BAŞKENT UNIVERSITY
INSTITUTE OF SOCIAL SCIENCES
DEPARTMENT OF PSYCHOLOGY
MASTER'S IN SOCIAL PSYCHOLOGY

THE EFFECTS OF HIERARCHICAL RELATIONSHIP ON WELL-BEING: EXAMPLE OF HEALTHCARE PROFESSIONALS

BY

MURAT TÜMER

MASTER'S THESIS

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To my beloved father Muammer Tümer and my beautiful son M. Ayaz Tümer

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ÖZET

Murat Tümer

Hiyerarşik İlişkilerin İyi Oluş Üzerine Etkileri: Sağlık Çalışanları Örneği

Başkent Üniversitesi

Sosyal Bilimler Enstitüsü

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Modern toplumlarda kurumlar, bazı meşru hiyerarşiler üzerinde örgütlenmişlerdir. Bu tezde hiyerarşik motiflerin sağlık çalışanlarının iş ilişkilerine ve psikolojik iyi oluşları üzerine uygulanmasını keşfetmeyi amaçladık. Kesitsel (N=226) ve 15 günlük anketler (N=156) halinde tasarlanan çalışmamızda, iç grup kimliğinin, kişilik özelliklerinin (sistemin meşrulaştırılması, sosyal baskınlık kuramı ve 5 büyük faktör kişilik kuramı) ve hiyerarşideki konumun sağlık çalışanlarının psikolojik iyilik oluşları ile ilişkisini inceledik. Sonuçlarımız sağlık çalışanı olarak kimliklenmenin ve duygusal stabilite kişilik özelliğinin iyi oluş ve olumlu deneyim ile ilişkili olduğunu gösterdi. Ayrıca, katılımcıların günlük olarak hiyerarşinin üst konumunda daha fazla bulunmalarının o günün psikolojik iyi oluşunu, olumlu deneyimi, o gün işten keyif almayı ve ertesi gün işe gelme motivasyonunu pozitif yönde etkilediğini bulduk. Bununla birlikte katılımcıların hiyerarşinin altında olmalarının sıklığı psikolojik iyi oluş sonuçlarıyla ilişkili değildi. Bulguları işyeri organizasyonel yapısı ve sağlık çalışanlarının psikolojik iyi oluşları açısından tartıştık.

Anahtar Kelimeler*:* hiyerarşi, psikolojik iyi oluş, sosyal kimlik, sistemi meşrulaştırma, sosyal baskınlık, sağlık çalışanları

ABSTRACT

Murat Tümer

The Effects of Hierarchical Relationship on Well-Being: Example of Healthcare Professionals

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Institutions of modern societies are organized around some legitimate hierarchies. In this thesis, we aimed to explore the association implementing hierarchical motives into work relationships and the well-being of healthcare professionals. In a cross-sectional (N = 226) and a 15 days daily diary (N = 156) designs, we explored how ingroup identification, personality traits (system justification, social dominance orientation, and Big5), and hierarchical positions were associated with the well-being of healthcare professionals. Our results showed that identification with healthcare professionals and emotional stability were associated with well-being and positive experience. We also found that higher frequency of daily hierarchical relationships when the participants were in a superior position was positively associated with that day's well-being, positive experience, enjoying working on the same day, and motivation to go to work on the following day. However, the frequency of relationships when the participants were in a subordinate position was not associated with the well-being outcomes in our sample. We discussed the implications of the findings in terms of workplace organization structures and the well-being of healthcare professionals.

Keywords: hierarchy, well-being, social identity, system justification, social dominance, healthcare professionals

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LIST OF ABBREVIATIONS

AR	Authority Ranking
CS	Communal Sharing
EM	Equality Matching
ESJ	Economic System Justification
MP	Market Pricing
NE	Negative Experience
PE	Positive Experience
RMT	Relational Models Theory
SDO	Social Dominance Orientation
SDT	Social Dominance Theory
SheS	Subjective Health Scale
ShiS	Subjective Hierarchy Scale
SJT	System Justification Theory
SPANE	Scale of Positive and Negative Experience
TIPI	Ten- item Personality Inventory
WCQ	Work Climate Questionnaire
WHO-5	World Health Organization-5 Well-Being Index
WSJ	Workplace System Justification

THE EFFECTS OF HIERARCHICAL RELATIONSHIP ON WELL-BEING: EXAMPLE OF HEALTHCARE PROFESSIONALS

1.1. General Introduction

A sense of power and rank in a social group is associated with well-being (Anderson et al., 2012; Brown et al., 2008). There is substantial evidence that social status is linked to the physical and psychological health of individuals (Adler, 2013; Binning et al., 2009; Prag et al., 2016; Simandan, 2018). However, most of these research focus on the subjective or objective socioeconomic status or social class as a measure of power and rank in the hierarchy, and to our knowledge, there is little evidence for the link between wellbeing and rank of individuals in a small group (ingroup) (Anderson et al., 2012). Admitting the role of social class and socioeconomic status to predict individuals' health and wellbeing, we suspect that the application of power and occurrences of hierarchies in daily life are much more common in small groups including workplaces. Thus, we believe that investigating the association between social rank within a small group and wellbeing is important for individuals' everyday functioning.

To investigate the association between individuals' rank in a hierarchy and their wellbeing, we thought it would be best to observe a group that has a natural hierarchical organization. The workplace groups are usually organized around a natural hierarchy, in which individuals have distinct roles and statuses (Gilbert, 2012). For instance, hospitals are organized in hierarchical structures that different sections of healthcare professionals have varying status in the organization with different roles and power. In this study, we selected the surgical branches of hospitals to observe their implementation of hierarchy in the workplace. We applied the theoretical postulates of Relational Models Theory (RMT: Fiske, 1992; 2004) to understand how healthcare professionals implement rules of hierarchy and power in their daily workplace relationships.

RMT is a well-studied topic in social and moral psychology literature in various cultural and social contexts (see http://www.rmt.ucla.edu for some bibliography of the research for RMT). The theory examines human sociality in terms of four elementary level relational

models: *communal sharing, authority ranking, equality matching, and market pricing* (Fiske, 1991; 1992; 2004). Defining a distinct set of rules, the so-called models provide a rich ground to study interpersonal and intergroup relationships in workplaces.

In this thesis, we investigated the association between individuals' status in their workgroup and their wellbeing in relational models framework. The hierarchical structure is essential in many parts of medical services, but the implementation of rules of hierarchies is quite high especially in surgical branches. Although there are numerous studies on the wellbeing of healthcare professionals in the literature, to our knowledge, the relationship between the rank in the hierarchy of the workplace and the well-being has not been adequately studied. Therefore, this thesis focused on the relationship between the hierarchy and well-being of anesthesiologists, surgeons, and other surgical medical staff like nurses and anesthesia technicians in operation rooms.

1.2. Effects of Social Hierarchy

Social hierarchy is defined as the inequality of a social value between people (Greer & van Kleef, 2010; Hays & Bendersky, 2015). It occurs spontaneously and is present in almost all types of social groups (Anderson et al.,2001; Greer et al., 2018). Social status is a basic need for humans (Anderson et al., 2015; Maner, 2017) and social ranking is one of the most important factors that shape social relationships and social behavior. Therefore, there are a lot of studies in the literature about power and social status (Galinsky et al., 2015; Magee & Galinsky, 2008). Hierarchy, such an important thing to exist, also has biological bases. As a result of interdisciplinary studies, it has been shown that neuropharmacological agents such as dopamine, serotonin, and testosterone are associated with the learning and application of social hierarchy in primates (Qu et al., 2017).

Because hierarchy is one of the most important features of social life, it deeply shapes human psychology (van Kleef & Lange, 2020). Negative emotions and stress are higher in individuals who are at the lower levels of the hierarchy (Anderson et al., 2015; Gilbert, 2000; Keltner et al., 2003). Positive emotions are higher in people at the higher levels of the hierarchy

(Anderson & Berdahl, 2002). In a study conducted by Greer and van Kleef (2010), it was stated that people with lower hierarchical levels were better at perceiving and reacting to other people's emotional expressions. On the other hand, in the same study, it was stated that those at high hierarchical levels respond to other people's emotions only if they are relevant to them. Being at the bottom or the top of the hierarchy is an important predictor of happiness, health, and longevity (Fournier, 2020; Marmot, 2015). There is a positive relationship between being in a lower hierarchy status and being exposed to physical and psychological stressors. Therefore, there is a relationship between social rank and diseases (eg. cardiovascular, respiratory, rheumatoid, and psychiatric) that may be related to stressors (Fournier, 2020; Sapolsky, 2004). Also, the change in social status difference itself creates different stress effects in the group above or below the hierarchy. It has been shown that social status differences can cause neuroendocrine and cardiovascular diseases in the lower groups when the difference is stable and in the upper groups when the difference is unstable (Scheepers & Knight, 2020).

1.3. Hierarchical Organizational Structure

Organizational structure describes the coordination and supervision ways of tasks to achieve the organizational objectives (Pugh & Pugh, 1971). There are a substantial number of organizational structure types according to the physical and social conditions of the organizations (Ahmady et al., 2016). Social types of organizational structures are relationships between social elements (such as peoples); physical types are the buildings and places such as business.

The application of power and ranking professionals is very common to organize workplaces. Usually, professionals or groups of professionals ranked around some leaders, which in turn linked to other supervisors or chiefs. Hierarchy in the organisational structure is useful because it makes clear authority and responsibility levels (Sy et al.,2005). In hierarchical organizations, group members may receive clearer messages about their responsibilities than non-hierarchical organizations. Through these clear messages, rapid decision-making mechanisms can be provided. But, the success of a hierarchical organisational structure depends on the perception of the employee on leaders' and organisation's power; and leadership behavior

is the major determinant in these organizational structures (Taucean et al., 2016). The way leaders use their power and employees' perception of the power of the organization constructively are factors that increase success. Assistants in surgical branches, which are in a hierarchical working structure, act more enthusiastic for teamwork when they perceive the power of their experts on them as constructive while working with their senior specialists. Thus, they can work more efficiently, and the success of the operational structure is higher.

Hierarchy is not always positive for teams. Different types of hierarchical differentiation (status based vs. power-based hierarchies) have different effects on the destructive competitive behavior of subordinate group members. Status based hierarchies are more variable than power-based hierarchies for subordinate group members (Hays & Bendersky, 2015). There are aspects of hierarchy that can be detrimental to team effectiveness. Team structure, team tasks, the mutability of hierarchy, and the form of the hierarchy can affect these two opposite effects of hierarchy on teamwork. While hierarchy negatively affects team effectiveness in conflict situations, it affects positively in coordination situations (Greer et al., 2018).

Healthcare providers are bureaucratic structures governed by formal rules and hierarchies, often with separate offices and departments devoted to various tasks (Wingfield & Chavez, 2020). The organisational structure of medical departments in hospitals can be very complex. Healthcare workers often work in large groups. The job descriptions are well defined and job distributions are often drawn with sharp limits within each department. In surgical branches, job distribution is generally clearly defined. The surgery teams in hospitals consist of anesthesiologists, surgeons, assistant doctors, nurses, anesthesiology technicians, and support staff (such as surgery technicians, cleaning, and transporting stuff). Everybody in this large group knows his job descriptions and distributions. The reason for this certainty may be that health workers mostly use hierarchical organizational structure. As in the whole world, in Turkey, the organizational structure used by doctors, especially those working in surgical branches, has a hierarchical organisation structure.

