2.7 Social Exchange Theory

Social Exchange Theory (SET) is widely used to understand organizational attitudes and behavior of employees, especially regarding organizational commitment, and also actions of organizations (Cropanzano & Mitchell, 2005). It involves sets of interactions likely resulting in related obligations. These interactions are regarded to be interdependent with the actions of another individual or entity, and can create long lasting, quality relationships between the involved parties (Emerson, 1976).

In Social Exchange Theory, reciprocal and negotiated rules and norms define the criteria of interactions and exchanges (Cropanzano & Mitchell, 2005). These rules and norms create guidelines that allow exchanging parties to follow certain interaction paths in order to initiate and be involved in the exchange processes without major problems (Emerson, 1976). Considering these norms, reciprocity rules are the ones mostly considered in management and organizations literature (Cropanzano & Mitchell, 2005). The reciprocity rules rest on three different types of interactions: interdependent transactions, folk belief and moral norms (Gouldner, 1960). In terms of interdependent exchanges, the interacting parties can adopt three attitudes towards themselves and each other. The first attitude is independence, where results are obtained by each party without any reliance on each other. The second attitude is dependence, where results are reached solely by the initiative of one party while the other party rests totally on the acting side. The third attitude is interdependence, where results are based on the combination of each party's actions, allowing for the creation a bidirectional relationship (Molm, 2003). Note here that attitudes of independence

and dependence do not result in social exchange. Interdependence, on the other hand, is regarded to be a major characteristic of the social exchange theory (Molm, 1994). In the interdependent transaction situation, as one party provides benefits for another and receives parallel benefits in return, as long as the mutual benefit exchange continues, the interaction is also likely to continue. This potentially creates a self-reinforcing cycle (Cropanzano & Mitchell, 2005). Folk belief interactions involve the expectations that if one acts righteously, he or she will receive benefits as he or she deserves, and vice versa, similar to the concept of karma (Bies & Tripp, 1996). Moral norm reciprocity, on the other hand, entails personal or organizational dispositions towards interacting in predetermined, mandatory rules (Gouldner, 1960). Moral norm reciprocity may be altered depending on one's perspective of reciprocity rules and their violation sanctions (Cropanzano & Mitchell, 2005).

Another set of rules can also be discussed, namely negotiated rules, which are mostly parts of economical transactions (such as wage increase, promotion and fringe benefits). These transactions, though, are less likely to result in mutual trust and commitment than reciprocal interactions (Molm, Takashi, & Peterson, 2000). In terms of interpersonal exchanges, as they can be regarded to be individual decisions, rules other than reciprocity may come to guide them as well. These rules are considered to be rationality: use of logic to determine the means to be used for reaching aimed ends, altruism: benefiting others without expecting anything in return, group gain: contributing to a common pool and taking from it as necessary, status consistency: allocation of benefits based on one's hierarchy in a group, and competition: getting even with others even when its costly to do so (Meeker, 1971).

The exchanged resources can also be grouped according to their types, since they may not always have to be economic or tangible. These resources can be love,

status, information, money, goods and services (Foa & Foa, 1980). While more particular or universal resources provide symbolic benefits as socioemotional outcomes, concrete ones present tangible gains as economic outcomes (Cropanzano & Mitchell, 2005).

Social exchange relationships, then, may occur between individuals or entities, and in organizational terms, employees' relationships with their colleagues and organizations can both be considered (Foa & Foa, 1980; Rhoades & Eisenberger, 2002). The difference between social and economic exchanges is that in social ones the exchanged resources cannot be measured in exact terms, and these type of interactions potentially lead to the formation of trust, gratitude, attachment, commitment and obligation among the involved parties. This likely strengthens the relationships between the parties in exchange relationships, due to the fact that the exchanged resources are not negotiated but reciprocal (Molm, Takashi, & Peterson, 2000). In such cases, employees who receive benefits from their organizations are prone to seeing their employers in a good light and forming a tendency towards their organizations to return the favor via increased performance, organizational citizenship behavior, organizational commitment, decreased absenteeism and turnover intentions (Cropanzano & Mitchell, 2005).

2.7.1 Social exchange and organizational commitment

An individual's commitment towards an employer is developed as a result of an exchange association between them (Gouldner, 1960; Shore & Terrick, 1991). This implies that individuals working in organizations are likely to exchange their commitments towards their organizations in return for the wages, status, networking opportunities and support of their institutions (Rhoades & Eisenberger, 2002). As

such, organizational commitment develops within employees towards their organizations as a result of the desirable and beneficial working environment their organizations provide (Liu, 2005). In this type of interdependent transaction, as an organization provides benefits to its employees, they become more attached to their organizations, thus creating a cycle of continuous reinforcement (Cropanzano & Mitchell, 2005). This potentially results in increased commitment, performance and intention to stay by the employees (Bishop, Scott, & Burroughs, 2000; Howes, Cropanzano, Grandey, & Mohler, 2000; Rhodes, Eisenberger, & Armeli, 2001). Depending on their attachments to their organizations, increased commitments by employees can be affective, normative or both. This is because internalization of the work experiences and organizational norms can also be explained by the principles of Social Exchange Theory (Emerson, 1976; Gouldner, 1960; Meyer & Allen, 1991). Employees internalize a reciprocity norm or exchange ideology, and they contribute to their organizations because they want to (affective commitment / reciprocity by desire) or feel it is the right thing to do (normative commitment / reciprocity by obligation). There is a relative risk with reciprocity by obligation for organizations, though. It is that once employees perceive themselves as having paid their debts towards their employers, they may decrease their efforts, or even choose to leave their organizations, since they no longer feel that they are obligated to stay with them. In reciprocity by desire, however, such a risk is unlikely to exist (Meyer & Allen, 1991).

The current study, in examining the factors related to organizational commitment and its mediating effect on the relationship between the antecedents of workload and emotional labor and outcome of intention to stay, adheres to the tenets of the discussed social exchange theory. This implies that as employees, namely doctors in health organizations, receive benefits from their organizations, such as

manageable workload and low emotional labor, they will likely repay the favor by increasing their commitments towards, and so intentions to stay in their health organizations. This will likely occur since their institutions provide them the opportunity to go through positive work experiences. The opposite case can also be expected in that if the provided positive experiences of these institutions tends to be low, due to factors such as heavy workload and intense emotional labor, the resulting commitment and so intention to stay will likely be low as well. This is likely to occur because, in this scenario, employees get to experience undesirable or unfavorable working conditions within their organizations.

2.7.2 Social exchange and emotions

It is stated in relevant literature that Social Exchange Theory is not commonly considered with functioning in terms of emotions (Lawler & Thye 2006). However, current research regarding social exchange more and more considers the role of emotions in reciprocal relationships between people and organizations (Lawyer & Thye, 1999). This perspective in terms of an emotional look at social exchange theory results in the formation of Affect Theory of Social Exchange (Lawler, 2001). The theory argues that emotions can play important roles in the exchange relationships between people, both as influences and outcomes. In other words, the exchange of emotions between the interacting parties can make them more or less attached or committed towards each other (Lawler & Yoon, 1996). This is because emotions are argued to be integral parts of exchange relationships (Hoschild 1979, 1983).

The exchanged emotions between parties can be both positive and negative. As such, positive exchange of emotions are argued to increase parties' attachments to each other. The exchange of negative emotions, on the other hand, likely decreases people's

and organizations' commitments towards each other (Lawler, 2001). As such, the exchange of emotions between employees, organizations and their customers can also be examined within the perspective of Social Exchange Theory, or more specifically via the Affect Theory of Social Exchange. Resulting from emotional labor demanded by organizations, emotions, felt and displayed, fake or genuine, are spread in organizations. Here, emotional labor can be considered as a functional gesture in social exchange gesture (Hoschild, 1979). This spread of emotions is then enhanced or inhibited by people's susceptibilities to emotional contagion. As such, people's commitments towards their organization increase or decrease as a result of this emotional exchange process (Lawler, 2001; Lee et al., 2010).

As such, emotional and cognitive exchanges in organizations can both be considered with the Social Exchange Theory. Health and service employees have professional obligations towards their clients to satisfy their emotional needs as well. Moreover, they are obliged to do this in an understanding, positive manner (Cropanzano & Mitchell, 2005). This implies that the social exchanges of these employees entail cognitive, economic and emotional elements. As a result, emotional labor likely plays a role in the process of these social exchanges (Grandey, 2000).

2.8 Emotions in organizations

Emotions can be defined as packages that exist in people. They consist of various psychological and physiological activities such as consciousness, awareness, expressions, nervous system activity and behavior (Hatfield, Bensman, Thornton, & Rapson, 2014). Early theorists try to find an order or sequence to the working of emotions by examining whether their cognitive, somatovisceral or behavioral aspects come first. Recent research, however, has moved away from this linear,

unideterministic fashion towards a more reciprocal view. In other words, cognitive, somatovisceral and behavioral aspects can all trigger and / or be trigger by each other, resulting in a complex system of emotional structure in humans (Laird & Bresler, 1992). Emotions have been investigated in numerous contexts within more than 4,000 studies (Schneider, 2008), and are still being analyzed as a popular research topic in relevant literature.

In terms of emotions in organizational contexts, it is argued in relevant literature that organizations focusing on customers and customer relations may tend to give too much attention to technical and demographic information, and neglect the emotional aspects of their customers (O'Connell, 2006). However, in developing countries, such as Turkey (Wasti, 1998; Wasti, 2002), social and economic value starts with measuring commodities and goods, and moves on to evaluating services and experiences. In other words, employees, especially those with frequent interactions with clients (Dormann & Zjilstra, 2003), can create value through emotions via their interactions with customers (Lin, Huang, & Chiang, 2008). As such, emotions are being more and more recognized as potent parts of interpersonal interactions and tools to secure successful relationships (Guillemette, 2011). As a result, recent trends in literature shift their focus towards the concepts of emotional intelligence, emotional labor, emotional competence and emotional contagion (Scott & Barnes, 2011). This is because such a shift allows researchers and practitioners to better understand employee attitudes and behavior in organizations (Fisher & Ashkanasy, 2000).

One reason for the current prevalence of emotional issues is that organizations are shifting from individual driven entities to synergistic group work intensive systems. So, the concept of group emotion is gaining importance. Group

emotion is what defines and distinguishes a group from any other collection of individual persons (Barsade, 2002). In group settings, individuals bring their own feelings and emotions into the group. This is then most likely transferred to other people in the group via emotional contagion (Hatfield et al., 1994). The individuals' feelings themselves can undergo certain changes as they are combined with the feelings of others. This means that group emotion does not imply arriving at a common collective emotion by averaging out the emotions of the members of the group. Rather, it is more similar to the concept of synergy due to the fact that individuals in group settings experience and express new qualities as a result of this synergetic emotional effect (Barsade, 2002). The emotions and mood of an individual influences the mood of a team (Totterdell, Kellett, Teuchmann, & Breiner, 1998) and individual level effects transform and combine as a result of group collectivism. They thus form what is called the collective affect (Barsade & Gibson, 2007). This transformation is argued to be reciprocal. In other words, collective affect is influenced by and at the same time influences individual affect (Vijayalakshmi & Bhattacharyya, 2012). The collective affect that occurs as a result of emotional contagion affects everyone in the group (Barsade, 2002; Nadler, Rabi, & Minda, 2010). This effect alters the group's emotional state, performance and organizational commitment (Hatfield et al., 1994). That is why each individual is assumed responsible for bringing their own emotions to the group, which may be as important as the cognitive skills they provide (Schwartz, 2012). Figure 3 shows the basic emotions observed in organizations:

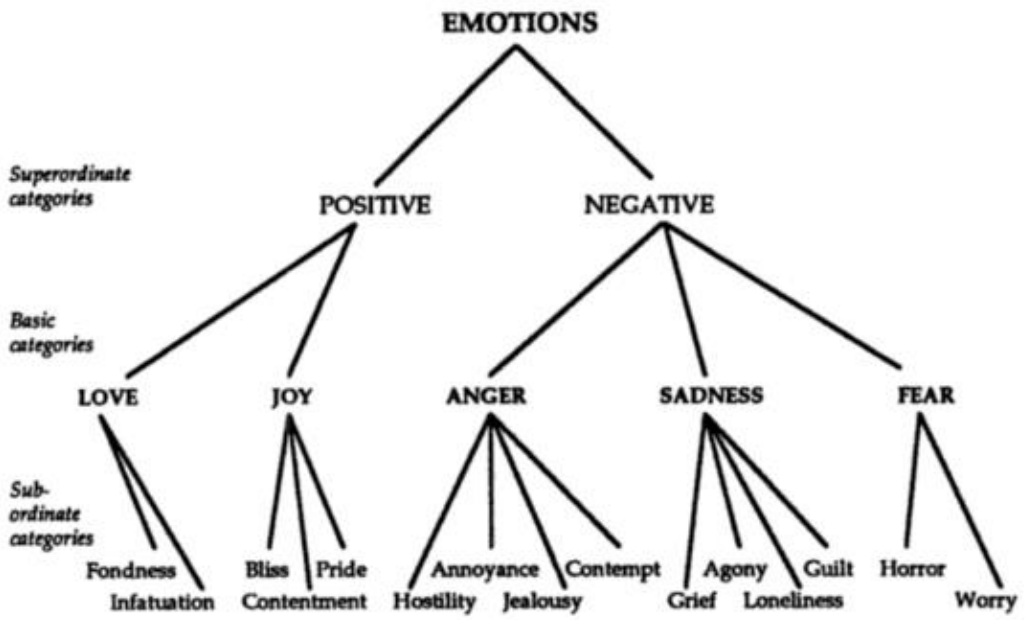


Figure 3. Hierarchy of basic emotions

Source: Hatfield et al., 1994

2.9 Emotional contagion

No emotional experience can be thought of in isolation from a relationship (Bion, 1962). In social relationships, emotional contagion is argued to be the building block of interactions between people (Hatfield et al., 2014). This is because the emotional links that connect people and their constituents account for all interpersonal relationships (Arizmendi, 2011). During social interactions, people focus not only on themselves but on others as well. This means that the attention given and received by people are mutual and reciprocal (Hatfield et al., 2014). This mutual interaction forms the basis of emotional contagion, where emotional stimuli are taken and received on a continuous basis through attentional, emotional and physiological coordination, mimicry and synchrony (Arizmendi, 2011; Hatfield et al., 2014). These emotional stimuli can be categorized as either positive or negative (Doherty, 1997;

Hatfield et al., 1994). Mimicry is also argued to play an evolutionary role in that it aids social survival by emotionally binding people together. Synchrony, on the other hand, has the same adaptive functions for social groups as it does for individuals. (Chartrand et al., 2005; Lakin & Chartrand, 2013; Lakin, Jefferis, Cheng, & Chartrand, 2003). As such, synchrony and mimicry lead to reciprocal feedback between people, which then leads to emotional contagion (Hatfield, Carpenter, & Rapson, 2014; Levenson & Friesen, 1983; Laird, 1984).

As such, emotional contagion is defined as the tendency of people to automatically synchronize and mimic facial, vocal, postural and muscle expressions, and movements with those of others, and converge emotionally as a result (Hatfield et al., 1994). It is conceptualized as a multiply determined bundle of psychological, physiological, multilevel, social and behavioral phenomena (Hatfield et al., 2014). It is multiply determined because it can be produced by innate, acquired, mental or emotional stimuli (Hawk, Fischer, & van Kleef, 2012). It is a bundle due to the fact that it can manifest responses that are similar or complementary (counter-mimicry / counter-contagion; Lanzetta & Englis, 1989; McHugo, Lanzetta, Sullivan, Masters, & Englis, 1985). And it is multilevel for it can stem from one individual and be perceived and interpreted by other individuals, resulting in a variety of emotional responses (Hatfield et al., 2014). As such, a significant part of emotional contagion is emotional, attentional and behavioral synchrony (Söderlund & Rosengren, 2004). Emotional contagion also has a primitive or rudimentary side in that it can occur automatically and inadvertently. It can thus be difficult to control and access on a conscious awareness level (Hatfield et al., 2014).

Another type of emotional contagion can be referred to as cross-channel contagion (Hatfield et al., 2014; Hietanen, Surakka, & Linnankoski, 1998). This can

be thought of as emotional contagion on a large scale, where numerous emotional expressions, stimuli and messages are transferred reciprocally in an environment within and between a large number of people (Hawk et al., 2012).

It must be noted here that emotional contagion differs from empathy in that empathy is referred to as an affective state caused by and congruent with the acknowledgement of another person's emotional condition. It is the potential or capacity to recognize other people's feelings and emotions (Muchinsky, 2003). Emotional contagion, on the other hand, is the process of feeling what other people feel, and not the capability to cognitively sense the emotional moods in them. So, while emotional contagion occurs through parallel emotional responses and results in 'feeling with' another person, empathy works via nonparallel emotional responses and ends with 'feeling for' another person (Miller, Birkholt, Scott, & Stage, 1995). Emotional contagion is the attachment to emotional states, while empathy is the conscious judgment of emotional states (Siebert et al., 2007). As such, empathy moves beyond attunement to others and emotional synchrony (Arizmendi, 2001). A summary of the views on the relationship between empathy and emotional contagion can be seen in Figure 4:

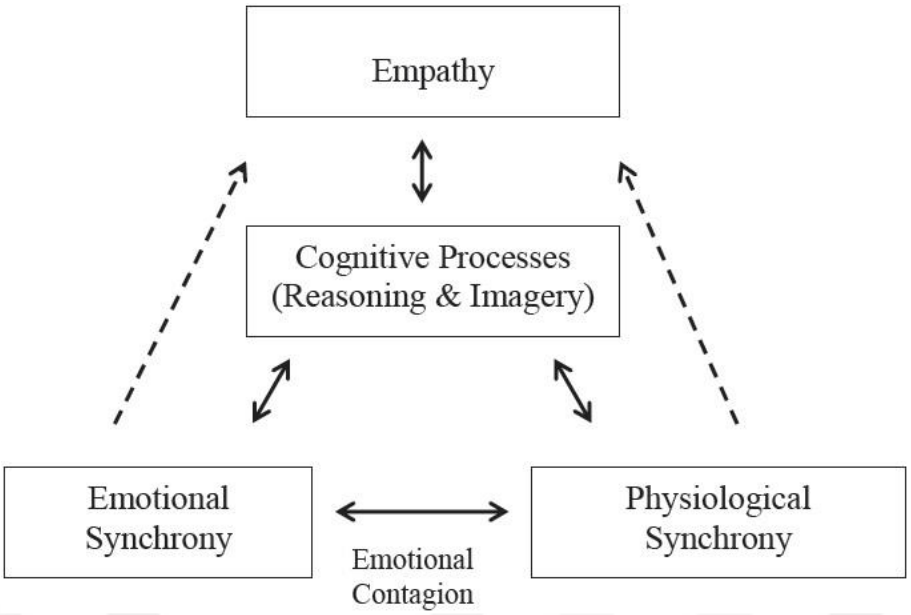


Figure 4. Emotional contagion, empathy and relevant relationships

Source: Arizmendi, 2011

2.10 Susceptibility to emotional contagion

Susceptibility to emotional contagion is basically the tendency to catch the emotions of others (Lundqvist, 1993; Robbins & Judge, 2011; Schwartz, 2012; Siebert, Siebert, & Taylor-McLaughlin 2007). As people to mimic certain elements of emotional expressions of others via emotional contagion, they then consequently experience the related feeling states themselves (Balconi & Canavesio, 2013; Doherty, 1997). The process is a psychophysiological, dispositional, cognitive, behavioral, cultural and social phenomenon in which the influential stimuli stem from one person and act upon others. As they do so, these stimuli produce emotional responses that are congruent or complementary, similar to approach and avoidance behaviors, respectively (McHugo et al., 1985; Nummenmaa et al., 2008) between people. Susceptibility to emotional contagion, then, is the frequency with which emotional stimuli create an emotional expression similar to the eliciting emotion in

the person. The emotional response can then be expressed cognitively, behaviorally, emotionally or physiologically (Doherty, 1997; Hatfield et al., 1994).

While everyone can be affected by the emotions of others around them, some tend to be more resistant while others are likely to be relatively more vulnerable to being influenced by these external emotions (Doherty et al., 1995). Other people's emotions are not just sensed or comprehended, though. They are received and expressed in a way characteristic of the particular emotions. As such, emotions move from person to person fluidly, and individual susceptibility differences affect the extent to which people are influenced by others' emotional expressions (Doherty, 1997).

The effects of emotional contagion and the susceptibility to it are bidirectional, that is, in a single transaction, emotions displayed by a sender cause a change in the emotions of the receiver (Rafaeli & Sutton, 1989). This change in the receiver is then reflected back to the sender (McHugo, Lanzetta, Sullivan, Masters, & Englis, 1985), and so on. This results in a continuous exchange of roles throughout the transaction process. The primary order or the causal direction is firstly from sender to receiver, and so from employee to customer (Pugh, 2001)

2.10.1 Antecedents and outcomes of emotional contagion

Factors that influence the level of emotional contagion in organizations can be categorized as individual, interpersonal and contextual factors. In terms of individual factors, people who are especially susceptible to emotional contagion are those that pay close attention to others' emotional cues, see themselves as more interpersonal than independent, define themselves as social and collectivistic rather than individualistic, frequently mimic other people's expressions, are more emotionally

aware and whose conscious emotional experience is significantly affected by peripheral feedback from others (Doherty, Orimito, Singelis, Hatfield, & Hebb, 1995; Doherty, 1997). Here, emotional awareness not only leads to the realization of one's own feelings, but also helps people comprehend the emotions expressed by others (Hsee, Hatfield, & Chemtob, 1992; Neal & Chartrand, 2011). Thus, increased emotional awareness leads to increased emotional contagion and susceptibility to it. People who are more prone to being manipulated by their own emotional expressions (cue-responsiveness) are also more likely to be influenced by the emotional expressions of others (Doherty, 1997). Self-monitoring alters levels of felt and expressed emotional contagion as well. People with high levels of self-monitoring are found to be more in control of their emotions than those with lower levels (Friedman & Miller-Herringer, 1991). This finding suggests that emotional intelligence might also play a role here. On this matter, it is argued that higher emotional intelligence is associated with higher self-monitoring. It is also discussed that there is a positive association between emotional intelligence and positive emotional contagion (Goleman, 1995). The bidirectional relationship of emotional contagion and its susceptibility can also play a role here. The reciprocity of the emotional exchange between the sender and receiver imply that not only the emotional intelligence of the senders, but also those of the receivers can affect emotional contagion in social interactions (Pugh, 2001).

Emotional contagion has a non-linear relationship with psychoticism, where moderately self-centered people are more susceptible to emotional contagion than others. Introverted people are more likely to be influenced by other people's positive emotions, while extroverted people tend to be affected more by other's negative emotional states (Hatfield et al., 1994). Susceptibility to emotional contagion is

found to be positively correlated with affective orientation, emotionality, sensitivity to others, emotional awareness, self-esteem, emotional expressiveness and emotional empathy. It is negatively correlated with self-assertiveness, emotional stability and alienation. Moreover, it is found not to be related to masculinity and approval motivation (Doherty, 1997; Hsee et al., 1992; Omdahl & O'Donnell, 1999; Vijayalakshmi & Bhattacharyya, 2012). It is also discussed that self-confidence and agreeableness are positively correlated with positive emotional contagion (Vijayalakshmi & Bhattacharyya, 2012). Also, emotional contagion occurs more frequently in cases where individuals with a high need for socially comparative information are present. This is because people with such needs, since they are likely to frequently observe, probe and examine the people around them, are also more likely to be susceptible to emotional contagion in their environments (Bakker et al., 2001).

In terms of other individual factors related to susceptibility to emotional contagion, genetics, gender, early experience, personality characteristics, approach / withdrawal tendencies, distractibility, attention span and threshold / intensity of responsiveness can be mentioned as affecting susceptibility to emotional contagion (Doherty, 1997; Hatfield et al., 1994). Personality traits such as reward and punishment sensitivity, and impulsivity-thrill seeking also predict different levels of susceptibility to emotions (Zelenski & Larsen, 1999).

In terms of interpersonal factors in groups, emotional contagion emerges through two facets: displayed emotional energy and emotional direction. The level of emotional energy displayed in group settings, and the positivity / negativity of these emotions influence people's susceptibility to emotional contagion. In return emotional contagion has effects on moods, judgments and behaviors at both

individual and group levels (Barsade, 2002). Mood transfers in organizations can be both voluntary and involuntary. This occurs through the mechanism of empathy in the voluntary condition, where a person takes on the perspective of another person on purpose. In the involuntary situation, it occurs through mimicking of emotional expressions. This intentional factor also has an influence on the felt emotions in others (Vijayalakshmi & Bhattacharyya, 2012).

Considering emotional contagion in groups, it is found that positive emotional contagion is positively related to cooperativeness, conflict resolution and task performance (Hatfield et al., 1994). Also, by its direct and indirect effects on people, emotional contagion can lead to ripple effects in groups and organizations. The probability of people realizing this effect in their groups depends on their emotional awareness. (Hsee et al., 1992). It is also discussed that there is a decreased amount of emotional contagion in groups that include individuals with higher emotional stability (Vijayalakshmi & Bhattacharyya, 2012). Emotional contagion is considered to be higher in more cohesive groups and groups with greater interpersonal congruence (Polzer, Milton, & Swann, 2002). The issue of trust also affects group performance subtly by allowing group members to channel their energies towards alternative goals (Dirks, 2000). So mutual trust within a group can lead to increased positive emotional contagion. This can likely result in increased performance for the group (Vijayalakshmi & Bhattacharyya, 2012).

In terms of contextual factors that influence emotional contagion, though internal emotional awareness is important, being aware of the emotional states of others is also essential. This is because if a person understands the feelings of others, he or she can manage his or her own emotions by associating or dissociating with them (Rempala, 2013; Siebert et al., 2007). This can be achieved by modifying one's

affective state such that it becomes harmonious with others in the environment. This is especially useful in turning a negative affective state into a positive one (Hatfield et al., 1994). Mood congruence is also an important variable that affects emotional contagion. In cases of environments of positive emotional contagion, mood congruence is found to be higher. On the other hand, in situations where the people are influenced by negative emotions, mood congruence is found to be lower (Neumann & Strack, 2000; Totterdell, 2000). The psychological climate in the workplace also affects positive emotional contagion (Pugh, 2001).

In terms of occupational differences, people may have a tendency to choose occupations that fit their personalities and habits. As people advance in their careers, the occupations they stick to affect and shape their characteristics and behavior in return. As such, people in different occupations are likely to differ concerning emotional contagion and the susceptibility to it (Doherty, 1997). For those in the same occupations, though, differences can exist in terms of their personal dispositions. This implies that people with different personalities in the same occupation might differ regarding their emotional vulnerability and contagiousness (Doherty et al., 1995).

People who are able to disentangle their emotions from others are different than those who are susceptible to emotional contagion. While the former rely on internal references, the latter rely on external cues (Doherty et al., 1995). Being able to dissociate oneself from some interactions is crucial for certain employees because an environment made up of depressed people is likely to induce negative moods in its inhabitants (contagious depression; Bakker et al., 2005; Rempala, 2013). In such cases, the more in tune people are with the emotions of those around them, the more likely they are to catch the feelings of depression and hence enter a state of negative

mood (Chartrand, Maddux, & Lakin, 2005; Hess & Fischer, 2013) This occurs because negative emotions tend to spread faster than positive ones (Hatfield et al., 1994; Schwartz, 2012). This may then result in employees absorbing the negative emotions of others and being consumed by this distress. This can then lead to emotional exhaustion, dissatisfaction with the job, professional impairment (working ineffectively due to negative mood), burnout and decreased organizational commitment (Miller et al., 1995; Omdahl & O'Donnell, 1999; Siebert et al., 2007; Wright & Cropanzano, 1998).

Moreover, people can use their own intuitions and / or emotional states to understand the emotional conditions of others (Hsee et al., 1992). Emotional contagion allows them to feel what others feel, thus leading to a better understanding of the other people in the interaction (Hatfield et al., 1994). Here, affect regulation plays an important role. It refers to the process of balancing emotions to maintain a distinction between oneself and the other during the process of emotional empathic relating (Arizmendi, 2011). It is an important step in sustaining interpersonal relationships including emotional contagion. By combining affect regulation with emotional intelligence (Goleman, 1995) people can maintain their emotional and cognitive balances, even while trying to adopt another person's emotional perspective (Arizmendi, 2011; Hatfield et al., 1994). Emotional contagion can even give clues regarding the social context of shared emotions. In other words, through emotional contagion, people can not only understand how another person feels, they may also be able to grasp clues as to the social identity of the emotion eliciting person (Hess & Fischer, 2013). As such, one can deduce the social context in which the emotional interaction takes place (Hatfield et al., 2014).

These interactions, however, may also initiate negative emotional contagion in that people who try to understand how others feel spend effort to get into similar moods and feel alike emotions. This leads them to become affected by the feelings of the other parties they try to understand (Hatfield et al., 1994). In such cases, people with negative emotions are more likely to affect those with positive emotions negatively, rather than vice versa. This is due to the fact that negative feelings tend to be more effective in influencing people then positive ones (Doherty et al., 1995; Rempala, 2013). This then potentially increases the spread of burnout and depression by being transferred from person to person (Bakker et al., 2005).

In terms of its relationship with empathy, emotional contagion does not have to result in empathy. In fact emotional contagion can lead to personal distress and lessening of one's tendency to help others (Rempala, 2013). This occurs if self-awareness and cognitive ability are missing from people's interactions with others. This is because self-awareness allows the person to avoid confusing one's own subjective experiences with those of others, while cognitive ability enables him or her to take the perspective of other people (Decety & Jackson, 2004).

Research on certain personality traits and their relationships with emotional contagion contributes to the understanding of transformational leadership behavior as well. Considering leadership, emotional contagion may have important influences on follower attributions, follower affect and ultimately performance (Johnson, 2008). This is especially the case with transformational and charismatic leadership. Leaders in a positive affect state show better leadership behavior. Their expressions of positive affect help in creating more positive follower attributions via emotional contagion. This in turn alters objective leadership behavior (Vijayalakshmi & Bhattacharyya, 2012). Emotion recognition, positive affectivity and agreeableness

are found to be positive predictors of such leadership behavior as well (Rubin, Munz, & Bommer, 2005).

Customer affect is also discussed to be influenced by emotional contagion. This is due to the fact that displayed emotions of employees are related to certain service quality factors such as employee empathy, assurance and reliability. As such, they can be viewed as expected services by the customers (Huang & Dai, 2010; Tsai & Huang, 2002). It is found that all other factors being equal, customers in positive affective states rate service quality higher than those in neutral or negative states (Parasuman, Zeithaml, & Berry, 1988; Pugh, 2001). As such, positive employee affect can result in positive customer affect. This is because on site interactions and transactions of employees act as determinants of the experience of service quality by the customers (Pugh, 2001). This experience, in return, affects their overall perceptions of the organizations they receive their services from. Customers arrive at their evaluations based on the service they receive, and that, in turn, is directly related to the actual emotional states the interacting employees are in (Lemmink & Mattson, 2002). Hence, the relationship between employee affect and customer affect, occurring as a result of emotional contagion and people's susceptibilities to the emotions around them, can be established (Howard & Gengler, 2001). In situations of increased service friendliness, employees express more positive feelings towards customers. This results in an increase in the willingness to come back to the store for the customers. These customers also tend to spread more positive word-of-mouth about the organization (Tsai, 2001). A positive manner of service by the employees, then, results in positive moods and heightened perceived friendliness. This in return increases positive behavioral intentions towards organizations regarding customers (Vijayalakshmi & Bhattacharyya, 2012) through emotional

contagion (Hatfield et al., 1994). As such, emotional contagion can affect customer perceptions of service quality, even if this is an indirect process through customer affect. The reason for this is that people tend to formulate judgments based on their current affective moods (Parasuman, Zeithaml, & Berry, 1988). This is called affect infusion, where people's evaluative judgments are based on their current affective states, which they use as information to evaluate the services they receive at their current affective states (Barger & Grandey, 2006; Schwarz & Clore, 1983).

Emotional contagion can also be considered to play a role in the Job Demands-Resources Model approach. This role is that the more susceptible people are to emotional contagion, the more likely they will be affected by the negative consequences of demands around them (Lee et al., 2010). In other words, the less resilient people are to being affected by the emotions around them, the more they will be influenced by organizational demands. This is because the relationship between external demands and resulting attitudes can be moderated by employee dispositions (Bono & Wey, 2005; Weiss & Beal, 2005). These high job demands, then, lead to burnout (Demerouti et al., 2001; Lee et al., 2010), decreased organizational commitment (Miller et al., 1995; Omdahl & O'Donnell, 1999; Siebert et al., 2007) and turnover intentions (Le Blanc et al., 2001; Leiter & Shaughnessy, 2006; Xiaming et al., 2014).

2.10.2 Emotional contagion in service and health organizations

Emotional contagion is prominent and dominant in the social interactions of adults; be they casual or professional. One such occurrence is the health organizations or clinical environments in which a special relationship between patients and doctors exist (Hatfield et al., 1994).

On this issue, Sigmund Freud (1912) warns health professionals, saying: “I cannot advise my colleagues too urgently to model themselves during psychoanalytic treatment on the surgeon, who puts aside all his feelings, even as human sympathy, and concentrates his mental forces on the single aim of performing the operation as skillfully as possible.” (Freud, 1912, p. 115) and tells them to be sufficiently distant from their patients due to the risk of being negatively affected by them. Nevertheless, doctors, therapists and clinicians do seem to catch the feeling of their patients. The more powerful and intense the negative feelings are, the more the risk there is that doctors will be affected by those negative feelings. Jung (1968) also comments on this issue and states that: “Emotions are contagious, because they are deeply rooted in the sympathetic system… In psychotherapy, even if the doctor is entirely detached from the emotional contents of the patient, the very fact that the patient has emotions has an effect upon him. And it is a great mistake if the doctor thinks he can lift himself out of it. He cannot do more than become conscious of the fact that he is affected. If he does not see that, he is too aloof and then he talks beside the point. It is even his duty to accept the emotions of the patient and to mirror them.” (Jung, 1968, p. 155). This implies that it is inevitable, and maybe even necessary for doctors and patients to form emotional bonds for effective treatment.