1.4. Relational Models Theory

Relational models theory (RMT) is a well-established theory on human sociality to understand how individuals relate to each other in different domains and contexts. The four elementary models, defined by the theory, are claimed to capture all diversity in human social relationships at a very basic level (Fiske, 1992; 2004). These models are generative cognitive structures that human beings implement to conceive, form, and sustain social relationships. Each model has a specific set of rules that govern certain types of relationships, and there is substantial research that shows the universality of the models (Dalgar, 2012; Haslam, 2004; Vodosek, 2009; Zickfield et al., 2018). Another feature of these models is their flexibility to generate social relationships that combine different models. For example, models in family relationships are intertwined. While the relationship between father and son is, on the one hand, the communal because of common goals and kinship, on the other hand, it is hierarchical due to its difference in authority between father and son.

The first relational model is Communal Sharing (CS). The motto of CS is one for all, all for one (Fiske,1992). In this model, relations are based on unity and common bonds. Members of these groups cannot be separated from each other. Members think they have a common substance such as blood or body fluids. Close kinship, family relations, intense romantic relationships, salient group identities, and nationhood are the typical examples of CS in different levels. In workplace practices, individuals can become a part of the unit where their selves merge with the workplace and with their co-workers although the dominant model implemented in workplaces is market pricing. CS creates a collective responsibility in the group members. Everyone in the group does as much work as they can to achieve the common goal. People work collectively in CS organizations. When this model is applied in the workplace, everyone feels their work and effort contribute to the common goal. Thus, their work motivation increases, and slacking reduces. Job descriptions of health workers are given the meaning of this type of collective structuring. We suspect that the CS model can explain the organizational structure of anesthesiologists due to their close working environments and similar appearance and job descriptions.

Authority Ranking (AR) is the second relational model. In AR, being above and below in hierarchical order structures the relationships. The duties and responsibilities of people are asymmetrical between higher and lower status. Those super-ordinates have power and rights

above the subordinates. They are also responsible for the protection, leading, and care of subordinates. At the same time, the subordinates should show respect and obey their super-ordinates. Military order and person to god relations are typical examples of AR (Fiske, 1991) in most societies. As detailed above, the medical doctors especially those who are in surgical branches work in strictly hierarchical groups. People in those groups naturally implement AR rules to regulate their relationships in hospitals. AR is perhaps a model that may be necessary for the rapid operation of decision-making in emergencies like surgical operations. For instance, in a patient with difficult intubation, the senior anesthesiologist quickly determines the techniques to be used in advanced airway management and expects a junior anesthesiologist to assist himself. The patient's life-threatening condition will decrease by acting fast. As can be seen, the powers and rights are asymmetrical. For example, working time, number of shifts, the right to decide (and responsibility).

In the Equality Matching (EM) model, people have equal rights and responsibilities. So there is a concrete balance within the relationship. So, individuals can track what they give to the relationship and what they will expect. If this balance is disturbed, it turns to eye-for-an-eye revenge. Democratic voting, cooperatives, and equal rights in exams are some of EM examples (Fiske, 1991). Decision-making mechanisms are in the form of one person having one vote. Everyone has the right to an equal vote (Fiske,1991). In most workplaces, the decisions are made by people who have equal powers and then declare to subordinates. So only the workers who are in the same status implement EM in their relationships. For instance, EM can be cited as an example in medical council decisions, well each member of the council has one vote. Otherwise, workers in different positions implement AR.

The last relational model is *Market Pricing* (MP). In this model, relationships are determined according to cost and benefits. Proportionality is the direction indicator of relationships. Money, rents, and gain to loss ratios are some determinants of this proportionality. Worker to the workplace, salary for labor, and modern justice system are some examples of MP. MP is the dominant relational model in workplaces, even people may feel a communal bond to their workplaces and workgroups, and even they implement AR, and sometimes EM rules with their coworkers.

1.5. System Justification Theory

System Justification Theory (SJT) developed by Jost and Banaji (1994), is a theory which argues that justification of a system acts as a psychological palliative function. SJT aims to answer the question of how and why hierarchical structures are protected by both advantageous and disadvantageous members of a group (Jost & Banaji,1994).

There are three justification types in SJT. The first one is the tendency of individuals to perceive their behaviors valid and legitimate to create a positive self-perception, which is defined as the ego-justification. The second one is the valid and legitimate perceptions of group membership, constituting an important part of an individual's identity, which is the group-justification. And the third one is the need to see the status quo valid, legitimate and justified, which is defined as the motivation to system-justification (Jost & Hunyady, 2003). An example for ego-justification is a smoker attributing this harmful behavior to his stressful job. On the other hand, explaining the aggressive behavior of the hooligans with team spirit is an example for group-justification behavior. And, believing that poverty is part of this world (believe in a just world) is an example for system-justification. The SJT was studied for inter-group inequalities in political psychology many times (Jost et al., 2004; Hoffarth et al., 2019). We want to use the SJT to explain dynamics within the group. We aimed to investigate how in-group hierarchy in the workplace is legitimized.

Motivations for justification to ego, group, and system in the SJT are different for members of advantageous and disadvantageous groups. In disadvantageous groups, the group members internalize the inferiority and show implicit in-group favoritism to increase their self-esteem and achieve a sense of stability, safety, and certainty (Jost et al., 2004). Who creates inequalities in hierarchies in workplaces? Most of the time, people in the workplace believe that this is legitimate even if they are aware of this inequality. System justification is associated with increased positive affect and decreased negative affect (Jost et al., 2008) and has a palliative function in both society and individual levels (Vargas-Salfate et al.2018). Therefore, we think that the level of legitimacy can have an impact on people's well-being in hierarchical structures.

Relational Models Theory claims that social hierarchies are legitimate, and both subordinates and superordinates benefit from that hierarchy. Thus, it can explain why people

justify these inequalities. For instance, the hierarchies between the medical doctors provide economic and social status to senior doctors and professors over their subordinates, and juniors are taught and get experienced. In this way, they feel more secure about themselves and their relationships. This hierarchy provides benefit for both the super and subordinates. Therefore, the ideology of the group below and above in the hierarchy in the Authority Ranking model can be explained by SJT.

1.6. Social Dominance Theory

Apart from SJT, other theories examine interpersonal and intergroup hierarchical relationships. One of them is Social Dominance Theory (SDT). Sidanius and Pratto (1999) developed the SDT to explain how relationships work despite hierarchy. According to SDT, societies are built on group-based hierarchical structures. Some of these groups are in the upper layer of the hierarchy that holds power and authority, while the others are in the lower layer of the hierarchy. The positive attitude of these advantageous and disadvantageous groups towards the hierarchy is the research area of SDT.

Although SJT and SDT are similar in many ways, the most important difference between them is that, the ideological structure supporting the hierarchy is slightly higher in the subordinates in SJT, whereas, it is slightly more in dominants in SDT (Sidanius et al., 2004). Another difference between SJT and SDT is that, SDT is more dynamic. Social Dominance Orientation (SDO) is a measure of an individual's choice of hierarchy within any social system and his dominance over groups of low-status (Sidanius et al., 2001). SDO was created so that SDT can be explained and measured. Contextual and organizational conditions can change SDO levels (De Oliveira et al.,2012).

Age, gender, and arbitrary-set based (differs according to societies such as ethnicity and race) hierarchies are the three-way hierarchical structures of SDT (Pratto et al., 2006). Accordingly, those younger in the age system and females in the gender system are the subordinate groups. These hierarchical structures can also be seen in hospitals. The age of a healthcare professional is an important factor affecting the number of his duties within a month.

The prevailing opinion is those male surgeons are more dominant in operation rooms. In a longitudinal study by Lepice et al. (2016), it was shown that the search for hierarchy and SDO levels of medical students increased towards the clinical phase of the curriculum.

The use of myths that increase hierarchy is higher in people with high SDO levels (Pratto et al., 2006). There is a positive correlation between hierarchy and high SDO levels (Sidanius et al.,2004). Therefore, we measured the SDO levels of the participants to examine their attitudes to accept the hierarchy.

1.7. Personality Traits

Social Dominance Orientation can be misunderstood as a personality trait. But, SDO should not be considered as a personality trait because it can be affected by many factors (Pratto et al., 2006). Personality is one of the major topics of psychology. It is inborn and shaped by interacting with the environment and does not change easily (Goldberg, 1992).

The Big Five personality traits (BFPT), also known as the five-factor model (FFM) and the OCEAN model, are a classification for personality traits (Rothmann & Coetzer, 2003). These five personalities are extroversion, agreeableness, conscientiousness, neuroticism, and openness to experience. Studies about personality traits and SDO have shown a negative correlation between SDO and openness to experience (Heaven & Bucci, 2001), as well as, agreeableness (Ekehammar et al., 2004). In this study, we examined the attitudes of people towards the hierarchy, ensuring the control over the effect of their personality traits. We used Ten - Item Personality Inventory (TIPI) Scale (Gosling et al, 2003) to measure the personality of healthcare professionals.

1.8. The well-being of Healthcare Professionals

There is a growing body of literature that recognizes the importance of the well-being of healthcare professionals. Factors found to be influencing the well-being of medical doctors have been explored in several studies. Many recent studies (e.g. Looseley et al., 2019; Sousa & de

Barros Mourão, 2018; Schaufeli et al., 2009) have shown that stress, burn out, depression and work satisfaction are the main reasons that negatively affect the well-being of healthcare workers.

There are studies in the literature stating that high social status predicts better psychological well-being (Adler et al, 2000; Lorant et al. 2003). Relationship structures between leaders and members in hospitals is also an important factor for maintaining the well-being (Brunetto et al., 2013). Thus, we believe that there is a relation between hierarchical relationships in workplace environments and the well-being of healthcare professionals.

1.9. Social Identity Theory

Social identity theory (SIT) was developed by Tajfel and Turner (1979). According to SIT, individuals tend to evaluate the groups they belong to and, themselves with a more positive perspective towards other individuals and social groups. For this reason, they display a more privileged attitude towards ingroup members, while they display discriminatory attitudes towards outgroup members (Tajfel &Turner, 1979). Identifying oneself with a group and comparing oneself or his group with other members and groups, are the most important characteristics of SIT (Hortaçsu 2012).

Social categorization, social comparison, group distinctiveness, and social identity are the main four concepts of the SIT (Tajfel, 1982). Social categorization is the process of classifying people according to some common characteristics, such as ethnic or political identity (Tajfel &Turner, 1979). Social comparison is the comparing process of the ingroup characteristics with the outgroup characteristics. Group distinctiveness is the motivation of group members to evaluate their ingroup as more distinct and positive compared to other groups. Social identity, as detailed before, is a kind of group identity.

Ingroup identification is when a person internalizes his group by defining group membership as a part of self (Tajfel &Turner, 1979). As ingroup identification increases, group members perceive their ingroups more valuable (Hortaçsu 2007). To compare the positive

effects of increased identification with the negative effects of hierarchy, we decided to measure the degree of identification of the participants in our study.