Hatfield and her colleagues (1994) state that in terms of the emotional relationship and communication between doctors and patients, there are two dimensions to the knowledge shared between them. The first dimension is the portion gained via our conscious senses, namely hearing, sight, touch and smell. The second dimension is what is observed and absorbed unconsciously, which is as important, if not more, as the first dimension. Doctors, taking into account these two dimensions, have to emotionally get close enough to the patient to understand how the patient is

feeling, yet not so close as to fall deeply into the negative feelings of the patient. They do this so in four steps: identification, incorporation, reverberation and detachment. In identification, the doctor gives attention to the patient, allowing him or her to be absorbed in contemplation of the patient. Incorporation is next, where the doctor internalizes the patient's emotional experience, making it become his or her own. With reverberation, the doctor, while experiencing the emotional state of the patient, simultaneously attends to his or her own affective and cognitive connection to the emotional experience. Finally, in detachment, the doctor removes himself or herself from the emotionally merged identity and moves back to a being separate, detached person. This way, he or she can form a response which reflects his or her personal opinions supported by understanding of the feelings of the patient. As such, doctors can both experience what the patient feels, and also save themselves from spiraling into negative emotions by detaching themselves from emotionally loaded situations.

Hatfield and her colleagues (1994) argue that other methods are also discussed in literature as strategies doctors can adopt to deal with patients with intense negative emotional situations. When clients feel certain emotions, doctors can respond in two ways. They either exactly feel what the patient is feeling, which is referred to as concordant identification, or they can feel emotions complementary to those felt and shown by the patient, which is called countertransference. In concordant identification, doctors can share similar experiences regarding how the patient should deal with situations of negative emotional load. With countertransference, on the other hand, doctors can adopt a role of facilitation where they provide related guidance for the patient's emotional problem. Whichever the case, doctors need to be able to carefully observe and when necessary imitate the

emotional expressions of their patients so that they can gain insight towards the character, personality and perspectives of their patients. Here, imitation allows doctors to understand the emotional expression within themselves, thus helping them to better analyze it and recommend complementary actions if and when required.

Hatfield and her colleagues (1994) discuss that naturally, not all patients are willing to open up and share their most intimate feelings at their first encounters with doctors. They may thus take a defensive stance, referred to as armoring. Experienced doctors can determine whether the patient is withholding significant information via examining the tenseness and nervousness of their patients. Those who suppress their emotions and show restraint in revealing them will likely emit tension via postural cues (tense muscles, pulled-back shoulders, crossed arms, suppressed breathing, thrust out chest etc.). If not realized soon and dealt with appropriately, this anxious situation may lead to conflicts between the doctor and patient. One reason for the possibility of this conflict is that people who adorn a rigid emotional armor tend to be insensitive not only to their own feelings but also to those of others as well. Regardless of the repression efforts of patients, though, one way or another human beings betray themselves and give away their true emotions, motives and motivations. Hence, it is the doctor's job to make the process of reaching the core of the patient as easy and painless as possible by taking into account the potential emotional and physical cues in the therapeutic environment.

Hatfield and her colleagues (1994) mention that in terms of clinical situations for doctors, there exist two main ways for gaining insight into the emotional world of patients. The first is the conscious examination of emotional cues and information. Doctors can advertently analyze their patient's statements, actions and also facial, vocal and postural expressions. They can thus come upon an understanding based on

the context of the emotional interaction. In the second way, doctors can focus on and monitor their own emotional responses to the emotional expressions of patients at each moment to better grasp the emotional load of the ongoing session. The best case scenario, naturally, is that both ways are in synchrony with each other and doctors come to similar conclusions as a result of both methods. In cases of conflict, such as when the patient verbally communicates one emotion but the doctor feels there are different emotional forces at play, doctors should rely on and use both conscious analyses and monitoring their own emotions. The understanding and realization that emotions between a doctor and patient are contagious gives them a useful tool for better comprehending emotionally loaded situations. One important aspect of such interactions is that doctors can have certain notions on and expectations of their patients. This may hence influence their understanding and evaluations of their patients' emotional expressions. In other words, doctors might come to fall into the trap of selective attention and choose to attend to emotional cues that are in line with their beliefs and expectations. This thus potentially clouds their vision into what their patients' are actually going through emotionally. That is why it is crucial that doctors, before treating their patients, are themselves aware of their beliefs and expectations, and try to act as objectively as possible so that they can understand the emotional situations of their patients in an undiluted manner.

It can thus be seen that emotional contagion and the susceptibility to it plays important roles in the treatment of patients for health professionals in health organizations. Moreover, as discussed in previous sections, with high workload and emotional labor, health personnel may become likely to experience burnout as a result of physical and emotional exhaustion in health organizations (Bakker et al., 2001). Susceptibility to emotional contagion plays an important role at this stage.

The more susceptible health personnel are to emotional contagion, the more likely they are to automatically mimic and synchronize the emotional expressions of others in the environment (Hatfield et al., 1994). This makes them more prone to being influenced by the emotional consequences of the stressors and demands around them, and so more likely to suffer from workload and emotional labor (Bakker et al., 2001). This process, as a result, potentially decreases their commitments towards their organizations (Miller et al., 1995; Omdahl & O'Donnell, 1999; Siebert et al., 2007). By such mechanisms, the effects of workload and emotional labor, through burnout, can be spread to others via emotional contagion. This can occur unconsciously by automatic mimicry and synchrony in organizational interactions (Levenson & Friesen, 1983; Laird, 1984). It can also occur consciously during the process of tuning in to the emotions of others, via empathic concern, in order to understand them better (Bakker et al., 2005). As such, susceptibility to emotional contagion can moderate the influence of organizational stressors on individuals' commitments to their institutions (Bono & Wey, 2005; Weiss & Beal, 2005) such that the more vulnerable they are to being affected by the emotions in the environment, the more they will suffer the consequences of the organizational stressors (Lee et al., 2010), and the less their organizational commitments will become (Miller et al., 1995; Omdahl & O'Donnell, 1999; Siebert et al., 2007).

It is argued that for health personnel, as an occupational group, it is imperative that they be sensitive to the emotions of those around them so that they can better understand and diagnose the problems of their clients (Lee et al., 2010). Healthcare employees who are better at observing and understanding the feelings of their patients have higher rates of treatment success and frequency in patient visits (Doherty et al., 1995). It is also crucial for them to be able to detach themselves from

detrimental emotional situations (sessions with terminally ill patients, autopsies etc.) if necessary. This is so that they can maintain their own emotional wellbeing (Bakker et al., 2005; Rempala, 2013). This makes health employees' jobs even harder, though. This is because as health employees are expected to comprehend the emotional states of their patients closely. They are also expected to not be affected by the emotions of their patients to the extent that they won't have the motivation and energy to cheer up the patients and administer treatments (Doherty et al., 1995). At times, this might be difficult to accomplish, since attitudes containing high levels of empathy and empathetic concern to understand others may lead to an increase in the susceptibility to emotional contagion for health personnel (Hatfield et al., 1994). In other words, their empathic attitude can be a weakness rather than strength, since in cases of negative emotional contagion, this may potentially lead to physical and emotional exhaustion, and eventually burnout (Miller et al., 1988; Williamson, 1989). This is due to the fact that health personnel more susceptible to the negative emotions of others in the environment are more likely to be detrimentally influenced by the stressors around them (Le Blanc et al., 2001). Feeling too much like a patient may also lead to the formation of negative affect, and hence depersonalization, reduced personal accomplishment and occupational commitment (Omdahl & O'Donnell, 1999). Moreover, health personnel may become physically and emotionally exhausted as a result of this process, and as a result, be less committed to their organizations (Wright & Cropanzano, 1998). So, health personnel need to be sensitive, mindful and protective of themselves and their patients, and also emotional contagion in their environments, so that they can maintain their own stability and wellbeing while treating their patients (Doherty et al., 1995).

Quantitative job demands have significant effects on the emotional exhaustion and depersonalization dimensions of burnout, and susceptibility to emotional contagion is found to moderate the relationship between emotional job demands and burnout in health organizations (Le Bakker et al., 2001, 2005; Blanc et al., 2001; Lee et al., 2010). Health personnel who have the highest susceptibilities to emotional contagion are also likely to perceive and display relevant symptoms of burnout the most (Miller et al., 1988; Williamson, 1989). Here, emotional contagion takes places not only between care providers and their patients, but is likely to occur among all personnel working in health organizations as well (Hatfield et al., 1994). So, health personnel have to take good care of their physical and emotional wellbeing, and if possible, refrain from spending time with those personnel who are continuously in a negative contagious mood. This is so that they are able to maintain their own psychological balances (Le Blanc et al., 2001).

CHAPTER 3

CURRENT STUDY

3.1 Theoretical framework

Based on the literature review, the current study aimed to determine the effect of workload and emotional labor as organizational stressors on organizational commitment, specifically affective commitment, and intention to stay. The study also aimed to investigate the mediating effects of affective commitment and moderating effects of susceptibility to emotional contagion on the relationships between stressors and intention to stay for doctors in Turkey.

In terms of its theoretical framework the current research looked at the relationships between the stressors of workload and emotional labor, and affective commitment and intention to stay. The reason for this was to investigate what factors affect doctors' affective commitments and intention to stay in their health organizations. Naturally, the direction and intensity of this effect was also of interest. Another reasoning for the investigation of these variables and relationships was try to confirm the existence of their associations. These relationships are observed mostly in the Western literature (Alnajjar, 1999; Suliman & Al-Junaibi, 2010; Suliman & Iles, 2000). The current study investigated if these associations held for doctors in hospitals in Turkey (Meyer, 1997).

3.2 Hypothesis development

3.2.1 Workload and outcomes

Workload refers to organizational demands that exceed people's time and resources. Employees are expected to do too much in too little time with too few resources (Allard, Haas, & Hwang, 2011; French & Caplan, 1972; Ippolito, Hines, Mahmood, & Cordova, 2010). The antecedent of workload was used as an independent variable for the purposes of the current research conducted with doctors in health organizations in Turkey.

Workload, as one of the main contextual stressors mentioned in relevant literature (Le Blanc et al., 2001), is expected to lead to physical and emotional exhaustion, and so relevant outcomes such as burnout, decreased commitment and turnover intentions (Demerouti et al., 2001; Lee et al., 2010). This expectation is in line with the Job Demands-Resources model in that as a contextual demand, workload is argued to be an influential stressors in many organizations. It is considered to be high in the service sector (Pugh, 2001; Siebert et al., 2007) and specifically so in the health sector (Cordes & Dougherty, 1993; Erlen & Sereika, 1997; Le Blanc et al., 2001; Miller et al., 1990; Omdahl & O'Donnell, 1999; Smith, 1992; Wharton, 1993; Xiaoming et al., 2014). Moreover, it is regarded to be positively associated with low performance (Leiter et al., 1998; Shafiezadeh, 2011), damaged relationships, reduced work and service quality (Marina, 2012), emotional exhaustion (Dyrbye et al., 2011; Ramires et al., 1995) and burnout (Lee & Ashforth, 1996), and negatively associated with affective and organizational commitment (Deepak, 2013) and intention to stay (Brannon et al,, 2007; Glaser et al., 1999; Houlihan, 2004; Lesage et al., 2013; Xiaoming et al., 2014). As such, in line with the

tenets of Job Demands-Resources Model, and parallel to the hypothesized and tested relationships in relevant literature, for the purposes of this study conducted with doctors in health organizations in Turkey, workload was expected to be negatively related to affective commitment. This means that as workload of doctors increase, their affective commitment will likely decrease. Workload was also expected to be negatively related to intention to stay. This implies that as workload of doctors increase, their affective commitment will likely decrease. The resulting relevant hypotheses were developed as follows:

H_1: Workload will be negatively associated with Affective Commitment

H_2: Workload will be negatively associated with Intention to Stay

3.2.2 Emotional labor and outcomes

Emotional labor is the expectation of expressions of certain emotions by employees during interpersonal transactions at work. It is a form of emotional regulation determined and enforced by organizations (Pugh, 2001; Robbins & Judge, 2011).

Emotional labor is an important interpersonal stressor mentioned in related literature (Le Blanc et al., 2001). Similar to workload, in line with the Job Demands-Resources model as an interpersonal demand, it is expected to lead to physical and emotional exhaustion, and so relevant outcomes such as burnout, decreased commitment and turnover intentions (Demerouti et al., 2001; Lee et al., 2010). Emotional labor is considered to be prevalent in the service sector (Pugh, 2001; Siebert et al., 2007) and especially so in the health sector (Cordes & Dougherty, 1993; Erlen & Sereika, 1997; Le Blanc et al., 2001; Miller et al., 1990; Omdahl & O'Donnell, 1999; Smith, 1992; Wharton, 1993; Xiaoming et al., 2014). Furthermore, it is considered to be positively associated with emotional dissonance (Robbins &

Judge, 2011; Zerbe, 2000), burnout (Kane, 2010; Lee & Ashforth, 1996; Sheldon et al., 1997), emotional exhaustion (Dyrbye et al., 2011; Lee et al., 2010) physical exhaustion (Lee et al., 2010), depersonalization, expressive, negative affectivity (Kruml & Geddes, 1998). Moreover, it is regarded to be negatively associated with perceived achievement, role identification (Kruml & Geddes, 1998), emotional control (Grandey, 2000), affective and organizational commitment (Deepak, 2013) and intention to stay (Qureshi et al., 2013). As such, in alignment with the hypothesized and tested relationships in relevant literature, for the purposes of this study conducted with doctors in health organizations in Turkey, emotional labor was expected to be negatively related to affective commitment. This means that as emotional labor of employees increase, their affective commitment will decrease. Emotional labor was also expected to be negatively related to intention to stay. This implies that as emotional labor of employees increase, their organizational commitment decreases. The resulting relevant hypotheses were developed as follows:

H_3: Emotional Labor will be negatively associated with Affective Commitment

H_4: Emotional Labor will be negatively associated with Intention to Stay

3.2.3 Intention to stay and affective commitment

Intention to stay refers to an employee's attachment to and interest in continuing to work for and willingness to remain in an organization (Lyons, 1981). The outcome of intention to stay is used as a dependent variable for the purposes and analyses of the current research.

In terms of intention to stay, the study argued that as people's commitments to their organizations increase, they become more intent on staying in these

organizations. Moreover, affective commitment is found to be positively associated with intention to stay in numerous studies in related literature, and even meta-analyses of relevant researches (Cotton & Tuttle, 1986; Steel & Ovalle, 1984). Thus, the study argued that as employees' affective commitments towards their institutions increase, so likely will their intentions to stay in these organizations. This is based on Social Exchange Theory in that employees likely choose to remain in organizations that they are committed to because of the positive work experiences they go through in these organizations (Emerson, 1976; Gouldner, 1960; Meyer et al., 1993). The resulting relevant hypothesis was developed as follows:

H_5: Affective Commitment will be positively associated with Intention to Stay

3.2.4 Mediation of affective commitment

Organizational commitment refers to the intensity of an individual's affinity with and participation in an organization or employer (Mowday et al., 1982). Organizational commitment consists of three components. The first type is affective commitment, in which the individual willingly wishes to remain with the current employer due to his or her emotional bond with it. The second type is normative commitment, where the employee working in the organization feels himself or herself indebted and so obligated to stay in it. The third type is continuance commitment, in which the individual calculates the costs of leaving his or her current employer and as a result chooses to continue to remain with it due to the perceived costs and lack of better alternatives in terms of potential employment (Meyer et al., 1993). Affective commitment, as the major component of organizational commitment, is used as a mediator variable for the purposes and analyses of the current research. Affective commitment has been argued the affective component best represents employees'

attachments towards their organizations (Wasti, 2002). An aggregate construct with normative and continuance aspects are additionally presented in further analyses.

Regarding its mediator positioning, it was discussed is that, as can be deduced from the review of organizational commitment in service and health organizations, commitment plays a vital part in the effective functioning of employees in various sectors. This is due to the fact that it has associations with numerous antecedents and outcomes. For health organization personnel, especially doctors, organizational commitment, and specifically affective commitment, may carry significant meaning and impact. The period of doctors' employment, starting from its educational phases to professorship, tends to be much longer in duration compared to other occupations in different sectors. This longevity of time is likely to influence the context and intensity of their affective and organizational commitment. People may form strong emotional bonds with the health organizations and personnel they work with, may make serious sacrifices and investments in order to advance in their careers and remain in their organizations, and gain a sense of obligation to do the right thing and remain due to the nature of their jobs being helping others in times of need. Thus, the concept has a crucial role in the current study as well. This is because it aims to test the notion that affective commitment mediates the relationship between the antecedents of workload and emotional labor, and outcome of intention to stay. This implies that when employees are detrimentally affected and thus emotionally, physiologically and psychologically hindered by workload and emotional labor, they are likely to experience decreased commitment towards their organizations. This is due to the fact that these negative effects influence employees in their current organizations. Due to this decrease in their commitment, employees are also less likely to stay in the organizations they are employed in. This is because as Social

Exchange Theory argues, people going through negative experiences in their organizations are less likely to be committed to them. In other words, when organizations do not provide desirable work environments to their employees, these employees, in return, become less prone to committing and contributing to their organizations (Emerson, 1976; Gouldner, 1960). This likely results in a decrease in these employees' intentions to stay. This meditation of affective commitment approach is important due to the fact that the current research is focused on a unique group of employees, namely doctors. Doctors go through intense and long educational periods to reach specialized positions in their highly sought after professions. This education can be considered to continue throughout their whole lives, as they keep themselves constantly updated on advances in modern medicinal theories and practices, lest they lose prestigious positions. As such, their commitments towards their organizations may tend to differ from other health personnel. If so, this is of special interest to the current research. By examining if and how doctors are affected by workload and emotional labor, and the influence of their affective commitments on the relationship between these antecedents and intention to stay, one can potentially deduce some of the factors affecting their intentions to stay in their organizations. This finding has potential implications for health organizations, their personnel, management and even patients who receive care in them. The finding is also for relevant literature, hence the focus of the current research on affective and organizational commitment as mediators between emotional labor, workload and intention to stay.

Affective and organizational commitment are also found to play mediating roles in various researches throughout relevant literature. They are observed to have mediating effects on the relationships between the antecedents of job security

(Chirumbolo & Hellgren, 2003; Chirumbolo & Areni, 2005; Zeytinoğlu et al., 2010), emotional exhaustion (Rehman et al., 2012), human resources management (HRM) practices (Guchait & Cho, 2010) and tenure (Suliman & Al-Junaibi, 2010), and outcomes of intention to stay, performance and absenteeism in service and health organizations. As such, parallel to its consideration in related literature, affective commitment was expected to have a mediating role between the antecedents of workload and emotional labor, and outcome of intention to stay, for the purposes of the current study conducted with doctors in health organizations in Turkey. The relevant the mediation hypotheses were developed as follows:

H_6: Affective Commitment will have a mediating effect on the relationship between Workload and Intention to Stay

H_7: Affective Commitment will have a mediating effect on the relationship between Emotional Labor and Intention to Stay

3.2.5 Moderation of susceptibility to emotional contagion

Emotional contagion can be defined as the ‘catching’ of emotions from others (Robbins & Judge, 2011). When people spend time with others, eventually, their emotions ‘rub off’ on each other (Hamilton, 2011). In its most basic state, which is also referred to as ‘primitive empathy’, it entails the automatic synchronization and mimicking of other people’s action cues and their emotional convergence. The mechanism of emotional contagion is proposed as follows: first, in interactional situations, people automatically and continuously mimic and synchronize their facial expressions, voices, postures and movements with those of others (Hatfield, Cacioppo & Rapson, 1993). This occurs via the Mirror Neuron System (MNS), which observes and records people's facial expressions, body language, pupil

movements and vocal tones (Hamilton, 2011). Second, subjective emotional experience is affected each moment by the activation / feedback from mimicry. Third, as a consequence, people are inclined to observe and gather other people's emotions and feelings (Hatfield et al., 1993). The emotions that are perceived by others can be positive or negative, meaning both good and foul moods are contagious (Carter, 2012b; Kreitner & Kinicki, 2004). In cases of negative effects, it is probable that the influence on others is unintentional (Aronson, 1999). Susceptibility to emotional contagion is the propensity of people to be affected by others in the environment. It is the predisposition to experience other people's emotions (Doherty, 1997; Manera, Grandi, & Colle 2013). The more the level of susceptibility to emotional contagion, the more likely that one will be swayed by the positive or negative emotional influencers in the environment. The level of susceptibility to emotional contagion depends both on dispositional and contextual factors (Carter, 2012b; Doherty, 1997). Susceptibility to emotional contagion is used as a moderator variable for the purposes and analyses of the current research.

Regarding its moderation standing, the research expected that doctors who are more susceptible to emotional contagion will likely be more prone to be affected by the physiological and psychological consequences of the organizational stressors of workload and emotional labor. This is because doctors' susceptibility to emotional contagion moderates to what extent they are affected from the antecedents of workload and emotional labor in health organizations. In other words, doctors more prone to being affected by the feelings of others and emotional events around them are more likely to feel the detrimental consequences of intense workload and emotional labor. Higher contextual and interpersonal demands likely lead to physical and emotional exhaustion for doctors. In return, this likely decreases their

commitments towards their organizations. In this regard, the current study aimed to find out whether doctors with high susceptibility to emotional contagion, when affected by high workload and emotional labor, have lower affective and organizational commitment towards their organizations than those with low susceptibility to emotional contagion.

Susceptibility to emotional contagion is also found to play moderating roles in certain studies throughout related literature. It is observed to have a moderating effect on the relationships between the antecedents of empathic concern (Omdahl & O'Donnell, 1999), workload and emotional labor, (Bakker et al., 2001; Bakker et al., 2005; Le Blanc et al., 2001; Lee et al., 2010), and outcomes of occupational commitment and burnout in service and health organizations. As such, in alignment to its consideration in related literature, susceptibility to emotional contagion was expected to have a moderating role between the antecedents of workload and emotional labor and mediator of affective commitment, for the purposes of the current study conducted with doctors in health organizations in Turkey. The relevant moderation hypotheses are as follows:

H_8: Susceptibility to Emotional Contagion will have a moderating effect on the relationship between Workload and Affective Commitment such that doctors susceptible to emotional contagion will be affected more by workload and less committed towards their organizations than those resilient to emotional contagion.

H_9: Susceptibility to Emotional Contagion will have a moderating effect on the relationship between Emotional Labor and Affective Commitment such that doctors susceptible to emotional contagion will be affected more by emotional labor and less committed towards their organizations than those resilient to emotional contagion.

3.3 Research model

The research model, based on the discussed notions and expectations formulated in the current research, is developed to be as follows in Figure 5:

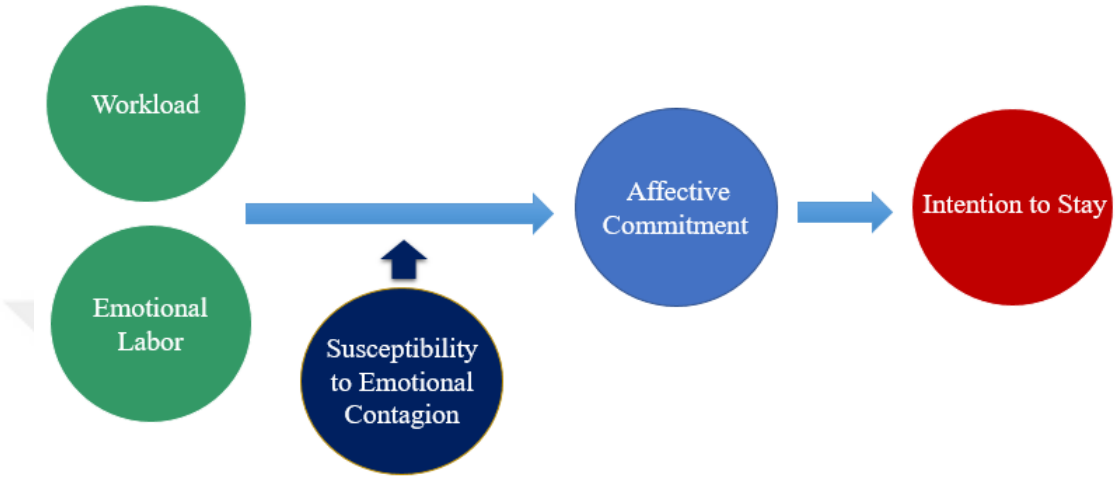


Figure 5. Preliminary research model

Based on the literature review, in terms of the associations between antecedents of workload, emotional labor, affective commitment and intention to stay, it was argued that as workload and emotional labor increases, employee's physical and emotional exhaustions also increases (Lee et al., 2010). This likely results in a decrease in their commitment towards their institutions, and as a result to the diminution of their intentions to stay with their employers. Affective commitment's association with intention to stay was also examined in detail for doctors working in health organizations in Turkey. This was due to the prevalent significance of this relationship in health organizations in related literature (Deepak, 2013). The current study expected that, based on the norms of Social Exchange Theory (Emerson, 1976; Gouldner, 1960), as affective commitment increases,

employees will become more attached to the organizations they are currently working in, thus leading to an increase in their intentions to stay in these institutions.

Regarding affective commitment, it was also investigated as a mediator between the antecedents of workload and emotional labor, and outcome of intention to stay. This was done with regard to Social Exchange Theory norms. Various examples in relevant literature consider affective and organizational commitment to be a mediating factor on the relationships between organizational stressors and outcomes (Chirumbolo & Hellgren, 2003; Chirumbolo & Areni, 2005; Guchait & Cho, 2010; Rehman et al., 2012; Suliman & Al-Junaibi, 2010; Zeytinoğlu et al., 2010). The current study similarly argues that as demands and stressors of organizations, workload and emotional labor in this case, increase for employees, their commitments to their organizations decrease, and as a result their intentions to stay also decrease. This is because employees are less inclined to be committed to and so intent to stay organizations in which they go through detrimental experiences. So, the current research also considered organizational commitment as a mediator between organizational stressors and outcomes. Affective commitment's relationship with susceptibility to emotional contagion was also examined to see whether susceptibility to emotional contagion has a moderating role to play in the associations between workload and emotional labor, and affective commitment for doctors working in hospitals in Turkey.

In the next stage of the current study, relationships in terms of emotional contagion and the susceptibility to it were looked at. The notion here was that since emotional labor implies that employees show and display emotions other than those they are actually feeling, it becomes more difficult for them to apply emotional restraint if they are prone to being easily affected by the emotions around them. In

other words, the more susceptible an employee is to emotional contagion, the more likely he or she is to be affected by emotional labor in the workplace (Lee et al., 2010). Since this effect may consist of negative emotional consequences such as increased emotional exhaustion and dissonance, it likely results in a decrease in the employee's affective commitment towards his or her organization (Hatfield et al., 1994). This is because such negative consequences probably take their toll on the employees in time. Susceptibility to emotional contagion was found to play a moderating role on the associations between organizational stressors and outcomes in relevant literature (Bakker et al., 2001; Bakker et al., 2005; Le Blanc et al., 2001; Lee et al., 2010; Omdahl & O'Donnell, 1999). As such, it was also be expected to play a moderating role in the relationship between workload and emotional labor, and affective commitment

The expectation for workload was that the more susceptible an employee is to emotional contagion, the more he or she will be affected by increased workload in the workplace. This is because more workload means deeper and longer interactions with more customers and personnel, and less time and resources for personal needs, wants, rest or relaxation (Shinn et al., 1984). This likely results in increased emotional exchanges and contagion, and so additional emotional instability and disorientation (Lee et al., 2010). As such, it likely results in a decrease in the employee's affective commitment towards his or her workplace (Wright & Cropanzano, 1998).

As can be seen, in line with the current study's arguments, affective commitment is expected to have a mediating effect on the relationship between the antecedents of workload and emotional labor and outcome of intention to stay. Susceptibility to emotional contagion, on the other hand, is anticipated to have a

moderating effect on the relationship between the antecedents of workload and emotional labor and mediator of affective commitment.

CHAPTER 4

RESEARCH DESIGN AND METHODOLOGY

Duncan (1984) states that "All measurement… is social measurement. Physical measures are made for social purposes." Regardless of the research motives, each scientific area develops a unique set of measurement tools and procedures. Theory plays a vital role in the development of behavioral and social sciences. As such, psychometrics is frequently used to measure psychological and social phenomena. Measurement, in itself, is not just the allocation of numbers to occurrences according to certain rules. Rather, it is the assignment of numerals done in such a way as to correspond to the varying degrees of a quality. Different constructs require different assessment strategies. Some constructs can be measured with the tools already present in the literature. Others, however, may require more initiative and demand combinations of the existing tools in order to be assessed comprehensively (DeVellis, 2012). As such, the current study uses a number of different measurement tools for various constructs in combination for its research purposes.

4.1 Sample characteristics

The sample of the current study included 270 doctors working in public, private and university hospitals in the Marmara region in Turkey. Considering the sample, the results of the descriptive and frequency analyses conducted for the sample in the current research are as follows in Table 1:

Table 1. Descriptive and Frequency Analyses for the Research Sample

Sample characteristics N = 270	Category	Frequency	Valid Percent
Personal characteristics			
Age	younger than 30 years	137	50.7%
	older than 30 years	133	49.3%
Gender	Male	137	50.7%
	Female	133	49.3%
Marital status	Married	160	59.3%
	Not married	110	40.7%
Number of children	No children	12	32.4%
	1 child	49	18.1%
	2 children	49	18.1%
	3 children	14	5.2%
Medicinal degree	Assistant	167	61.9%
	Specialist	64	23.7%
	Assistant professor	2	0.7%
	Associate professor	15	5.6%
	Professor	22	8.1%
Workplace Characteristics			
Hospital type	Public	145	53.7%
	University	115	42.6%
	Private	10	3.7%
Working time	Full time	257	95.2%
	Part time	13	4.8%
Administrative duty	None	256	94.8%
	Supervisor	10	3.7%
	Department head	2	0.7%
	Chief doctor	2	0.7%
Work place	None	70	25.9%
	Service	71	26.3%
	Clinic	62	23%
	Both	67	24.8%
Work experience	less than 10 years	182	67.4%
	more than 10 years	88	32.6%

The results of the descriptive and frequency analyses conducted for the sample in the current research, which can be seen in detail in Appendix A, are as follows: For the current sample of 270 participants, the ages of the participants range from 24 to 70,

with 50.7% of the participants being below 30 years old (137 people) and 49.3% above 30 years old (133 people). Almost half of the participants are male (137 males, 49.3%) and the remaining half are female (133 females, 50.7%). While 59.3% of the participants are married (160 people), 40.7% of them are not married (110 people). 61.9% of the participants are assistants (167 people), 23.7% are specialists (64 people), 0.7% are assistant professors, 5.6% are associate professors (15 people), and 8.1% are professors (22 people). 94.8% of the participants are not positioned in any administrative jobs (256 people), while 5.2% have administrative duties (14 people). 95.2% of the participants are working as full time employees (257 people), while 4.8% are part time employees (13 people). 53.7% of the participants are working in public hospitals, 42.6% in university hospitals, and 3.7% in private hospitals. While 26.3% of the participants are working in service departments (71 people), 23% are working in clinics (62 people), 24.8% are working in both (67 people) and 25.9% are working in none of these departments (70 people). Finally, 67.4% of the participants have less than 10 years of working experience (182 people), while 32.6% of them have more than 10 years of working experience (88 people).

4.2 Measures

The measures used in the scale can be considered in two sections: demographics and measurement scales for variables.

4.2.1 Demographics

The demographics section includes the demographic items of age, gender (male, female), marital status (married, not married), number of children (if any), medicinal degree (prof., ass. prof. etc.), administrative duties (if any), working time (full time

vs. part time), type of hospital (public, private, university), work place (service, clinic, both), number of work years and medicinal branch (cardiology, psychiatry etc.). The English and Turkish versions of the questionnaire can be found in Appendix B and C, respectively.

4.2.2 Workload

The workload subscale of The Areas of Worklife Scale (AWS), which includes six items, was used to measure the workload of employees as a contextual stressor in their work lives (Leiter & Maslach, 2004). In this perspective, workload is considered to be one of the six areas of work life that are predominantly related to and associated with organizational burnout, along with control, reward, community, fairness and values. The scale measures the level of mismatch between the employee and the job or the environment, caused by workload. The greater this mismatch is, the more negatively the employee will be affected in the job and organization. The scoring is done on a 5 point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Higher scores indicate higher mismatch in terms of workload. The results of the scale analyses conducted to test the reliability and sampling adequacy of the workload subscale were as follows: the scale is reliable with a Cronbach's Alpha value of 0.749 and adequate in terms of sampling with a KMO value of 0.817. The items of the scale are shown in Table 2:

Table 2. Individual Items of Workload in AWS

No	Item
1	I do not have time to do the work that must be done
2	I work intensely for prolonged periods of time
3	After work I come home too tired to do the things I like to do
4	I have so much work to do on the job that it takes me away from my personal interests
5	I have enough time to do what's important in my job (RS)
6	I leave my work behind when I go home at the end of the day (RS)

Source: Leiter & Maslach, 2004

4.2.3 Emotional labor

Emotional labor, as an interpersonal stressor people experience in their jobs, was measured by the Revised Emotional Labor Scale (ELS-R). The scale was first designed as a 14 item survey in 1998, then was revised to a 15 item emotional labor scale (ELR) in 2002, then took its final form in 2006 (Lee et al., 2010). ELS-R consists of nine items which measure the two dimensions of emotional labor: deep acting and surface acting. Surface acting is measured with its two sub-dimensions of hiding feelings and faking emotions. The scoring of the responses to the scale is done on a 5 point Likert scale ranging from 1 (never) to 5 (always). Higher scores indicate more frequent engagement in emotional labor. The results of the scale analyses conducted to test the reliability and sampling adequacy of ELS-R were as follows: the scale is reliable with a Cronbach's Alpha value of 0.762 and adequate in terms of sampling with a KMO value of 0.750. The items of the scale can be seen in Table 3:

Table 3. Revised Emotional Labor Scale

No	Item
1	Show emotions that I don't feel.
2	Make an effort to actually feel the emotions that I need to display to others.
3	Hide my true feelings about a situation.
4	Pretend to have emotions I have to show as part of my job.
5	Really try to feel the emotions I have to show as part of my job.
6	Show emotions that are expected rather than what I feel.
7	Resist expressing my true feelings.
8	Conceal what I'm feeling.
9	Try to actually experience the emotions that I must show.

Deep acting Items: 2, 5 & 9
Hiding feelings items: 3, 7 & 8
Faking emotions Items: 1, 4 & 6

Source: Lee & Brotheridge, 2006

4.2.4 Intention to stay

Intention to stay was measured with The Propensity to Leave Scale (PtLS; Lyons, 1981). The scale consist of three positively-worded items related to working and staying in the employee's current organization (Lyons, 1981). The scale was first created in order to measure the propensity to leave levels of hospital nurses in relation to the concepts of role ambiguity and clarity. It was later enhanced to use positive wording rather than questions for the items. The responses to the scale items are scored on a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Higher scores obtained from the scale reflect higher tendencies to stay. The results of the scale analyses conducted to test the reliability and sampling adequacy of PtLS were as follows: the scale is reliable with a Cronbach's Alpha value of 0.915 and adequate in terms of sampling with a KMO value of 0.727. PtLS includes the following items in Table 4:

Table 4. Propensity to Leave Scale

No	Item
1	If I were completely free to choose, I would prefer to keep working in this organization
2	I would like to stay at this organization for a long time
3	If I had to quit work for a while (for example because of personal / family reasons), I would return to this organization.

Source: Lyons, 1981

4.2.5 Organizational commitment

Organizational and affective commitment were measured by the Organizational Commitment Scale (OCS; Meyer et al., 1993). The scale includes the three components of organizational commitment which are affective, continuance and normative commitment. The scoring of the scale is done on a 5 point Likert scale ranging from 1 (never) to 5 (always). Higher scores indicate higher commitment towards an organization. The results of the scale analyses conducted to test the reliability and sampling adequacy of OCS were as follows: the scale is reliable with a Cronbach's Alpha value of 0.795 and adequate in terms of sampling with a KMO value of 0.727. The affective commitment subscale is also reliable with a Cronbach's Alpha value of 0.842 and adequate in terms of sampling with a KMO value of 0.820. The items of the scale can be seen in Table 5:

Table 5. Organizational Commitment Scale

No	Affective commitment item
1	I would be very happy to spend the rest of my career with this organization.
2	I really feel as if this organization's problems are my own.
3	I do not feel a strong sense of "belonging" to my organization. (RS)
4	I do not feel "emotionally attached" to this organization. (RS)
5	I do not feel like "part of the family" at my organization. (RS)
6	This organization has a great deal of personal meaning form me.
No	Continuance commitment item
7	Right now, staying with my organization is a matter of necessity as much as desire.
8	It would be very hard for me to leave my organization right now, even if I wanted to.
9	Too much of my life would be disrupted if I decided I wanted to leave my organization now.
10	I feel that I have too few options to consider leaving this organization.
11	If I had not already put so much of myself into this organization, I might consider working elsewhere.
12	One of the few negative consequences of leaving this organization would be the scarcity of available alternatives.
No	Normative commitment item
13	I do not feel any obligation to remain with my current employer. (RS)
14	Even if it were to my advantage, I do not feel it would be right to leave my organization now.
15	I would feel guilty if I left my organization now.
16	This organization deserves my loyalty.
17	I would not leave my organization right now because I have a sense of obligation to the people in it.
18	I owe a great deal to my organization.

Source: Meyer at al., 1993

4.2.6 Susceptibility to emotional contagion

Susceptibility to emotional contagion was measured via The Emotional Contagion Scale (ECS), a 15-item scale that measures people's susceptibility to emotional contagion (Doherty, 1997). It includes Fischer's (1990) five basic emotions of happiness, love, fear, anger and sadness. These items measure the susceptibility to two positive (happiness, love) and three negative (fear, anger, sadness) emotions. These subgroups are referred to as Positive Affect Factor and Negative Affect Factor, respectively. The higher the score obtained from the scale, the more susceptible to emotional contagion the participant is. The scoring of ECS is done on a 5 point Likert scale ranging from 1 (never) to 5 (always agree). The results of the scale analyses conducted to test the reliability and sampling adequacy of ECS were as follows: the scale is reliable with a Cronbach's Alpha value of 0.858 and adequate in

terms of sampling with a KMO value of 0.866. The items of the scale can be seen in Table 6:

Table 6. Emotional Contagion Scale

No	Item
1	If someone I'm talking with begins to cry, I get teary-eyed.
2	Being with a happy person picks me up when I'm feeling down.
3	When someone smiles warmly at me, I smile back and feel warm inside
4	I get filled with sorrow when people talk about the death of their loved ones.
5	I clench my jaws and my shoulders get tight when I see the angry faces on the news.
6	When I look into the eyes of the one I love, my mind is filled with thoughts of romance.
7	It irritates me to be around angry people.
8	Watching the fearful faces of victims on the news makes me try to imagine how they might be feeling.
9	I melt when the one I love holds me close.
10	I tense when overhearing an angry quarrel.
11	Being around happy people fills my mind with happy thoughts.
12	I sense my body responding when the one I love touches me.
13	I notice myself getting tense when I'm around people who are stressed out.
14	I cry at sad movies.
15	Listening to the shrill screams of a terrified child in a dentist's waiting room makes me feel nervous.

Happiness items: 2, 3 & 11

Love items: 6, 9 & 12

Fear items: 8, 13 & 15

Anger items: 5, 7 & 10

Sadness items: 1, 4 & 14

Source: Doherty (1997)

As can be seen, the Cronbach Alpha and Kaiser-Meyer-Olkin values of the scales confirm their reliability and sampling adequacy. As such they were used without any item deletions in the current research. The results for the scale analyses conducted to test the reliability and sampling adequacy for all the scales and their subscales in the study can be seen in detail in Appendix D.

4.3 Procedure

Information from the doctors working in health organizations was collected via a questionnaire prepared by the author specifically for this research. In total, 350 questionnaires were distributed to six hospitals in Turkey: one private hospital in Istanbul, three public hospitals in Istanbul, one university hospital in Istanbul and one public hospital in Yalova. Only 274 of the questionnaires were received in return and the response was 78%. The questionnaires were then analyzed in terms of usability in the research, and four of them had missing factors and were omitted from the analyses. Thus, 270 of the questionnaires were used in the final analyses of the current research. The research questionnaire consists of a combination of relevant and proven to be reliable measurement tools from the literature. It was used to investigate the relationship and interactions between and within the research variables. In terms of anonymity, the questionnaire's sole academic purpose and anonymity were explicitly written on every questionnaire form and verbally repeated during delivery or administration.

Snowball sampling was used to obtain data from the doctors in the health organizations. Goodman (1961) defines this non-probability sampling technique as follows: a random sample of people are selected from a finite population. They are then asked to name a certain number of individuals to be further included in the research sample. Then those individuals ask other individuals to name even more people to be a part of the current research. This creates a snowball effect via chain referral that starts from a few individuals leading to many. This type of sampling can also be referred to as chain sampling, chain-referral sampling or referral sampling. The types of snowball sampling can be seen in Figure 6:

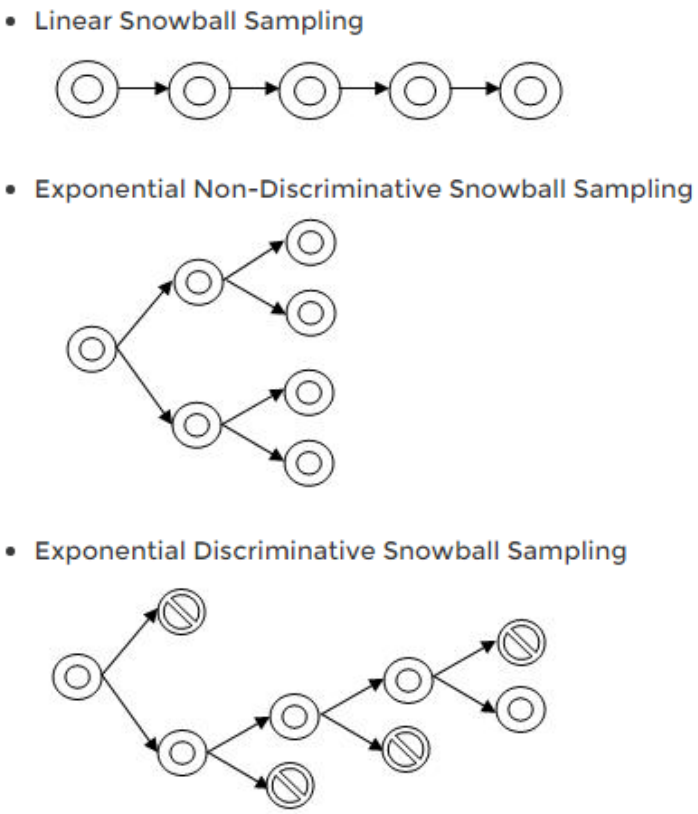


Figure 6. Types of snowball sampling

Source: Dudovskiy, 2013

For this research, doctors and hospital managers from different hospitals were selected and informed about the research content and aims in detail, including its academic purpose and anonymity. They were then asked for permission and help in distributing or delivering this questionnaire to their colleagues (doctors) or employees (managers) in order to grow the sample size via chain referral. The questionnaires were distributed to these participants via exponential non-discriminative sampling. The targeted doctors were chosen and convinced to partake via multiple chain referrals by the initially selected doctors and hospital managers.

CHAPTER 5

DATA ANALYSIS AND RESULTS

The current study begins the data analysis stage with normality, multicollinearity, common method bias, reliability and sampling adequacy tests. It then moves on to comparative analyses of demographics. Next, descriptives and correlations among the antecedent, mediator, outcome and moderator variables are presented. The study then moves on to multivariate analyses. It uses hierarchical regression analyses for testing the research hypotheses with mediation and moderation to obtain reliable and solid results (Suliman & Al-Junaibi, 2010). This is similar to how such analyses were conducted in the studies of Lee at al. (2010), Blanc et al. (2001), Zeytinoğlu et al. (2010) and Kaja et al. (2015). The analyses conducted in the current study are executed via IBM Statistical Procedures for Social Sciences (SPSS) Statistics 23 software.

5.1 Normality and multicollinearity analyses

The descriptive and regression analyses conducted to test the normality and multicollinearity of the variables in the current research (i.e. workload, emotional labor, affective commitment, susceptibility to emotional contagion and intention to stay) showed that though non-normality conditions exist, the sample size is sufficient enough to diminish related negative effects. Also, since the VIF values are below four, no significant multicollinearity problems can be assumed to exist (Hair et al., 2010). These analyses can be seen in detail in Appendix E.

5.2 Harman's single factor test

The results of the factor analysis conducted to test for the existence of common method bias for the variables in the current research showed that total variance explained is 12.4% for these variables. This does not exceed 50%, so no common method bias problem exists (Hair et al., 2010). These analyses can be seen in detail in Appendix F.

5.3 Reliability and sampling adequacy analyses

The results of the exploratory factor analysis conducted to test the sampling adequacy of the variables in the current research are as follows in Table 7:

Table 7. Sampling Adequacy for Research Variables

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.81
Bartlett's Test of Sphericity	Approx. Chi-Square	6429.56
	df	1275
	Sig.	.00

The results show that the sampling adequacy is sufficient with a KMO value of 0.81.

5.4 Comparison analyses

The results of the comparison analyses conducted for the demographics in the current study for the sample of 270 doctors can be seen in detail in Appendix G. In terms of gender, the comparison analyses showed that female doctors reported higher workload ($F = 1.08$, $p < 0.05$) and susceptibility to emotional contagion ($F = 0.43$, $p < 0.01$), and lower emotional labor ($F = 0.41$, $p < 0.05$) and intention to stay ($F = 0.54$, $p < 0.10$, approaching significance) than their male counterparts. Considering marital status, married doctors have higher susceptibility to emotional contagion ($F =$

0.22, $p < 0.05$) than their not married counterparts. Regarding hospital types, doctors working in university hospitals have higher commitment ($F = 3.52$, $p < 0.05$) and intention to stay ($F = 0.02$, $p < 0.00$) than their counterparts working in public hospitals. Private hospitals are not included in the analysis since there are only 10 doctors in the subject group. In terms of age (below 30 years old vs. above 30 years old), doctors above 30 years old have higher intention to stay ($F = 1.14$, $p < 0.05$) and susceptibility to emotional contagion ($F = 0.32$, $p < 0.05$) than younger ones. For work years (below 10 years vs. above 10 years), doctors with more than 10 years of experience have higher intention to stay ($F = 0.55$, $p < 0.01$) and lower workload ($F = 5.50$, $p < 0.01$) than their less experienced colleagues.

5.5 Descriptive and correlation analyses

The descriptives and correlations between the variables (i.e. workload, emotional labor, organizational commitment, susceptibility to emotional contagion and intention to stay) are presented in Table 8. The regression analyses conducted to investigate these relationships among the variables are presented in Appendix H:

Table 8. Descriptive and Correlation Analyses for Research Variables

No	Variable	Mean	Standard Deviation	WL	EL	AC	StEC	ItS
1	Workload	35.26	.72	1				
2	Emotional Labor	25.10	.58	.09	1			
3	Affective Commitment	3.28	.85	-.09	.02	1		
4	Susceptibility to Emotional Contagion	32.47	.57	.16***	.05	.00	1	
5	Intention to Stay	35.59	.56	-.11*	.05	.67***	.07	1

*** Correlation is significant at the 0.01 level (2-tailed)
** Correlation is significant at the 0.05 level (2-tailed)
* Correlation is significant at the 0.10 level (2-tailed)

H_1 stated that workload would be negatively associated with affective commitment. The results showed that workload was not significantly associated with affective commitment ($r = -0.09$, $p > 0.05$). Regression analysis also showed that workload was not a significant predictor of affective commitment ($t = -1.53$, $p > 0.05$). This implies that doctors that are affected more from workload do not have lower affective commitment than those that are affected less from workload. As such, H_1 was not supported.

H_2 stated that workload would be negatively associated with intention to stay. The results showed that workload was negatively associated with intention to stay and approaches significance ($r = -0.11$, $p < 0.10$). Regression analysis also showed that workload is approaching significance in predicting intention to stay ($t = -1.80$, $p < 0.10$). This implies that doctors that are affected more from workload reported lower intention to stay than those that are affected less from workload. So, though a correlation approaching significance was found, H_2 was not supported.

H_3 stated that emotional labor would be negatively associated with affective commitment. The results showed that emotional labor was not significantly associated with affective commitment ($r = 0.02$, $p > 0.05$). Regression analysis also showed that emotional labor was not a significant predictor of affective commitment ($t = 0.34$, $p > 0.05$). This implies that doctors that are affected more from emotional labor have not reported higher levels of affective commitment than those that are affected less from emotional labor. As such, H_3 was not supported.

H_4 stated that emotional labor would be negatively associated with intention to stay. The results showed that emotional labor was not significantly associated with intention to stay ($r = 0.05$, $p > 0.05$). Regression analysis also showed that emotional labor was not a significant predictor of intention to stay ($t = 0.80$, $p > 0.05$). This

implies that doctors that are affected more from emotional labor did not report lower intention to stay than those that are affected less from emotional labor. As such, H_4 was not supported.

H_5 stated that affective commitment would be positively associated with intention to stay. The results showed that affective commitment was positively and significantly associated with intention to stay ($r = 0.67$, $p < 0.01$). Regression analysis also showed that affective commitment was a significant and positive predictor of intention to stay ($t = 14.82$, $p < 0.01$). This implies that doctors that reported high affective commitment have higher intentions to stay than those that reported low affective commitment. As such, H_5 is confirmed.

5.6 Hierarchical regression analyses

In terms of multivariate analyses for hypothesis testing, hierarchical regression was used to measure the mediating and moderating roles of affective commitment and susceptibility to emotional contagion, respectively, on the relationships between the antecedents (workload, emotional labor) and outcomes of the current research. The focus of the current study puts emphasis on the sequential investigation of the effects of the research variables in hypothesis testing. In this way the relative importance of these variables can be evaluated based on how much they support and add to the prediction of criterions. Hierarchical regression analysis is one of the best options to use for these analyses because it is developed to assess such specific and theory driven hypotheses (Petrocelli, 2003). Hierarchical regression analysis can also be used to measure mediation and moderation effects (Hair et al., 2010; Hayes, 2013). As such, it was used as the primary analysis method for hypothesis testing for the current study.

5.6.1 Mediation analyses

For mediation, Baron and Kenny (1986) state that a variable can be considered to be a mediator to the degree that it is responsible for the association between a predictor and criterion. While moderators define when certain influences will occur, mediators specify how or why this influence occurs. Their proposed mediation model is as follows in Figure 7:

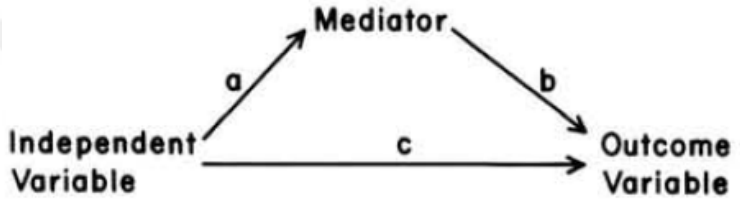


Figure 7. Model of mediation

Source: Baron and Kenny, 1986

Baron and Kenny (1986) mention that this model includes two causal paths leading to the outcome variable: the direct impact of the predictor (path c) and the influence of the mediator (path b). A connection between the predictor and mediator also exists (path c). A mediation hypothesis can be supported if the association between the independent and outcome variables is reduced to zero, implying full or perfect mediation. A mediation hypothesis can also be supported if the relationship between the independent and outcome variables is reduced significantly, referring to partial mediation. This reduction is neither necessary nor sufficient for the occurrence of an effect, though. The aim of mediation analysis, then, is the indirect investigation of the effect of an antecedent on an outcome through a mediator. This way, mediation

analyses can go beyond the descriptive understanding of the relationships among the investigated variables to a more functional one. This understanding becomes deeper because the goal of such analyses is not only the validation of an association between two research variables, but also the comprehension of the background processes that produce these associations (Preacher & Hayes; 2004).

Baron and Kenny (1986) mention that while moderators are predominantly used in cases of unpredictable or negligible associations between predictors and criterions, mediators are mostly called for in situations with strong relationships between predictors and criterions. They also argue that depending on the context, focus and purpose of the research, certain variables can be considered to be mediators at first, then used later as moderators, or vice versa.

Baron and Kenny (1986) state that there are four steps for mediation analysis that are required to be met to form a true mediation relationship: (1) The independent variable is a significant predictor of the dependent variable, (2) The independent variable is a significant predictor of the mediator, (3) The mediator is a significant predictor of the dependent variable, while the independent variable is controlled for and (4) The coefficient relating the independent variable to the dependent variable is higher in absolute value than the coefficient relating the independent variable to the dependent variable, with both the independent and mediating variable predicting the dependent variable (Mackinnon, Fairchild, & Fritz, 2007). Thus, the current research also uses these four steps to test its hypotheses in terms of compatibility to mediation analyses (Baron & Kenny, 1986).

It is argued in relevant and current literature that although the mediation steps of Baron and Kenny (1986) are deemed as prerequisites for mediation analyses, among the four mentioned mediation steps, the first one may not always be necessary

to conduct analyses for mediation. This is due to the fact that sample size and various extraneous factors may cause there to be not enough power to predict the association between the dependent variable and independent variable which may potentially exist (Collins et al., 1988; Kenny, Kashy, & Bolger, 1988; Mackinnon, 2000; Shrout & Bolger, 2002). In fact, the first step is routinely violated in social sciences literature (Preacher & Hayes, 2004). However, it is also argued that the violation of the first step of mediation results in a variation in the effect of the variable presumed to be the mediator (Preacher & Hayes, 2004). Using the same method of hierarchical analyses, when there indeed is a significant correlation between the dependent and independent variables, in other words when the first step of mediation is satisfied, the resulting effect of the mediator variable is referred to as the mediation effect. On the other hand, when there is no significant association between the dependent and independent variables, meaning when the first step of mediation is not satisfied, the influence of the variable assumed to be the mediator leads to the formation of an indirect effect of the independent variable on the dependent one (Preacher & Hayes, 2004). The current study investigated these indirect effects as well.

H_6 stated that affective commitment would have a mediating effect on the relationship between workload and intention to stay. The results showed that, since workload was not significantly associated with affective commitment ($r = -0.09$, $p > 0.05$), the second step of Baron and Kenny's (1986) mediation steps was not satisfied. So further analyses were not conducted. As such, H_6 was not supported.

H_7 stated that affective commitment would have a mediating effect on the relationship between emotional labor and intention to stay. The results showed that, since emotional labor was not significantly associated with affective commitment ($r =$

0.02, $p > 0.05$), the second step of Baron and Kenny's (1986) mediation steps was not satisfied. So further analyses were not conducted. As such, H_7 was not supported.

5.6.2 Moderation analyses

Hierarchical regression analysis was used to measure moderation effects in the current study (Hair et al., 2010; Hayes, 2013). Baron and Kenny (1986) state that a moderator is a quantitative or qualitative variable influencing the strength and direction of an association between an independent variable and dependent variable. It affects the zero-order correlations between these variables. A moderator effect is said to occur when the direction of this association changes or a relationship is significantly reduced. Their proposed moderation model is as follows in Figure 8:

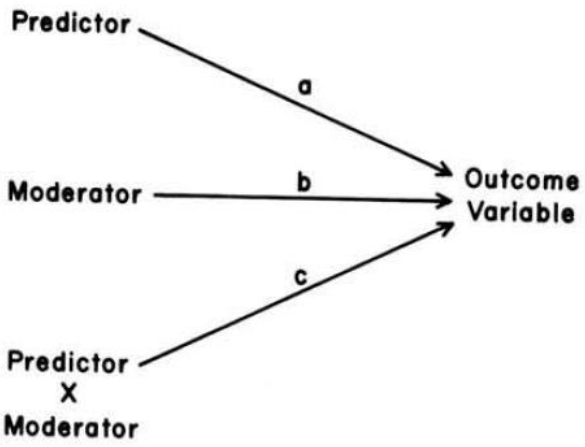


Figure 8. Model of moderation

Source: Baron and Kenny, 1986

Baron and Kenny (1986) mention that the model includes three causal paths leading to the outcome variable: the impact of the predictor (path a), influence of the moderator (path b) and the effect of their interaction term (path c). A moderation

hypothesis can be supported if the effect of this interaction term is significant. In terms of path a and b, meaning the relationships between the predictor and outcome variables, and moderator and outcome variables, they need not be significant for analytic purposes. Though Baron and Kenny (1986) argue that for a better interpretation of the effect of the interaction term, it is more desirable that the moderator variable be correlated to neither the predictor nor the outcome variable. In moderation analyses, unlike in mediation, all analysis variables are at the same level in terms of being antecedents. This means that moderators can be considered to be independent variables, whereas the role of mediators change depending on the context and focus of the desired analysis. Baron and Kenny (1986) argue that moderation refers to the change in the causal relationship between two variables as a result of the moderator. As such, its measurement should be conducted by investigating the differential effect of the independent variable on dependent variable as a function of the moderator.

H_8 stated that susceptibility to emotional contagion would have a moderating effect on the relationship between workload and affective commitment, meaning that doctors with high susceptibility to emotional contagion would have lower affective commitment when affected by workload than those with low susceptibility to emotional contagion. The results are presented in Table 9:

Table 9. Hierarchical Regression Analysis for Hypothesis 8

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.094[a]	.009	.001	.85173	.009	1.198	2	267	.303
2	.154[b]	.024	.013	.84694	.015	4.025	1	266	.046

a. Predictors: (Constant), EMOTIONAL CONT., WORKLOAD
b. Predictors: (Constant), EMOTIONAL CONT., WORKLOAD, Workload_ECS

ANOVA[a]

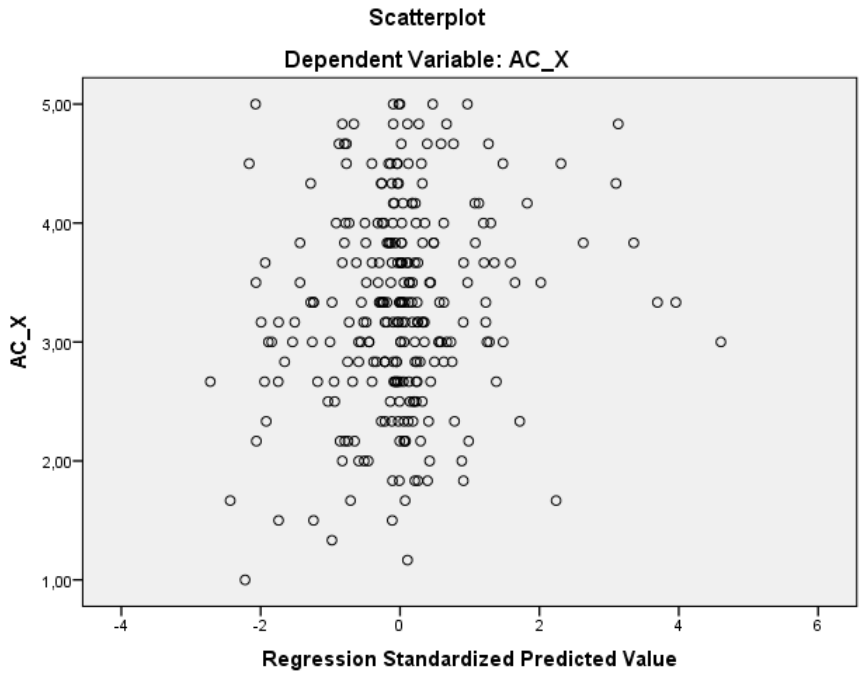
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1.739	2	.869	1.198	
	Residual	193.691	267	.725		
	Total	195.430	269			
2	Regression	4.626	3	1.542	2.150	.094[c]
	Residual	190.805	266	.717		
	Total	195.430	269			

a. Dependent Variable: AFF. COMM.
b. Predictors: (Constant), EMOTIONAL CONT., WORKLOAD
c. Predictors: (Constant), EMOTIONAL CONT., WORKLOAD, Workload_ECS

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	3.591	.391		9.190	.000
	WORKLOAD	-.114	.074	-.096	-1.548	.123
	EMOTIONAL CONT.	.026	.094	.017	.278	.781
2	(Constant)	.503	1.587		.317	.752
	WORKLOAD	.771	.447	.647	1.724	.086
	EMOTIONAL CONT.	.908	.449	.599	2.021	.044
	Workload_ECS	-.251	.125	-1.023	-2.006	.046

a. Dependent Variable: AFF. COMM.



The results showed that susceptibility to emotional contagion had a significant moderating effect on the relationship between workload and affective commitment ($F = 4.03$, $p < 0.05$). The model was also approaching significance ($F = 2.20$, $p < 0.10$). The workload coefficient was also approaching significance ($t = 1.72$, $p < 0.10$) while susceptibility to emotional contagion ($t = 2.02$, $p < 0.05$) and interaction term ($t = -2.01$, $p < 0.05$) coefficients were also significant. The results confirm that susceptibility to emotional contagion had a significant moderating effect on the relationship between workload and affective commitment. This implies that doctors with high susceptibility to emotional contagion have lower affective commitment when affected by workload than those with low susceptibility to emotional contagion. As such, H_8 was supported.

H_9 stated that susceptibility to emotional contagion would have a moderating effect on the relationship between emotional labor and affective commitment, meaning that doctors with high susceptibility to emotional contagion would have lower affective commitment when affected by emotional labor than those with low susceptibility to emotional contagion. The results are presented in Table 10:

Table 10. Hierarchical Regression Analyses for Hypothesis 9

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.021[a]	.000	-.007	.85535	.000	.059	2	267	.943
2	.032[b]	.001	-.010	.85669	.001	.162	1	266	.687

a. Predictors: (Constant), EL_X, ECS_X
b. Predictors: (Constant), EL_X, ECS_X, EL_x_ECS

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	.087	2	.043	.059	.943[b]
	Residual	195.344	267	.732		
	Total	195.430	269			
2	Regression	.206	3	.069	.093	.964[c]
	Residual	195.224	266	.734		
	Total	195.430	269			

a. Dependent Variable: AC_X
b. Predictors: (Constant), EL_X, ECS_X
c. Predictors: (Constant), EL_X, ECS_X, EL_x_ECS

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	3.200	.396		8.087	.000
	ECS_X	.001	.093	.001	.011	.991
	EL_X	.031	.091	.021	.343	.732
2	(Constant)	3.709	1.324		2.803	.005
	ECS_X	-.143	.369	-.094	-.387	.699
	EL_X	-.184	.541	-.124	-.340	.734
	EL_x_ECS	.061	.151	.179	.403	.687

a. Dependent Variable: AC_X

The results showed that susceptibility to emotional contagion did not have a significant moderating effect on the relationship between emotional labor and affective commitment ($F = 0.16$, $p > 0.05$). This implies that doctors with high susceptibility to emotional contagion do not have lower affective commitment when affected by workload than those with low susceptibility to emotional contagion. As such, H_9 was not supported.

5.7 Additional analyses

The subscale and aggregate organizational commitment investigations of the relationships between the research variables were examined in the additional

analyses section. Note here that when considering the relationships between the subscales of the antecedent, mediator, moderator and outcome variables of the current research, all of the relevant relationships are to be tested for. Only the ones with significant or meaningful contributions to the research goals are listed in the relevant sections as additional analyses and discussions, though. The faking emotions dimension of emotional labor is not included in the current study as it is argued to be the least used dimension of emotional labor in relevant literature (Lee et al., 2010). The positive affect factor facet of susceptibility to emotional contagion is also not included in the current research. This is because relevant health literature shows that for health personnel, the probability of being affected by the negative emotions in the environment is higher than the probability for being influenced by positive feelings (Doherty et al., 1995). Also, greater contagion in terms of negative feelings are more commonly observed than that for positive feelings (Rempala, 2013).

The additional analyses were conducted an aggregate component of organizational commitment along with its subdimensions (i.e., affective, continuance and normative commitment). Since the current study is conducted for an understudied population of doctors in health organizations, it warrants a comprehensive examination of organizational commitment. As a concept, it characterizes an employee's relationship with an organization (Meyer & Allen, 1991). It refers to a link between the organization and its employees that potentially influences their turnover intentions (Allen & Meyer, 1990). In other words, organizational commitment reflects the common denominator underlying its components, representing employees' psychological states that bind them to their employers (Allen & Meyer, 1990). Moreover, employees can simultaneously experience all three states of commitment to varying degrees. Hence, they are

regarded as related components rather than separate constructs (Meyer & Allen, 1991). They are also like to interact in affecting employee attitudes and behavior. In other words, they can exert interdependent joint effects on employees' organizational behavior. So, for organizations concerned with reducing turnover and increasing retention, components of organizational commitment can be used together in predicting employee attitudes and behavior (Meyer & Allen, 1991). This is because turnover intentions show a tendency to decrease as all components of organizational commitment increase. As such, a better understanding of employee attitudes and behavior can be reached if all three components of organizational commitment are considered together (Meyer et al., 1993).

5.7.1 Additional descriptive and correlation analyses

The descriptives and correlations between the subscale variables analyzed in the context of the current research, namely deep acting and hiding feelings (emotional labor), affective, continuance and normative commitment (organizational commitment), and negative affect factor (susceptibility to emotional contagion), are as follows in Table 11:

Table 11. Descriptive and Correlation Analyses for Subscale Variables

No	Variable	Mean	SD	WL	EL	DA	HF	ItS	OC	AC	CC	NC	StEC	NAF
1	WL	3.53	.72	1										
2	EL	2.51	.58	.09	1									
3	DA	2.81	.80	.02	.67**	1								
4	HF	2.53	.77	.12*	.75**	.18**	1							
5	ItS	3.28	1.02	-.11	.05	.04	.01	1						
6	OC	3.25	.56	.07	.16**	.13*	.10	.56**	1					
7	AC	3.28	.85	-.09	.02	.08	-.03	.67**	.64**	1				
8	CC	3.25	.89	.16*	.13*	.02	.13*	-.05	.52**	-.23**	.22**			
9	NC	3.21	.78	.07	.16**	.17**	.10	.52**	.86**	.55**	.22**	.09		
10	StEC	3.56	.56	.16**	.05	.22**	-.05	.07	.07	.00	.04	.09	.89**	
11	NAF	3.28	.71	.17**	.06	.22**	-.07	.01	.07	-.03	.09	.08	.89**	1

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

* Correlation is significant at the 0.05 level (2-tailed)

The results show that organizational commitment was positively and significantly associated with intention to stay ($r = 0.56$, $p < 0.01$). Normative commitment was also positively and significantly associated with intention to stay ($r = 0.52$, $p < 0.01$). Regression analyses also confirmed these findings ($t = 11.06$, $p < 0.01$ and $t = 10.08$, $p < 0.01$, respectively). Affective commitment was also positively and significantly associated with normative commitment ($r = 0.55$, $p < 0.01$), while it was negatively and significantly correlated with continuance commitment ($r = 0.23$, $p < 0.01$). Interestingly, emotional labor was significantly and positively associated with organizational commitment ($r = 0.16$, $p < 0.01$). Regression analysis also showed that emotional labor was a significant and positive predictor of organizational commitment ($t = 2.60$, $p < 0.01$). Emotional labor was positively and significantly associated with normative commitment ($r = 0.16$, $p < 0.01$) and regression analysis also shows this positive prediction ($t = 2.72$, $p < 0.01$). Deep acting is significantly

and positively associated with organizational commitment ($r = 0.13$, $p < 0.05$) and normative commitment ($r = 0.17$, $p < 0.05$). Regression analyses showed these positive predictions as well ($t = 2.12$, $p < 0.05$ and $t = 2.8$, $p < 0.05$). Susceptibility to emotional contagion ($r = 0.16$, $p < 0.01$) and negative affect factor ($r = 0.17$, $p < 0.01$) were positively and significantly related to workload. Finally, deep acting was positively and significantly associated with susceptibility to emotional contagion ($r = 0.22$, $p < 0.01$).