1.10. Overview of The Current Thesis

In literature, studies showed that identity is positively correlated with communal sharing (Dalgar et al.,2014; Fiske, 2004). As we described before, communal sharing is a type of relationship that is almost the opposite of authority ranking. Therefore, increased identification can suppress the effects of hierarchy. We added the identification variable to our study, as we thought that healthcare workers may have increased identification due to the COVID-19 pandemic.

The purpose of this thesis was to investigate the effects of hierarchical relationships on individuals' well-being in different positions of the hierarchy and the factors that may cause these effects. We expected that the structure of relationships would be related to the well-being of healthcare professionals, whereas, the strict and hierarchical nature of the healthcare workplace would affect how individuals feel about their work life. We suspected that habits and learning, seniority, personality traits, justification of the system, and social dominance orientation would contribute to this relationship.

As stated previously, this thesis focused on the relationship between the hierarchical relationship structures and the well-being of healthcare professionals. Although it is known that there are many studies on the well-being of healthcare professionals in literature, there is a lack of data on the effect of relationship models and especially hierarchy on this well-being. It is important to ask questions about how hierarchy affects the well-being of healthcare professionals working with a hierarchical relationship structure.

2.METHOD

2.1. Procedure

After having the ethical approval from the Social Sciences, Humanities, and Art Field Research Committee of Başkent University, we prepared two online surveys via the Qualtrics Survey Tool. Since the target participants, healthcare professionals were working hard due to the COVID-19 pandemic, we tried to shorten the duration for data collection in each session. Thus, we reallocated scales in the baseline survey into two parts and shared with the participants in a week apart. The first part of the survey (Wave 1) lasted 15 minutes on average and included demographics, Work Climate Questionnaire (Baard et al., 2004), Social Dominance Orientation Scale (Alparslan 2017), Economic System Justification Scale (Jost & Thompson, 2000), Workplace System Justification Scale (adapted from Kay & Jost, 2003), one item subjective hierarchy question, 5-item identification scale (Dalgar et. al, 2014), Ten - Item Personality Inventory Scale (Gosling et al, 2003; Atak,2013), Scale of Positive And Negative Experience (Diener et al, 2010; Telef, 2015), and World Health Organization-5 Well-Being Index (Word Health Organization, 1998; Eser et al., 2019). The second part of the baseline survey (Wave 2) lasted 15 minutes on average and included only the Modes of Relationship Questionnaire (Haslam and Fiske,1999; Dalgar, 2012).

We distributed the first wave survey link on social media and professional communication listservs (e.g., Facebook groups, mail groups, etc.). All participation was voluntary, but we made a small donation to KAHEV (https://www.kahev.org) to contribute an education scholarship to be given to the children of healthcare professionals who died during the COVID-19 pandemic in the name of our participants. After participants completed the first wave of the survey, we asked their email addresses to send and synchronize the second wave and the daily diary surveys. One week after the first wave, the participants got the second wave survey. One week after the second wave survey, the daily diaries started for a successive 15 days. The participants got the links for the daily diaries at 16.50 each day and they had to complete the surveys before 1 a.m. on that night. The daily diaries included SPANE, WHO-5, one question on subjective health, one question on motivation to go to work the next day, one question on enjoying work that day, and two questions for daily experiences of hierarchical relationships in the workplace, and lasted 32 minutes on average. At the end of the 15th day, all participants were thanked and informed about the donation we have done.

We pre-registered some inclusion and exclusion criteria that we performed all analyses only with surgical branches of health professionals, and we used the diary data of participants who completed diaries at least 7 days of possible 15 days.

2.2. Participants

Bolger and colleagues (2011) recommended indicated that to detect a small effect size (Cohen's d = 0.28) in daily diary designs, 1650 observations (by N*time) would achieve 90% power. Thus, projecting their simulation to our design, to detect a small effect size with 90% power for 15 successive days of observations we needed 118 participants. Considering possible dropouts in daily diaries, we tried to recruit as many as possible healthcare professionals in the first wave, and 722 participants completed the survey. The second survey was sent to 428 participants who provided an active email address and 288 participants completed the second survey. Thus, we started daily diaries with 288 participants. At the end of the diaries, we removed 62 participants who were not in surgical branches of the healthcare profession from both baseline and daily diary datasets leaving 226 participants (Female = 144, Male = 82) in the baseline dataset. The mean age of the participants was 37.35 (SD = 8.38).

Relying on our pre-registration (https://osf.io/fs35d) removed 70 participants who did not complete at least 7 days of the diaries leaving 156 participants (Female = 104, Male = 52) in the daily diaries dataset. The mean age of the participants was 37.58 (SD = 7.87). The mean working year of the participants was 10.61 (SD = 8.10). The total number of nurses and anesthesiology technicians was 24 (15.4%). The assistant doctor's number was 40 (25.6%). The total number of specialist and lecturer doctors was 56 (35.9%), senior lecturer and the associate professor was 24 (15.4%), professor and managers was 12 (7.7%).

2.3. Measures

In the first wave, the informed consent form was presented to the participants. Then, participants completed the following questionnaires in random order: Workplace System

Justification Scale, Subjective Health Scale (SheS), and Subjective Hierarchy Scale (ShiS). At the end of the first wave, e-mail addresses will be requested from the participants to send the next surveys. One week after the first wave, the second wave was sent to the emails of the participants who participated in the first wave of the study. In the second wave, participants completed the Modes of Relationship Questionnaire.

After the second wave of the study, participants started completing daily diaries for 15 successive days. Participants completed the following questionnaires in daily diaries; WHO-5, SPANE, SheS, questions about motivation to go to work the next day, enjoying work that day, and their experiences of hierarchical relationships on that day. At the end of the diaries, the participants were debriefed and thanked. Detailed information about the procedure and materials of this survey can also be found via this link (https://osf.io/fs35d).

2.3.1. Questionnaires in Baseline Survey

Demographic information form:

Participants filled out the demographic information form, including date of birth, sex, marital status, work area, year in the workplace, title in the workplace, and the number of coworkers. and perceived socioeconomic status (socioeconomic status ladder: "1" was the bottom and "10" was, the top).

Work Climate Questionnaire (WCQ):

WCQ was developed by Baard and colleagues (2004) as a long (15-item) and a short (6-item) form to measure how the professionals evaluate their managers' or supervisors' attitudes. We used the short version of the scale. We translated the items (e.g., I feel that my manager provides me choices and options.) into Turkish and applied to the participants on a 7-point Likert type scale (1= *strongly disagree*, 7 = *strongly agree*). Higher scores in the variable referred to the positive evaluations in the workplace towards leaders. To test the factorial structure of the scale, we conducted an exploratory factor analysis using the principal axis factoring extraction method. The results indicated one factor based on eigenvalues greater than

one. The factor accounted for 74.02% of the variance, and the factor loadings ranged between .80 to .91. The scale was also found to be reliable with a Cronbach's alpha of .94.

Social Dominance Orientation Scale (SDO)

SDO scale was originally developed by Pratto et al. (1994) to assess individuals' support for hierarchy-enhancing strategies and adapted into Turkish by Karacanta (2002). Then, Alparslan (2017) used a 15-item version of the scale (In this version "*In getting what you want, it is sometimes necessary to use force against other groups."* was dropped from the scale). In this thesis, we used the 15-item version (e.g*., "It's probably a good thing that certain groups are at the top and other groups are at the bottom"*) on a 7-point Likert type scale (1= *very wrong*, 7 = *very correct*). Seven items represented support for the hierarchy-enhancing statements and 8 items represented support for the hierarchy-reducing statements. The higher scores in the variable indicated higher support for the hierarchy-enhancing structure. The reliability of the scale was found to be good (Cronbach's α = .88).

Workplace System Justification Scale (WSJ)

General System Justification (GSJ) Scale is generated by Kay and Jost (2003) to measure how much individuals justified the system they live in (e.g., "*In general, you find society to be fair."*). Turkish adaptation of the GSJ scale is done by Yıldırım (2010). We adapted the Workplace System Justification Scale for this thesis using the six items of the Turkish version of the General System Justification Scale (see Appendix A for all items). In our version of the scale, the participants responded to questions about the system of their workplace (e.g., *In general, I find our working conditions to be fair.) on a* 7-point response scale (1= *strongly disagree*, 7 = *strongly agree*). The results indicated one factor based on eigenvalues greater than one. The factor accounted for 64.25 % of the variance, and the factor loadings ranged between .52 to .83. Cronbach's alpha was found to be .88.

Subjective Hierarchy Scale (ShiS)

We measured how participants perceived their status in the hierarchy of their workplace with one question: *"Please indicate your position in your workplace on the below scale from 0 to 10 where 0 represents the bottom and 10 represents the top."*

Identification Scale

We measured participants' identification with other health professionals with 5 items adapted from Dalgar et al. (2014) on a 7-point response scale (1= *strongly disagree*, 7 = *strongly agree*). An example item is "I feel strong ties with health professionals". To test if the items were loading into one factor, we conducted an exploratory factor analysis using principal axis factoring. The results indicated one factor based on eigenvalues greater than one. The factor accounted for 67.80% of the variance, and the factor loadings ranged between .66 to .87. Cronbach's alpha was found to be .88.

Ten - Item Personality Inventory (TIPI)

TIPI is generated by Gosling et al. (2003) and measures personality traits in a 10-item short questionnaire. Turkish adaptation is done by Atak (2013). The five personality traits (i.e., Extraversion, Agreeableness, Conscientiousness, Emotional Stability, Openness to Experience) were measured by 2 items each. The test-retest reliability of the subscales was found to be good and ranged between .81 to .89 in Turkish adaptation (Atak, 2013). We used a 7-point response scale (1= *disagree strongly*, 7 = *agree strongly*) in this study.

Modes of Relationship Questionnaire (MORQ)

MORQ is developed by Haslam and Fiske (1999) and adapted into Turkish by Dalgar (2012). First, we asked the participants to make a list of 15 people working and communicating with them in their workplaces. After that, we asked the participants to write the 1st, 4th, 7th, 10th, 13th, and 15th persons on the list to evaluate their relationships on the MORQ. The MORQ is composed of 20 items to evaluate relationships with the listed persons. The participants evaluated their relationships with six persons from their 15-person list on a 7-point Likert type scale (1 = *absolutely wrong for this relationship and* 7 = *absolutely true for this relationship*). The scale has 4 subfactors that participants evaluate their relationships with those people in terms of how much they implement the rules of communal sharing, authority ranking, equality matching, and market pricing.

2.3.2. Questionnaires in both Baseline and Daily Diaries

Scale of Positive and Negative Experience (SPANE)

SPANE is developed by Diener et al. (2010) and Turkish adaptation is done by Telef (2015). The scale consists of 12 statements on how individuals feel. The scale has two subfactors, positive (e.g., *Pleasant*) and negative (e.g., *Afraid*). In the first wave of the data collection (baseline data) we asked participants to evaluate their feelings for the last two weeks. In the diaries, we asked participants to evaluate their feelings on the day the questionnaire was delivered. We used a 7-point Likert type scale (1 = *never*, 7 = *always*) in this study. The positive (PE) and negative experience (NE) subfactors were also found to be reliable (αs were .94 and .87, respectively).