5.7.2 Additional hierarchical regression analyses

The results of the hierarchical regression analysis conducted to test the moderating effect of negative affect factor on the relationship between workload and organizational commitment, meaning that doctors with high susceptibility to negative affect factor would have lower organizational commitment when affected by workload than those with low susceptibility to negative affect factor, are presented in Table 12:

Table 12. Hierarchical Regression Analysis for Moderation: Workload, Organizational Commitment

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.087[a]	.008	.000	.55925	.008	1.027	2	267	.359
2	.152[b]	.023	.012	.55591	.015	4.217	1	266	.041

a. Predictors: (Constant), NEG. AFFECT, WORKLOAD
b. Predictors: (Constant), NEG. AFFECT, WORKLOAD, Workload_NAF

ANOVA[a]

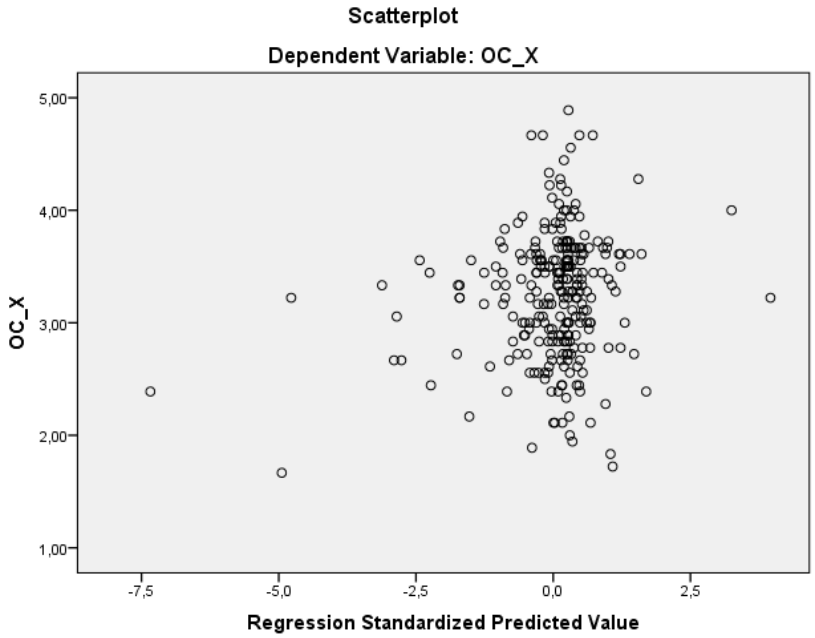
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	.643	2	.321	1.027	.359[b]
	Residual	83.508	267	.313		
	Total	84.150	269			
2	Regression	1.946	3	.649	2.099	.101[c]
	Residual	82.204	266	.309		
	Total	84.150	269			

a. Dependent Variable: ORG. COMM.
b. Predictors: (Constant), NEG. AFFECT, WORKLOAD
c. Predictors: (Constant), NEG. AFFECT, WORKLOAD, Workload_NAF

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.942	.216		13.638	.000
	WORKLOAD	.045	.048	.057	.927	.355
	NEG. AFFECT	.045	.049	.057	.918	.359
2	(Constant)	1.524	.723		2.108	.036
	WORKLOAD	.457	.206	.585	2.214	.028
	NEG. AFFECT	.489	.222	.620	2.206	.028
	Workload_NAF	-.128	.062	-.845	-2.054	.041

a. Dependent Variable: ORG. COMM.



The results showed that susceptibility to negative affect factor had a significant moderating effect on the relationship between workload and organizational commitment ($F = 4.22$, $p < 0.05$). The model is also approaching significance ($F = 2.10$, $p < 0.11$). The workload ($t = 2.21$, $p < 0.05$), negative affect factor ($t = 2.21$, $p < 0.05$) and interaction term, ($t = -2.05$, $p < 0.05$) coefficients were also significant. The results confirm that susceptibility to negative affect factor had a significant moderating effect on the relationship between workload and organizational commitment. This implies that doctors with high susceptibility to negative affect factor have lower organizational commitment when affected by workload than those with low susceptibility to emotional contagion.

5.8 Results

The summary of the main analysis results can be seen in Table 13:

Table 13. Main Analysis Results

Hypothesis Number	Hypothesis	Results	Significance
H_1	Workload will be negatively associated with Affective Commitment	Not supported	$\beta = -0.09$, $p > 0.05$
H_2	Workload will be negatively associated with Intention to Stay	Not Supported	$\beta = -0.11$, $p < 0.1$
H_3	Emotional Labor will be negatively associated with Affective Commitment	Not supported	$\beta = 0.02$, $p > 0.05$
H_4	Emotional Labor will be negatively associated with Intention to Stay	Not supported	$\beta = 0.05$, $p > 0.05$
H_5	Affective Commitment will be positively associated with Intention to Stay	Supported	$\beta = 0.67$, $p < 0.01$
H_6	Affective Commitment will have a mediating effect on the relationship between Workload and Intention to Stay	Not supported	2nd step of Baron & Kenny (1986)
H_7	Affective Commitment will have a mediating effect on the relationship between Emotional Labor and Intention to Stay	Not supported	2nd step of Baron & Kenny (1986)
H_8	Susceptibility to Emotional Contagion will have a moderating effect on the relationship between Workload and Affective Commitment such that doctors susceptible to emotional contagion will be affected more by workload and less committed towards their organizations than those resilient to emotional contagion.	Supported	$F = 4.025$, $p < 0.01$
H_9	Susceptibility to Emotional Contagion will have a moderating effect on the relationship between Emotional Labor and Affective Commitment such that doctors susceptible to emotional contagion will be affected more by emotional labor and less committed towards their organizations than those resilient to emotional contagion.	Not supported	$F = 0.16$, $p > 0.05$

5.9 Additional analyses results

The results of the additional analyses can be seen in Table 14:

Table 14. Additional results

Tested Relationship	Significance
Organizational Commitment	
Affective Commitment is positively associated with normative commitment	$r = 0.55$, $p < 0.01$
Affective Commitment is negatively associated with continuance commitment	$r = 0.22$, $p < 0.01$
Organizational Commitment - Intention to Stay	
Organizational Commitment is positively associated with Intention to Stay	$\beta = 0.56$, $p < 0.01$
Normative Commitment is positively associated with Intention to Stay	$\beta = 0.52$, $p < 0.01$
Emotional Labor - Organizational Commitment	
Emotional Labor is positively associated with Normative Commitment	$\beta = 0.16$, $p < 0.01$
Deep Acting is positively associated with Organizational Commitment	$\beta = 0.13$, $p < 0.05$
Deep Acting is positively associated with Normative Commitment	$\beta = 0.17$, $p < 0.05$
Workload - Susceptibility to Emotional Contagion	
Workload is positively associated with Susceptibility to Emotional Contagion	$r = 0.16$, $p < 0.01$
Workload is positively associated with Negative Affect Factor	$r = 0.17$, $p < 0.01$
Emotional Labor - Susceptibility to Emotional Contagion	
Deep Acting is positively associated with Susceptibility to Emotional Contagion	$r = 0.22$, $p < 0.01$
Moderation of Susceptibility to Emotional Contagion	
Negative Affect Factor will have a moderating effect on the relationship between Workload and Organizational Commitment (WL & NAF ↑, OC ↓)	$F = 4.22$, $p < 0.05$

5.10 Final research model

The revised research model, based on the findings of the current research, is developed to be as follows in Figure 9:

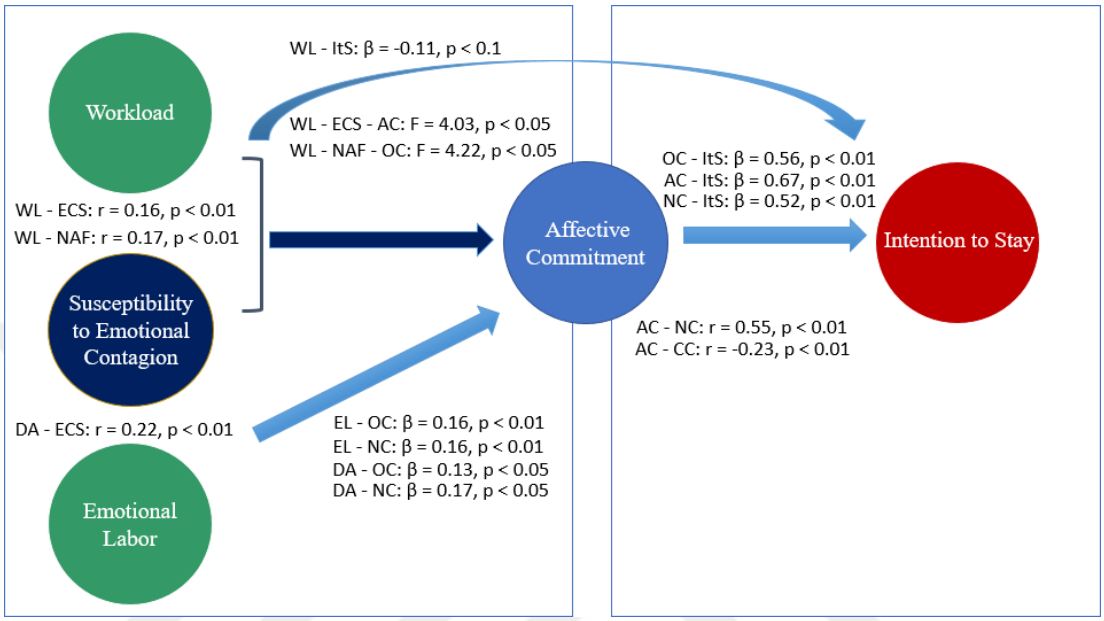


Figure 9. Final research model

The final research can be examined in two parts. The first part shows the relationships between the organizational stressors of workload and emotional labor, and moderator of susceptibility to emotional contagion with affective commitment as an outcome. Here, it can be see that workload and susceptibility to emotional contagion form an interaction effect on affective and organizational commitment. The second part of the model shows the relationship of affective and organizational commitment, and its normative component, with intention to stay.

CHAPTER 6

DISCUSSION

The purpose of the current study is to examine what factors and stressors influence the organizational outcomes for personnel working in service and health organizations. As such, it assesses the relationships between workload, emotional labor, susceptibility to emotional contagion, commitment and intention to stay, based on the tenets of Social Exchange Theory and Job Demands-Resources Model. The results of the current study are discussed in the following section.

6.1 Demographics

Considering the demographic factors investigated in the current study, the findings indicate that female doctors reported higher workload and susceptibility to emotional contagion, and lower emotional labor and intention to stay than male doctors. Married doctors have higher susceptibility to emotional contagion than not married doctors. Doctors above 30 years old have higher intention to stay and susceptibility to emotional contagion than their younger counterparts. Doctors with more than 10 years of experience have higher intention to stay and lower workload than the less experienced doctors.

In terms of the gender issues women are expected to be more vulnerable to being affected by the emotions around them than men (Doherty, 1995). This is argued to be due to their upbringing, regarding stereotypical gender roles, as sensitive, socialized, nurturing, compassionate and emotionally expressive and responsive. As such, they are expected to be less resilient towards emotional contagion (Rempala, 2013). The current research confirms these findings and

observes that female doctors are more susceptible to emotional contagion than male doctors. This is in line with the social upbringing arguments in a patriarchal country like Turkey (Wasti, 1998). In terms of working in public vs. university hospitals, doctors working in university hospitals are found to have higher organizational commitment and intention to stay than their counterparts working in public hospitals. Both groups of doctors, though, show above average levels of organizational commitment and intention to stay according to the results of the current study. A reason for this may be that university hospitals are likely to offer better services and technology to doctors than publics ones. However, the current study finds few references to studies in Turkey comparing public and university hospitals. As such, what creates this difference between public and university hospitals, at this stage, is open to discussion and should be studied more in order to be more comprehensively understood.

6.2 Workload

In medicinal literature, workload is observed to be negatively associated with intention to stay (Qureshi, 2013). In the context of health organizations, workload refers to high patient volumes, and time and resource constraints (Lee et al., 2010). This implies that the more patients doctors have to treat with limited resources and time, the more their workloads increase. The findings of the current research show that workload is approaching significance in a negatively association with intention to stay for doctors working in hospitals in Turkey. This means that as employees' workloads increase, their intention to stay tends to decrease. Health literature on workload and intention to stay also discuss the role of burnout, which, though can be observed in various sectors and institutions, is most commonly stumbled upon in the

service sector (Blanc et al., 2001). High patient volumes, time pressures and resource constraints, which make up the workload of healthcare employees, are proposed as determinants and predictors of emotional exhaustion, and so burnout, at the workplace (Bakker et al., 2005; Mojsa-Kaja, 2015; Le Blanc, 2001). In fact, as job stressors, workload factors are at times associated more with burnout than individual level stressors such as challenging patient relations (Lee et al., 2010). Moreover, the dimensions of burnout are considered to be negatively correlated to intention to stay in health organizations (Leiter & Maslach, 2008; Omdahl & O'Donnell, 1999; Shimizu, Feng, & Nagata, 2005; Xiu, 2009; Zhang & Feng 2011). Relevant literature also shows that burnout can play a significant mediating role on the relationship between workload and intention to stay, due to the fact that the correlations between workload and burnout, and burnout and intention to stay, tend to be stronger than the association between workload and intention to stay, even though this association may also be significant (Xiaoming et al., 2014). The findings of the current research partially confirm these arguments on workload and intention to stay made in relevant health literature in that the relationship between workload and intention to stay could be stronger. This is because workload, by itself, only explains a small percentage of the total variance in intention to stay (below 5%). In other words, it is likely that workload in health organizations is mediated or moderated by a factor such as burnout, which is also frequently considered in management and healthcare literature.

The indication that burnout be included as a mediator or moderator in relation to workload may be a likely reason that workload is found not to be associated with commitment. Workload is at times considered to be a predictor of burnout in organizations (Bakker et al., 2005; Blanc, 2001; Mojsa-Kaja, 2015). Burnout, then, is

considered in relation to affective and organizational commitment (Leiter & Maslach, 2004). In other words, though workload might not always have a direct effect on commitment, it might come to have a mediated or moderated influence on commitment via variables such as burnout.

Naturally, it might also be found that, even with the addition of extra mediators or moderators, workload may still come to exhibit no influence, direct or indirect, on commitment. In other words, the two concepts might exist simultaneously in organizations, and affect and be influenced by certain similar stimuli, but still not be associated with each other to a significant degree. This is likely due to the fact that these associations only provide partial explanations in the total variances of each other, meaning that commitment having an influence on intention to stay does not imply that it will also influence all other variables related to intention to stay. This is because these organizational and emotional concepts are shaped, influenced and moved by numerous factors that cannot always wholly be controlled for. In other words, there is a plethora of factors that directly or indirectly affect commitment (Griffeth et al., 2000). So the proposed inclusion of burnout, which is expected to be related to workload due to previous argued associations (Bakker et al., 2005; Blanc, 2001; Mojsa-Kaja, 2015) as a moderator or mediator of the relationship between workload and commitment may not be strong or meaningful enough to make workload become a factor affecting commitment for doctors working in health organizations in Turkey.

No mediation effect of affective or organizational commitment was found on the relationship between workload and intention to stay in the current study. This is because workload itself was found not to have a direct link with commitment,

dispelling any notions of possible mediation by affective or organizational commitment for the current research (Baron & Kenny, 1986).

As a result of the findings of workload and commitment with intention to stay, it could be said that, as the current research's findings also imply, doctors who are affected less by their workloads and more committed to their institutions are more likely to stay in their health organizations.

6.3 Emotional labor

In consideration of the antecedent of emotional labor, the management literature argues that it is negatively associated with affective and organizational commitment (Le Blanc, 2001). As employees try to display feelings that are contrary to their dispositions and current emotions, the energy they spend on these effort leads to emotional exhaustion and dissonance (Hoschild, 1983), ultimately negatively affecting their commitment. It is found in the current research that as emotional labor of doctors working in health organizations increases, so does their organizational commitment. In terms of explanation power, though, the results of the current study show that emotional labor accounts for a small percentage (below 5%) of the total variance explained in organizational commitment for doctors in health organizations in Turkey. This positive association is contrary to relevant literature in that the probability that emotional labor, which exhausts and drains individuals emotionally and physically, increases their organizational commitments is unlikely. However, once the finding is exposed to deeper investigations in related service and health literature, it is seen that the positive association between emotional labor and organizational commitment may not be as conflicting and unlikely as it at first seems to be.

Additional analyses indicated that only one dimension of emotional labor, namely deep acting, was significantly and positively related to organizational commitment. The literature on emotional labor states that it is generally associated with emotional dissonance. However, there are contrary cases where employees, as they genuinely feel the emotions they display, do not need to fake their emotions in order to display conflicting feelings. This is due to the fact that emotional labor is argued to be context dependent (Heuven & Bakker, 2003). These contrary cases can occasionally occur via passive deep acting (Ashforth & Humphrey, 1993; Zapf, 2002). They are more likely to occur, though, via deep acting, which is a component of emotional labor, where one pumps up oneself to align his or her feelings with those that are appropriate to be felt in socially and organizationally applicable environments (Hülsheger & Schewe, 2011). Emotions requested to be displayed by organizations, if they are in line and compatible with employees' affective dispositions and self-expectations, are adopted more easily, and likely without negative psychological consequences (Brotheridge & Lee, 2003). Relevant literature also states that deep acting, as the alignment of felt and expressed emotions, is negatively related to depersonalization and positively associated with role identification. This is because it might result in people feeling authentic during their interactions and experience a sense of personal accomplishment at work (Lee et al., 2010). In terms of role identification, if employees feel that the display of emotions expected of them in their organizations are parallel to their personalities and roles, they may engage in deep acting and try to feel these emotions themselves (Hülsheger & Schewe, 2011). This is because they consider the output of these emotions as a part of their roles which they identify themselves with. This process which can be considered to be a social act executed for the benefit of others in the environment

(Domagalski, 1999), does not lead to emotional exhaustion, strain or dissonance (Vijayalakshmi & Bhattacharyya, 2012). Moreover, the greater employees identify themselves with their roles, the more likely they are to internalize the feelings they ought to display via deep acting. This results in a self-reinforcing cycle of role identification leading to increased deep acting, which in turn reinforces the role identification for these employees (Brotheridge & Lee, 2003). The greater an employee perceives himself or herself to be in congruence and alignment with his or her job, the greater the resulting engagement with one's work will be (Leiter & Maslach, 2008). Role identification contributes to this alignment process as well in that as employees identify themselves with their roles, the process of internalizing requested feelings is likely to become smoother for them, since it is easier to adopt emotions that are felt for longer periods of time (Pugh, 2001). This process can also be referred to as emotional harmony, where employee emotions are set in line with the expected feelings they are required to display (Vijayalakshmi & Bhattacharyya, 2012). Emotional harmony allows healthcare employees to be able to show a variety of emotions, both positive and negative, as the situation they find themselves in deems appropriate. As they frequently use emotional expressions (Pugh, 2001), this results in beneficial outcomes such as reduced physical symptoms and decreased depersonalization, leading to better relations with patients, favorable and reciprocal patient responses, more adherence to treatments and so improved patient outcomes (Lee at al., 2010).

The results of the current study show that emotional labor is significantly and positively correlated with organizational commitment and its dimension of normative commitment. The deep acting dimension of emotional labor is also significantly and positively associated with organizational and normative commitment. For doctors

working in health organizations in Turkey, emotional labor seems to be a factor which fosters their organizational commitment towards their institutions rather than diminishes it. This likely occurs because of the process of deep acting, where doctors, rather than forcing themselves to fake emotions required to be shown by their hospitals, internalize their organizations' values, norms and requested feelings. This is because it is argued that employees committed to their organizations more easily accept its norms and values (Mowday et al., 1982). Thus, doctors align their feelings with the organizationally required ones as a consequence. This alignment allows them to better identify themselves with their roles and acknowledge that the feelings requested to be displayed organizationally are meaningful parts of their jobs. This then neutralizes the negative results of emotional labor, and enables doctors to feel important and competent in their jobs. This implies that in health organizations in Turkey, institutional norms and values may not be in dire conflict with those of their employees. They may in fact be fitting for their employees' dispositions and personalities, hence easing the acceptance of these norms by employees. As employees become more accustomed to these institutional norms and customs, their behavior becomes more natural and genuine. They see the results of this authenticity as positive responses from their patients and peers in social and organizational interactions. This is because the more heartfelt the displayed emotions of the doctors are, the better they are likely to be perceived by their patients and peers (Vijayalakshmi & Bhattacharyya, 2012). This process of the acceptance of organizational norms, internalization of appropriate feelings and positive feedback from their peers and patients potentially enables doctors to feel more at ease and satisfied in their organizations, arguably increasing their affective and normative commitments, and so organizational commitments towards their organizations.

It can thus be argued that individuals are more likely to be affectively attached to their organizations if they internalize the norms and values of the organizations they work for through the deep acting dimension of emotional labor (O'Reilly & Chatman, 1986). By becoming more committed to their institutions based on shared values, they strive to work for the success of their organizations, and by doing so they also come to adopt behaviors consistent with their own feelings and values, thus increasing their affective commitments towards their organizations (Meyer & Allen, 1991). Internalization of norms and values also plays a role for organizational commitment in that this internalization leads to the occurrence of feelings of obligation to remain with the organization, thus increasing employees' normative commitment towards their organization (Wiener, 1982). Moreover as one starts to behave and act in a certain manner, even if this behavior is contrary to how he or she feels or is in the mood for, this behavior starts to affect the individual such that he or she starts to feel the emotions which the these actions lead to, such as becoming happier when in a sour mood as a result of forced smiling (Doherty, 1997). In other words, people can find themselves in self-reinforcing cycles of emotions and behaviors. As they act in a certain way, they come to feel the emotions associated with their actions, and as they continue to feel emotions relevant to these actions, they start to behave more in this manner to enhance the related resulting feelings. This occurs due to the fact that emotional expressions and feelings are likely to continuously and reciprocally supplement each other (Hatfield, 1994). This means that as doctors internalize the feelings they are expected to display, their emotional expressions also follow suit and become more genuine and natural. This is due to the fact that there is no longer a discrepancy between their felt and displayed emotions. Thus, the more authentic their emotional expressions become, the better they are

perceived by the patients (Doherty et al., 1995), since internalized feelings are the most vital predictors of emotional displays (Pugh, 2001). As doctors display the appropriate emotions when interacting with their patients, their evaluation by their patients becomes more positive, yet when they act inappropriately, the reactions of their patients may be discouraging. These evaluations of patients become more positive if they perceive that the display of emotions presented by doctors is sincere and authentic (Vijayalakshmi & Bhattacharyya, 2012). What may encourage and strengthen this self-reinforcing cycle even more are the reactions people observe when they act in these ways. Doctors who display the appropriate emotions in interactions with their patients receive positive feedback, while those who show inappropriate feelings are evaluated in a negative light, and in this regard, it has been found in the health sector that doctors that are relatively more sensitive to the emotions of their patients are likely to be more successful than their peers (Doherty et al., 1995). These reactions, for doctors, may act as rewards and punishments from patients, respectively. Via operant conditioning, the reactions of doctors' patients can influence their behavior such that the more positive reactions they get from their patients by showing the appropriate emotions in their interactions (positive reinforcement), the more they will continue to display the requested feelings. Similarly, the more negative evaluation they receive from their patients, due to display of inappropriate emotions (positive punishment), the less they will engage in the display of unsuitable feelings (Hergenhahn & Olson, 2003). In other words, the more doctors display organizationally requested feelings and receive positive feedback from their patients, the more they will internalize these feelings and so be encouraged to continue to show them.

It could also be argued, in terms of the relationship between emotional labor and organizational commitment, that people who are already dispositioned to help others and act in the appropriate ways in communicating with them choose their professions accordingly. Or, that these people, as a result of the vigorous training they go through as a part of their occupations, become accustomed to displaying the appropriate feelings as necessary when interacting with their customers and colleagues. It may also be that these processes are not independent of each other, and affect one another in a reciprocal manner (Doherty et al., 1995). People may choose to become doctors based on their personalities, and as the circumstances and context of the job they choose shapes them further in a manner parallel to their dispositions, they become even more accustomed to being as they are meant to be in their jobs. This thus decreases effects of emotional labor they are likely to suffer from in their jobs (Pugh, 2001).

6.4 Organizational commitment

In terms of attitudes, affective commitment is one of the most commonly researched factors associated with intention to stay (Cotton & Tuttle, 1986; Cohen, 1993; Griffeth et al., 2000). Intention to stay is significantly and positively affected by an employee's commitment to his or her organization (Cohen, 1993). It is a negative indicator of turnover and turnover intention (Meyer et al., 2002). The findings of the current research confirm the literature on the positive relationship between commitment and intention to stay (Griffeth et al., 2000). The more employees are committed to their organizations, the more their intentions to stay in these organizations become. In this specific case of doctors working in hospitals in Turkey, organizational commitment explains more than 30% of the total variance in their

intention to stay with their current employers. It must be noted here that the type of organizational commitment to be promoted matters as well (Meyer & Allen, 1991; Meyer et al., 2002). This issue is discussed in more detail below. The findings of the current study are also in line with Social Exchange Theory in that the more positive experiences health organizations provide to doctors, the more doctors become attached to their institutions. This results in a reciprocal and mutual beneficial exchange (Emerson, 1976; Gouldner, 1960).

The type of organizational commitment to be promoted in organizations is important. As a type of commitment, affective commitment stems from employees feeling physically and psychologically comfortable in their organizations, and competent and important in their work roles (Steel & Ovalle, 1984). When employees go through work experiences that are parallel to their own dispositions, such as fulfilling their needs, utilizing their abilities and expressing their values, they are more likely to develop positive work attitudes, which in turn lead to affective commitment towards their institutions (Meyer & Allen, 1991). People who are affectively committed to their organizations will be more likely to spend effort to contribute to them, and so potentially perform better (Meyer et al., 2002). It is also discussed in related literature that though affective and normative commitment are separate concepts, there exists an overlap between them, in terms of their antecedents and effects (Cohen, 1993). Continuance commitment, on the other hand, is relatively separate from both of the other components of organizational commitment (Allen & Meyer, 1990). Similar to affective commitment, normative commitment also likely leads to exertion of effort on behalf of the organization and so better performances by employees (Meyer & Allen, 1991). Affective and normative commitment are positively associated with job performance, positive work experiences and

organizational citizenship behavior (İnelmen et al., 2010), whereas continuance commitment is either unrelated or negatively correlated (Meyer at al., 1993) to these outcomes. It is thus argued that in certain situations, it may be difficult to distinguish between affective and normative commitment, whereas continuance commitment is clearly and visibly different from them (Meyer & Allen, 1991). In fact, the same positive associations between affective and normative commitment exist in their occupational counterparts as well (Meyer at al., 1993). One reason for this positive correlation is that these two components of commitment share certain antecedents, such as going through positive work experiences, which leads to a sense of obligation and affective attachment towards one's employer. These two types of commitment are also both positively related to desirable organization or occupation relevant outcome variables, behaviors and behavioral intentions, and are negatively associated with undesirable behaviors (Meyer at al., 1993). Affective commitment and normative commitment are stated to be two of the most important factors that matter to a great extent in organizations (Meyer et al., 2002) for service and healthcare professionals. The literature also states that in the healthcare sector, as continuance commitment increases, affective and normative commitment decrease (Meyer at al., 1993). This is due to the fact that affective and normative commitment are argued to be positively correlated with long-term healthcare career establishment intentions, while continuance commitment is negatively associated with them.

The findings of the current research confirm the discussions in relevant literature on affective and normative commitment as well. Both are found to be significantly and positively associated with intention to stay. They are also found to be significantly and positively correlated with each other. This implies that doctors who go through positive experiences throughout their jobs which are in line with

their dispositions and internalize the working standards of the organizations they are employed in feel comfortable, competent and important in their jobs, develop positive work attitudes towards their jobs, spend serious effort to contribute to their institutions, and so become more committed to them. This results in an increase in their intentions to stay with their current employers (Cohen, 1993). Continuance commitment, on the other hand, is not correlated with contribution to or exerting effort for the organization (Meyer et al., 2002). This is due to the fact that the effort required to be able to remain with their current organizations due to necessity is generally at a basic level and does not demand extra effort from employees. In other words, employees who experience continuance commitment towards their organizations will likely only do the bare minimum amount of work, since this potentially will allow them to remain in their institutions as long as necessary. Continuance commitment is also negatively associated with organizational citizenship behavior (Meyer & Allen, 1991), and has a negative relationship with affective commitment (Meyer et al., 1993). The results of the analyses conducted in the current research confirm the arguments in related literature. Continuance commitment is found to have a significant and negative association with affective commitment, and is not related to intention to stay.

It is stated in related literature that continuance commitment occurs as a result of cumulative perceived costs related to leaving the organization. These costs increase either when employees expect that their investments will be lost or useless if they leave the organization, or when they presuppose that potential job alternatives are not available to them. They thus choose to remain in their jobs due to necessity (Allen & Meyer, 1990). However, an alternative discussion is also raised by researchers, stating that employees who make investments in gaining transferable

skills in their organizations might be more prone to leaving their organizations (Meyer & Allen, 1991). This is because they believe that their skills will be useful for whatever employer they work for, guaranteeing that the resources they spent on gaining them hasn't been in vain. Also, due to the transferability of their skills, it will likely be easier for them to find new jobs and positions in new institutions. Building on the arguments provided in related literature on continuance commitment, the current research's findings on its negative association with affective commitment and insignificant relationship with intention to stay can potentially be explained. First of all, while affective and normative commitment are positively associated with long-term healthcare career intentions, continuance commitment is negatively associated with them (Meyer at al., 1993). For doctors, whose careers require continuous extensive studying, take a long time to build up, require dedication and occupational commitment, and include intense workloads (Miller et al., 1990; Xiaoming et al., 2014), it is unlikely that they will embark on such arduous journeys with short term career intentions in mind. On the contrary, being a doctor is one of the few occupations which is considered to be a lifelong journey, similar to being an academician. Thus, continuance commitment's insignificance for the intentions of doctors to remain in their organizations for the current research can likely be understood. Also, continuance commitment stems from necessity and relies on the satisfaction of minimum requirements to be able to stay on the job (Meyer et al., 2002). Being a doctor almost always requires one to exert more effort than the job or organization requires, as clients in this case do not demand satisfaction for their higher order needs but for their most basic, crucial and vital hygiene factors: their health (Herzberg, 1968; Maslow, 1943). Hence, to satisfy these needs, doctors need to go through the challenging processes that surpass and move beyond the basic

requirements of the job. This makes it meaningful that continuance commitment remains obsolete in the explanation of their intention to stay in their organizations. The study thus argues that they do not intend to remain in their organizations because they need to remain, they do so because they are affectively and normatively committed to them. Moreover, continuance commitment can also stem from associated costs of leaving organizations due to accumulated investments on oneself (Meyer & Allen, 1991). For doctors, this argument may be arguable, since they can use their knowledge and skills in any hospital or health organization they choose to work for. In other words, since their skills rely largely on their abilities and dispositions, and so are transferrable, they can be utilized in any organization they choose if they intend to leave (Meyer & Allen, 1991). Therefore, they are less likely to be concerned about perceived costs of leaving their organizations compared to employees working in other sectors. The current study shows that intention to stay of doctors in the current study, working in health organizations in Turkey, are associated with affective and normative commitment, and not continuance commitment. In other words, doctors who want to remain in their institutions do so because they feel emotionally attached and obligated to contribute to their organizations. Moreover, perceived costs of leaving these organizations do not affect their intentions to stay in their institutions due to the transferability of their obtained skills. Naturally, other reasons such as prestige or better administrative duties may also play a role here.

6.5 Mediation of organizational commitment

The current study is unable to find a mediation effect of affective commitment on the relationship between workload or emotional labor and intention to stay. One major

reason for this is that workload and emotional labor are found not to be significantly associated with affective commitment. Moreover, intention to stay is one of those concepts that is prone to be influenced by a variety of personal, social and organizational factors (Cohen, 1993).

The fact that no mediation is found has ramifications in terms of Social Exchange Theory as well. The findings of the study show that the commitment of doctors to their organizations are not detrimentally affected by organizational stressors to a large extent. As such, the findings of the current research show that what determines doctors' intentions to stay in their organizations to a significant extent is their affective and organizational commitment. This finding can be discussed in two perspectives. The first perspective is that doctors, as an occupational group, are aware that regardless of wherever they are employed, their workload will be above a certain level. This is because the occupation itself has certain requirements that are to be met. These can be frequent interactions with patients, constant self-updating on new medicinal theories and applications, dealing with emergent situations, unpredictable shifts, teaching their assistants and students, and where applicable administrative duties. Therefore, doctors may believe that their workload will more or less be the same regardless of the institution they work in. Hence, their commitments towards their organizations may not be affected to a significant extent by their workload.

The second discussion is that since their intentions to stay in their organizations largely depends on their affective and normative commitments, as the study finds, they may come to see some parts of their workload not as burdens. In other words, they may believe that the purpose they serve as an occupational group, which is healing others, may trump all other aspects of their jobs. This means that

they may be prone to considering parts of their workload, namely those that contribute directly to this healing process, such as patient visits, specialist training and medicinal literature and application updates, as necessary evils for the grander purpose they serve. As such, they may not put much emphasis on their workloads, since it contributes to their healing services to those in need.

It is found that organizational commitment accounts for more than a third of the total variance explained in intention to stay for doctors in health organizations in Turkey. This means that two thirds of this variance is still unaccounted for. This implies that for doctors employed in health organizations in Turkey, emotional labor, though it affects their organizational commitment to a degree, may not be a pertinent factor influencing their intentions to stay. It could be that affective or organizational commitment potentially plays a mediating or moderating role on the relationships between other factors, such as job security or perceived job security (Zeytinoğlu et al., 2012), and intention to stay. It could also be that factors other than affective and rganizational commitment, such as burnout or emotional dissonance (Bakker et al, 2001; Bakker et al., 2005; Le Blanc, 2001), play a mediating or moderating role between emotional labor and intention to stay.

6.6 Susceptibility to emotional contagion

Emotional contagion and the susceptibility to it may have potential roles to play in the relationship of emotional labor, and especially its deep acting dimension, with organizational commitment. In terms of findings of the current research, deep acting is found to be is positively and significantly related to susceptibility to emotional contagion. It is argued in relevant literature that emotional contagion can be a desirable trait, as it is likely to increase empathic concern, altruism, self-esteem and

communication skills (Doherty, 1997; Omdahl & O'Donnell, 1999), and foster social interactions (Rempala, 2013). How patients come to feel as a result of these interactions with their doctors thus influences their opinions on doctors and the service they receive (Pugh, 2001). Exposure to other people's emotions, positive or negative, produces corresponding feelings in the parties involved in the interaction (Hatfield et al., 1994). In this case, doctors, as they receive feedback from their patients, come to be affected in alignment with the emotional direction and intensity of these feedbacks, and so adjust their own feelings and internalize them accordingly via deep acting (Pugh, 2001). This understanding of other people's feelings allows doctors to shield themselves from emotional stressors which may potentially lead to burnout, such as alienation and depersonalization (Doherty, 1997). The same process may work for patients as well. As patients comprehend the emotional displays of their doctors as pleasant or inauthentic, they also change their own emotional responses. By the continuous exchange of emotions and expressions via emotional contagion and the susceptibility to it, this process becomes one of fostering reciprocal positive feedbacks and internalizing emotions that result in positive reactions from doctors and patients towards each other (Pugh, 2001). In other words, the more doctors are prone to being influenced by emotions of others around them, the more they may be likely to engage in deep acting to internalize organizationally appropriate emotions (Laird et al., 1994) in order to manage their responses to these external feelings occurring in their interactions with their patients and colleagues. Emotional contagion and the susceptibility to it can also play a role between doctors themselves. This means that the less experienced doctors who follow suit in pursuit of their more experienced counterparts take them to be their role models, especially in the health sector (Martini et al., 1994; Xu et al., 1995). They may thus come to

observe and consciously or unconsciously mimic their emotional expressions and behaviors, and internalize similar norms and values as (Bakker et al., 2015). In other words, the more susceptible doctors are to emotional contagion, the more they will likely be affected by and so synchronize with their colleagues, making them become more like them. As such, the ongoing system of internalization and reciprocal emotional contagion continues to endure as a result.

This discussion implies that susceptibility to emotional contagion, due to its positive relationship with deep acting, may be considered to be a correlate of deep acting in health organizations. In other words, as deep acting potentially increases susceptibility to emotional contagion, this vulnerability to the feelings of others may also increases deep acting. Naturally, this is only a proposed relationship which must be further studied to be confirmed.

6.7 Moderation of susceptibility to emotional contagion

As can be expected, considering emotional contagion and the moderator of susceptibility to it, emotional occurrences in organizations may not always result in reinforcing and beneficial possible results. This is because they include not only the transfer of positive emotions, but the transmittance of negative ones as well. It is stated in relevant literature that emotional contagion may not always lead to empathy and understanding, and in situations of frequent exposure to negative emotions, can result in emotional and psychological distress. In fact, it may even lead to a diminishing in an individual's tendency to help others (Rempala, 2013). So, emotional contagion can be beneficial or detrimental to people's emotional states depending on its intensity, direction and context (Le Blanc et al., 2001). This is due to the fact that, though emotional contagion can foster socialization, it may also make

people more vulnerable to suffering from negative emotions of others. It is in fact observed that people are more likely to experience emotional contagion in situations of frequent and intense negative emotional stimuli than those of positive ones (Doherty et al., 1995; Rempala, 2013). In the health sector, this may be somewhat prevalent, especially in situations where health personnel have to care for terminally ill patients for long periods of time. This is because experiencing frequent and intense emotional demands is likely to make people more vulnerable to job stressors and interpersonal ones (Lee et al., 2010). This likely results in emotional exhaustion, strain and depletion, which may then lead to burnout (Bakker at al., 2005; Omdahl & O'Donnell, 1999). Moreover, the process of emotional contagion takes place not only between patients and caretakers, but between health personnel themselves. This may lead to emotionally depleted doctors affecting their colleagues, even if inadvertently, in detrimental manners (Bakker et al., 2001). The more doctors spend time with other health personnel who are emotionally drained, the more likely they are to be affected by their negative emotional and psychological states (Le Blanc et al., 2001). Regarding the issue of burnout, it is found for the health sector that doctors' susceptibility to emotional contagion is positively related to burnout, specifically when they are perceptive of the symptoms of burnout among their colleagues (Le Blanc et al., 2001). In fact, doctors focusing on the problems of their peers while trying to boost their morale may end up becoming more emotionally exhausted themselves. This is due to the proposed strength of negative feelings, attitudes and behavior over positive ones in emotional transactions (Bakker et al., 2005; Doherty et al., 1995; Hatfield et al., 1994). If doctors cannot maintain an emotional balance between understanding emotional states of their patients and colleagues, and being affected to a major extent by their emotional fluctuations, and

if they cannot at times be able to distance themselves from their patients and peers by tuning out when necessary (Doherty et al., 1995), they may be influenced to such a degree that their performance is detrimentally influenced. This occurs due to their susceptibility to emotional contagion. As a result of this processes, doctors may face physical and emotional exhaustion, form negative attitudes towards their jobs (Bakker et al., 2001; Bakker et al., 2005), and even come to feel diminished commitment towards their occupations within which they go through these negative and emotionally draining experiences (Omdahl & O'Donnell, 1999). These negative attitudes, if emotionally exhausting interactions continue at length, may lead to the formation of detrimental feelings and behavior in doctors towards their peers and patients. This is because as emotions and actions spread among their colleagues through emotional contagion, depending on individuals' susceptibilities to it, they may come to affect not only doctors as individuals but whole units and departments as well (Bakker et al., 2005). In other words, emotional contagion may have observably inhibiting effects if not cared about and proactively controlled for in health organizations.

Regarding susceptibility to emotional contagion, the current study finds that it has a moderating effect on the relationship between workload and affective commitment. This means that doctors susceptible to the effects of emotional contagion, as they get affected by workload, are likely to be negatively influenced in terms of their affective commitments towards their organizations. This finding is in line with the Job Demands-Resources Model (JD-R) in that people with higher susceptibility to emotional contagion are effected more detrimentally by the consequences of contextual and interpersonal demands, which are workload and emotional labor, respectively, for this study (Lee et al., 2010).

The findings of the current study can also help determine the direction of this effect. In other words, the findings of the current research show whether this influence is more likely to result from positive or negative emotions, since it is found that the negative affect factor of susceptibility to emotional contagion, which refers to people's vulnerabilities towards the catching of negative emotions around them, has a moderating effect on the relationship between workload and organizational commitment. In other words, doctors who are more prone to being influenced by negative feelings within their environments, as they suffer from workload, are more likely to become less organizationally committed towards their organizations. This occurs through emotional contagion. This implies that the degree of susceptibility to emotional contagion, especially to negative feelings, of doctors, affects the extent to which their organizational and affective commitments towards their institutions are influenced by how much they are affected from workload. The more vulnerable doctors are to the emotional contagiousness in health organizations, and resulting negative emotions, the more likely the detrimental effects of workload is to lead to decreased affective and organizational commitment for them. This finding confirms the literature on emotional contagion in that harmful effects of emotional contagion can increase the extent to which individuals are influenced by the job and interpersonal stressors in their environments (Lee et al., 2010). This weakens their own emotional and psychological states, and decreases their commitments towards their organizations where they experience these negative consequences (Miller et al., 1995; Omdahl & O'Donnell, 1999; Siebert et al., 2007; Wright & Cropanzano, 1998). This implies that susceptibility to emotional contagion likely plays an inhibiting role for individuals' commitments towards their organizations by

moderating the extent to which people are affected from the intensity and consequences of their workload.

In terms of other associations with the moderator of susceptibility to emotional contagion, workload is found to be positively and significantly related to susceptibility to emotional contagion and negative affect factor. This implies that since workload is an important predictor of emotional exhaustion and burnout (Bakker et al., 2005; Mojsa-Kaja, 2015; Le Blanc, 2001), as people's workloads increase, they tend to become emotionally drained, and may not have enough time to attend to themselves in order to improve their mental states. As such, they are likely to become more vulnerable to being influenced by the emotions of others around them, including the negative ones. This as a result likely increases their susceptibility to emotional contagion. In other words, in terms of health organizations, workload may potentially be considered as an antecedent of susceptibility to emotional contagion, although this is a finding that needs further research in order to be theoretically and practically validated.

6.8 Professional Socialization Theory and professional control perspective

One reason for the somewhat unconventional findings obtained in the current research could be that there is a difference between occupations and professions. As such, a similar distinction can also exist between formal organizations and professional organizations. This is because while formal organizations tend to mostly contain occupational positions, professional ones include mostly professional ones. Therefore, Weberian approaches may come to possess little hold on organizations dominated by professionals (Bucher & Stelling, 1969). As such, the Theory of Professional Socialization is developed (Bucher & Stelling, 1977).

Bucher and Stelling (1969, 1977) argue that being a professional implies an honorific status that arises from interactions with specific audiences. It thus refers to status of an individual in a particular occupational position. Doctors, attorneys, teachers, scientists and engineers are considered as professionals in relevant literature (Hoff, 2001). Professionals are special employees who have an extensive education and specialization. This specific training allows them to obtain spaces for their own demands and discretion, making them relatively unaffected by management or administration in their organizations (Young, Charns, & Heeren, 2004). It also creates differences between them and other employees in that professionals tend to have more control within the work they do than other types of employees. This is because professional organizations contain individuals with specialized training who are likely to be members of different outside communities as well. These external communities have their own norms, procedures and policies, which define the boundaries of the work professionals conduct in their organizations (Sharma, 1997; Wallace, 1995). As such, professionals tend to have higher autonomy and control in their work compared to other employees. It is also argued that they place high value in their freedom to be able to, to an extent, control the work they do and the space or environment they function in (Young et al., 2012). Moreover, even when professionals are employed in positions other than those in professional organizations, they are still considered and treated as distinct employees (Heckman, Bigley, Steensma, & Hereford, 2009; Pratt, Rockman, & Kaufmann, 2006; Wallace, 1995). Regarding the current study, doctors can be considered as an example of professionals in health and other relevant organizations via their autonomy, independence and control over the work they do and how they perform their jobs (Young, Beckman, & Baker, 2012).

Bucher and Stelling (1969, 1977) state that there are three major properties that separate professionals from other employees. The first property is that the professional claims to be competent in specific areas of expertise. The extent to which this claim is accepted determines the professional's power and authority in an organization. Here, authority is defined as the ability to lead others to make voluntary decisions and act accordingly towards one's goals. Power, on the other hand, refers to reputation among colleagues and holding key organizational positions. The second characteristic differentiating professionals from other employees is that the acknowledgement of a professional's expertise claim only holds for certain areas of work and may not be reflected to others. The third property is that the acceptance of a professional's expertise claims is not a onetime process. Rather, the professional has to continuously keep oneself updated so that his or her expertise can be maintained to be in a sufficient level throughout his or her employment in an organization. Only then can one's expertise claim can be acknowledged for his or her employment through socialization by one's peers in an organization.

Bucher and Stelling (1969, 1977) mention that professionals differ from other employees in terms of behavior as well. The professional has more at stake regarding the outcome of his or her efforts in an organization. This is because one's efforts and resulting accomplishments directly affect one's professional career. As such, one's recognition and reputation are directly at stake. On the contrary, with other employees, their stakes mostly have to do with their convenience and comfortability in their jobs rather than success. In other words, the career success of professionals depends on their ability to control their working conditions. For other employees, however, their career rests on the extent to which they can accept and adapt to working conditions set by their organizations.

At this point, the current study's findings regarding workload and emotional labor, and their limited influence on organizational commitment and intention to stay, can be explained via the professional organizations perspective. The approaches by conventional theories towards organizational stressors mainly include the ability of an individual to be able to overcome them via resistance or adaptation. Professionals, however, are those individuals who have a direct effect on determining their own physical and emotional loads. Therefore, Social Exchange Theory comes to have a restrained effectiveness in explaining professionals and professional organizations. This is because it emphasizes people's responding behavior to organizational factors, whereas for professionals, these factors are partially determined by themselves. In other words, while Social Exchange Theory concerns interdependent interactions, professionals tend to be more independent than interdependent in terms of their positions in their organizations.

Professionals are argued to rely on intrinsic motivation to a major extent in their professions. They derive job satisfaction from the task itself without immediate consideration for external rewards or punishments (Young et al., 2012). Here, intrinsic motivation occurs as a function of one's sense of autonomy with respect to his or her work or activity. In other words, it implies a feeling of choice in choosing and maintaining one's activities at work (Deci, Connell, & Rayn, 1989). As such, external stimuli can only become effective in influencing doctors if they are in line with their values, thus adding to their intrinsic motivations. Emotions thus become important for doctors because without a feeling of autonomy, comfortability and independence at their work and in their organizations, and also stimuli enhancing these feelings, their performance is likely to suffer (Deci, Koestner, & Ryan, 1999; Deci & Ryan, 2000; Frey, 1997; Frey & Jegen, 2001). This is because professionals'

responses to organizational factors depend largely on their perceptions of these stimuli curtailing their autonomy, independence and control (Young et al., 2012). This shows that it is important to satisfy both the emotional and psychological needs of professionals as well as their material ones (Young et al., 2002).

The importance of senses and emotions for doctors points to another reason for the potential misfit between traditional theories, such as Social Exchange Theory, and professionals and their organizations. This is because traditional theories and models largely do not incorporate professional dispositions and attitudes towards organizational incentives or punishments. In other words, professionals assess and evaluate organizational stimuli, both tangible and intangible, based on how these stimuli correspond to their own professional values (Young et al. 2012). Therefore, their dispositions come to influence their attitudes towards organizational factors, ultimately affecting their intrinsic motivation and behavior. In the context of the current research, susceptibility to emotional contagion can be considered as a potential disposition affecting doctors' resilience or vulnerabilities towards emotional stressors in their organizations. As such, it affects the extent to which doctors are affected from the effects of organizational stressors, workload in this case, and how this influence changes their attitudes towards their organizations, implying organizational commitment,

At this stage, Professional Control Perspective can be adhered to in order to explain the emotional reactions people show to organizational stimuli in their work. The basic premise of this perspective is that professionals' values and norms can significantly change the effects of organizational stressors and incentives (Kunz & Pfaff, 2002). In other words, the motivational effects of organizational incentives will depend on the professionals' attitudes toward the incentives relative to their

professional values and dispositions. Moreover, professionals will be more prone to work to accomplish organizational goals if they believe the vision and mission of their organizations to be in line with their own values, aims and goals (Locke, Latham, & Eres, 1998; Wright, 2007). This is because goals derive their significance from the legitimacy of the authorities who assign them (Locke & Latham, 2002). For professionals, this legitimacy comes from the values, norms and standards of their professions. Therefore, organizational interventions, requests and suggestions are likely to create changes in professionals' intrinsic motivations only when they are perceived to be related to professionals' standards, norms and values (Frolich, Talvera, Broadhead, & Dudley, 2007). Professionals, then, who perceive organizational actions as in line with their own values, will feel more competent to follow them, and so become more likely to internalize them as a result (Ryan & Deci, 2000). This will in return increase their intrinsic motivations, and likely performances in their professional organizations (Young et al., 2012).

Regarding the current study, the effects of workload and emotional labor on doctors' organizational commitment can also be investigated through the Professional Control Perspective. Workload, without the moderation of susceptibility to emotional contagion, was found not to be a major stressors in terms of doctors' commitments towards their organizations. This is likely due to the fact that doctors are relatively more able to determine their own workload than other types of employees. Moreover, the workload, however demanding or tight it may be, is ultimately there to help the patients (Bucher & Stelling, 1969). Therefore, the extent of workload which is partially determined by the professionals themselves, and its context focused on helping those in need is unlikely to clash with the feelings and values of professionals. Emotional labor, on the other hand, is found to positively

affect doctors' organizational commitments through deep acting. This also makes sense considering Professional Control Perspective in that internalization of organizational norms, the necessary feelings to be displayed in this case, becomes easier if they are in line with professionals' values (Young et al., 2012). Since showing the appropriate emotions to help patients become better is parallel to the professional values and norms of supporting and helping patients for doctors, it is found that emotional labor acts as an incentive rather than a stressor in this study. In other words, according to the findings of the current study and tenets of the Professional Control Perspective, doctors perceive organizational demands to show compassion and understanding towards patients as actions in unison with their values. They thus internalize these feelings, and become more committed towards their professional organizations as a result.

According to Professional Control Perspective, professionals' dispositions can play moderating roles between the perception of the effects of organizational incentives or stressors and attitudes towards organizations (Young et al., 2012). Considering the current study, susceptibility to emotional contagion is found to play a similar moderating role for the effects of workload on organizational commitment for doctors as well. One explanation for this can be that high resilience to being affected by the emotions of others, especially negative ones, helps enhance the sense of control and autonomy doctors feel in their professions. As such, they are affected to a lesser extent by the effects of workload in their organizations, and their commitments towards their organizations are not detrimentally affected (Lee et al., 2010). A similar argument can also be made for the opposite case where high vulnerability to negative emotions may result in the formation of a diminishing effect on doctors' feelings of independence and control. This may thus potentially point to

being more influenced by the consequences of organizational stressors such as workload, and as a result a decrease in doctors' organizational commitment towards their organizations.

Bucher and Stelling (1969, 1977) state that professional organizations, especially health organizations, have two primary attributes: role creation and negotiation. These properties coexist simultaneously in professional organizations. Role creation implies that when a professional is hired by an organization, his or her role may not be explicitly and clearly defined, and also may differ from that of the previous professional who held the same position. Therefore, a professional is inclined to initiate and develop his or her own standing and place in the organization, thus helping create the specific role he or she is expected to play. A professional then engages in socialization via bargaining and negotiation with other parties in the organization so that he or she can acquire the resources necessary to build his or her role. Schatzman and Bucher (1964) mention that there is a struggle between different professional groups in organizations for recognition, success and resources in this role building stage through negotiations. The reward for these struggles is argued to be autonomy and influence in one's professional role.

Considering negotiation, in relation to the current study, when Social Exchange Theory (SET) is considered, it can be said that while reciprocity rules focus more on social transactions, negotiated rules emphasize economic ones regarding resources (Cropanzano & Mitchell, 2005). It can thus be deduced that another reason for the limited applicability of Social Exchange Theory to professionals and professional organizations stems from the fact that while it focuses on reciprocity rules, professional organizations function more on negotiated rules and professional socialization (Bucher & Stelling, 1969, 1977).

Bucher and Stelling (1969, 1977) argue that the interaction of professionals with peers and patients is an important factor in negotiations and also the creation of professional identities. Here, the interacting individuals can be thought of as forming a team. In this context, a team implies people working together towards a common goal by personal contributions. As teams come together in professional organizations, segmentalization occurs. Here, interdisciplinary individuals and teams group together towards shared purposes and form segments. These segments are mostly not initiated by organizations, and as such result in conflicts over resources of the organization between the formed segments. This is because as individual values and interests differ, so do group ones. These resources can be budget, work space, personnel, curriculum placement and power to influence organizational policies. In terms of organizational policies, especially in health organizations, conflicts tend to occur because potential problems and solutions may differ among different professional segments. Therefore, conflicts and resulting struggles can occur between various professionals in their organizations regarding both tangible (e.g. workspace) and intangible (e.g. power) organizational resources.

Bucher and Stelling (1969, 1977) state that the organizational policy formation issue is specific to professional organizations because in other types of formal organizations, these policies are made by the management and employees are then expected to adhere by the norms set by the management. In professional organizations, however, professional segments may form their own norms, values and systems, and function within these determined norms. As such, policy formation and maintenance becomes a continuous process of political transactions. For health organizations, these processes can be staff meetings, health committees and legislations of chief medical personnel.

Considering the conflicts between professionals over resources, it can be argued that the Job Demands-Resources (JD-R) Model can be adhered to in this context by considering resources rather than demands. In other words, whereas the current study focuses on contextual and interpersonal demands, such as workload and emotional labor, respectively, a focus on organizational resources rather than demands may be more beneficial in health organizations. This is because while professionals, due to their authority and autonomy, can partially determine their own physical and emotional loads, they still have to struggle to take control of organizational resources. Their physical and emotional wellbeing, and so relevant attitudes are likely to be influenced by this potential effort to continuously struggle for resource control. The Job Demands-Resources Model can thus be used to assess the extent to which professionals' attitudes are affected from intergroup conflicts and resulting effort spent for the control of organizational resources.

6.9 Turkish service and healthcare context

The variables of workload, emotional labor, organizational commitment and intention to stay are found to be studied in the Turkish service and healthcare sectors in various times and researches within relevant literature. However, these variables have not been analyzed together in consideration with their relationships in the context of the current research. It is discussed in these studies that the service and healthcare sectors in Turkey are labor-intensive and people-oriented. It is also stated that infrastructure and resources in these sectors are somewhat limited, while demands are high and ever growing (Cam, 2001; Mollahaliloğlu, Metin, Kosdak, & Uner, 2015). It is also stated that job descriptions are not as clear as they should be

(Yıldız, Ayhan, & Erdoğmuş, 2009), and there is a lack of support from peers and supervisors (Alimoglu & Donmes, 2005) in service and health sectors in Turkey.

When considering the current study, one must keep in mind that it is conducted with health personnel working in hospitals, meaning that its participants and their organizations are at the heart of the health sector in Turkey. One of the most unique characteristics of this sector should not be overlooked, which is treating people and saving lives. Health personnel are likely to be aware that most of their actions and behavior at work, at some point, indirectly or directly affect the lives of people. This gives them responsibility and puts them in a special health relevant context in regard to other service sector employees. The case is even more intense for doctors, as they are expected and required to be the most knowledgeable and reliable people in their organizations. They are looked upon for making life and death decisions, and also communicating the results of those decisions, positive or negative, to their patients and families (Xiaoming et al., 2014). As such, the contents of their jobs can be considered to be the most vital and critical ones, as there is likely nothing carrying more importance to a person than his or her own health state, or those of their families and significant others. Health personnel, and especially doctors, go through their educational and professional lives with this fact in mind, and this most likely creates incomparable pressures and responsibilities for them (Mollahaliloğlu et al., 2015). This is because they are responsible for the health and wellbeing of all their patients, and are even expected to emotionally and psychologically support their patients, families and close ones as well (Lee et al., 2010). Thus, the findings of the current study would be better considered in light of these special properties of the health sector and employees working in it.

Workload in service and health organizations in Turkey is found to be relatively high (Kara et al., 2008; Mollahaliloğlu et al., 2015; Usubutun et al., 2011; Tay et al., 2014; Yaylak et al., 2014), including high patient loads for health personnel (Demir, Ulusoy, & Ulusoy, 2003; Yildiz et al., 2009). It is also observed to increase with tenure due to expanded administrative duties (Apaydin, 2012). Moreover, it is found to be positively associated with burnout (Calgan, Aslan, & Yegenoglu, 2011; Yurur & Sarikaya, 2012), stress (Ugurlu et al., 2015), depersonalization (Calgan et al., 2011; Cam, 2001; Yurur & Sarikaya, 2012), counterproductive work behavior (Bayram, Gursakal, & Bilgel, 2009) and turnover intentions (Demir et al., 2003; Yildiz et al., 2009; Yurumezoglu & Kocaman, 2015), and negatively associated with job satisfaction (Kocogly, Gurkan, & Aktas, 2014) for service and health personnel working in Turkey. As such, regarding the findings of the current study, it could be said that the negative correlation of workload with intention to stay confirms related literature's findings on this relationship for doctors working in health organizations in Turkey. This implies that higher workloads result in lower intentions to stay for doctors in Turkey.

Emotional labor, on the other hand, is found to be positively associated with neuroticism (Basim, Begenirbas, & Yalcin, 2013), emotional exhaustion (Basim et al., 2013; Iplik, Topsakal & Iplik, 2014), burnout (Akın, Aydın, Erdoğan, & Demirkasımoğlu, 2014; Altuntas & Altun, 2015; Bayram, Aytac, & Dursun, 2012; Cagliyan, Findik, & Doganalp, 2013; Toprak, Sercek & Karakas, 2015; Yildiz, Caglar, & Saglik, 2014) and depersonalization (Yildiz, Caglar, & Saglik, 2014). It is found to be negatively associated with job satisfaction (Anafarta, 2015; Gursoy, Boylu, & Avci, 2011), intention to stay (Anafarta, 2015), organizational commitment and person-job fit (Yurur & Mengenci, 2014), performance (Bursali, Bagci & Kok,

2014; Cagliyan et al., 2013) and sense of achievement (Yildiz, Caglar, & Saglik, 2014) for health and service employees in Turkey. The positive relationship between emotional labor and organizational commitment is somewhat contradictory to findings of relevant literature. Similar contradictory findings were also observed between emotional labor and job satisfaction (Iplik et al., 2014) and innovative job performance (Bursali et al., 2014) as positive associations in the service sector. As such, these findings should be considered in the context of service and health organizations and sectors. For health organizations in Turkey, doctors may be intended to believe that the norms, values and requested behaviors and feelings put forth by their organizations exist for providing the best treatments for their patients and optimal circumstances that allow health personnel to give the best care possible as quickly and efficiently as they can. This implies that doctors may be less prone to question the policies and structure of the healthcare system they are employed in. This is because, at the end of the day, impromptu violation of these norms or rules can result in other people living or dying in the healthcare sector. As such, it might be relatively easier and more meaningful for doctors, as they are fully in the know in terms of the significance of these norms, to internalize the values of their organizations via deep acting. This way, they likely become more committed towards their organizations (O'Reilly & Chatman, 1986).

It is also seen that for researches on emotional labor in the Turkish context, the results relating to intention to stay are somewhat contradictory. While in some studies emotional labor is found to negatively affect intention to stay (Anafarta, 2015), others, similar to the current study, do not find such a relationship (Toprak et al., 2015). This implies that the relationships between emotional labor, and

organizational commitment and intention to stay are prone to further research and investigation in the Turkish organizational context.

One other observation regarding the investigation of emotional labor in the Turkish context is that considering the execution dates of these studies, it can be seen that they are all conducted after 2010. This implies that emotional labor, as a research topic, is relatively new and fresh in terms of being considered for investigatory purposes. As such, the number of studies to reach generalizable findings seem insufficient and so is in a need of increase and expansion in terms of the investigation of emotional labor for Turkish organizations and employees.

Regarding affective and organizational commitment, they are found to be positively related to job satisfaction (Aydogdu & Asikgil, 2011; Gunlu, Aksarayli, & Sahin Perçin, 2010; Wasti, 2003a; Yucel, 2012; Zehir, Muceldili, & Zehir, 2012), intention to stay (Aydogdu & Asikgil, 2011; Bal et al., 2014; Calisir, Gumussoy, & Iskin, 2011; Wasti, 1999a, 1999b, 2005), loyalty (Wasti, 1999b), employee wellbeing loyalty (Wasti, 2009), organizational citizenship behavior (İnelmen et al., 2010; Wasti, 1999b), and promotion and relations with supervisors (Wasti, 2003a), organizational justice (Turgut, Tokmak, & Gucel, 2012; Yavuz, 2010), organizational culture (Yavuz, 2010) and organizational learning (Atak, 2010; Atak & Erturgut, 2010) for employees working in the service and health sectors in Turkey. A mediation of organizational commitment on the relationship between organizational factors and intention to stay, similar to the current study, is also tested for, yet not found (Karavardar, 2014). The cross-cultural generalizability of organizational commitment and its affective and normative dimensions are confirmed in the Turkish context as well (Wasti, 2002, 2003a, 2003b; Wasti & Özge, 2008). The notion that affective and normative commitment are distinct yet high

correlated constructs is also confirmed for Turkey (Wasti, 2005). Regarding the findings of the current study, it could be argued that the positive correlation of organizational commitment, and its components of affective and normative commitment, with intention to stay confirms related literature's findings on this issue. This implies that the more committed doctors are to their institutions, the higher their intentions to stay with their employers. Here, the properties of the healthcare sector may affect the rapidity of the development of doctors' commitment towards their employers. This is because their organizations are built with the sole purpose of helping people get better and prolong their lives. In other words, it might make relatively more sense to become committed to an organization whose solitary goal is to provide treatment to those in need for doctors employed in health organizations in Turkey. As such, affective and organizational commitment for countries like Turkey can best be identified as carrying both etic and emic aspects. This implies that findings regarding the Turkish concept can be generalizable to collectivist cultures, and also simultaneously specific to the Turkish culture, respectively (Wasti, 1999b).

A similar commitment, then, can also be expected from doctors towards their occupations as well. This is because the context and content of their jobs make them unique as potential lifesavers, so the inclusion of occupational commitment in further researches as a relevant variable can shed light and provide further insight into the relationship between doctors' affective and organizational commitment towards and intention to stay in their organizations.

Intention to stay in the Turkish context, considering its associations other than the one with organizational commitment, is found to be positively correlated with job satisfaction (Aydogdu & Asikgil, 2011; Calisir et al., 2011; Tutuncu & Kozak, 2007;

Sabanciogullari, & Dogan, 2015; Yildiz et al., 2009; Yucel, 2012; Yurumezoglu & Kocaman, 2015), organizational support, motivation, interest and lack of job alternatives (Yildiz et al., 2009), tenure (Yurumezoglu & Kocaman, 2015) and organizational career growth (Karavardar, 2014) for Turkish employees working in service and health organizations. On the other hand, emotional exhaustion and depersonalization (Yurumezoglu & Kocaman, 2015), and burnout (Toprak et al., 2015) are found to be negatively associated with intention to stay for employees working in service and health organizations in Turkey.

Emotional contagion or susceptibility to emotional contagion are found not to be investigated at all in Turkey, let alone in service and health organizations. This conclusion is reached in terms of publications in established journals and databases. One study is observed to test the validity and reliability of the translated version of the Emotional Contagion Scale (Doherty, 1997), and it is found that this scale is a valid and reliable measurement instrument for use in the Turkish context (Akin, Uysal, & Akin, 2015). This implies that the consideration of emotional contagion and the susceptibility to it requires a plethora of researches and investigations in order to be formed and developed as a literature area. As such, the current research will hopefully be a starting point in this aim.

The findings of the current study are crucial for one more reason, and it is that Turkey, in relevant literature, is argued to be a predominantly collectivistic (Wasti, 1999b) and developing country (Wasti, 2002) with a dynamic economy (Aycan, 2001). It is discussed to be rapidly going through a transition from a rural and patriarchal society to an urban and egalitarian society (Wasti, 1998). As an emerging market and developing country, Turkey has unique and unlikely dynamics of its own, in terms of economics, politics, policies and investments. Considering politics, the

country has been experiencing instability and conflicts, on and off, for decades, and the economic policies in this period have led to a relatively unstable economy, fluctuating markets and unpredictable crises, with high inflation, exceptional exchange rates, low wages, trade limitations, high unemployment -especially for educated people-, frequent price hikes and rapidly changing policies, and though these might be expected of a developing country (Wasti, 1998; Wasti, 2002), they nevertheless affect everyone living and working in Turkey. As such, they lead people to foremost seek stability in their lives (Zeytinoğlu et al., 2012). Also, these recurrent policy changes not only occur for economics but for all aspects of life including the most vital ones such as law, education and healthcare. Additionally, along with Albania, Montenegro, Serbia and Macedonia, Turkey is one of the few countries that adheres to the European Union norms but is not a member of it (Dülger et al., 2014). This creates even more dilemmas in terms of local and global economic policies and sanctions. All of these factors create an environment of social, political and economic unpredictability, and as a result relatively unstable job markets. As such, Turkey can carry contrasting properties when compared with the individualistic and more individualized context of the United States (Wasti, 2000).

Relating to the service and healthcare sectors, the frequent change of regulations in terms of laws related to health personnel affects doctors directly. Health insurance conflicts between public and private health institutions ever remain a current issue, as do policies regarding part-time vs. full time doctors. Low wages and limited resources for doctors working in public hospitals in Turkey are discouraging, and they influence the service quality presented in these organizations as well (Taner & Antony, 2006; Yesilada & Direktor, 2010). Moreover, the health sector in Turkey, partly due to foreign investments, has substantially grown over the

last decades, leading to the initiation of various new health organizations, mainly private, which creates an environment of competition in terms of wages and benefits among hospitals to obtain knowledgeable and specialized doctors. This creates opportunities for many doctors since, as mentioned, their skills are transferable, meaning that there exist relatively few perceived costs for leaving their organizations (Meyer & Allen, 1991). However, this also makes the situation in public hospitals more difficult, as it may potentially become more and more difficult for them to keep their doctors employed due to these reasons. These factors, though may be subject to discussion and create an environment of insecurity. As such, it is argued that job insecurity, rather than job security has become the norm in Turkey, especially in the service sector (Zeytinoğlu et al., 2012). Combining all these factors, one would imagine that doctors, with transferable skills and highly specialized trainings, would choose better alternatives in terms of organizations, local or abroad, if and when they get the chance to do so. However, despite all these factors unique to Turkey, the current study finds that doctors, including those working in public hospitals, have above average intentions to stay in their organizations, and these intentions are predominantly influenced by their organizational (affective and normative) commitments.

That is why, keeping in mind all these considerations, the finding that organizational commitment by itself accounts for almost a third of the factors influencing intention to stay for doctors working in Turkey is an important result. A large portion of relevant literature on organizational behavior and management is based on American studies, and as can be seen, the conditions and circumstances in terms of economics and healthcare are observably different in Turkey than in the United States (Wasti, 1999b). As such, though a strong significant link between

affective commitment and intention to stay could be considered the norm in such geographies, it is likely a bit far from being the reality in Turkey. Hence, regardless of all other possible factors, affective and organizationalcommitments' significant effects and major explanatory powers on intention to stay for doctors in Turkey, and that commitment itself is affected by the internalization of organizational norms and values in these health institutions, despite all their shortcomings, becomes a crucial finding.

It should also be noted that due to the unique properties of Turkey, some seemingly obvious correlations which have been confirmed time upon time in relevant Western literature may not be found in related researches in Turkey. Moreover, other surprising and uncommon ones, such as emotional labor being positively associated with organizational commitment, can be stumbled upon in further research and investigations as well. Therefore, studies confirming or enhancing the validity of the relationships among popular concepts in the Western literature, such as the ones included in the current study, should be increased in both number and depth (Alnajjar, 1999; Meyer, 1997; Suliman & Al-Junaibi, 2010; Suliman & Iles, 2000) so that the unique properties of Turkey can be better understood and comprehended, and theories and notions applicable to these unique settings can be developed and utilized by academicians, professionals and organizations.

CHAPTER 7

CONTRIBUTIONS, LIMITATIONS AND IMPLICATIONS

7.1 Contributions

The current research hopes to make contributions in terms of certain theoretical and practical uses. The first of these contributions is the consideration of organizational commitment for doctors in health organizations in Turkey. Regardless of problems health institutions currently face, their employees' intentions to stay is found to still be dependent on their organizational commitment to their organizations. In other words, for health personnel, the meaning and purpose of the organization itself matters to a significant extent such that they feel emotional attachments and contribution obligations towards their institutions. This makes them more intent to remain with their employers and so continue to provide services to those in need. The internalization of organizational values and norms also seems to be important for health personnel. As they, via deep acting, more strongly identify themselves with their occupational roles by accepting and acknowledging the requested emotions to be displayed, they become more resilient to the negative effects of emotional labor in the process. As a result, they increase their commitments towards their institutions.

The interesting finding that emotional labor has a positive effect on doctors' organizational commitments through deep acting is another contribution of the study. Emotional labor, as seen in relevant literature, is normally expected to bear negative effects and so relevant detrimental outcomes for employees. However, in this case of doctors working in hospitals in Turkey, the opposite is true. In other words, emotional labor, via deep acting, makes doctors more committed towards their organizations. This finding also implies that doctors, as a professional and

occupational group, may be better off being considered as a unique group of employees with distinctive properties. As such, they may be influenced by factors different from those generally considered by the literature. This signals to their investigation as a distinct group by further studies, which is discussed more in the implications sections of the current study.