World Health Organization-5 Well-Being Index (WHO-5)

We measured the well-being levels of participants by using the WHO-5 which was developed by the World Health Organization (1998). Turkish adaptation is done by Eser and colleagues (2019). The scale consisted of 5 items about individuals' well-being perspectives. A 6-point response scale (1= *All of the time,* 2= *Most of the time*, 3= *More than half of the time,* 4= *Less than half of the time,* 5= *Some of the time,* 6= *At no time)* was used. In the baseline data collection, we asked participants to evaluate their last two weeks to respond to the items. In the daily diary data, they responded to the items for how they felt on the day they got the questions. Cronbach's alpha was found to be .85.

Subjective Health Scale (SheS)

We measured the health of participants with one question (DeSalvo et al., 2006; Meng et al., 2014) in both baseline data and daily diaries. The question of baseline data was "*Please indicate the situation that best reflects your health status in the LAST TWO WEEKS on the scale below*." and it was in the daily diaries "*Please state the situation that best reflects your health status TODAY on the scale below*." We used an 11-point Likert type scale (0= *very bad*, 10 = *very good*).

2.3.3. Questionnaires in only Daily Diaries

Daily Diary Hierarchy Questions

We measured how much the participants implemented hierarchy in their interactions in their work each day by two questions. Participants evaluated their positions in the hierarchy on two questions: (1) when they were in a higher position and (2) when they were in a lower position (*"When you consider all your social contacts and interactions at your institution, what percentage of your relationships were as the described way?"*) after reading two versions of the below paragraph (adapted from Haslam, et al., 2002) describing hierarchical relationships that the protagonist is a superordinate or a subordinate.

> *"One of you tends to "call the shots" and take initiative in this relationship and the other tends to follow along. One of you makes most of the decisions and the other one goes along with that person's choices. The one in charge usually gets their way and takes responsibility for things. The other is a follower in this relationship and backs the other person up, knowing that they can depend on the one in charge to lead and protect them when it's needed."*

Enjoying the work in the workplace

We measured how much participants enjoyed their work in the workplace with one question: *"Please indicate your enjoyment of work today on the percentage? (0 - I never enjoyed it, 100 - I enjoyed it very much)"*

Motivation to go to work the next day

We measured participants' motivation to go to work the next day with one question: *"Please indicate your willingness to go to work tomorrow on the percentage? (0 - I don't want it at all, 100 - I want it very much)*"

2.4. Analysis Strategy

Statistical models

We explored the baseline dataset to investigate how participants' positions in the workplace, their evaluations about the hierarchies and the workplace system, and their personality traits were related to their well-being and affective states. We used bivariate correlations between study variables and multiple regression analyses to test these associations.

In regression models, well-being and affective state were the outcome variables whereas the personality traits, participants' scores on SDO, WSJ, position in the workplace, WCQ, and identity were the independent variables.

Multilevel modeling (mixed-effects models with random intercepts) will be performed to analyze the daily diary dataset for testing the thesis hypotheses. The daily responses of participants were level 1 units which were nested to the individuals. The daily experiences of hierarchy in the workplace and daily health scores were used as the level 1 independent variables and daily well-being, daily enjoyment from the work, and daily motivation to go work the next day were the level 1 dependent variable in separate models. To analyze the models, we adapted the SPSS syntax recommended by (Bolger & Laurenceau, 2013).

3. RESULTS

3.1. Descriptives of The Baseline Survey

Descriptive statistics of variables and scales are summarized in Table 3.1. Distributions of all variables were evaluated with skewness and kurtosis values and histograms (min. skewness = -.91, max. skewness = 1.22, min. kurtosis = -.99, max. kurtosis = 1.47). According to these values and histograms, distributions appeared to be normal (Tabachnick & Fidell, 2013).

Table 3.1. *Descriptive Statistics of the* ***Baseline Study*** *Variables*

Variables	*Mean*	*SD*	Minimum	Maximum	Skewness	Kurtosis
Age	37.35	8.39	23.00	67.00	.72	.53
Year	10.34	8.53	.50	43.00	1.22	1.47
Socio Economic Status	6.11	2.12	1.00	10.00	-.35	-.41
Well-being	3.47	.92	1.00	6.00	-.15	-.11
Positive Experience	4.41	1.15	1.00	7.00	-.31	-.31
Negative Experience	3.28	1.25	1.00	7.00	.58	-.45

Health	8.32	2.15	1.00	11.00	-.91	.60
Identity	5.03	1.36	1.00	7.00	-.65	.01
Subjective Hierarchy	6.10	2.01	1.00	10.00	-.67	.01
Social Dominance Orientation	2.66	.99	1.00	5.80	.33	-.30
Work Climate Questionnaire	3.78	1.70	1.00	7.00	.13	-.99
Workplace System Justify	2.90	1.29	1.00	6.50	.59	-.34
Openness	5.11	1.20	2.50	7.00	-.19	-.90
Agreableness	5.30	1.11	2.00	7.00	-.34	-.52
Emotional Stability	4.52	1.22	1.50	7.00	-.50	-.10
Conscientiousness	5.56	1.18	2.00	7.00	-.69	-.30
Extraversion	5.01	1.44	1.00	7.00	-.50	-.30

3.2. Correlations of Baseline Survey Variables

The bivariate correlations between the main study variables and age and gender of participants were estimated (Table 3.2.). There were substantial relationships between dependent variables of the study: Well-being was positively correlated with positive experience (r =.70) and negatively correlated with negative experience (r = -.62). First of all, the subjective health status of participants was found to be an important indicator of well-being (r = .47), positive experience (r = .44), and negative experience (r = -.43). However, the social dominance orientation did not correlate with well-being, positive experience, and negative experience, but subjective hierarchy was positively correlated with well-being (r = .27). Workplace system justification positively correlated with well-being (r = .18), positive experience (r = .28), and work climate questionnaire (r = .53), indicating that participants that highly justified the organization of their workplace had also higher well-being scores and higher positive experience and lower negative experience in general.

Similarly, the work climate questionnaire positively correlated with well-being (r = .16) and positive experience (r = .26), however, it was negatively correlated with negative experience

(*r* = -21). Positive perceptions of the managers or supervisors in the workplace related to higher well-being and positive experience and related to lower negative experience in general.

Identification with other healthcare professionals was positively correlated with well-being (*r* = .30) and positive experience (*r* = .28), but negatively related to negative experience (*r* = -21).

Furthermore, identification with the other health professionals appeared to be another associated variable with well-being *(r* = .30), positive experience (*r* = .28), and negative experience (*r* = -.21). Participants working year in their profession was positively correlated with well-being (*r* = .18), positive experience (*r* = .20), and negatively correlated with negative experience (*r* = -.21). However, the age of the participants was not correlated with well-being and positive experience. Seniority in the profession appeared to be more important than the age of the participants on well-being. Finally, personality traits were positively correlated with well-being and positive experience but negatively correlated with negative experience (absolute *r*s ranged between .19 to .42)

Table3.2. *Correlations for Study Variables*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1.Sex	1																
2.Age	-.06	1															
3.Year	-.09	.86**	1														
4.WHO	.02	.12	.18**	1													
5.PE	.02	.14*	.20**	.70**	1												
6.NE	-.04	-.16*	-.21**	-.62**	-.74**	1											
7. Heath	.04	.04	.06	.47**	.44**	-.43**	1										
8. Identity	.01	.28**	.26**	.30**	.28**	-.21**	.11	1									
9. SH	-.06	.45**	.42**	.27**	.15*	-.15*	.11	.40**	1								
10. SDO	.20**	-.19**	-.18**	-.00	.01	.00	.05	-.09	-.06	1							
11.WCQ	-.03	.28**	.28**	.16*	.26**	-.21**	.17*	.28**	.32**	.01	1						
12.WJS	-.01	.13*	.17*	.18**	.28**	-.20**	.19**	.20**	.18**	.20**	.53**	1					
13. Openness	-.10	.14*	.19**	.20**	.21**	-.20**	.07	.10	.18**	-.18**	.08	-.10	1				
14. Agreeableness	-.15*	.08	.10	.13	.25**	-.22**	.07	.19**	.13*	-.11	.10	.06	.30**	1			
15. Emotional Stability	.09	.09	.10	.31**	.32**	-.42**	.21**	.19**	.17*	.03	.06	.09	.21**	.29**	1		
16. Conscientiousness	-.26**	.21**	.27**	.19**	.18**	-.18**	.04	.10	.12	-.18**	.10	-.03	.31**	.29**	.21**	1	
17. Extraversion	-.06	.18**	.23**	.30**	.31**	-.25**	.25**	.30**	.27**	-.10	.11	.06	.42**	.38**	.23**	.31**	1

*WHO-5 = World Health Organization-5 Well Being Scale, PE= Positive Experience, NE= Negative Experience, SH= Subjective Hierarchy, SDO= Social Dominance Orientation, WCQ = Work Climate Questionnaire, WSJ = Workplace System Justification, * $p < .05$, ** $p < .01$.*

3.3. Regression Analyses of Baseline Survey Variables

To test if subjective hierarchy, workplace system justification, work climate questionnaire, social dominance orientation, identification, and personality traits (openness to experience, agreeableness, emotional stability, conscientiousness, and extraversion) were associated with the well-being, positive, and negative experience in the workplace, we conducted three separate linear multiple regression analyses.

In the first regression analyses (Table 3.3.), the model was significant (Adjusted R^2 = .184, $F(10, 215) = 6.057$, $p < .001$) when all variables were predicting the well-being. We checked the regression coefficients to identify which variables were uniquely contributed to the model. From all predictors, identification (b = .107, *SE* = .047, *95% CI* [.014, .199], β = .158, p = .024) and emotional stability (b = .156, *SE* = .049, *95% CI* [.059, .253], β = .207, p = .002) was positively associated with well-being of participants.

Table 3.3. *Summary of Linear Regression of Variables on Well Being*

	Model						
Variable	*B*	*SE*	*β*	% 95 CI		*p*	Partial Correlation
Subjective Hierarchy	.047	.032	.102	-.016	.109	.143	.100
WSJ	.085	.053	.119	-.019	.189	.111	.109
WCQ (admevo)	-.009	.041	.016	-.089	.072	.833	-.014
SDO	.021	.059	.023	-.096	.138	.723	.024
Identity	.107	.047	.158	.014	.199	.024	.153
Openness	.066	.054	.086	-.041	.172	.225	.083
Agreeableness	-.068	.057	-.082	-.180	.044	.231	-.082
Emotional Stability	.156	.049	.207	.059	.253	.002	.211
Conscientionusness	.061	.052	.079	-.042	.164	.242	.080
Extraversion	.090	.047	.140	-.003	.182	.057	.129
R^2				.220			
Adjusted R^2				.184			
F				6.057			

WSJ = Workplace System Justification, WCQ = Work Climate Questionnaire, SDO= Social Dominance Orientation

As depicted in Table 3.4, the regression model was significant when predicting positive experience of the participants (Adjusted R^2 = .221, F(10, 215) = 7.383, p < .001). Investigating the unique associations revealed that workplace system justification (*b* = .176, *SE* = .065, *95% CI* [.048, .303], β = .197, *p* = .007), identification (*b* = .120, *SE* = .058, *95% CI* [.006, .233], β = .141, *p* = .039), emotional stability (*b* = .192, *SE* = .060, *95% CI* [.072, .311], β = .202, *p* = .002), and extraversion (*b* = .117, *SE* = .057, *95% CI* [.004, .231], β = .146, *p* = .043) were positively associated with positive experiences in the workplace.