The addition of significant data and knowledge on emotional contagion and the susceptibility to it is another contribution of the current research. The current study, by providing various relevant data, is likely to be a beneficial resource for any academician or practitioner interested in conducting research or creating applications on the topics of emotional contagion and the susceptibility to it in social and organizational settings. This is because the literature on emotional contagion is fairly recent and so in need of development for providing a thorough understanding (Vijayalakshmi & Bhattacharyya, 2012). Moreover, this is the first research conducted on emotional contagion in Turkey, as far as the author is concerned. The current research, by considering emotional contagion and the susceptibility to it within organizational settings, delivers arguments and discussions on multiple levels and dimensions so that the construct and a portion of the variables related to it are considered and investigated on various possible perspectives. This is done by the consideration of these variables either directly as research variables or indirectly by being suggested as future research implications. This gives research enthusiasts plenty of relevant material to either use or refer to in their own studies, or take inspiration and guidance from to form their own research focuses on the concepts of emotional contagion and the susceptibility to it.

One more contribution of the current study is that in terms of receivers of emotions, that is, people who are influenced by emotions of others around them via

emotional contagion, the current study provides information and measurement of the amount of vulnerability to emotions via the Emotional Contagion Scale (ECS), which examines how susceptible people are to emotional contagion (Doherty, 1997). Though information regarding senders of emotions is also presented in the current study, due to a lack of resources regarding senders of emotions in relevant literature, and also absence of a reliable and valid tool to measure the levels of emotional contagiousness (Vijayalakshmi & Bhattacharyya, 2012), the current study focuses its discussions more on receivers of emotions. As such, it contributes to relevant literature by presenting thorough analyses that explain and discuss the mechanisms of emotional contagion and the susceptibility to it regarding receivers of emotions.

Another contribution of the current research is that though the literature on emotional contagion is sparse and so relatively not as informative as it should be, its consideration in organizational settings and practical uses is even rarer in (Vijayalakshmi & Bhattacharyya, 2012). The current research, by focusing on emotional contagion and the susceptibility to it in organizational settings, emphasizes the importance of these concepts for organizations. This is so that not only are they better understood theoretically, but methods and applications for regulating, enhancing or inhibiting their effects can be considered, developed and implemented by organizations. This way, not only is the importance of emotional contagion and the susceptibility to it in relevant literature mentioned and emphasized for theoretical purposes, by considering its organizational uses, its significance for organizations and their personnel is shed light upon and signaled to action for examination as well.

Many articles visited upon the literature review part of the current study consider emotional contagion and the susceptibility to it in health organizational settings (Doherty, 1995; İnelmen et al., 2010; Lee et al., 2006; Lee et al., 2010;

Omdahl & O'Donnell, 1999). The current study, by taking inspiration from these studies, also focuses on these constructs in health organizations. These organizations, as stated, due to their context and nature, are those that a plethora of emotions run rampant and unrestrained. Such emotions are likely to affect almost everyone present in these institutions at the occurrence of these events; doctors, nurses, patients, staff etc. This implies that everyone in such situations is prone to be influenced by emotional contagion, and show its consequences via their behavior towards each other. These reactions can be positive and constructive as well as negative and detrimental, depending on the direction and intensity of the felt emotions within and caught feelings from the emotional environment. This thus creates the need for the investigation of emotional contagion and the susceptibility to it in health organizations for both employees and patients (Kevrekidis et al., 2008; Lundqvist, 2006). Health personnel who interact with patients and each other should be careful in showing understanding, empathy and empathic concern towards the psychosomatic situations of those around them. As such, they should aim to maintain a balance between experiencing the emotions of others in need in the environment, while also regulating their own emotions so that they are not detrimentally affected to the extent that their treatment capabilities are hindered. In other words, they need to feel what and how others feel in order to thoroughly understand them, yet also remain in control of their feelings and not be negatively affected by those of others. This is so that they are motivated, charged and rational enough to administer their treatments. This study, by providing sufficient data from different types of health intuitions and relevant references from related literature, emphasizes the importance of emotional contagion and the susceptibility to it in health organizations in Turkey. It also points out theoretical and practical factors that should be carefully

investigated by service and health organizations so that the negative effects of emotional contagion and the susceptibility to it can be proactively observed for and prevented before occurring, while the positive ones can be enhanced and bolstered to reach an optimal level of emotional stability in these institutions to influence employees and as a results customer attitudes in a positive direction (Pugh, 2001).

Another contributing factor of the study is that most of the research conducted in health organizations in relevant literature considers the participation of nurses in terms of research samples, yet significantly lower amounts of studies exist that are done with doctors as sample members (Lee et al., 2010). The current research provides sound and sufficient data regarding various demographic, emotional and organizational factors on 270 doctors working in different hospitals in Turkey. By the inclusion and investigation of this data, the current study contributes to relevant literature in terms of the processes doctors go through and situations they face during their work periods, their emotional states throughout these processes, organizational factors and commitments these states affect, and positive or negative consequences of these influences for their organizations and themselves. In other words, the current study, by putting emphasis on doctors instead of other health personnel, confirms the validness of the effects of workload, emotional labor, emotional contagion and the susceptibility to it on health personnel for doctors, and how such effects influence doctors' organizational commitments and as a result intentions to stay, while presenting various findings on this population which other researchers can use or make reference to in their own academic or practical endeavors for current and future studies.

These findings, hopefully, will inspire academicians and theoreticians interested in the workings of the healthcare sector in Turkey to conduct further

researches in order to find more about what affects doctors and related personnel in health and service organizations, and what can be done to improve their conditions so that they will be able to provide better and more efficient services to their customers.

7.2 Limitations

7.2.1 Theoretical limitations

As there is with any research, there are certain limitations with the current study that need to be addressed at this stage as well. One of these limitations is that though there is a vast literature on organizational behavior, management, psychology and emotions, the same cannot be said for emotional contagion and the susceptibility to it; there are only a limited number of studies conducted on emotional contagion, and even less on susceptibility to emotional contagion, and these are mostly considered and taken into account in psychology literature for social settings (Vijayalakshmi & Bhattacharyya, 2012); the number of researches in investigation of emotional contagion and the susceptibility to it in organizational settings are still relatively unsatisfactory, considering the importance of these concepts. As mentioned, to the knowledge of the author, there is no globally reliable scale that measures emotional contagion, and only one that measures susceptibility to emotional contagion (Doherty 1997), hence its usage and inclusion in the current study. The scarcity of resources in terms of emotional contagion and the susceptibility to it results in limited availability of relevant reference points for researchers to get support and inspiration from, and so likely hinders their theoretical mobility in the subject uncharted research areas. It is thus apparent that these concepts related to emotional contagion need to be

researched more thoroughly so that its antecedents and outcomes in organizational and social settings can be better evaluated and understood.

This literary limitation can also be discussed for emotional contagion in terms of the senders of emotions; though not extensive, relevant information in the literature exists in terms of emotional contagion and the susceptibility to it regarding their antecedents and outcomes for the receivers of emotion, who are the people that are affected in various ways as a result of the emotional contagion around them. For senders, on the other hand, lesser resources exist, especially in terms of what factors make people emotionally contagious, how this contagiousness varies from one person to another, and whether this contagiousness can be scientifically measured to determine emotionally contagious and not contagious people in organizations for theoretical and practical purposes. Though the current study proposes a potential guideline for those that are to take on the challenge of developing such a measurement tool to measure the emotional contagiousness levels of people, the scarcity of the resources in relevant literature makes their jobs somewhat more difficult, as not only this scale but management and organizational behavior literature themselves need to be extended in order to provide a more comprehensive understanding of emotional contagion in consideration of the senders of emotions rather than receivers.

A similar limitation can be touched upon in terms of health organizations as well, though there are numerous studies on various different constructs and their antecedents and outcomes, the situation is somewhat different when it comes to emotional contagion and the susceptibility to it. These concepts, though are crucial for health organizations and personnel, are studied to a lesser extent and so are not investigated to their full extent by neither theoreticians nor practitioners (Kevrekidis

et al., 2008; Lundqvist, 2006;), even though their acknowledgment can lead to potential improvements for organizations and employees, as mentioned several times in the current study. Thus, the need for expanding the existing literature on emotional contagion and the susceptibility to it in health organizational settings, for emotional issues to be appropriately managed and controlled in health organizations, becomes vital.

One must note here that the scarcity of resources and limited literature on emotional contagion and the susceptibility to it, be it in health or any other organizations, should be considered relatively, that is, the subject lack of research can be said to exist in comparison to research on other related constructs in organizational behavior, management, healthcare and psychology literature. There is no disrespect or disregard intended towards those theoreticians and practitioners who helped develop the literature on emotional contagion to its current level; what is implied and emphasized here is that when compared to the amount and depth of literature on issues such as job satisfaction, organizational citizenship behavior or burnout, or even emotional intelligence and empathy, the literature on emotional contagion and the susceptibility to it can be considered to be in early stages of its development.

Regarding service and health organizations and related literature, one other relevant limitation is that most of the studies conducted for health organizations are done by the participation of nurses; though the subject health personnel group is vital for the functioning of health organizations, treatment of patients and supporting of doctors, they are only parts of a complex organizational and sectoral structure. Considering the significance of health for all individuals, doctors, due to their knowledge and expertise, carry a crucial and vital importance for all kinds of people

and organizations, yet compared to the number and depth of studies conducted with nurses, those done so with doctors remain inadequate in terms of consideration in organizational behavior, and management literature (Lee et al., 2010). Though it is apparent that executing such studies with doctors has certain significant difficulties, such as the unavailability of doctors in terms of time and workload, their relatively smaller numbers compared to other members of health organizations, and the somewhat stereotypical yet also real difficulty in approaching and reaching them, research on doctors ought to be increased to a sufficient extent so that the numerous and various factors that influence them, such as workload, emotional labor, emotional contagion and the susceptibility to it, and potentially affect their perspectives and behavior on organizational commitment, and as a related result intention to stay, can be better understood and so increased and benefited from, or hindered and protected from, in terms of organizational applications, interventions and implementations.

7.2.2 Methodological limitations

In terms of methodological limitations, the first one can be considered to be the sampling method used in the current study. As with all sampling methods, there are advantages and disadvantages to snowball sampling as well. First of all, snowball sampling allows researchers to contact difficult to reach sample members, and for this research, snowball sampling allowed reaching doctors, who are by nature likely to be difficult to contact or interact with. Without this method's referral advantage, it would have been much more difficult to obtain data on doctors in health organizations. This data collection method, compared to others, is relatively simpler, cheaper and more cost efficient, for the method, once initiated, accelerates by itself.

This automatic and autonomous acceleration, though an advantage for the researcher, is also one of the disadvantages of the sampling method as well. This is because it leaves the researcher with little control over the course and progress of the sampling process. The method also does not allow the researcher to understand the clear true distribution of the population sample, and so its representativeness is not guaranteed. Lastly, subjects in the sample that nominate others to increase the sample size likely get into contact with those whom they already know, possibly sharing similar characteristics with their target colleagues. This potentially disturbs the heterogeneity of the sample, which can lead to sampling bias (DeVellis, 2012; Goodman, 1961). Nevertheless, due to all the reasons mentioned before, this method is used in the current research by the author to collect data via a questionnaire, and the disadvantage points are carefully considered as parts of the process to be continually mindful and aware of.

Due to certain resource constraints, the health organizations that the sample of doctors was obtained from were either located in Istanbul or in nearby cities. There were also some difficulties faced by the author in distributing the research questionnaire to doctors; some members of the management of these institutions refused to accept the questionnaire due to the potential detrimental effects it can have on their employees. These concerns were mostly raised due to the inclusion of intention to stay and organizational commitment variables. The hospital management, by applying a questionnaire with these two variables in their health organizations, did not want to give the impression of doctors being investigated and evaluated in terms of their organizational commitment and intention to stay. The questionnaire's anonymity was explicitly emphasized by being written on every questionnaire form and also verbally while being delivered or administered, though.

Some doctors themselves were reluctant to answer the questionnaire due to concerns of their answers being noticed by the hospital management and thus regarded as reasons for managerial intervention. Again, the questionnaire was declared to be anonymous beforehand. And in some cases, doctors had little if no time to complete the questionnaires, so not all the questionnaires that were distributed were completed by doctors in the included health organizations.

One limitation of the current study is that in terms of private health institutions, only 10 members were included as participants for data collection. 100 questionnaires were distributed to a private hospital in Istanbul, yet hospital managers did not agree to the distribution of the research questionnaire, due to reservations of their employees perceiving themselves as being evaluated by management. As such, though the research could provide relevant analyses, results and discussions in terms of the differences between public and university hospitals, the same cannot be said for private hospitals. It would be beneficial, then, to include health organizational members from private institutions so that comparisons can be made between public, private and university hospitals. This way, the found similarities or differences can be better interpreted, and health organizations in Turkey can be understood more comprehensively.

In terms of other limitations, the research can be expanded to areas outside of the Marmara region, and even to the whole of Turkey, so that the results can be compared among different geographical regions. This is also true for the expansion to new countries as well. The more places relevant researches are conducted in, the more comparison and confirmatory power they will have in the future. In terms of sample size, different sampling methods other than snowball sampling can be used so that a larger number of people to be included in the study can be reached, and

limitations of snowball sampling can be, to an extent, omitted (Dudovskiy, 2013; Goodman, 1961). To extend the scope of the research, different sample groups other than doctors can also be included. These can be health personnel for health organizational research, service personnel in the service sector, or any kind of employee for research in various organizational settings. In other words, the investigations and analyses in the study could be extended to various sectors and institutions so that meaningful comparisons can be made to come up with more comprehensive findings, and thus a more thorough understanding of organizational commitment and emotional contagion for different organizations and employees. Also, to increase the power of the research variables, different and new concepts and measurement tools can be introduced to the research as well. This is the reason for the inclusion of a dedicated section to possible new variables and concepts in terms of future implications in the current study.

In terms of measurement tools, one other methodological limitation is that though the mediation analysis of Baron and Kenny (1986) is popular and widely used, it is being more and more criticized by current researchers. As such, alternative mediation analysis methods might also prove to be fruitful if applied in further researches. As one alternative, Sobel's test (1982) can be used to look for the significance of the effect of the mediator variable on the tested relationship between the antecedents of workload and emotional labor, and outcome of intention to stay. Though this test may provide a more accurate analysis, its statistical power will likely be lower than that of Baron and Kenny's (1986) mediation analysis (MacKinnon et al., 2002). Also, the method is relatively old compared to newer methods of mediation analysis. Preacher and Hayes (2004), on the other hand, with their more current bootstrapping method, present some advantages over the relatively

older methods, such as increased testing power and usability with smaller sample sizes, since this method does not violate normality assumptions (MacKinnon et al., 2007). The method is also easier to use with officially provided macros to implement into statistical analysis software such as SPSS. Thus, the current data, in terms of mediation analyses, can be analyzed in further researches with different methods in order to overcome the limitations of Baron and Kenny's (1986) mediation analysis. Thus, the mediating effect of organizational commitment on the research antecedents and outcomes can be better understood.

Another important limitation is the discussion in terms of the usage of self-report measures in investigating the complex and multidimensional variables in the study. This is due to fact that participants may themselves not be able to comprehend and investigate how receptive or resistant they are to the emotions of others, and also their own feelings. This discussion is featured in relevant literature somewhat frequently (Hatfield et al, 1994). Though this is an issue not to be taken lightly, the fact that the measurements and scales used in the current study, which have been used sufficient times before in the literature, are reliable and valid, and have been stated to be safe to use with confidence through participants' self-evaluations such that people's own assessments tend to be parallel to the evaluation of others about them (Hatfield et al, 1994), gives the author a measure of comfort in using such tools to conduct the current study. However, the reservations mentioned by other researches throughout relevant literature still hold, and further researches should be conducted in order to confirm whether the self-reports used in the current study are in line with those to be reported by others for the participants. This confirmation can also be done via using different measurement tools created for examining the same concepts; self-report or otherwise. One final limitative aspect of self-report

instruments is that most of them are executed as Likert-type questionnaires. This diminishes opportunities of participants to explain their answers in detail and in their own words. As such, the usage of measures including open ended questions can be beneficial in understanding organizational issues for employees better (Flinkman et al., 2010). Naturally, tools that measure concepts other than the ones in this study can also be used to further enrich the research context, and examples of such variables and tools will be touched upon in the implications part of the current study.

In terms of the measurement of emotional contagion, there is a major limitation in that there are no measurements that focus on the emotional contagiousness levels of the senders; as mentioned in the literature review, emotional contagion is a two way street, where senders and receivers continuously and momentarily influence each other's emotional states, resulting in a mutual exchange of emotions. The only valid and reliable scale on emotional contagion measures the susceptibility of people to emotional contagion (Doherty 1997), who are the receivers of emotion in the environment. Though, as is apparent from the current research, this tool is useful and fruitful for management and organizational behavior literatures, a tool to measure the emotional contagiousness levels of people, both positive and negative, would be beneficial for any kind of organization (Vijayalakshmi & Bhattacharyya, 2012); the concepts of employee selection, promotion, training and leadership would be benefit significantly from the formation of such a measurement. The current study outlines a potential direction which briefly explains the formation of such a tool for researchers interested in the relevant topics, but as can be expected, the formation of such a measurement requires comprehensive research and studies to be conducted; the somewhat limitedness of emotional contagion literature also adds to the potential difficulty of such an ordeal.

Nevertheless, the creation of such a tool is crucial for theorists and practitioners to understand the workings of emotional contagion in terms of the senders on a deeper and more fruitful level.

7.3 Implications

7.3.1 Theoretical implications

From the literature review, study findings and their discussion, it can be deduced that professionals and professional organizations differ from other types of employees and institutions. This is because formal organizations entail clear cut bureaucratic systems, hierarchies, distinct and defined roles, and set procedures (Thompson, 1965). Professional organizations, on the other hand, mainly include employees that are independent, autonomous, authoritative and powerful. Therefore, doctors, as professionals, can be viewed as employees having great stakes in their organizations, in terms of their influences on their careers, values and professional identities. Professional organizations, such as hospitals, then become those where professionals come to have considerable influence and control in them (Bucher & Stelling, 1969).

These facts create a situation where new perspectives and approaches to predetermined models and theories may need to be adopted in order to better understand professionals. Regarding the current study, doctors can be considered to be a group of such professionals. That is why, theories and models considering such independent employees and their negotiated transactions may be more suitable to investigating doctors in health organizations for further studies. Moreover, consideration of the Job Demands-Resources Model with resources relevant to

professional organizations, rather than a focus on demands, can be fruitful in better understanding doctors and health organizations.

In this part of the current study, several variables related to professionals and their organizations are provided in order to guide researchers interested in these areas for finding new directions and conducting relevant studies. Their inclusion as variables in further researches could provide new concepts relevant to health organizations in order to better understand doctors and their work processes. Inclusion of new variables could also enhance the predictive power of workload and emotional labor as organizational stressors, and so potentially account for the unexplained part of intention to stay. Inclusion of such related concepts, then, could also be beneficial in understanding the scope and direction of the possible indirect effect of workload on organizational commitment in health organizations. Those variables the research sees as potentially likely to be associated with these concepts are explained briefly, while others to be considered as connected to various organizational and emotional concepts in the study are sited as reference points.

Occupational commitment refers to an individual's commitment to the profession (Omdahl & O'Donnell, 1999). Those who are committed to their occupations are more likely to keep themselves updated on new developments relevant to their occupations and become members of related associations. (Meyer at al., 1993). Organizational commitment is highly likely to carry special importance and relevance to doctors, since they are a unique occupational group. Their occupation has an incomparable purpose in that it entails preserving or developing the health of those in need. As such, its investigation in further researches carries the utmost importance. This is because, as the study shows, doctors' intention to stay in their organizations largely depend on their organizational commitments. Therefore, occupational

commitment carries high probability in terms of explaining doctors' variance in their intentions to stay in their organizations.

Career commitment can be explained as an attachment to the foreseeable potential internal and subjective career by the person (Blau, 1985). It is positively correlated to professionalism and organizational citizenship behavior (İnelmen et al., 2010). Career commitment is also highly likely to carry special significance and applicability to doctors as a unique professional group. Therefore, its study in further researches becomes vital and crucial to better understand doctors in health organizations. As such, similar to occupational commitment, career commitment also carries high probability in terms of explaining doctors' variance in their intentions to stay in their organizations.

It can thus be argued that both occupational and career commitment may be important latent variables that would potentially explain some of the relationships and missing links in the current study. This is because they are likely to be especially important for doctors as professionals working in professional organizations. Both types of commitment are positively related to organizational commitment. Moreover, all three types of commitment may play an interactive role in organizations considering their effects on employee behavior (Meyer et al., 1993). This implies that their inclusion in further researches may provide fruitful answers to the relationship between organizational stressors and doctors' commitments to their organizations. Moreover, their consideration will also likely be useful in explaining the intention to stay of doctors in health organizations.

Job security can be defined as an employee's assessment of his or her current work circumstances and evaluation of their probable future in the job which they are currently working; while the subject evaluation is positive, it is called to as job

security, and when it is negative, it is referred to as job insecurity. Perceived Job Security is the personnel's understanding that he or she feels safe and content in the current job, and will continue working for the current employer without the threat of being fired as long as he or she wants to stay in the subject organization; perceived job security implies an employee's subjective evaluation of his or her safety and security in the job rather than a corporeal contract / agreement that ensures his or her stable, safe and advertent employment. Job security and perceived job security can potentially influence emotional contagion such that people feeling secure in their jobs are likely to emit positive emotions and vice versa. Job security can also significantly affect organizational commitment, since the less secure people feel in their jobs, the more likely that they will be less committed to the organizations in which they execute these jobs (Zeytinoğlu et al., 2012).

Emotional intelligence gained its prominent status in popular literature by Goleman's (1995) book, in which he discusses two ways of knowing: rational and emotional, which entails how people deal with their own and other people's emotions and how effective they are in managing them (Merriam, Caffarella, & Baumgartner, 2007). EQ contains five dimensions, three of which are intrapersonal: knowing one's emotions, managing them and motivating oneself, while the remaining two are interpersonal: recognizing emotions in others and handling relationships (Muchinsky, 2003). The former 3 form personal competence, while the latter two result in social competence (Kreitner & Kinicki, 2004). People with high emotional intelligence are able to eliminate encounter stressors in the workplace more effectively than others, since there is less conflict, more collaboration and higher quality in their relationships (Whetten & Cameron, 2005). Emotional intelligence also includes an intuitive appeal, combining street smarts and social intelligence, and is assumed to be

positively correlated with criteria such as job performance and predicted life success (Robbins & Judge, 2011). Though there are a number of scales developed to measure emotional intelligence, the Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT), Schutte Self Report Emotional Intelligence Test (SSEIT) and Wong's Emotional Intelligence Scale (WEIS) are some of the more frequently used ones in the literature (Merriam et al., 2007). As stated in the literature review part of this research, emotional intelligence is likely to be a factor effecting emotional contagion and the susceptibility to it, since it entails awareness of and controlling one's own emotions, understanding those of others, and manipulating them to form a resistance or perceptiveness to contagion as necessary (Hatfield et al., 1994).

Empathy is defined as the affective state initiated by and consistent with the recognition of another person's emotional condition; it is the capability to acknowledge other people's feelings. Individuals who are more perceptive of the elusive social signs other people display are seen as more empathetic than others (Muchinsky, 2003). Empathy is one of the frequently mentioned concepts related to emotional contagion, since it allows one to understand the feelings of others and act accordingly, and thus partially control the effects of emotional contagion (Arizmendi, 2011; Nummenmaa et al. 2008)

Emotional contagiousness refers to the extent of people's conscious or unconscious capacity to affect those around them; the more emotionally contagious a person is, the more he or she emotionally influences others in the environment (Hatfield et al., 1994). Though it is mentioned occasionally in relevant literature, it is not as focused upon as susceptibility to emotional contagion, which focuses more on the receivers of emotions, and as a result no measurements tools are developed to investigate the level of emotional contagiousness of people. A focus on emotional

contagiousness in organizations, and foundation of a scale to measure it, will likely prove beneficial in terms understanding the processes, effects, antecedents and outcomes of emotional contagion from the perspective and consideration of the senders of emotions.

Emotional expressiveness: Emotional expressiveness is the level of usage of facial expressions, gestures, postures and body language to convey emotions. It offers guidance for employers and managers looking to hire people that are able to transmit certain emotions. It is affected by self-monitoring and emotional stamina, and is correlated with exhibition and extraversion. It is measured by the Emotional Expressivity Scale (EES), and also within the Affective Communication Test (ACT) as a self-reported measure (Pugh, 2001). Emotional expressiveness directly affects emotional contagiousness, and so can be considered to be an important future research variable related to emotional contagion (Hatfield et al., 1994).

Felt emotions are those that are actually felt by the people at the subject moment, while displayed emotions are those they display due to occupational emotional requirements. They can also be referred to as experienced / expressed emotions. The distinction exists because the occurrence of a match between felt and displayed emotions, especially in organizational contexts, is somewhat rare, if not non-existent. The display of fake emotions requires people to suppress, or at least temporarily mask their true feelings for the required interaction time; this can occur in two ways, by surface acting and deep acting. Surface acting occurs on a superficial level, and only emotional expressions are sacrificed; the experienced feelings remain intact. Deep acting, on the other hand, entails modification of one's inner feelings in accordance with the emotional requirements of the situation. While the former deals with displayed emotions, the latter is concerned with felt emotions. Felt emotions can

significantly influence displayed emotions, and if the subject emotions are discrepant, people may start experiencing emotional dissonance. Since emotional contagion has important influences on felt emotions, it is a significant topic to be considered for related further research. (Pugh, 2001; Robbins & Judge, 2011).

Emotional dissonance is the emotional disparity and distress that occurs due to the projection of one emotion by a person while feeling a different emotion. Though somewhat tolerable in the short run, as time progresses, it can lead to detrimental consequences for the people going through the dissonance; such as the building up of frustration, anger and resentment. When people reach an emotional bottleneck, they can end up going through emotional exhaustion. The relevance of emotional dissonance to emotional contagion and the susceptibility to it is similar to that of felt / displayed emotions, and so can also be considered for future research purposes. (Robbins & Judge, 2011).

Cultural intelligence can be defined as the capacity of an individual to adapt effectively across different cultures. In practice, it allows the person to understand unfamiliar cues of a culture as though he or she were a national resident of it; so higher levels of CQ indicate higher intercultural competence. It includes 4 components: strategy, knowledge, motivation and behavior. It is argued that it shares certain common features with emotional intelligence, in that they both allow the individual to temporarily suspend judgment and think before acting. Emotional intelligence develops within the confines of a single culture, though, whereas cultural intelligence requires exposure to different cultures. Cultural intelligence is measured by the Cultural Intelligence Scale (CQS), and can be regarded for research related to emotional contagion along with emotional intelligence (Brewster, Sparrow, Vernon, & Houldsworth, 2011). It can also be considered in relation to organizational

commitment, as an individual who is better able to adapt to new cultures and institutions is likely to potentially be more committed to them compared to those having problems in adaptation.

Customer affect is the emotional state adopted by the customer due to emotional contagion that occurs as a result of interactions with employees; so it depends on employee affect as well. Employee affect determines the felt and expressed emotions of the employee, and so the direction of the emotional interaction. The resulting customer affect is thus either positive or negative. Both employee and customer affect can be measured by Job Affect Scale (JAS) or Positive and Negative Affect Schedule (PANAS) Scale (Pugh, 2001), and can be included in further research in relation to understanding the reciprocal effects of emotional contagion between employees and customers.

Cognitive dissonance is the incompatibility people perceive between their attitudes and behavior. When it is felt, people try to minimize it by seeking cognitive consistency and stability; they do this by either altering the attitude / behavior, or by finding rationalizations for the felt discrepancy. The efficiency of the dissonance reduction methods depends on the importance of the components creating it, degree of influence people believe to have over them, and rewards associated with the dissonance. It can be considered a related research topic to emotional contagion by being analyzed together with emotional dissonance (Robbins & Judge, 2011).

As can be seen, there is a large number of antecedents, mediators, moderators and outcomes to be considered for further research regarding their relationships with organizational commitment, emotional contagion and the susceptibility to it. To provide even more directions for future research, certain comparable variables other than the aforementioned ones can be considered based on their previous inclusion in

organizational behavior and management literature within the framework of commitment and emotions in organizations, such as empathic concern (Omdahl & O'Donnell, 1999; Siebert et al., 2007), association / dissociation (Rempala. 2013), prosocial behavior (Cole & Cole, 2001; Omdahl & O'Donnell 1999), introversion / extroversion (Jung, 1921; Doherty, 1997), physical / emotional burnout / exhaustion (Lee et al., 2010; Omdahl & O'Donnell, 1999; Siebert et al., 2007), emotional conflict / harmony (Lee et al., 2010), cognitive intelligence (IQ) (Arizmendi, 2011; Nummenmaa et al., 2008), self-awareness (Rempala, 2013), physical / emotional synchrony (Arizmendi, 2011), conflict resolution (Vijayalakshmi & Bhattacharyya, 2012; Whetten & Cameron, 2005;), performance (Vijayalakshmi & Bhattacharyya, 2012), stress (Omdahl & O'Donnell, 1999; Pugh, 2001; Siebert et al., 2007; Whetten & Cameron, 2005), charismatic and transactional leadership (Vijayalakshmi & Bhattacharyya, 2012), power (Hatfield et al., 1994; Hsee et al., 2010), positive / negative affect (Pugh, 2001), emotional responsiveness (Hatfield et al., 1994), attitude formation / expression (Hatfield et al., 1994), consumer behavior (Becker, 1988; Court et al., 2002; Laibson, 2001; Wathieu, 2004;), job satisfaction and organizational citizenship behavior (Meyer & Allen, 1991).

The results of the current study show that the positive relationship between organizational commitment and intention to stay accounts for almost a third of the variance of the factors affecting doctors' intentions to stay with their employers in Turkey. The remaining factors, some of which are suggested in the implications part of the current research, could be ones relevant to the constructs of the current research, such as occupational commitment, burnout, job security and job satisfaction. Their inclusion in further studies by interested parties could explain the

remaining two thirds of the variation in intention to stay for doctors employed in health institutions in Turkey.

The results of the study also show that previously developed theories and models in the Western literature may not always account for the Turkish context. This can be seen as organizational commitment is found not to have a mediating role between organizational stressors and outcomes. Emotional labor having a positive effect on organizational commitment is also an interesting finding. This implies that doctors, as an occupational group, may have unique characteristics and properties. They are highly educated and specialized, carry vital functions and power within their organizations, treat patients from all kinds of cultures and socioeconomic backgrounds, and are relatively more mobile in terms of their transferrable skills compared to other occupations. Therefore, new theories and models specifically tailored for the investigation of doctors might need to be developed in order to better understand them. These theories or models are better off if they focus on doctors as a distinct group of people rather than among other health personnel. They are also likely to be more fruitful if they focus on different stressors, such as the ones mentioned above, rather than more traditional ones. This is because doctors may be affected by different stressors as a unique occupational group. More investigations in terms of what these factors may be, and how they influence doctors in health organizations, is likely to be fruitful for both theory and practice.

7.3.2 Practical implications

The current research is aimed at contributing not only to relevant literature but also to practical uses as well. The unison of theory and practice is vital, especially in such fields as management, and healthcare, where relevant researches are closely related

to individuals operating in organizational settings. This is due to the fact that concepts included in such literary areas are of interest to both academicians and professionals. Regarding this perspective, one property of the current study is that it tries not only to theoretically enrich and elaborate the issues of organizational commitment and emotional contagion in different organizational settings, it also aims to include practical applications to be used by organizations. These be communication training, counseling, coaching, skill and attitude development courses, teamwork enhancement, job redesign and flexible work schedules (Bakker et al., 2005; Hülsheger & Schewe, 2011; İnelmen et al. 2010; Mojsa-Kaja et al., 2015; Le Blanc et al., 2001; Lee et al., 2010; Leiter & Maslach, 2008) In this regard, service and health organizations, by considering the provided information in the current study, can try to proactively implement programs or applications in their organizations as to prevent or shield their employees from the occurrence of the negative effects of organizational stressors. They can thus create applications that enhance the positive influences of emotional concepts while at the same time increase their personnel's organizational commitments towards them. This is because the capacity to identify problems early provides organizations the flexibility to find timely, customized and preventive solutions for their employees (Leiter & Maslach, 2008). The current research hopes to create an awareness of organizational and practical implications of organizational commitment and susceptibility to emotional contagion so that practitioners and professionals may benefit from understanding and utilizing the effects of these organizational realities.

As can be seen from the results of the current paper, for health organizations, excessive workload and emotional labor, directly or through potentially resulting burnout, can have detrimental effects for health personnel and the organizations

themselves, especially in turns of intention to stay (Cordes & Dougherty, 1993). These implications for employees' psychological and physiological health can even lead to serious illnesses if not proactively prevented. These implications are not only observed within people that experience the subject burnout, but can also be present among those they interact with, such as their colleagues, patients or students. In other words, the negative physical and emotional effects of burnout experienced by one person can be transferred to other people in the environment in social or organizational interactions via emotional contagion (Mojsa-Kaja et al., 2015). These findings show that organizations may be better off if they increase their employees' intention to stay. This way, they will decrease loss of talented individuals, and so prevent costs of replacement and training, and negative emotional and performance effects of quitting on others (Frank, Finnegan, & Taylor, 2004; Loi, Hang-yue, & Foley, 2006; Weisberg & Kirschenbaum, 1991; Zeytinoğlu et al., 1992) As such, organizations should broaden their perspectives of healthcare management such that job demands in health organizations include not only quantitative ones but dispositional and emotional ones as well. In terms of workload, this can be done by developing more favorable shift times and increasing breaks and day-offs, increasing the number of hired health staff (Xiaoming et al., 2014), reducing workload related stress (Glaser et al., 1999) and aligning employees' expectations and capacities with the amount of work they are assigned with (Leiter & Maslach, 2004). This gains more and more importance over time as today's market and organizational environment is full of global competition yet also suffers from daily shrinking resources (Le Blanc et al., 2001). Health personnel may also be trained and given consultancy to in terms of coping with emotionally demanding patients and cases, developing the ability to show detached concern rather than empathy when the

situation deems necessary (Le Blanc et al., 2001; Mann, 2005; Zapf, 2002) and interpersonal support between supervisors and subordinates (Hiroto, Susan, Lloyd, Osamu, & Hisateru, 2001). The regulation of emotions during doctors' interactions with their patients of diverse sociocultural backgrounds (Shapiro et al., 2002) and varying illness levels requires the attention of health organizations and management; relevant communication training courses can be implemented to the subject organizations in order to develop the interaction skills of the health personnel, in this case doctors specifically.

Organizations should thus take into account that certain sectors such as service or healthcare may have significant contextual (workload) and interpersonal (emotional labor) requirements. They should thus choose and train their employees accordingly (Pugh, 2001). These employees can range from nurses (Omdahl & O'Donnell, 1999; Smith, 1992) to doctors (Wharton, 1993) and social workers (Siebert et al., 2007). This issue is important to organizations because the strains of these contextual and interpersonal requirements are likely to effect the service quality the employees provide. In return, the provided service quality will likely affect their relationships with their customers through perceived service quality (Vijayalakshmi & Bhattacharyya, 2012). It will thus potentially lead to the evaluation of employees and also organizations by the customers. In other words, customers' evaluations of the service they receive not only opinionates them in terms of employees but also organizations (Pugh, 2001). It should also be noted here that service quality is important to not only the customers but also to the employees themselves. In other words, especially for health personnel, it is found that the quality of the healthcare provided carries a high priority considering the factors these personnel deem as important for themselves in their organizations (Flanagan, 1997).

The positive relationship between organizational commitment and intention to stay has two important implications. The first one is that organizational commitment of these doctors accounts for almost one third of the factors that affect their intention to stay in their organizations. This makes it a crucially important concept to consider for these organizations which will likely want to continue to keep their doctors working for them. Management and owners of the hospitals, then, should focus on activities and interventions that will increase organizational commitment in the workplace, thus increasing the probability of their doctors remaining with them for longer periods of time. The second important implication of the positive relationship between organizational commitment and intention to stay for doctors working in health organizations in Turkey is that two thirds of the factors explaining organizational commitment of these doctors remain unaccounted for. Workload only predicts a small percentage of doctors' intention to stay (below 5%), and almost 65% of the variance in intention to stay is not explained by the concepts in this study. This leads to a whole new and interesting area of research for health organizations in terms of finding out which factors influence the remaining percentage of intention to stay for doctors employed in Turkey.

Organizations looking to implement ways to strengthen the commitment of their employees, then, should keep in mind how their actions can be perceived by the employees, and design programs focusing on positive work experiences to increase overall organizational commitment (Meyer et al., 2002). This method is argued to be a better alternative than trying to hire employees that are predisposed to be affectively committed beforehand for organizations (Irving & Meyer, 1994; Meyer, Bobocel, & Allen, 1991).

The results of the study also show that emotional contagion plays an important role both inside and outside the organization (Hatfield et al., 1994, 2014). This implies that a positive emotional change within the organization, that is, positive employee affect initiated by a positive influencer, can then be reflected to customers as positive customer affect (Pugh, 2001). This positive customer affect in return will be reflected to employees as even more positive employee affect (Lemmink & Mattson, 2002). As such, a more positive attitude towards the organization by the customers will also be likely observed (Huang & Dai, 2010; Tsai & Huang, 2002). This self-reinforcing cycle can have detrimental effects, though, if the felt affect by employees or customers is negative. So, organizations have to be careful about negative emotional influencers as well. Thus, understanding the nodes and links in the emotional contagion and susceptibility chain, and managing employee, customer and service strategies accordingly is crucial for any organization (Lin et al., 2008; Pugh, 2001). A summary of the ideas on the service quality and emotional contagion relationship can be seen in Figure 10:

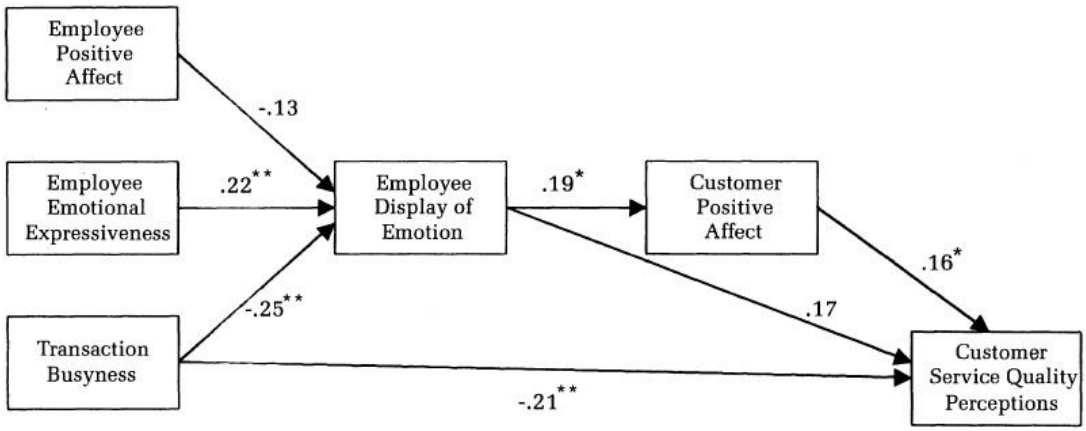


Figure 10. Employee - customer affect link

Source: Pugh, 2001

People do not live isolated in their own emotional deserts, but rather, groups of people continuously experience and exchange emotions at work. This affects almost all of the included parties in the interaction. Emotions spread through emotional contagion lead people who feel them to bivalent behavior (approach or withdrawal) towards the source of the received emotional stimuli (Hatfield et al., 1994). The acknowledgement of emotional contagion as a legitimate influencing factor in organizations, then, can help people get a sense of how they can control their emotions. It will thus help them augment the process of self-management (Hsee, Hatfield, Carlson, & Chemtob, 1990). This augmentation, in turn, will enable people to understand the emotional states of others around them (Hatfield et al., 1994). What organizations ought to do, then, is to ensure that beneficial, positive emotions spread across people by fostering emotionally positive work environments. They should develop proactive strategies to manage and restrain the contagion of negative emotions so that a favorable organizational climate facilitating the effective performance of people can be created (Vijayalakshmi & Bhattacharyya, 2012). This argument is also in line with Social Exchange Theory in that an emotionally positive work environment will be more attractive to employees, hence potentially making them more committed towards and satisfied in organizations providing such environments (Emerson, 1976; Gouldner, 1960). As such, if the mechanisms of emotional contagion can be better understood, it could lead to the creation of application-intensive intervention tools aimed at enhancing the sensory acuities of people (Vijayalakshmi & Bhattacharyya, 2012). This would in return help them manage their emotions better to build a more positive work climate (Hatfield et al., 1994). Moreover, though emotions originate in individuals, they function in groups.

So utilizing the transfer of mood in a beneficial manner is likely an issue that organizations will have to proactively manage (Pugh, 2001).

As can be seen, in positive moods and experiences, emotional contagion helps people adapt to different situations, increases altruistic behavior and is highly correlated with social competence (Hatfield et al., 1994). However, it can also make the person vulnerable to experiencing the negative moods and emotions of others (Vijayalakshmi & Bhattacharyya, 2012). In fact, continuous exposure to people feeling negative affect may result in the person suffering as if he or she was experiencing those feelings themselves. This occurs as a result of transmitting these unpleasant emotions to others around, and so becomes a negative affect cycle that needs to be dealt with (Rempala, 2013). As a coping mechanism, health personnel can be trained such that they should feel concerned for the wellbeing of their patients (empathic concern), but they should not take on the negative emotional states of them (emotional contagion / empathy). They should be able to think and feel, to an extent, like their patients, but be careful in maintaining their own identity in this process (Omdahl & O'Donnell, 1999). So, susceptibility to emotional contagion may end up disrupting the helping process, and care should be taken while educating employees in service and health organizations on emotional contagion. Empathic concern, the concern one feels for the wellbeing of another person which does not necessarily require the sharing of emotions between them (Siebert et al., 2007), and emotional contagion should be clearly differentiated in training employees, and each should be taught to be used in appropriate conditions (Omdahl & O'Donnell, 1999; Siebert et al., 2007).

For health organizations, susceptibility to emotional contagion may play both beneficial and detrimental roles in them depending on its context, direction and

possible effects. That is why, the current study puts significant emphasis on the issue, especially for doctors, who deal with patients and also peers of varying needs and wants on a daily basis in an emotionally volatile environment with limited time and resources (Miller et al., 1990; Xiaoming et al., 2014). The study urges institutions and their members to become aware of the concept of susceptibility to emotional contagion as soon as possible, observe for its possible positive and negative effects, and try to act proactively to decrease negative effects to a minimum while supporting and extending positive ones as much as possible. This is so that people's susceptibilities to emotional contagion can help them benefit and get inspiration from positive emotions around them, and better understand, learn from and even act altruistically in order to find solutions for negative ones. Naturally, they ought to do this simultaneously as they protect themselves from the unfavorable effects of the dissemination of negative emotions in health organizations.

The discussions on susceptibility to emotional in health organizations imply that it carries significant importance for health professionals. As such, susceptibility to emotional contagion can also be considered as a current resilience construct to be developed for health organizations. It can be developed via training programs that emphasize the detrimental effects of the spread of negative emotions and how to deal with them. The extent to which it can be developed, however, will likely depend on other dispositional factors people come to possess. Moreover, the beneficial consequences of the spread of positive feelings can also be mentioned in these trainings as well. This way, by implementing such training programs into their orientation or personal development programs, organizations can ensure that their personnel are less vulnerable to effects of negative feelings around them, while they make the best use of the positive emotions within their environments. Moreover, this

will also ensure that health professionals have less conflicts between their emotions and cognitions and so be able to better function as providers of help to those in need in health organizations. Here, it is also likely of interest to consider whether a resilience to emotional contagion can be developed as an aggregate resistance to emotions, or resistance to only negative emotions while proneness to positive ones. Both theorists and practitioners, then, must work hand in hand in order to determine if and how people's dispositions towards emotional contagion can be shaped in formal and professional organizations.

The conflict between emotions and cognitions in the health sector may reflect broader divergences between personality and culture as well (Lutz & White, 1986). This implies that doctors should be encouraged not only to master steadiness, the rational component of their practice, but also tenderness (Coulehan, 1995), its affective component, in unison with each other. This way they can better maintain their physiological and psychological wellbeing and be engaged in the treatment of their patients (Lee et al., 2010). As such, it is argued in relevant literature that health organizations should strive to be attractive institutions. This implies that employees in these health organizations have high job satisfaction and organizational commitment (Tourangeau et al., 2009). Health organizations can achieve to be attractive by increasing their social capital, and adopting a caring, fair, supportive and just organizational culture (McLure, 2005; Stordeur & Hoor, 2006). This way, they can thus increase the intentions to stay of their employees, and continue to work with them for longer periods of time (Flinkman et al., 2010).

Among an organization's powers, human resources is considered to be one of the most important ones. This is because the organization's success relies largely on the performances of its employees (Bal, Bozkurt & Ertemsir, 2014). The attitudes of

employees in an organization are also crucial for the employer since an organization's image is reflected to customers as they are observed from its employees' images (İnelmen et al., 2010; Pugh, 2001). Naturally, an organization should first select employees that fit its values and norms. This is because not all individuals might be emotionally and mentally prepared to work in more demanding organizations and occupations for a long time (Kim & Kao, 2014). Once the right employees are found, though, it then becomes any organization's one of main missions to be able to keep its employees as long as possible. This can be done via different incentives to overcome turnover issues so that the employees continue to function and perform adequately. Thus, it might be beneficial to train and develop people on the issues of teamwork, interpersonal relationships and leadership styles, so that they are more prepared to deal with the negative consequences of workload and emotional labor in their organizations as to prevent the development of burnout, depression and turnover intentions (Bakker et al., 2005). Proactive and preventive measures must be applied by organizations as for employees enduring job stressors for long periods of time, such as job redesign and more flexible work schedules (Mojsa-Kaja et al., 2015). The solution for organizations is, then, to create a work environment which promotes the ideas and ideals that employees wish to spend time and effort on trying to reach (Leiter & Maslach, 2004), thus enhancing their intentions to stay in the workplaces they are currently employed in. If the employees do decide to leave however, organizations can use exit interviews to better understand the factors leading to these leaving decisions (Flinkman et al., 2010).

Thus, based on the results of the current research, which is supported by relevant literature regarding the significant and positive association between organizational commitment, and its components of affective and normative

commitment with intention to stay (Carmeli & Gefen, 2005; Cotton & Tuttle, 1986; Jaros, Jermier, Koehler, & Sincich, 1993; Igharia & Greenhaus, 1992; Loi et al., 2006; Meyer et al., 1993; Mohammad, Taylor, & Ahmad, 2006; Mowday et al., 1982; Rehman et al., 2012; Somers, 1995; Suliman & Al-Junabi, 2010; Tett & Meyer, 1993; Udo, Guimares, & Igbaria, 1997; Yousef, 2002; Wong, Ngo, & Wong, 2001), it can safely be said that organizations that want to keep their employees should give attention to and spend effort and resources on enhancing the affective and normative commitments of their employees, rather than their continuance commitments (İnelmen et al., 2010). They should thus shift their focus towards how they can make their employees want to stay in their institutions by increasing their organizational commitment, instead of how they can stop these employees from leaving their jobs and organizations.

Another practical implication of the current research is that, though not extensively, it provides an outline for the development of a scale that measures how emotionally contagious individuals are. There is no sound tool to investigate this issue in relevant literature, and by presenting step-by-step guidance regarding the preparation of the proposed scale, the current study aims to motivate researchers interested in the topics of emotional contagion and the susceptibility to it in organizational settings to undertake the challenging yet rewarding task of creating the proposed scale. Naturally, the realization of this scale is likely to require more than what is suggested in the current research as a guideline for the development of it. Hopefully, the current study provides sufficient relevant information on the variables and relationships to be considered when designing the scale so that researches have a resource to get inspiration from and also use the provided data to conduct their researches.

As such, in this part of the current study, a brief guideline is provided for researchers who may want to get inspiration to undergo the scientific journey of creating such an assessment tool. Scales are measurement tools entailing a collection of items combined into a composite score, with the intention of revealing the levels of and relationships among a theoretical phenomenon's variables that are not initially manifest. The included measures are tools used for construct assessment; they are proxies for variables that cannot be observed directly. In other words, by evaluating the relationships between the measures, the relationships between constructs can be inferred. Naturally, the more researchers are knowledgeable about the subject construct, the more equipped they are to create reliable and valid scales. Most of the time, these scales need to be multi-dimensional, since it is likely that measurements of socially constructed and less tangible concepts will require the target respondents to think on, evaluate, compare / contrast and even use judgment on less available and accessible information. This means that a single item cannot capture the complexity of the topic of interest due to the fact that the required degree of precision may only be reached via the inclusion of multiple items; thus the need for a multi-item scale emerges (DeVellis, 2012).

A scale involves effect indicators; items whose values are caused by the underlying research construct. The scale measurement model assumes that individual items are related but different indicators of the subject construct. The construct, which is the actual phenomenon of interest, is also referred to as the latent variable; it is latent since it is not apparent at first sight, and it is a variable since it is not a constant concept. For the purposes of the proposed future study, the latent variable is emotional contagion, and an interesting characteristic of most latent variables is that they are a characteristic of the individual who also is the source of information. In

other words, the measured levels of emotional contagion are characteristics of the emotionally contagious people themselves and not the affected people in the environment, so the measurement relies on self-reports rather than proxy reporting (DeVellis, 2012).

Though, as stated, the latent variable is not observable directly, it takes an assumed specific value during the measurement process under certain specified conditions; this measurement intends to estimate the actual magnitude of the construct, and the resulting magnitude is called the true score. The strength of the latent variable is presumed to cause an item to take on a certain value, so the construct is regarded as the source of the item scores. Each item, then, gives an indication as to how strong the measured construct is, which means that item scores are correlated to the true score of the latent variable. Since each item correlates with the construct, they should also correlate among themselves. This enables researchers to measure the correlation levels between the items, invoke the latent variable as the reason for this correlation, and use this resulting information to deduce the level of correlation of each item with the construct (DeVellis, 2012).

The first and one of the most important parts of methodology in scale development is clearly defining what it is one wants to measure. In this case, the study aims to direct future researchers to develop a scale for measuring the level of emotional contagion of people, that is, determining how emotionally contagious a person is. In other words, the scale will be built to provide an answer to the research question: “Is the subject person emotionally contagious, and if so, what is the level of his or her emotional contagiousness?” The proposed scale carries one particular common point with Doherty’s Emotional Contagion Scale; ECS aims to measure how susceptible a person is to emotional contagion (Doherty, 1997), and the scale

created by the subject proposed study will try to assess how emotionally contagious a person is. So, while ECS focuses on finding information about the receivers, that is, people that are being affected by emotional contagion, the subject proposed scale aims to reach data about the senders, the people that are actually affecting the others. The resulting scores from the test will help both academicians and practitioners determine whether a person is emotionally contagious or not, and the level of his or her emotional contagion. The scale will also try to measure the direction of the emotional contagion, that is, whether it is positive or negative. This aim will be reflected to the second step of the methodology, which is the generation of a pool of items that reflect the scale's purpose. In this step, items that represent both the positive and negative dimensions of emotional contagion will be included. Since the properties of a scale are established by the items that are contained within (DeVellis, 2012), by this method of item inclusion, the proposed scale will reflect two dimensions: positive emotional contagion and negative emotional contagion. This way, the scale will be balanced in terms of measuring contagion on both ends, and also help determine, after the initial emotional contagion level of a person is found, the direction of this contagion as well. As seen numerous times within the literature, the contagion of positive and negative emotions can have significantly different effects on people depending of the context they are disseminated in. In the creation of the proposed item pool, a qualitative study will be conducted in order to see what people think the properties of an emotionally contagious person are. These can be done by interviews as well as focus groups, and the information gained in this phase will be valuable because the literature on emotional contagion, as stated, is somewhat lacking in certain areas, and the opinions of people may provide new insights for consideration in the item pool. The gathered data will then go through a content

analysis, resulting in the determination of the most frequently stated properties of emotionally influential people. After the items derived from the literature and qualitative research are pooled together, the third step will be their review by experts on the issue; colleagues, academicians and practitioners can all be included in this step. This will help in the selection of items that are most relevant to the latent variable and most effective in measuring it, while also increasing the content validity of the scale. Along with relevance, the items will also be evaluated for clarity, conciseness and consistency (DeVellis, 2012). The fourth step in methodology will be deciding on the measurement format, that is, the type scale to be developed, such as Thurstone, Guttman, Likert etc. Naturally, this choice will be evaluated after the formation of the pool of items, since without the pool it is difficult to try to predict the format of the scale beforehand. The fifth step will be actually administrating the scale to a sufficiently large sample and seeing the results for further evaluation. Target population for the administration of the scale, again, will be determined after the items of the pool are clarified.

The sixth step is assessing the results of the administration of the scale, and evaluating the items accordingly. This appraisal of the items will show how highly they are correlated with the true score of the latent variable, and is also closely related to the reliability of the items and so the scale as well. Here, a factor analysis is likely to be used to determine which groups of items in the scale, if any, form one-dimensional sets, and can be taken into account together in a similar context. The length of the scale will also be optimized at this stage, and though shorter scales are easier to administer, longer scales tend to be more reliable, hence a balance will have to be reached between brevity and reliability.

As can be seen, the suggestions for the development of the proposed scale are provided only as reference points. They should be taken into account if one wants to formulate such a measurement tool. The rest, naturally, lies thorough extensive literature review, longitudinal and cross-sectional field studies, and thorough analyses of relevant findings.

CHAPTER 8

CONCLUSION

Health personnel, especially doctors, are expected to treat their patients, save their lives, emotionally reassure and support them and their families, and convey relevant information regarding their health situations, good or bad, to them simultaneously. Moreover, they are required to do these in environments where, due to the nature of their jobs, they deal with an abundance of patients and colleagues, with time and resource limitations, and continuous exposure to suffering and even death; yet they still are expected to remain calm and show comforting manners as to psychologically not affect their patients throughout this whole endeavor they go through almost each day (Le Blanc et al., 2001). In other words, they are made to work with limited physical and emotional resources, and expected to come up with nothing short of miracles on a daily basis, and this is one of the main reasons for conducting the current research on doctors in Turkey, as they are a unique and highly specialized group of people, and the examination of the effects of workload and emotional labor on their physical and psychological states, and how these states affect their organizational commitment and in return intentions to stay in an organization, and how emotional contagion and the susceptibility to it influence this commitment process, is likely to be of interest to researchers and practitioners in management, human resources, organizational behavior, psychology and medicine areas.

The current research shows that for doctors employed in health organizations in Turkey, organizational commitment is a major determinant of intention to stay, and this implies that health organizations, if they want to keep their medical staff working for them, are better off focusing on strategies and implementations aimed at

increasing the organizational commitment of their personnel. In other words, rather than focusing on how they can stop their personnel from leaving their institutions, they should instead focus on how they can make them stay, and proactively develop relevant applications and interventions to foster their organizational commitment. As another result, emotional labor is found to be positively associated with organizational commitment, meaning that health organizations should also emphasize the altruistic facets of their values and fitting emotions so that doctors can more easily internalize them via deep acting, and hence increase their commitments towards these organizations.

Emotional contagion and the susceptibility to it, on the other hand, are found to have dual roles in that they can play an enhancing effect on deep acting and increase the frequency and extent of the internalization of emotions, while at the same detrimentally affect various interacting parties in health organizations by making them more vulnerable to being influenced by the emotions around them, increasing the strains they suffer due to workload, and so potentially decreasing their organizational commitment towards their institutions. Health organizations, then, should be aware of the concept of emotional contagion and watch out for its negative effects on their personnel, while at the same time foster its positive effects, in terms of socialization, communication and internalization of feelings, so that their organizations become institutions where negative emotions affect people minimally while positive ones are spread rapidly and extensively, and even strategically, by the organizations themselves (Pugh, 2001).

As can be deduced from the current study, emotions play a crucial role wherever and whenever the human factor is involved, especially in service and health organizations, be they in the form of emotional labor, organizational commitment or

emotional contagion, and so should be comprehended and interpreted better such that their effects on people and organizations can be understood, controlled for, and if possible utilized for the benefit of the employees, institutions and clients, since only this way can people and organizations prosper and maintain their emotional wellbeing in the long run.

APPENDIX A

DESCRIPTIVE AND FREQUENCY ANALYSES

Descriptive Statistics

	N	Range	Minimum	Maximum	Sum	Mean		Std. Deviation	Variance
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error	Statistic	Statistic
Age	270	46	24	70	9393	34.789	0.6831	11.2241	125.981
Gender	270	1	1	2	403	1.493	0.0305	0.5009	0.251
Marital Status	270	1	1	2	380	1.407	0.03	0.4923	0.242
Number of Children	270	3	0	3	189	0.7	0.0573	0.942	0.887
Medicinal Degree	270	4	1	5	471	1.744	0.0751	1.2336	1.522
Administrative Duties	270	3	0	3	20	0.074	0.0218	0.3582	0.128
Working Time	270	1	1	2	283	1.048	0.0131	0.2145	0.046
Type of Hospital	270	2	1	3	405	1.5	0.0347	0.5703	0.325
Work Place	270	3	0	3	396	1.467	0.0685	1.1262	1.268
Number of Work Years	270	45	0	45	2459	9.107	0.6024	9.8987	97.985
Medicinal Branch	270	28	1	29	2717	10.063	0.555	9.1188	83.152
Valid N (listwise)	270								

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	137	50.7	50.7	50.7
	Female	133	49.3	49.3	100.0
	Total	270	100.0	100.0	

Marital Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Married	160	59.3	59.3	59.3
	Not Married	110	40.7	40.7	100.0
	Total	270	100.0	100.0	

Number of Children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	None	158	58.5	58.5	58.5
	1.0	49	18.1	18.1	76.7
	2.0	49	18.1	18.1	94.8
	3.0	14	5.2	5.2	100.0
	Total	270	100.0	100.0	

Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	24.0	3	1.1	1.1	1.1
	25.0	22	8.1	8.1	9.3
	26.0	26	9.6	9.6	18.9
	27.0	29	10.7	10.7	29.6
	28.0	32	11.9	11.9	41.5
	29.0	25	9.3	9.3	50.7
	30.0	16	5.9	5.9	56.7
	31.0	11	4.1	4.1	60.7
	32.0	2	.7	.7	61.5
	33.0	7	2.6	2.6	64.1
	34.0	3	1.1	1.1	65.2
	35.0	6	2.2	2.2	67.4
	36.0	5	1.9	1.9	69.3
	37.0	5	1.9	1.9	71.1
	38.0	5	1.9	1.9	73.0
	39.0	4	1.5	1.5	74.4
	40.0	6	2.2	2.2	76.7
	41.0	7	2.6	2.6	79.3
	42.0	3	1.1	1.1	80.4
	43.0	3	1.1	1.1	81.5
	44.0	1	.4	.4	81.9
	45.0	2	.7	.7	82.6
	46.0	5	1.9	1.9	84.4
	47.0	1	.4	.4	84.8
	48.0	3	1.1	1.1	85.9
	49.0	3	1.1	1.1	87.0
	50.0	1	.4	.4	87.4
	51.0	1	.4	.4	87.8
	52.0	2	.7	.7	88.5
	53.0	2	.7	.7	89.3
	54.0	3	1.1	1.1	90.4
	55.0	1	.4	.4	90.7
	56.0	2	.7	.7	91.5
	57.0	1	.4	.4	91.9
	58.0	3	1.1	1.1	93.0
	59.0	6	2.2	2.2	95.2
	60.0	1	.4	.4	95.6
	61.0	1	.4	.4	95.9
	63.0	2	.7	.7	96.7
	64.0	3	1.1	1.1	97.8
	65.0	1	.4	.4	98.1
	66.0	2	.7	.7	98.9
	68.0	1	.4	.4	99.3
	69.0	1	.4	.4	99.6
	70.0	1	.4	.4	100.0
	Total	270	100.0	100.0	

Administrative Duty

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	None	256	94.8	94.8	94.8
	Supervisor	10	3.7	3.7	98.5
	Department Head	2	.7	.7	99.3
	Chief Doctor	2	.7	.7	100.0
	Total	270	100.0	100.0	

Medicinal Degree

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Assistant	167	61.9	61.9	61.9
	Specialist	64	23.7	23.7	85.6
	Assistant Professor	2	.7	.7	86.3
	Associate Professor	15	5.6	5.6	91.9
	Professor	22	8.1	8.1	100.0
	Total	270	100.0	100.0	

Working Time

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Full Time	257	95.2	95.2	95.2
	Part Time	13	4.8	4.8	100.0
	Total	270	100.0	100.0	

Hospital Type

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Public	145	53.7	53.7	53.7
	University	115	42.6	42.6	96.3
	Private	10	3.7	3.7	100.0
	Total	270	100.0	100.0	

Work Place

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	None	70	25.9	25.9	25.9
	Service	71	26.3	26.3	52.2
	Clinic	62	23.0	23.0	75.2
	Both	67	24.8	24.8	100.0
	Total	270	100.0	100.0	

Work Years

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.0	1	.4	.4	.4
	1.0	28	10.4	10.4	10.7
	2.0	41	15.2	15.2	25.9
	3.0	31	11.5	11.5	37.4
	4.0	36	13.3	13.3	50.7
	5.0	17	6.3	6.3	57.0
	6.0	14	5.2	5.2	62.2
	7.0	7	2.6	2.6	64.8
	8.0	4	1.5	1.5	66.3
	9.0	3	1.1	1.1	67.4
	10.0	8	3.0	3.0	70.4
	11.0	2	.7	.7	71.1
	12.0	7	2.6	2.6	73.7
	13.0	6	2.2	2.2	75.9
	14.0	3	1.1	1.1	77.0
	15.0	14	5.2	5.2	82.2
	16.0	4	1.5	1.5	83.7
	17.0	1	.4	.4	84.1
	18.0	2	.7	.7	84.8
	19.0	1	.4	.4	85.2
	20.0	1	.4	.4	85.6
	21.0	1	.4	.4	85.9
	22.0	6	2.2	2.2	88.1
	23.0	2	.7	.7	88.9
	24.0	3	1.1	1.1	90.0
	26.0	3	1.1	1.1	91.1
	27.0	1	.4	.4	91.5
	28.0	1	.4	.4	91.9
	29.0	2	.7	.7	92.6
	30.0	6	2.2	2.2	94.8
	31.0	1	.4	.4	95.2
	33.0	2	.7	.7	95.9
	34.0	2	.7	.7	96.7
	35.0	3	1.1	1.1	97.8
	40.0	3	1.1	1.1	98.9
	41.0	1	.4	.4	99.3
	45.0	2	.7	.7	100.0
	Total	270	100.0	100.0	

Medicinal Branch

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Pediatric diseases	41	15.2	15.2	15.2
	Child psychiatry	1	.4	.4	15.6
	Dermatology	55	20.4	20.4	35.9
	Infectious diseases	14	5.2	5.2	41.1
	Physical therapy	2	.7	.7	41.9
	Pulmonology	19	7.0	7.0	48.9
	Internal diseases	46	17.0	17.0	65.9
	Cardiology	1	.4	.4	66.3
	Psychiatry	3	1.1	1.1	67.4
	Emergency medicine	7	2.6	2.6	70.0
	Anesthesia	1	.4	.4	70.4
	Surgery	2	.7	.7	71.1
	Pulmonary surgery	1	.4	.4	71.5
	Ophthalmology	4	1.5	1.5	73.0
	Gynecology	3	1.1	1.1	74.1
	Otorhinolaryngology	17	6.3	6.3	80.4
	Neurosurgery	3	1.1	1.1	81.5
	Orthopedics	17	6.3	6.3	87.8
	Plastic surgery	3	1.1	1.1	88.9
	Urology	15	5.6	5.6	94.4
	Radiology	11	4.1	4.1	98.5
	Other	4	1.5	1.5	100.0
	Total	270	100.0	100.0	

APPENDIX B

QUESTIONNAIRE (ENGLISH)

Dear participant, this research, supported by TÜBİTAK, is being conducted by Boğaziçi University, Department of Management, Ph.D. Program students, and all information will be used solely for academic purposes; thank you for your participation.

A. Participant information

A.1. Age: ……

A.2. Gender:

1	Male
2	Female

A.3. Marital status:

1	Married
2	Not married

A.4. Children:

1	Yes
0	No

=> Number of children: ……

A.5. Medicinal expertise:

1	Assistant
2	Specialist
3	Assistant professor
4	Associate professor
5	Professor

A.6. Administrative Duty (if any):

1	Chief
2	Department head
3	Head doctor
4	Dean
5	Rector

A.7. Working Time:

1	Full time
2	Part time (private office, hospital etc.)

A.8. Hospital type:

1	Public hospital
2	University hospital
3	Private hospital

A.9. Area of responsibility:

1	Service
2	Clinic
3	Both

A.10. Professional work experience: ……

B. Medicinal branch:

	Internal Diseases		Surgical Branches		Laboratory Group
1	Pediatric diseases	13	Emergency medicine	26	Nuclear medicine
2	Child psychiatry	14	Anesthesia	27	Pathology
3	Dermatology	15	Surgery	28	Radiology
4	Infectious diseases	16	Child surgery	29	Other
5	Physical therapy	17	Pulmonary surgery	30	Family doctor
6	Pulmonology	18	Ophthalmology		
7	Internal diseases	19	Gynecology		
8	Cardiology	20	Heart and vascular surgery		
9	Neurology	21	Otorhinolaryngology		
10	Oncology	22	Neurosurgery		
11	Psychiatry	23	Orthopedics		
12	Radiation oncology	24	Plastic surgery		
		25	Urology		

C. Workload

Please read the following sentences and evaluate their validness for yourself between 1 and 5.

		Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Disagree
C.1	1. I do not have time to do the work that must be done.	1	2	3	4	5
C.2	2. I work intensely for prolonged periods of time.	1	2	3	4	5
C.3	3. After work I come home too tired to do the things I like to do.	1	2	3	4	5
C.4	4. I have so much work to do on the job that it takes me away from my personal interests.	1	2	3	4	5
C.5	5. I have enough time to do what's important in my job.	1	2	3	4	5
C.6	6. I leave my work behind when I go home at the end of the day.	1	2	3	4	5

D. Emotional labor

		Never	Rarely	Sometimes	Often	Always
D.1	1. Show emotions that I don't feel.	1	2	3	4	5
D.2	2. Make an effort to actually feel the emotions that I need to display to others.	1	2	3	4	5
D.3	3. Hide my true feelings about a situation.	1	2	3	4	5
D.4	4. Pretend to have emotions that I don't really have.	1	2	3	4	5
D.5	5. Really try to feel the emotions I have to show as a part of my job.	1	2	3	4	5
D.6	6. Show emotions that are expected rather than what I feel.	1	2	3	4	5
D.7	7. Resist expressing my true feelings.	1	2	3	4	5
D.8	8. Conceal what I'm feeling.	1	2	3	4	5
D.9	9. Try to actually experience the emotions that I must show.	1	2	3	4	5

E. Emotional contagion

		Never	Rarely	Sometimes	Often	Always
E.1	1. If someone I'm talking with begins to cry, I get teary-eyed.	1	2	3	4	5
E.2	2. Being with a happy person picks me up when I'm feeling down.	1	2	3	4	5
E.3	3. When someone smiles warmly at me, I smile back and feel warm inside.	1	2	3	4	5
E.4	4. I get filled with sorrow when people talk about the death of their loved ones.	1	2	3	4	5
E.5	5. I clench my jaws and my shoulders get tight when I see the angry faces on the news.	1	2	3	4	5
E.6	6. When I look into the eyes of the one I love, my mind is filled with thoughts of romance.	1	2	3	4	5
E.7	7. It irritates me to be around angry people.	1	2	3	4	5
E.8	8. Watching the fearful faces of victims on the news makes me try to imagine how they might be feeling.	1	2	3	4	5
E.9	9. I melt when the one I love holds me close.	1	2	3	4	5
E.10	10. I tense when overhearing an angry quarrel.	1	2	3	4	5
E.11	11. Being around happy people fills my mind with happy thoughts.	1	2	3	4	5
E.12	12. I sense my body responding when the one I love touches me.	1	2	3	4	5
E.13	13. I notice myself getting tense when I'm around people who are stressed out.	1	2	3	4	5
E.14	14. I cry at sad movies.	1	2	3	4	5
E.15	15. Listening to the shrill screams of a terrified child in a dentist's waiting room makes me feel nervous.	1	2	3	4	5

F. Intention to stay

		Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Disagree
F.1	1. If I were completely free to choose, I would prefer to keep working in this organization.	1	2	3	4	5
F.2	2. I would like to stay at this organization for a long time.	1	2	3	4	5
F.3	3. If I had to quit work for a while (for example because of personal / family reasons), I would return to this organization.	1	2	3	4	5

G. Organizational commitment

		Never	Rarely	Sometimes	Often	Always
G.1	1. I would be very happy to spend the rest of my career with this organizations.	1	2	3	4	5
G.2	2. I really feel as if this organization's problems are my own.	1	2	3	4	5
G.3	3. I do not feel like part of the family at my organization.	1	2	3	4	5
G.4	4. I do not feel emotionally attached to this organization.	1	2	3	4	5
G.5	5. This organization has a great deal of personal meaning for me	1	2	3	4	5
G.6	6. I do not feel a strong sense of belonging to my organization.	1	2	3	4	5
G.7	7. It would be very hard for me to leave my organization right now even if I wanted to.	1	2	3	4	5
G.8	8. Too much of my life would be disrupted if I decided I wanted to leave my organization now.	1	2	3	4	5
G.9	9. Right now staying with my organization is a matter of necessity as much as desire.	1	2	3	4	5
G.10	10. I feel that I have too few options to leave this organization.	1	2	3	4	5
G.11	11. One of the few negative consequences of leaving this organization would be the scarcity of available alternatives.	1	2	3	4	5
G.12	12. If I had not already put so much of myself into this organization I might consider working elsewhere.	1	2	3	4	5
G.13	13. I do not feel any obligation to remain with my current employer.	1	2	3	4	5
G.14	14. Even if it were to my advantage I do not feel it would be right to leave my organization now.	1	2	3	4	5
G.15	15. I would feel guilty if I left my organization now.	1	2	3	4	5
G.16	16. This organization deserves my loyalty.	1	2	3	4	5
G.17	17. I would not leave my organization right now because I have a sense of obligation to the people in it.	1	2	3	4	5
G.18	18. I owe a great deal to my organization.	1	2	3	4	5

APPENDIX C

QUESTIONNAIRE (TURKISH)

Değerli katılımcı, TÜBİTAK burs destekli bu araştırma, Boğaziçi Üniversitesi İşletme Bölümü Doktora Programı öğrencileri tarafından yürütülmekte olup, tüm bilgiler akademik amaçlı olarak kullanılacaktır; katılımınız için teşekkür ederiz.