Table 3.4. *Summary of Linear Regression of Variables on Positive Experience*

	Model						
Variable	*B*	*SE*	*ß*	% 95 CI		*p*	Partial Correlation
Subjective Hierarchy	-.040	.039	-.070	-.117	.036	.302	-.070
WSJ	.176	.065	.197	.048	.303	.007	.182
WCQ (admevo)	.061	.050	.090	-.037	.160	.223	.083
SDO	-.004	.073	-.004	-.148	.139	.951	-.004
Identity	.120	.058	.141	.006	.233	.039	.140
Openness	.086	.066	.089	-.045	.216	.198	.088
Agreeableness	.055	.070	.053	-.082	.192	.428	.054
Emotional Stability	.192	.060	.202	.072	.311	.002	.211
Conscientionusness	.039	.064	.040	-.087	.165	.544	.041
Extraversion	.117	.057	.146	.004	.231	.043	.138
R^2				.256			
Adjusted R^2				.221			
F				7.383			

WSJ = Workplace System Justification, WCQ = Work Climate Questionnaire, SDO= Social Dominance Orientation

In the last regression model, when the negative experience in the workplace was the outcome, the model was significant (Adjusted R^2 = .207, F(10, 215) = 6.878, p < .001). From

the predictors, only the emotional stability predicted the negative experience in the workplace (*b* = -.354, *SE* = .066, *95% CI* [-.484, -.224], β = -.346, *p* = .007) (see Table 3.5 for all estimates).

The results of regression analyses indicated that identification with healthcare professionals and emotional stability as a personality trait were important indicators associated with the general well-being in the workplace. The results also revealed that justification of the workplace system positively related to positive experiences in the workplace in general, as well as identification, emotional stability, and being extraverted. At last, higher emotional stability was associated with lower negative experiences in the workplace.

Table 3.5. *Summary of Linear Regression of Variables on Negative Experience*

	Model						
Variable	*B*	*SE*	*β*	% 95 CI		*p*	Partial Correlation
Subjective Hierarchy	.015	.042	.025	-.068	.099	.719	.025
WSJ	-.100	.071	-.104	-.239	.039	.158	-.096
WCQ (admevo)	-.076	.055	-.104	-.184	.031	.164	-.095
SDO	4.632E-5	.079	.000	-.156	.157	1.000	.000
Identity	-.053	.063	-.058	-.177	.070	.397	-.058
Openness	-.074	.072	-.071	-.216	.069	.309	-.069
Agreeableness	-.027	.076	-.024	-.176	.123	.725	-.024
Emotional Stability	-.354	.066	-.346	-.484	-.224	.000	-.344
Conscientionusness	-.047	.070	-.044	-.184	.090	.502	-.046
Extraversion	-.072	.063	-.083	-.196	.051	.249	-.079
R^2	.242						
Adjusted R^2	.207						
F	6.878						

WSJ = Workplace System Justification, WCQ = Work Climate Questionnaire, SDO= Social Dominance Orientation

3.4. Results of Daily Diaries

The daily diary dataset included 2340 observations collected from 156 healthcare professionals working in surgical branches in 15 successive days. We adapted the SPSS MIXED command suggested by Bolger and Laurenceau (2013; p. 102) to test the effect of frequencies of daily hierarchical relationships (as implied by the application of authority ranking) on the daily well-being, daily positive and negative experiences in the workplace, daily enjoyment from the work in the workplace, the motivation to go to work the following day by controlling the effect of daily health status in five separate multilevel analysis with random intercepts and slopes. In our models, the frequency of daily hierarchical relationships was divided into two: as the participant was in a superordinate role and as the participant was in a subordinate role. We included daily health status in the models since the bivariate correlations indicated a substantial association between health status and well-being and positive and negative experience.

To interpret the intercepts we grand-mean centered all predictor variables by subtracting the variables' grand means from themselves. Then, to test within-participant variations of the predictors specifically, we created between- and within-participant versions of all predictors. We also added a centered version of the time to the model. To center the time we divided it to 15 as each unit change indicated one day in the variable.

The results of the analyses were summarized in Tables 3.6 to 3.10. The upper panel of each table depicts the fixed (average) effects of the predictors on the outcome, and the lower panel of each table depicts the random effects, variances, and covariances between the effects. Since we are interested in daily within-participant variation in the relationships between predictors and outcomes, we interpreted only the within-participant version of the predictors. To interpret the between-participant versions, these effects show the association between the average of the predictor across the 15-day diary period and average daily outcome.

First, we conducted multilevel models with random intercepts and slopes to predict daily well-being (Table 3.6). The results revealed that the participants reported 3.670 well-being scores on average in a typical day (the range was between 1 to 6). The association of implementing hierarchy on the relationships when the participants were in the superordinate situation with well-being was significant, (γ_{10} = 0.009, *SE* = 0.003, *p* = .010, *95% C.I.* [0.002,

0.016]). On days one unit increase in the rate of superordinate roles was associated with a 0.009 unit increase in well-being. However, the association of implementing hierarchy on the relationships when the participants were in the subordinate situation was non-significant, (γ_{10} = 0.002, *SE* = 0.004, *p* = .528, *95% C.I.* [-0.005, 0.010]). Daily health status was positively associated with well-being, (γ_{10} = 0.220, *SE* = 0.032, *p* < .001, *95% C.I.* [0.157, 0.282]). The random effects and covariances showed a significant variance of the intercepts (τ_{00} = 0.335, *SE* = 0.069, *p* < .001, 95% *C.I.* [0.224, 0.499]), indicating that after removing the variance explained by implementing hierarchy in daily relationships and daily health status, there remained substantial unexplained variation between participants.

Table 3.6. *Multilevel Model of Daily Well-Being as Associated with Daily Superordinate Position, Subordinate Position, and Health Status*

						CI_{95}	
Fixed effects		Estimate	*(SE)*	*t*	*p*	Lower	Upper
Intercept		3.669	.053	68.016	<.001	3,563	3.776
Time		.072	.062	1.170	.243	-,049	.195
wCup		.009	.003	2.660	.010	,002	.016
bCup		.000	.000	.999	.318	-.000	.002
wCsub		.002	.003	.639	.528	-.005	.009
bCsub		-.005	.001	-5.403	<.001	-.007	-.003
wChealth		.219	.031	6.917	<.001	.156	.282
bChealth		.258	.011	23.320	<.001	.236	.280
						CI_{95}	
Random effects ([co-]variances)		Estimate	*(SE)*	*z*	*P*	Lower	Upper
Repeated mesures	AR1 diagonal	.399	.016	24.530	<.001	.369	.433
	AR1 rho	.279	.030	9.227	<.001	.219	.337
intercept + wCup	UN (1,1)	.334	.068	4.883	<.001	.223	.449
+wCsub [subject	UN (2,1)	-.001	.001	-.949	.343	-.005	.001
= Pid]	UN (2,2)	.000	.000	.	.	.	.
	UN (3,1)	-.001	.001	-.879	.379	-.005	.002
	UN (3,2)	.000	.000	1.279	.201	-7.529	.000

UN (3,3)	.000	.000	.948	.343	2.962	.001

w: within, b: between, Cup: Superordinate Position, Csub: Subordinate Position, Chealth: Health Status

The multilevel models with random intercepts and slopes indicated that the participants in a typical day reported a 4.508 positive experience and a 2.497 negative experience scores on average (the range was between 1 to 7). The associations of implementing hierarchy in relationships both in superordinate position and subordinate position with both positive and negative experience were non-significant (See the Table 3.7 and Table 3.8 for fixed effects estimations). However, daily health status was positively associated with daily positive experience (γ_{10} = 0.282, *SE* = 0.040, $p < .001$, *95% C.I.* [0.202, 0.362]) and negatively associated with daily negative experience (γ_{10} = -0.240, *SE* = 0.033, $p < .001$, *95% C.I.* [-0.306, -0.173]). The random intercept estimates revealed significant intercept variances in both positive (τ_{00} = 0.548, *SE* = 0.148, $p < .001$, 95% *C.I.*[0.323, 0.929]) and negative (τ_{00} = 0.379, *SE* = 0.085, $p < .001$, 95% *C.I.* [0.245, 0.587]) experiences between participants. Even health status explained some variances in the daily positive and negative experiences, there were substantial unexplained variances between participants.

Table 3.7. *Multilevel Model of Daily Positive Experience as Associated with Daily Superordinate Position, Subordinate Position, and Health Status*

					CI_{95}	
Fixed effects	Estimate	*(SE)*	*t*	*P*	Lower	Upper
Intercept	4.508	.068	65.828	<.001	4.372	4.643
Time	.080	.083	.972	.332	-.082	.244
wCup	.007	.004	1.850	.087	-.001	.016
bCup	.005	.001	3.887	<.001	.002	.007
wCsub	.001	.004	.426	.674	-.006	.010
bCsub	-.006	.001	-5.084	<.001	.009	-004
wChealth	.282	.040	6.988	<.001	.202	.361
bChealth	.340	.015	22.465	<.001	.310	.370
					CI_{95}	

Random effects ([co-]variances)		Estimate	*(SE)*	*z*	*P*	Lower	Upper
Repeated mesures	AR1 diagonal	.724	.029	24.734	<.001	.669	.784
	AR1 rho	.265	.030	8.610	<.001	.204	.324
intercept + wCup +wCsub [subject = Pid]	UN (1,1)	.558	.147	3.715	<.001	.323	.928
	UN (2,1)	-.002	.004	-.559	.576	-.010	.005
	UN (2,2)	5.292E-5	.000	.075	.940	2.426E	11545147.65
	UN (3,1)	-.000	.005	-.035	.972	-.010	.010
	UN (3,2)	7.042	.000	.301	.763	-.000	.000
	UN (3,3)	.000	.000	.529	.597	5.79E-5	.009

w: within, b: between, Cup: Superordinate Position, Csub: Subordinate Position, Chealth: Health Status

Table 3.8. *Multilevel Model of Daily Negative Experience as Associated with Daily Superordinate Position, Subordinate Position, and Health Status*

Fixed effects	Estimate	*(SE)*	*t*	*p*	CI_{95} Lower	CI_{95} Upper
ntercept	2.496	.058	42.655	<.001	2.381	2.612
Time	-.481	.081	-5.918	<.001	-.641	-.321
wCup	.001	.003	.395	.695	-.005	.008
bCup	-.004	.001	-3.763	<.001	-.007	-.002
wCsub	,007	.003	2.041	.052	-5.29E5	.014
bCsub	.004	.001	3.631	<.001	.002	.007
wChealth	-.239	.033	-7.160	<.001	-.305	-.173
bChealth	-.266	.014	-18.623	<.001	-.295	-.238

Random effects ([co-]variances)		Estimate	*(SE)*	*z*	*P*	CI_{95} Lower	CI_{95} Upper
Repeated mesures	AR1 diagonal	.665	.027	24.256	<.001	.613	.721

	AR1 rho	.301	.029	10.142	<.001	.242	.358
intercept +	UN (1,1)	.379	.084	4.485	<.001	.244	.586
wCup +wCsub	UN (2,1)	-.001	.002	-.422	.673	-.006	.004
[subject = Pid]	UN (2,2)	.000	.000	.505	.614	2.43E-6	.005
	UN (3,1)	.003	.002	1.387	.165	-.001	.008
	UN (3,2)	1.80E-5	.000	.167	.868	-.000	.000
	UN (3,3)	4.51E-5	.000	.216	.829	5.22E-9	.389

w: within, b: between, Cup: Superordinate Position, Csub: Subordinate Position, Chealth: Health Status

As seen in Table 3.9., the multilevel models with random intercepts and slopes revealed that the mean enjoyment from the work in a typical day was 53.01 (scale was between 1 to 100). There was a positive association between implementing hierarchy as a superordinate and enjoyment from the work on average (γ_{10} = 0.538, *SE* = 0.787, $p < .001$, *95% C.I.* [0.378, 0.697]), indicating in days one unit increment in participants' superordinate situation in their daily relationships in the workplace was associated with a 0.538 unit increase in their enjoyment from their work. The association between implementing hierarchy as a subordinate and enjoyment from the work was non-significant, (γ_{10} =0.170, *SE* = 0.844, $p = .052$, 95% *C.I.* [-0.002, 0.342]). At last, the daily health status was positively related with the enjoyment from the work, (γ_{10} = 4.172, *SE* = 0.753, $p < .001$, 95% *C.I.* [2.683, 5.662]), in days that the health status increased one unit was associated with 4.172 units increment in the enjoyment of the work. Investigating the random coefficients and covariances showed that only the random intercepts were significant (τ_{00} = 159.049, *SE* = 41.567, $p < .001$, 95% *C.I.* [95.296, 265.455]). Although their implementing hierarchy as a superordinate and health status explained substantial variation between participants in their enjoyment from the work, there was also a substantial level of unexplained variation between participants.

Table 3.9. *Multilevel Model of Daily Enjoyment as Associated with Daily Superordinate Position, Subordinate Position, and Health Status*

							CI_{95}

Fixed effects		Estimate	*(SE)*	*t*	*p*	Lower	Upper
ntercept		53.007	1.285	41.240	<.001	50.466	55.548
Time		-4.362	1.582	-2.757	.006	-7.470	-1.254
wCup		.537	.078	6.830	<.001	.378	.696
bCup		.357	.027	12.928	<.001	.303	.412
wCsub		.170	.084	2.015	.052	-.001	.341
bCsub		.124	.028	4.364	<.001	.068	.180
wChealth		4.172	.752	5.542	<.001	2,682	5.661
bChealth		4.224	.310	13.608	<.001	3.615	4.833
						CI_{95}	
Random effects ([co-]variances)		Estimate	*(SE)*	*z*	*P*	Lower	Upper
Repeated mesures	AR1 diagonal	288.380	11.086	26.011	<.001	267.449	310.949
	AR1 rho	.164	.031	5.196	<.001	.101	.225
intercept + wCup	UN (1,1)	159.049	41.567	3.826	<.001	95.295	265.455
+wCsub [subject	UN (2,1)	-.694	1.099	-.632	.528	-2.850	1.460
= Pid]	UN (2,2)	.040	0.101	.401	.689	.000	5.425
	UN (3,1)	-1.496	1.289	-1.160	.246	-4.023	1.03
	UN (3,2)	.038	.071	.545	.586	-.100	.178
	UN (3,3)	.195	.130	1.495	.135	.052	.725

w: within, b: between, Cup: Superordinate Position, Csub: Subordinate Position, Chealth: Health Status

The multilevel models with random intercepts and slopes indicated that the estimated mean motivation to go work the next day in a typical day was 44.84 (the range was between 1 to 100) (Table 3.10.). There was a positive association between implementing hierarchy as a superordinate and motivation to go work the next day on average (γ_{10} = 0.550, *SE* = 0.101, $p < .001$, *95% C.I.* [0.345, 0.755]), indicating in days one unit increment in participants' superordinate role in their daily relationships in the workplace was associated with a 0.550 unit increase in their motivation to go work the following day. The association was non-

significant for the implementing hierarchy into the relationships when the participants was in a subordinate role, (γ_{10} = 0.195, *SE* = 0.108, *p* = .079, *95% C.I.* [-0.024, 0.413]). However, the daily reported health status was positively associated with the motivation to go work next day (γ_{10} = 3.730, *SE* = 1.023, *p* < .001, *95% C.I.* [1.707, 5.755]). The random covariances showed significant random intercepts (τ_{00} = 347.217, *SE* = 83.473, *p* < .001, 95% *C.I.* [216.754, 556.204]). Although implementing hierarchy as a superordinate and participants' health status explained substantial variation between participants in their motivation to go work the next day, there was also a substantial level of unexplained variation between participants.

Table 3.10. *Multilevel Model of Daily Motivation as Associated with Daily Superordinate Position, Subordinate Position, and Health Status*

						CI_{95}	
Fixed effects		Estimate	*(SE)*	*t*	*p*	Lower	Upper
Intercept		44.845	1.767	25.379	<.001	41.352	48.337
Time		-2.630	1.758	-1.496	.135	-6.086	0.825
wCup		.550	.101	5.425	<.001	.345	.755
bCup		.094	.283	3.334	.001	.038	.150
wCsub		.195	.108	1.812	.079	-.024	.413
bCsub		-.022	.028	-.774	.439	-.078	.034
wChealth		3.730	1.023	3.647	<.001	1.707	5.755
bChealth		3.573	.317	11.266	<.001	2.951	4.195
						CI_{95}	
Random effects ([co-]variances)		Estimate	*(SE)*	*z*	*P*	Lower	Upper
Repeated mesures	AR1 diagonal	319.227	13.094	24.379	<.001	294.567	354.952
	AR1 rho	.270	.031	8.517	<.001	.207	.332
intercept + wCup	UN (1,1)	347.216	83.472	4.160	<.001	216.754	556.203
+wCsub [subject	UN (2,1)	-.387	1.736	-.223	.823	-3.790	3.014
= Pid]	UN (2,2)	.039	.173	.226	.821	6.74E-6	228.582
	UN (3,1)	-2.618	2.284	-1.146	.252	-7.094	1.858
	UN (3,2)	.014	.089	.160	.873	-.161	.190

UN (3,3)	.249	.195	1.274	.203	.053	1.159

w: within, b: between, Cup: Superordinate Position, Csub: Subordinate Position, Chealth: Health Status

4. DISCUSSION

All modern societies were organized in some kind of hierarchies, as well as the smaller units within these societies (Rai & Fiske, 2015). To regulate the relationships between superordinates and subordinates in a hierarchy, certain norms, rules, and motives have emerged in the societies that were also shaped by cultural evolution. Relational models theory (Fiske, 1992; 2004) theorized how individuals, groups, or societies regulate and organize the hierarchies and how people implement the related cultural motives (i.e., moral motives and rules of authority ranking). However, the implementation of hierarchy in general, or being superordinate or subordinate in a specific context is associated with varying emotions and well-being of individuals (van Kleef & Lange, 2020). In this thesis, we explored how the hierarchical organization of the workplace and how the positions of individuals in these workplaces were related to the healthcare professionals' well-being and workplace experiences. We focused on surgical branches in health institutions to observe participants in their natural work settings, which have a vertical organization in general.

We repeatedly collected data from healthcare professionals to create baseline data and daily diary data. In baseline data, we explored *global associations* of how healthcare professionals evaluate the organization and hierarchy of their workplace (measured by their social dominance orientation, justification of their workplace system, evaluation of their superordinates—their managers or chiefs—, and their perceived status in the workplace hierarchy), how they identified themselves with other healthcare professionals and their personality traits with their well-being and positive and negative experience in the workplace. In the daily diary data, we explored the association between daily implementation of authority ranking rules (hierarchy motives and rules) in the workplace relationships and daily fluctuations in well-being, positive and negative experience, enjoyment working in the workplace, and the motivation to go working the next day after controlling their daily health status. Since the relationship pattern in the institutions are complex (Fiske, 2004), in other words since each individual have different roles, positions, and status in the workplace at the same time, we included two variables to measure the daily implementation of hierarchy: (1)

the participant in the superordinate position and (2) the participant in the subordinate position. Including both variables in the model enabled us to better capture the complexity of workplace relational structure.

First, we found that when participants have relatively higher positive evaluations and expectations about their superiors (work climate questionnaire), and when they have relatively higher justification for the way their workplace runs (workplace system justification), they also reported higher well-being and positive experiences. A Higher score in the work climate questionnaire is also an indicator of perceived autonomy support from supervisors and managers (Baard et al., 2004), which was found to be positively associated with autonomous work motivation, positive work behaviors, and well-being (Slemp et al., 2018). Thus, our findings also confirm the previous research that found positive associations between work climate questionnaire and well-being in workplaces (Schultz et al., 2015). Similarly, our findings are in line with the system justification theory (Jost & Banaji, 1994). The theory suggested that the legitimizing system has a psychological palliative effect on individuals (Jost & Banaji, 1994, 2004; Jost & Hunyady, 2003). Disadvantaged people may tend to evaluate their system as fair, even if it conflicts with their financial interests (Blasi & Jost, 2006; Jost & Hunyady, 2005). System justification provides psychological benefits through its role in fulfilling epistemic, existential, and relational needs by supporting self-esteem and life satisfaction (Harding & Sibley, 2013; Ozmen et al., 2017; Vargas-Salfate, 2018). Thus, our result that higher justification of the workplace system was correlated with higher well-being and positive experience supports the basic recommendations of system justification theory.

In our analyses, identification with the health professional appeared to be an important factor in the well-being and positive experiences of participants. The higher the identification with other health professionals was related to higher scores of well-being and positive experience, and lower levels of negative experience in the workplace. Medical staff working in the surgical department work together for long hours, share the same space during the day and wear the same type of uniform. All such features catalyze the identification between colleagues and help to form a sense of "us" (Tajfel & Turner, 1979). When a member of the group internalizes his or her roles and membership, the others in the group become the part of the self (Turner et al., 1982) which strengthens the social bond and connectedness. Social connectedness has a buffering effect on negative effects and stress in

the work environment (Haslam et al., 2005). For that reason, belonging in a group and group identity positively affects people's well-being (Jetten et al., 2014; Kyprianides et al., 2019). Furthermore, we collected the data during the COVID-19 pandemic; we believe that high risk of infection and harder work conditions unified all healthcare professionals in the hospitals and created a salient sense of "us". Our findings that identification was an important variable that was associated with well-being confirms the previous research (Haslam et al., 2008; Haslam et al., 2014; Inoue et al., 2015). Our findings on identification support the existing literature that identification with a specific group is related to individual and group well-being and enhanced health in close relationships (Chuang, 2015), in the clinical context (Study 1 in Haslam et al., 2005), and the work setting (Wegge et al., 2006).