C. Katılımcı bilgileri

A.1. Yaşınız: ……

A.2. Cinsiyetiniz:

1	Erkek
2	Kadın

A.3. Medeni durumunuz:

1	Evli
2	Evli değil

A.4. Çocuk durumunuz:

1	Evet => Çocuk sayınız: ……
0	Hayır

A.5. Uzmanlık düzeyiniz:

1	Asistan
2	Uzman
3	Yardımcı doçent
4	Doçent
5	Profesör

A.6. İdari göreviniz (varsa):

1	Şef
2	Anabilim dalı başkanı
3	Başhekim
4	Dekan
5	Rektör

A.7. Çalışma şekliniz:

1	Tam zamanlı
2	Yarı zamanlı (muayenehane, özel hastane vb.)

A.8. Çalıştığınız hastane türü:

1	Devlet hastanesi
2	Üniversite hastanesi
3	Özel hastane

A.9. Halihazırda çalıştığınız görev alanı:

1	Servis
2	Poliklinik
3	Her ikisi de

A.10. Profesyonel çalışma yılınız: ……

D. Çalıştığınız branş / tıp dalı:

	Dahili Bilimler		Cerrahi Bilimler		Laboratuvar Grubu
1	Çocuk Hastalıkları	13	Acil Tıp	26	Nükleer Tıp
2	Çocuk Psikiyatrisi	14	Anestezi	27	Patoloji
3	Dermatoloji	15	Cerrahi	28	Radyoloji
4	Enfeksiyon Hastalıkları	16	Çocuk Cerrahisi	29	Diğer
5	Fizik Tedavi	17	Göğüs Cerrahisi	30	Aile Hekimi
6	Göğüs Hastalıkları	18	Göz Hastalıkları		
7	İç Hastalıkları	19	Kadın Hastalıkları		
8	Kardiyoloji	20	Kalp ve Damar Cerrahisi		
9	Nöroloji	21	Kulak, Burun, Boğaz		
10	Onkoloji	22	Nöroşirurji		
11	Psikiyatri	23	Ortopedi		
12	Radyasyon Onkolojisi	24	Plastik Cerrahi		
		25	Üroloji		

C. İş yükü

Lütfen aşağıdaki cümleleri okuyup kendiniz için doğruluğunu 1 ile 5 arasında değerlendiriniz.

		Kesinlikle katılmıyorum	Katılmıyorum	Ne Katılıyorum Ne Katılmıyorum	Katılıyorum	Kesinlikle katılıyorum
C.1	1. Yapılması gereken işi yapacak zamanım olmuyor.	1	2	3	4	5
C.2	2. Uzun süreler boyunca yoğun olarak çalışıyorum.	1	2	3	4	5
C.3	3. İşten sonra eve, sevdiğim şeyleri yapamayacak kadar yorgun geliyorum.	1	2	3	4	5
C.4	4. İşyerinde yapacak o kadar çok işim var ki, kişisel ilgi alanlarımdan uzaklaşıyorum.	1	2	3	4	5
C.5	5. İşim için önemli olanı yapacak yeterli zamanım oluyor.	1	2	3	4	5
C.6	6. İş gününün sonunda eve iş getirmiyorum.	1	2	3	4	5

D. Duygusal yük

		Hiçbir zaman	Nadiren	Ara sıra	Çok sık	Her zaman
D.1	1. Hissetmediğim duyguları gösteririm.	1	2	3	4	5
D.2	2. Başkalarına göstermem gereken duyguları hissetmek için çaba harcarım.	1	2	3	4	5
D.3	3. Bir durumla ilgili gerçek duygularımı saklarım.	1	2	3	4	5
D.4	4. Sahip olmadığım duygulara sahipmişim gibi davranırım.	1	2	3	4	5
D.5	5. İşim gereği göstermem gereken duyguları gerçekten hissetmeye çalışırım.	1	2	3	4	5
D.6	6. Hissettiğim duyguları göstermek yerine beklenen duyguları gösteririm.	1	2	3	4	5
D.7	7. Gerçek duygularımı ifade etmeye direnç gösteririm.	1	2	3	4	5
D.8	8. Hissettiğim duyguları saklarım.	1	2	3	4	5
D.9	9. Göstermem gereken duyguları gerçekten deneyimlemeye çalışırım.	1	2	3	4	5

E. Duygusal bulaşıcılık

		Hiçbir zaman	Nadiren	Ara sıra	Çok sık	Her zaman
E.1	1. Konuştuğum biri ağlamaya başlarsa gözlerim dolar.	1	2	3	4	5
E.2	2. Kendimi kötü hissettiğimde mutlu bir insanla birlikte olmak moralimi düzeltir.	1	2	3	4	5
E.3	3. Biri bana sıcak bir şekilde gülümsediğinde ben de ona gülümser ve kendimi iyi hissederim.	1	2	3	4	5
E.4	4. İnsanlar sevdiklerinin ölümünden bahsederken içim üzüntüyle dolar.	1	2	3	4	5
E.5	5. Haberlerde sinirli yüzler gördüğümde çenemi sıkarım ve omuzlarım gerilir.	1	2	3	4	5
E.6	6. Sevdiğimin gözlerinin içine bakınca aklım romantik düşüncelerle dolar.	1	2	3	4	5
E.7	7. Sinirli insanların yanında olmak sinirlerimi bozar.	1	2	3	4	5
E.8	8. Haberlerde mağdur insanların korku dolu yüzlerini izlemek, nasıl hissettiklerini hayal etmeye çalışmama neden olur.	1	2	3	4	5
E.9	9. Sevdiğim kişi bana sarıldığında içim güzel duygularla dolar.	1	2	3	4	5
E.10	10. Hiddetli bir tartışmaya kulak misafiri olduğumda gerilirim.	1	2	3	4	5
E.11	11. Mutlu insanların çevresinde olmak aklımı mutlu düşüncelerle doldurur.	1	2	3	4	5
E.12	12. Sevdiğim bana dokunduğunda vücudumun karşılık verdiğini hissederim.	1	2	3	4	5
E.13	13. Stresli insanların çevresinde olduğumda gerildiğimi fark ederim.	1	2	3	4	5
E.14	14. Hüzünlü filmlerde ağlarım.	1	2	3	4	5
E.15	15. Dişçi bekleme odasında, korkmuş bir çocuğun kulak tırmalayıcı çığlıklarını dinlemek beni endişelendirir.	1	2	3	4	5

F. Kalma niyeti

		Kesinlikle katılmıyorum	Katılmıyorum	Ne Katılıyorum Ne Katılmıyorum	Katılıyorum	Kesinlikle katılıyorum
F.1	1. Bu organizasyonda uzun süre kalmak isterim.	1	2	3	4	5
F.2	2. Seçme şansım olsaydı, bu organizasyonda çalışmaya devam etmeyi tercih ederdim.	1	2	3	4	5
F.3	3. Bir süre işten ayrılmam gerekseydi (örneğin kişisel / ailevi sebeplerle) bu organizasyona geri dönerdim.	1	2	3	4	5

G. Kurumsal bağlılık

		Hiçbir zaman	Nadiren	Ara sıra	Çok sık	Her zaman
G.1	1. Kariyerimin geri kalanını bu organizasyonda geçirmekten mutlu olurum.	1	2	3	4	5
G.2	2. Gerçekten bu organizasyonun problemleri kendi problemimmiş gibi hissediyorum.	1	2	3	4	5
G.3	3. Organizasyonumda ailenin bir parçası gibi hissetmiyorum.	1	2	3	4	5
G.4	4. Organizasyona duygusal olarak bağlı hissetmiyorum.	1	2	3	4	5
G.5	5. Bu organizasyon benim için çok özel bir anlamı var.	1	2	3	4	5
G.6	6. Organizasyonuma güçlü bir aidiyet hissetmiyorum.	1	2	3	4	5
G.7	7. Şu anda istesem bile organizasyonumu bırakmam çok zor olurdu.	1	2	3	4	5
G.8	8. Şu anda organizasyonumu bırakmak istediğime karar verseydim hayatımın çok büyük bir bölümü sekteye uğrardı.	1	2	3	4	5
G.9	9. Şu anda organizasyonumda kalmam bir istek olduğu kadar ihtiyaç da meselesi.	1	2	3	4	5
G.10	10. Bu organizasyonu bırakmayı düşünmek için çok az seçeneğimin olduğunu hissediyorum.	1	2	3	4	5
G.11	11. Bu organizasyonu bırakmanın nadir negatif sonuçlarından biri mevcut alternatiflerin azlığıdır.	1	2	3	4	5
G.12	12. Bu organizasyona bu kadar çok yatırım yapmış olmasaydım başka bir yerde çalışmayı düşünebilirdim.	1	2	3	4	5
G.13	13. Mevcut işverenimle kalmak için herhangi bir zorunluluk hissetmiyorum.	1	2	3	4	5
G.14	14. Yararıma olsa bile şu anda organizasyonumu bırakmanın doğru olacağını hissetmiyorum.	1	2	3	4	5
G.15	15. Şu anda organizasyonumu bıraksam suçlu hissederdim.	1	2	3	4	5
G.16	16. Bu organizasyon benim sadakatimi hak ediyor.	1	2	3	4	5
G.17	17. Organizasyonumu şu anda bırakmazdım çünkü içindeki insanlara karşı sorumluluk hissediyorum.	1	2	3	4	5
G.18	18. Birçok şeyi organizasyonuma borçluyum.	1	2	3	4	5

APPENDIX D

RELIABILITY AND SAMPLING ADEQUACY ANALYSES

Reliability Statistics

Cronbach's Alpha	N of Items
.749	6

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
C1	17.941	12.933	.548	.696
C2	17.144	13.299	.590	.688
C3	17.219	12.900	.654	.671
C4	17.267	12.077	.684	.656
C5	18.441	15.779	.177	.793
C6	17.767	13.681	.360	.754

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.817
Bartlett's Test of Sphericity	Approx. Chi-Square	474.865
	df	15
	Sig.	.000

Reliability Statistics: Emotional Labor

Cronbach's Alpha	N of Items
.762	9

Item-Total Statistics: Emotional Labor

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
D3	19.981	21.743	.550	.726
D7	20.107	21.182	.496	.731
D8	20.093	22.055	.478	.735
D1	20.333	22.297	.391	.748
D2	20.130	21.727	.405	.746
D4	20.707	21.516	.528	.728
D5	19.456	23.119	.252	.771
D6	20.137	20.513	.575	.718
D9	19.767	22.261	.356	.754

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.750
Bartlett's Test of Sphericity	Approx. Chi-Square	678.159
	df	36
	Sig.	.000

Reliability Statistics

Cronbach's Alpha	N of Items
.858	15

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
E1	49.867	65.246	.542	.847
E2	49.059	68.926	.349	.857
E3	48.463	68.644	.452	.852
E4	48.952	65.050	.575	.845
E5	49.867	64.978	.493	.850
E6	49.215	68.281	.371	.856
E7	48.693	65.939	.568	.846
E8	49.026	66.144	.527	.848
E9	48.333	69.502	.438	.853
E10	48.896	64.264	.623	.842
E11	48.600	67.349	.571	.847
E12	48.630	68.457	.429	.853
E13	48.615	65.717	.612	.844
E14	49.626	64.168	.513	.849
E15	49.885	65.797	.433	.854

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.866
Bartlett's Test of Sphericity	Approx. Chi-Square	1352.116
	df	105
	Sig.	.000

Reliability Statistics

Cronbach's Alpha	N of Items
.915	3

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
F1	6.659	4.285	.804	.899
F2	6.596	4.078	.883	.831
F3	6.448	4.575	.803	.899

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.727
Bartlett's Test of Sphericity	Approx. Chi-Square	595.085
	df	3
	Sig.	.000

Reliability Statistics

Cronbach's Alpha	N of Items
.795	18

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
G1	55.274	89.159	.504	.778
G2	55.081	91.309	.437	.782
G3	55.185	95.891	.185	.798
G4	54.996	92.777	.328	.789
G5	55.363	89.057	.500	.778
G6	55.074	91.571	.375	.786
G7	55.048	91.719	.383	.786
G8	55.207	89.146	.451	.781
G9	54.878	94.479	.257	.793
G10	55.244	92.921	.281	.793
G11	55.344	97.736	.079	.806
G12	55.444	95.393	.200	.797
G13	55.204	95.620	.182	.798
G14	54.996	90.688	.432	.782
G15	55.381	86.088	.554	.773
G16	55.374	87.848	.528	.776
G17	55.096	86.771	.596	.771
G18	55.363	88.723	.523	.776

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.859
Bartlett's Test of Sphericity	Approx. Chi-Square	2032.475
	df	153
	Sig.	.000

Reliability Statistics

Cronbach's Alpha	N of Items
.628	3

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
D2	5.956	3.150	.384	.601
D5	5.281	2.909	.460	.496
D9	5.593	2.956	.468	.485

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.637
Bartlett's Test of Sphericity	Approx. Chi-Square	97.389
	df	3
	Sig.	.000

Reliability Statistics

Cronbach's Alpha	N of Items
.796	6

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
D1	11.919	12.254	.390	.802
D3	11.567	11.466	.635	.747
D4	12.293	11.397	.587	.756
D6	11.722	10.989	.569	.760
D7	11.693	11.158	.542	.767
D8	11.678	11.461	.600	.754

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.788
Bartlett's Test of Sphericity	Approx. Chi-Square	500.048
	df	15
	Sig.	.000

Reliability Statistics

Cronbach's Alpha	N of Items
.743	6

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
E2	19.519	9.433	.360	.745
E3	18.922	9.351	.495	.704
E6	19.674	9.053	.402	.734
E9	18.793	9.332	.577	.686
E11	19.059	9.067	.585	.681
E12	19.089	8.951	.528	.693

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.773
Bartlett's Test of Sphericity	Approx. Chi-Square	385.850
	df	15
	Sig.	.000

Reliability Statistics

Cronbach's Alpha	N of Items
.841	9

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
E1	26.856	32.511	.587	.821
E4	25.941	33.409	.527	.828
E5	26.856	32.131	.545	.826
E7	25.681	33.355	.587	.822
E8	26.015	33.517	.542	.826
E10	25.885	32.310	.626	.817
E13	25.604	33.251	.628	.819
E14	26.615	31.777	.545	.827
E15	26.874	33.137	.447	.838

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.862
Bartlett's Test of Sphericity	Approx. Chi-Square	797.872
	df	36
	Sig.	.000

Reliability Statistics

Cronbach's Alpha	N of Items
.842	6

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
G1	16.522	18.548	.639	.813
G2	16.330	19.783	.551	.829
G3	16.433	19.726	.502	.839
G4	16.244	17.985	.703	.799
G5	16.611	18.276	.658	.809
G6	16.322	18.100	.671	.806

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.820
Bartlett's Test of Sphericity	Approx. Chi-Square	689.063
	df	15
	Sig.	.000

Reliability Statistics

Cronbach's Alpha	N of Items
.833	6

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
G7	16.104	21.759	.514	.823
G8	16.263	20.395	.581	.811
G9	15.933	20.776	.632	.801
G10	16.300	18.806	.741	.776
G11	16.400	20.033	.600	.807
G12	16.500	21.032	.568	.813

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.820
Bartlett's Test of Sphericity	Approx. Chi-Square	581.418
	df	15
	Sig.	.000

Reliability Statistics

Cronbach's Alpha	N of Items
.723	6

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
G13	16.011	19.520	.081	.787
G14	15.804	17.326	.339	.717
G15	16.189	14.131	.603	.635
G16	16.181	14.960	.574	.648
G17	15.904	14.519	.652	.624
G18	16.170	15.555	.548	.658

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.801
Bartlett's Test of Sphericity	Approx. Chi-Square	399.166
	df	15
	Sig.	.000

APPENDIX E

NORMALITY AND MULTICOLLINEARITY ANALYSES

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
WORKLOAD	.116	270	.000	.973	270	.000
EMOTIONAL LABOR	.083	270	.000	.990	270	.075
ORG. COMM.	.075	270	.001	.987	270	.017
INT. STAY	.144	270	.000	.955	270	.000
EMOTIONAL CONT.	.061	270	.016	.985	270	.005

a. Lilliefors Significance Correction

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Collinearity Statistics	
		B	Std. Error	Beta			Tolerance	VIF
1	(Constant)	3.044	.298		10.204	.000		
	EMOTIONAL LABOR	.102	.077	.082	1.333	.184	.975	1.025
	ORG. COMM.	.069	.079	.054	.880	.380	.975	1.025

a. Dependent Variable: WORKLOAD

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Collinearity Statistics	
		B	Std. Error	Beta			Tolerance	VIF
1	(Constant)	1.777	.258		6.886	.000		
	ORG. COMM.	.156	.062	.151	2.504	.013	.995	1.005
	WORKLOAD	.065	.049	.081	1.333	.184	.995	1.005

a. Dependent Variable: EMOTIONAL LABOR

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Collinearity Statistics	
		B	Std. Error	Beta			Tolerance	VIF
1	(Constant)	2.730	.215		12.671	.000		
	WORKLOAD	.042	.047	.053	.880	.380	.992	1.008
	EMOTIONAL LABOR	.147	.059	.152	2.504	.013	.992	1.008

a. Dependent Variable: ORG. COMM.

APPENDIX F

HARMAN'S SINGLE FACTOR TEST

Total Variance Explained

	Initial Eigenvalues			Extraction Sums of Squared Loadings		
Factor	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	6.883	13.495	13.495	6.337	12.425	12.425
2	5.783	11.340	24.835			
3	4.415	8.656	33.491			
4	3.025	5.931	39.422			
5	2.717	5.327	44.749			
6	1.854	3.636	48.385			
7	1.560	3.059	51.444			
8	1.485	2.912	54.356			
9	1.408	2.760	57.116			
10	1.214	2.381	59.497			
11	1.187	2.328	61.825			
12	1.126	2.208	64.034			
13	1.060	2.078	66.112			
14	.980	1.922	68.034			
15	.933	1.830	69.863			
16	.867	1.699	71.563			
17	.786	1.541	73.104			
18	.773	1.516	74.620			
19	.713	1.398	76.018			
20	.698	1.369	77.387			
21	.679	1.331	78.718			
22	.648	1.271	79.989			
23	.637	1.249	81.237			
24	.597	1.171	82.409			
25	.573	1.123	83.532			
26	.539	1.057	84.589			
27	.522	1.023	85.613			
28	.492	.965	86.578			
29	.483	.946	87.524			
30	.476	.933	88.457			
31	.453	.888	89.345			
32	.410	.804	90.149			
33	.400	.784	90.932			
34	.387	.759	91.692			
35	.386	.757	92.449			
36	.348	.682	93.131			
37	.344	.675	93.807			
38	.315	.617	94.424			
39	.305	.597	95.021			
40	.280	.548	95.569			
41	.271	.532	96.101			
42	.252	.494	96.595			
43	.244	.478	97.073			
44	.230	.450	97.523			
45	.227	.446	97.969			
46	.222	.435	98.404			
47	.199	.390	98.794			
48	.189	.371	99.166			
49	.173	.339	99.505			
50	.147	.289	99.794			
51	.105	.206	100.000			

Extraction Method: Principal Axis Factoring.

APPENDIX G

COMPARISON ANALYSES

Group Statistics

	Gender	N	Mean	Std. Deviation	Std. Error Mean
WORKLOAD	Male	137	3.4063	.74504	.06365
	Female	133	3.6491	.66454	.05762
EMOTIONAL LABOR	Male	137	2.5929	.59214	.05059
	Female	133	2.4244	.54687	.04742
INT. STAY	Male	137	3.3893	.98979	.08456
	Female	133	3.1754	1.03685	.08991
ORG. COMM.	Male	137	3.2583	.56582	.04834
	Female	133	3.2352	.55441	.04807
EMOTIONAL CONT.	Male	137	3.3706	.54941	.04694
	Female	133	3.7525	.50939	.04417

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
WORKLOAD	Equal variances assumed	1.083	.299	-2.823	268	.005	-.24280	.08601	-.41213	-.07346
	Equal variances not assumed			-2.828	266.109	.005	-.24280	.08586	-.41185	-.07374
EMOTIONAL LABOR	Equal variances assumed	.409	.523	2.427	268	.016	.16847	.06942	.03179	.30515
	Equal variances not assumed			2.430	267.340	.016	.16847	.06934	.03195	.30499
INT. STAY	Equal variances assumed	.538	.464	1.734	268	.084	.21386	.12334	-.02899	.45670
	Equal variances not assumed			1.733	266.456	.084	.21386	.12343	-.02916	.45687
ORG. COMM.	Equal variances assumed	.079	.779	.339	268	.735	.02314	.06820	-.11113	.15741
	Equal variances not assumed			.339	267.976	.735	.02314	.06818	-.11109	.15737
EMOTIONAL CONT.	Equal variances assumed	.428	.514	-5.918	268	.000	-.38187	.06453	-.50891	-.25482
	Equal variances not assumed			-5.925	267.438	.000	-.38187	.06445	-.50877	-.25497

Group Statistics

	Marital Status	N	Mean	Std. Deviation	Std. Error Mean
WORKLOAD	Married	160	3.5333	.74037	.05853
	Not Married	110	3.5152	.68124	.06495
EMOTIONAL LABOR	Married	160	2.4701	.55733	.04406
	Not Married	110	2.5677	.59870	.05708
INT. STAY	Married	160	3.3250	1.02379	.08094
	Not Married	110	3.2242	1.00874	.09618
ORG. COMM.	Married	160	3.2389	.56748	.04486
	Not Married	110	3.2586	.54958	.05240
EMOTIONAL CONT.	Married	160	3.6387	.56830	.04493
	Not Married	110	3.4424	.53570	.05108

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
WORKLOAD	Equal variances assumed	.986	.322	.205	268	.838	.01818	.08880	-.15664	.19301
	Equal variances not assumed			.208	246.478	.835	.01818	.08744	-.15403	.19040
EMOTIONAL LABOR	Equal variances assumed	1.305	.254	-1.371	268	.172	-.09754	.07116	-.23764	.04256
	Equal variances not assumed			-1.353	223.245	.178	-.09754	.07211	-.23964	.04457
INT. STAY	Equal variances assumed	.040	.842	.799	268	.425	.10076	.12605	-.14742	.34893
	Equal variances not assumed			.802	236.676	.424	.10076	.12570	-.14688	.34840
ORG. COMM.	Equal variances assumed	.008	.928	-.284	268	.777	-.01970	.06939	-.15632	.11693
	Equal variances not assumed			-.286	239.239	.775	-.01970	.06898	-.15559	.11619
EMOTIONAL CONT.	Equal variances assumed	.221	.638	2.854	268	.005	.19629	.06878	.06088	.33170
	Equal variances not assumed			2.886	243.140	.004	.19629	.06802	.06230	.33028

Group Statistics

	Type of Hospital	N	Mean	Std. Deviation	Std. Error Mean
WORKLOAD	Public	145	3.5057	.66068	.05487
	University	115	3.6333	.69290	.06461
EMOTIONAL LABOR	Public	145	2.5011	.54435	.04521
	University	115	2.5130	.59773	.05574
INT. STAY	Public	145	3.0276	.98092	.08146
	University	115	3.5536	.96517	.09000
ORG. COMM.	Public	145	3.1571	.48641	.04039
	University	115	3.3575	.62053	.05786
EMOTIONAL CONT.	Public	145	3.5544	.56281	.04674
	University	115	3.5679	.55407	.05167

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
WORKLOAD	Equal variances assumed	.195	.659	-1.513	258	.131	-.12759	.08430	-.29359	.03842
	Equal variances not assumed			-1.505	239.211	.134	-.12759	.08477	-.29457	.03940
EMOTIONAL LABOR	Equal variances assumed	.570	.451	-.168	258	.867	-.01189	.07099	-.15170	.12791
	Equal variances not assumed			-.166	233.362	.869	-.01189	.07177	-.15329	.12950
INT. STAY	Equal variances assumed	.018	.894	-4.325	258	.000	-.52604	.12162	-.76553	-.28654
	Equal variances not assumed			-4.333	246.383	.000	-.52604	.12139	-.76514	-.28694
ORG. COMM.	Equal variances assumed	3.522	.062	-2.919	258	.004	-.20040	.06864	-.33557	-.06523
	Equal variances not assumed			-2.840	212.274	.005	-.20040	.07057	-.33951	-.06129
EMOTIONAL CONT.	Equal variances assumed	.087	.768	-.193	258	.847	-.01347	.06980	-.15091	.12398
	Equal variances not assumed			-.193	246.329	.847	-.01347	.06967	-.15069	.12376

Group Statistics

	Age_Gr	N	Mean	Std. Deviation	Std. Error Mean
WORKLOAD	<30	137	3.5949	.67724	.05786
	≥30	133	3.4549	.74905	.06495
EMOTIONAL LABOR	<30	137	2.4882	.54456	.04652
	≥30	133	2.5322	.60690	.05262
INT. STAY	<30	137	3.1460	.98673	.08430
	≥30	133	3.4261	1.03178	.08947
ORG. COMM.	<30	137	3.2360	.53812	.04597
	≥30	133	3.2581	.58216	.05048
EMOTIONAL CONT.	<30	137	3.4882	.55541	.04745
	≥30	133	3.6314	.56278	.04880

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
WORKLOAD	Equal variances assumed	.507	.477	1.612	268	.108	.14000	.08686	-.03100	.31101
	Equal variances not assumed			1.609	263.545	.109	.14000	.08699	-.03127	.31128
EMOTIONAL LABOR	Equal variances assumed	.532	.466	-.626	268	.532	-.04392	.07013	-.18200	.09415
	Equal variances not assumed			-.625	263.026	.532	-.04392	.07024	-.18223	.09438
INT. STAY	Equal variances assumed	1.141	.286	-2.280	268	.023	-.28008	.12285	-.52194	-.03821
	Equal variances not assumed			-2.278	266.528	.023	-.28008	.12293	-.52211	-.03805
ORG. COMM.	Equal variances assumed	1.460	.228	-.325	268	.746	-.02214	.06820	-.15641	.11214
	Equal variances not assumed			-.324	264.902	.746	-.02214	.06828	-.15657	.11230
EMOTIONAL CONT.	Equal variances assumed	.316	.574	-2.103	268	.036	-.14313	.06805	-.27712	-.00914
	Equal variances not assumed			-2.103	267.507	.036	-.14313	.06807	-.27714	-.00912

Group Statistics

	Year_G	N	Mean	Std. Deviation	Std. Error Mean
WORKLOAD	<10	182	3.6044	.64664	.04793
	≥10	88	3.3636	.82100	.08752
EMOTIONAL LABOR	<10	182	2.5324	.55917	.04145
	≥10	88	2.4634	.60840	.06486
INT. STAY	<10	182	3.1667	1.03810	.07695
	≥10	88	3.5265	.93153	.09930
ORG. COMM.	<10	182	3.2488	.56368	.04178
	≥10	88	3.2431	.55334	.05899
EMOTIONAL CONT.	<10	182	3.5345	.53347	.03954
	≥10	88	3.6089	.61872	.06596

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
WORKLOAD	Equal variances assumed	5.495	.020	2.619	268	.009	.24076	.09192	.05978	.42174
	Equal variances not assumed			2.413	140.924	.017	.24076	.09978	.04349	.43803
EMOTIONAL LABOR	Equal variances assumed	.750	.387	.923	268	.357	.06897	.07474	-.07817	.21612
	Equal variances not assumed			.896	159.770	.372	.06897	.07697	-.08304	.22098
INT. STAY	Equal variances assumed	.547	.460	-2.758	268	.006	-.35985	.13045	-.61670	-.10300
	Equal variances not assumed			-2.864	189.935	.005	-.35985	.12563	-.60765	-.11205
ORG. COMM.	Equal variances assumed	.091	.764	.079	268	.937	.00572	.07275	-.13752	.14897
	Equal variances not assumed			.079	175.030	.937	.00572	.07229	-.13694	.14839
EMOTIONAL CONT.	Equal variances assumed	1.448	.230	-1.019	268	.309	-.07441	.07304	-.21822	.06940
	Equal variances not assumed			-.968	151.385	.335	-.07441	.07690	-.22635	.07753

APPENDIX H

REGRESSION ANALYSES

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.067[a]	.005	.001	.55909	.005	1.212	1	268	.272

a. Predictors: (Constant), WL_X

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	.379	1	.379	1.212	.272[b]
	Residual	83.771	268	.313		
	Total	84.150	269			

a. Dependent Variable: OC_X
b. Predictors: (Constant), WL_X

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	3.062	.171		17.868	.000
	WL_X	.052	.048	.067	1.101	.272

a. Dependent Variable: OC_X

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.109[a]	.012	.008	1.01282	.012	3.234	1	268	.073

a. Predictors: (Constant), WL_X

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	3.317	1	3.317	3.234	.073[b]
	Residual	274.913	268	1.026		
	Total	278.230	269			

a. Dependent Variable: ItS_X
b. Predictors: (Constant), WL_X

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	3.831	.310		12.341	.000
	WL_X	-.155	.086	-.109	-1.798	.073

a. Dependent Variable: ItS_X

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.157[a]	.025	.021	.55344	.025	6.737	1	268	.010

a. Predictors: (Constant), EL_X

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	2.063	1	2.063	6.737	.010[b]
	Residual	82.087	268	.306		
	Total	84.150	269			

a. Dependent Variable: OC_X
b. Predictors: (Constant), EL_X

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.865	.151		18.975	.000
	EL_X	.152	.059	.157	2.596	.010

a. Dependent Variable: OC_X

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.048[a]	.002	-.001	1.01772	.002	.628	1	268	.429

a. Predictors: (Constant), EL_X

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	.651	1	.651	.628	.429[b]
	Residual	277.580	268	1.036		
	Total	278.230	269			

a. Dependent Variable: ItS_X
b. Predictors: (Constant), EL_X

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	3.069	.278		11.056	.000
	EL_X	.085	.108	.048	.793	.429

a. Dependent Variable: ItS_X

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.560[a]	.313	.311	.84427	.313	122.339	1	268	.000

a. Predictors: (Constant), OC_X

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	87.202	1	87.202	122.339	.000[b]
	Residual	191.028	268	.713		
	Total	278.230	269			

a. Dependent Variable: ItS_X
b. Predictors: (Constant), OC_X

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	-.021	.303		-.070	.944
	OC_X	1.018	.092	.560	11.061	.000

a. Dependent Variable: ItS_X

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.671[a]	.450	.448	.75541	.450	219.575	1	268	.000

a. Predictors: (Constant), AC_X

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	125.298	1	125.298	219.575	.000[b]
	Residual	152.932	268	.571		
	Total	278.230	269			

a. Dependent Variable: ItS_X
b. Predictors: (Constant), AC_X

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	.656	.183		3.580	.000
	AC_X	.801	.054	.671	14.818	.000

a. Dependent Variable: ItS_X

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.524[a]	.275	.272	.86772	.275	101.524	1	268	.000

a. Predictors: (Constant), NC_X

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	76.442	1	76.442	101.524	.000[b]
	Residual	201.789	268	.753		
	Total	278.230	269			

a. Dependent Variable: ItS_X
b. Predictors: (Constant), NC_X

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.088	.224		4.849	.000
	NC_X	.685	.068	.524	10.076	.000

a. Dependent Variable: ItS_X

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.164[a]	.027	.023	.76965	.027	7.399	1	268	.007

a. Predictors: (Constant), EL_X

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	4.383	1	4.383	7.399	.007[b]
	Residual	158.753	268	.592		
	Total	163.135	269			

a. Dependent Variable: NC_X
b. Predictors: (Constant), EL_X

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.652	.210		12.630	.000
	EL_X	.222	.082	.164	2.720	.007

a. Dependent Variable: NC_X

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.128[a]	.016	.013	.55571	.016	4.492	1	268	.035

a. Predictors: (Constant), DA_X

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1.387	1	1.387	4.492	.035[b]
	Residual	82.763	268	.309		
	Total	84.150	269			

a. Dependent Variable: OC_X
b. Predictors: (Constant), DA_X

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.994	.124		24.123	.000
	DA_X	.090	.043	.128	2.119	.035

a. Dependent Variable: OC_X

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.170[a]	.029	.025	.76882	.029	7.995	1	268	.005

a. Predictors: (Constant), DA_X

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	4.726	1	4.726	7.995	.005[b]
	Residual	158.409	268	.591		
	Total	163.135	269			

a. Dependent Variable: NC_X
b. Predictors: (Constant), DA_X

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.742	.172		15.967	.000
	DA_X	.167	.059	.170	2.828	.005

a. Dependent Variable: NC_X

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