Highlighted identification between healthcare professionals should have decreased the effects of different positions in the workplace hierarchy, varying duties and rights, and different work conditions by increasing unity motivations (i.e., communal sharing) in relationships between ingroup members (Dalgar et al., 2014; Ellemers, 1993; Fiske, 2004). Participants in different positions and rights in the workplace hierarchy (from nurses to assistants to professors and managers) could evaluate themselves as an indistinguishable part of a unit. Thus, we suggest that participants' global evaluations on their positions in the workplace hierarchy about their global well-being and positive experience ratings were influenced by the high identification scores (5.03 on average as the range was between 1 to 7). To make more robust explanations, future studies should conduct experimental or longitudinal studies on the moderator role of identification in the association between workplace hierarchy and well-being.

We also found that older and senior participants had higher subjective hierarchy levels. While there was a significant relationship between well-being and seniority, there was no significant relationship between well-being with age. We attribute this result to the fact that the hierarchy can stem from the status that can be established independent of the age of the participants. Social dominance orientation was not correlated with well-being, positive experience, and negative experience. But confirming the basic ideas of the theory (Pratto, 1994), social dominance orientation was positively associated with workplace system justification, indicating that participants who had high social dominance orientation scores more easily justify their workplace hierarchies.

Personality is a predictor of well-being (Burns et al., 2010). Therefore, personality and well-being were investigated in the baseline study to explore global associations between personality traits and well-being in our sample. Well-being and positive experiences were reported as high, negative experiences were reported as low in participants with high emotional stability. Similar to the literature, our findings showed that participants with higher traits in stabilizing their emotions had higher scores of well-being and positive experience (Grant et al., 2009; Kokko et al., 2013; Steel et al., 2008).

One of the most important features of our study was our investigation of the association between implementing hierarchy in the workplace and well-being indicators on a daily basis in addition to participants' global evaluations. We collected daily data in 15 successive days. In their global evaluations, participants might regress towards the mean or can recall their just most immediate thoughts or feelings. However, daily diary designs, as other longitudinal research, enabled us to observe our participants with their real-world behaviors and emotions, within their everyday environments in real relationships, and make cause and effect interpretations (Bolger & Rafaeli, 2003).

In daily diary analyses, we consistently found that implementing hierarchy rules in the workplace when the participants were in a superior position was positively associated with well-being, positive experience in the workplace, enjoyment in the workplace, and the motivation to go work the next day. In our sample, when the participants had a higher number of relationships as they were in *a superior position in a day*, they also reported higher well-being, higher positive experience, higher enjoyment in work *that day*, and higher motivation to go working *the following day*. Being superior in a workplace provides higher levels of freedom and control over the work, which are associated with higher well-being and job satisfaction (Frey & Benz, 2003). Also, being in a superior position provides more protection against workplace mistreatment, harassment, mobbing, and aggression compared to being subordinate, which impair the well-being and health status of the workers (Frone, 2000; Tepper et al., 2008). Similarly, a small meta-analysis revealed that individuals in higher positions report lower levels of stress (Moore & Cunningham, 2012). The higher status is also linked to a healthier life and behaviors (Marmot, 2004; Scheepers & Knight, 2020). Thus, our findings are in line with the literature that when individuals involved in relationships as superiors, they also had the benefits of being superordinate.

As opposed to superordinate experiences in a day, implementing hierarchical relationships as subordinates did not relate to any of the outcomes. We think the high levels of identification with health professionals we observed in the baseline survey was related to the non-significant associations of being subordinate. Experimental research on hierarchy in the workplace revealed that the status or position in a workplace is related to how people form identification within the workplace, which in turn was associated with well-being (Horton et al., 2014). Also, research showed that being in a significant group created a positive identity (Jetten et al.,2015). While we were collecting the data, a positive perception was formed against healthcare professionals due to the Covid-19 outbreak. Most institutions and individuals were making supportive campaigns and discourses for healthcare professionals. In this atmosphere, healthcare professionals may have thought they were included in an important group. This situation may have had a more positive effect on their identification. Being a member of the important group might have caused them to be less affected by the disadvantages of being a subordinate in the workplace hierarchy.

Limitations and implications of the study

The first limitation of the study was about daily diary surveys. Participants answered the same questions each day for a successive 15 days. Participants might get bored and give wrong and/or indifferent answers because of the same questions (Bolger et al., 2003).

Another limitation of the study was about the Covid-19 Pandemic. Data collection was done during the coronavirus pandemic in Turkey. At that time, some healthcare workers switched to flexible working hours due to the pandemic. Also, some participants were temporarily employed in the coronavirus outpatient clinic outside their departments where they always worked. This change may temporarily disrupt the hierarchical relationship structures of the participants during the day.

The third limitation of the study was about the well-being and emotional changes in healthcare professionals due to the Covid-19 pandemic. Kadhum and colleagues (2020) reported that the coronavirus outbreak is a significant stressor to surgeons. Because of this change, we may not have achieved the usual well-being results of the participants. Future research must reevaluate the post-pandemic situations. There are also some implications of the study. First, although there are many studies about the well-being of healthcare professionals in the literature (Eley et al.,2013; Firth-Cozens, 2003; Imo, 2017; Neto, 2014),

to our knowledge, there are no previous studies that directly investigated the effects of the hierarchical organization of healthcare institutions on the healthcare professionals. Thus, we were able to see more closely the effect of hierarchy, which is the basic structure of healthcare organizations, on the well-being of healthcare professionals.

The second implication was that we showed a causal relationship between implementing hierarchy as a superordinate on the well-being and work-related outcomes. It was a success to be able to make a survey that lasted almost 1 month for a group of participants consisting of surgical branches and to complete all the surveys with 156 participants. Daily methods have many advantages, such as shortening the time between events and measurements or observing people in their natural environment (Bolger et al., 2003; Laurenceau & Bolger, 2005).

Conclusion

The primary aim of this thesis was to investigate the effects of hierarchy on healthcare professionals' well-being in a global assessment and in a daily manner. Earlier studies showed that justification of the system and perception of autonomy support from supervisors had positive effects on well-being. Our study has supported the positive association of system justification and perceived autonomy support in surgical branches. Furthermore, our study showed that in-group identification was an important factor of well-being. We also showed that daily experiences of authority ranking (hierarchy motives) stating a superior position in a day, was positively related to this day's well-being, positive experience, and enjoying the work, as well as next day's motivation to go to work. Considering the importance of protecting well-being, health, work engagement, and motivation of healthcare professionals to maintain well-being and quality of healthcare system in optimum standards, we think that our findings have substantial potential to contribute to the literature to evaluate the organization of healthcare institutions.

There are also some practical suggestions from our study for the daily work life of healthcare professionals. The first is the importance of identification. Our study showed that identification can protects healthcare professionals from the negative effects of hierarchy. The activities of health institutions that strengthen the sense of belonging of their employees can help to increase the identification of healthcare professionals and thus eliminate the negative effect of the hierarchy. The second is the importance of regular measurement of

psychological well-being in healthcare workers. Although our study shows that those who are lower in the hierarchy are not negatively affected, this may not always be true. These well-being measurements should be repeated at certain time intervals in heath institutions. In this way, healthcare professionals should be protected from the negative effects of hierarchy.

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APPENDICES

APPENDIX A: SURVEY MATERIALS OF THE STUDY

Informed Consent

Sayın Katılımcı,
Bu araştırma, Başkent Üniversitesi Psikoloji Bölümü öğretim elemanlarından Dr. Öğr. Üyesi İlker Dalgar ve Başkent Üniversitesi Sosyal Psikoloji Tezli Yüksek Lisans programı öğrencilerinden Dr. Murat Tümer tarafından yürütülen bir çalışmadır. Bu form sizi araştırma koşulları hakkında bilgilendirmek için hazırlanmıştır.

Çalışmanın Amacı Nedir?

Araştırmanın amacı, **sağlık çalışanlarının çalışma ortamlarındaki sosyal ilişkileri** ile ilgili bilgi toplamaktır.

Bize Nasıl Yardımcı Olmanızı İsteyeceğiz?

Bu anketin katılım süresi ortalama olarak **10 dakika** sürmektedir. Araştırmaya katılmayı kabul ederseniz, sizden önümüzdeki günlerde 10 dakikalık başka bir ankete ve sonrasında 14 gün boyunca 1-2 dakikalık kısa anketlere katılmanız istenecektir. Bu **anketin sonunda diğer anketleri sizinle paylaşabilmemiz için e-posta adresinizi bizimle paylaşmanız istenecektir**. Anketlere verdiğiniz yanıtlar e-posta adreslerinizden ayrı olarak saklanacak ve çalışma bitiminde e-posta adresleriniz tamamen silinecektir.

Sizden Topladığımız Bilgileri Nasıl Kullanacağız?

Araştırmaya katılımınız tamamen gönüllülük temelinde olmalıdır. Anketlerde, sizden kimlik belirleyici hiçbir bilgi istenmemektedir. Cevaplarınız tamamıyla gizli tutulacak, sadece araştırmacılar tarafından değerlendirilecektir. Katılımcılardan elde edilecek bilgiler toplu halde değerlendirilecek ve bilimsel yayımlarda kullanılacaktır. Sağladığınız veriler gönüllü katılım formlarında toplanan kimlik bilgileri ile eşleştirilmeyecektir.

Katılımınızla ilgili bilmeniz gerekenler:

Anketler, genel olarak kişisel rahatsızlık verecek sorular içermemektedir. Ancak, katılım sırasında sorulardan ya da herhangi başka bir nedenden ötürü kendinizi rahatsız hissederseniz cevaplama işini yarıda bırakmakta serbestsiniz.

Araştırmayla ilgili daha fazla bilgi almak isterseniz:

Bu çalışmaya katıldığınız için şimdiden teşekkür ederiz. Çalışma hakkında daha fazla bilgi almak için Dr. Murat Tümer (E-posta: dr.m.tumer@gmail.com) ile iletişim kurabilirsiniz.

Yukarıdaki bilgileri okudum ve bu çalışmaya tamamen gönüllü olarak katılıyorum.

Evet **Hayır**

DEMOGRAPHIC INFORMATION FORM

Doğum yılınız nedir?

_____

Cinsiyetiniz nedir?

Kadın

Erkek

Diğer

Medeni Durumunuz Nedir?

Evli

Bekar

Boşanmış/Ayrılmış

Hangi alanda çalışıyorsunuz?

Hemşire

Anesteziyoloji ve Reanimasyon Asistanı

Anesteziyoloji ve Reanimaston Uzmanı

Cerrahi Branş Asistanı

Cerrahi Branş Uzmanı

Diğer (Belirtiniz)

Alanda kaçıncı yılınız (yıl olarak rakamla yazınız)?

_____

Çalıştığınız sağlık kuruluşu aşağıdaki kategorilerden hangisindedir?

Devlet Hastanesi

Üniversite Hastanesi

Özel Hastane

Diğer (Belirtiniz)

Çalıştığınız kurumdaki ünvanınız nedir?

Araştırma görevlisi/asistan

Uzman

Başasistan

Öğretim Görevlisi

Öğretim Üyesi

Profesör

Yönetici

Hemşire

Sorumlu Hemşire

Diğer

Çalıştığınız kurumdaki birlikte çalıştığınız yaklaşık kişi sayısını (rakamla) yazınız.

_____

Aşağıdaki merdivenin Türkiye'deki insanların durduğu yeri temsil ettiğini düşünün.

Merdivenin tepesindekiler her şeyin en iyisine (en çok paraya, en iyi eğitime ve en saygın mesleklere) sahip olanlar. Merdivenin en altındakiler ise, en kötü koşullara sahip olanlar (en az paraya, en az eğitime ve en az sayılan mesleklere sahip olanlar ya da hiçbir işi olmayanlar).

Bu merdivende daha yüksek bir konuma sahip olmanız en tepedeki insanlara daha yakın olduğunuz; daha aşağıda olmanız ise en alttaki insanlara daha yakın olduğunuzu gösterir.

Bu merdivende kendinizi nereye yerleştirirdiniz?

En alt 1

2

3

4

5

6

7

8

9

En üst 10

WORLD HEALTH ORGANIZATION-5 WELL-BEING INDEX (WHO-5)

Aşağıdaki beş tanımlamadan her biri için, son iki hafta süresince kendinizi nasıl hissettiğinize en yakın olan yanıtı veriniz. Daha büyük sayıların daha iyi bir iyilik hali anlamına geldiğine dikkat ediniz. Örnek: Son iki hafta süresince geçen sürenin yarısından çoğunda neşeli ve keyifli hissettiyseniz, sağ üst köşesinde 3 sayısı olan kutucuğu işaretleyin.

0	1	2	3	4	5
Hiçbir Zaman	Bazen	Geçen zamanın yarısından daha azında	Geçen zamanın yarısından daha çoğunda	Çoğu Zaman	Her Zaman

1. Kendimi neşeli ve keyifli hissettim	0	1	2	3	4	5
2. Kendimi sakin ve gevşemiş hissettim	0	1	2	3	4	5
3. Kendimi aktif ve dinç hissettim	0	1	2	3	4	5
4. Sabahları kendimi taze ve dinlenmiş hissederek uyandım	0	1	2	3	4	5
5. Günlük yaşantım beni ilgilendiren şeylerle dolu	0	1	2	3	4	5

WORK CLIMATE QUESTIONNAIRE (WCQ)

Bu anket, **en yakın amiriniz olan yöneticinizle** (bölüm başkanı, şef, kıdemli vb.) olan deneyiminizle ilgili öğeler içermektedir. Yöneticiler, çalışanlarla olan ilişkilerinde farklı stillere sahiptirler. Yöneticinizle olan karşılaşmalarınız hakkında nasıl hissettiğiniz hakkında daha fazla bilgi edinmek istiyoruz. Yanıtlarınız gizli tutulacaktır. Lütfen dürüst ve samimi cevap veriniz. **1: Kesinlikle Katılmıyorum, 7: Kesinlikle Katılıyorum.**

1. Yöneticimin bana tercihler ve seçenekler sunduğunu düşünüyorum	1	2	3	4	5	6	7
2. Yöneticim tarafından anlaşıldığımı hissediyorum	1	2	3	4	5	6	7
3. Yöneticim işimi iyi yapabildiğime dair güvenini gösterir.	1	2	3	4	5	6	7
4. Yöneticim soru sormak için beni cesaretlendirir.	1	2	3	4	5	6	7
5. Yöneticim işleri nasıl yapmak istediğimi dinler.	1	2	3	4	5	6	7
6. Yöneticim yeni yollar önermeden önce benim ne düşündüğümü anlamaya çalışır.	1	2	3	4	5	6	7

SCALE OF POSITIVE AND NEGATIVE EXPERIENCE (SPANE)

Şimdi Lütfen SON 2 HAFTADA neler yaptığınızı ve neler yaşadığınızı düşünün. Yaşadıklarınızı düşünerek aşağıdaki duygu türlerini son 2 haftada ne kadar deneyimlediğinizi verilen ölçek üzerinde belirtin. (1 = Hiçbir zaman, 7 = Her zaman)

1 2 3 4 5 6 7
Hiçbir Zaman Her Zaman

1. Olumlu	1	2	3	4	5	6	7
2. Olumsuz	1	2	3	4	5	6	7
3. İyi	1	2	3	4	5	6	7
4. Kötü	1	2	3	4	5	6	7
5. Keyifli	1	2	3	4	5	6	7
6. Keyifsiz	1	2	3	4	5	6	7
7. Mutlu	1	2	3	4	5	6	7
8. Üzgün	1	2	3	4	5	6	7
9. Korkmuş	1	2	3	4	5	6	7
10. Neşeli	1	2	3	4	5	6	7
11. Öfkeli	1	2	3	4	5	6	7
12. Hoşnut	1	2	3	4	5	6	7

SOCIAL DOMINANCE ORIENTATION SCALE (SDO)

Aşağıdaki ifadelere katılıp katılmadığınızı, 1 (çok yanlış) ile 5 (çok doğru) arasında bir rakamı işaretleyerek belirtiniz. Soruların doğru ya da yanlış bir yanıtı yoktur önemli olan sizin düşüncelerinizdir. Her ifadeyi samimiyetle cevaplamanız çok önemlidir. Her madde için sadece bir rakamı işaretleyebilirsiniz.

1.....2.....3.....4.....5

Çok Yanlış Çok Doğru

1. Kim ne derse desin, bazı gruplar diğerlerinden daha değersizdir.	1	2	3	4	5
2. Tüm gruplara yaşamda eşit şans verilmelidir.	1	2	3	4	5
3. Bazı grupların hayatta diğerlerine göre daha fazla şansa sahip olmaları gayet doğaldır.	1	2	3	4	5
4. Toplumda hiçbir grup baskın konumda olmamalıdır.	1	2	3	4	5
5. Eğer belli gruplar konumlarına razı olsalardı, şimdi daha az sorunumuz olurdu.	1	2	3	4	5
6. Belirli grupların en üstte, diğer grupların ise en altta olması belki iyi bir şeydir.	1	2	3	4	5
7. Sosyal eşitlik arttırılmalıdır.	1	2	3	4	5
8. Bazen diğer gruplar oldukları yerde tutulmalıdırlar.	1	2	3	4	5
9. Eğer bütün gruplar eşit olabilseydi iyi olurdu	1	2	3	4	5
10. Grupların eşitliği idealimiz olmalıdır.	1	2	3	4	5
11. Farklı grupların koşullarını eşitlemek için elimizden geleni yapmalıyız.	1	2	3	4	5
12. Aşağı düzeydeki gruplar konumlarına razı olmalıdırlar	1	2	3	4	5
13. Eğer insanlara eşitlik gözeterek davransaydık, şimdi daha az sorunumuz olurdu.	1	2	3	4	5
14. Gelirleri olabildiğince eşit hale getirmek için çaba göstermeliyiz.	1	2	3	4	5
15. Hayatta ilerleyebilmek için bazen diğer grupları çiğneyip geçmek gereklidir.	1	2	3	4	5

ECONOMIC SYSTEM JUSTIFICATION SCALE (EJS)

Aşağıda bazı ifadeler sunulmuştur. Lütfen her cümleyi dikkatlice okuyunuz ve sizin için ne derece doğru olduğunu belirtmek için cümlenin yanındaki (1'den 7'ye kadar olan) rakamlardan size göre en doğru olan rakamı işaretleyiniz.

1 ..... 2 ..... 3 ..... 4 ..... 5 ..... 6 7

Hiç Katılmıyorum — Tamamen Katılıyorum

1. Gruplar arası hiyerşiyi ortadan kaldırmak imkansızdır.	1	2	3	4	5	6	7
2. Gruplar arası eşitsizlik doğa yasalarının bir sonucudur.	1	2	3	4	5	6	7
3. Gruplar arası eşitsizliğin adil olmadığını düşünmek için bir çok sebep vardır.	1	2	3	4	5	6	7
4. Hiyerarşinin altındakilerin üsttekilerden özünde bir farkı yoktur.	1	2	3	4	5	6	7
5. Sistemimizde kaynakların eşit paylaşımı mümkündür.	1	2	3	4	5	6	7
6. Sınıflar arası farklar doğadaki şeylerin düzenini yansıtmaktadır.	1	2	3	4	5	6	7
7. Gruplar arası ekonomik farklar kaynakların gayrimeşru dağılımını göstermektedir.	1	2	3	4	5	6	7
8. Kişilerin statüleri başarılarının meşru göstergeleridir.	1	2	3	4	5	6	7
9. Eğer insanlar sistemi her şeyi daha eşit yapmak için değiştirmek isterlerse yapabilmeliler.	1	2	3	4	5	6	7
10. Kaynakların eşit dağılımı doğal değildir.	1	2	3	4	5	6	7
11. Gelirleri daha eşit yapmaya çalışmanın bir anlamı yoktur.	1	2	3	4	5	6	7
12. İnsanlar çok çalışırlarsa neredeyse her zaman istediklerini alırlar.	1	2	3	4	5	6	7
13. Gruplar arası ekonomik farkların yaygınlığı bu farklılıkların kaçınılmaz oldukları anlamına gelmez.	1	2	3	4	5	6	7
14. Toplumumuzda gelişme göstermeyen çoğu kişi sistemi suçlamamalı; sadece kendilerini suçlamalıdır.	1	2	3	4	5	6	7
15. Asla herkes için yeterli sayıda iş olmayacağı için her zaman fakir insanlar olacaktır.	1	2	3	4	5	6	7
16. Aynı anda aşırı zenginlik ve aşırı yoksulluk üreten bir ekonomik sisteme sahip olmak haksızlıktır.	1	2	3	4	5	6	7
17. Zengin ve fakir arasında kalıtsal bir fark yoktur; bu sadece içinde doğduğunuz koşulların sonucudur	1	2	3	4	5	6	7

WORKPLACE SYSTEM JUSTIFICATION SCALE (WSJ)

Aşağıda bazı ifadeler sunulmuştur. Lütfen her cümleyi dikkatlice okuyunuz ve sizin için ne derece doğru olduğunu belirtmek için cümlenin yanındaki (1'den 7'ye kadar olan) rakamlardan size göre en doğru olan rakamı işaretleyiniz.

1 ..... 2 ..... 3 ..... 4 ..... 5 ..... 6 7

Hiçbir Zaman Her Zaman

1. Genel olarak çalışma şartlarımızı adil bulurum	1	2	3	4	5	6	7
2. Genelde çalışma sistemimiz olması gerektiği gibi, doğru biçimde işlemektedir.	1	2	3	4	5	6	7
3. Çalışma sistemimiz ciddi biçimde yeniden yapılandırılmaya ihtiyaç duymaktadır.	1	2	3	4	5	6	7
4. İşyerimde izlenen çoğu politika, çalışanların çoğunluğunun yararınadır.	1	2	3	4	5	6	7
5. İşyerimizde herkes adil bir biçimde, payına düşeni alır.	1	2	3	4	5	6	7
6. İşyerimiz çalışanların genellikle ne hak ederlerse onu alacakları şekilde düzenlenmiştir.	1	2	3	4	5	6	7

SUBJECTIVE HEALTH SCALE (SHeS)

Lütfen SON İKİ HAFTA İÇİNDEKİ sağlık durumunuzu genel olarak en iyi yansıtan durumu aşağıdaki ölçek üzerinde belirtiniz. (0 = Çok kötü, 10 = Çok iyi)

0 1 2 3 4 5 6 7 8 9 10

Çok kötü

0	1	2	3	4	5	6	7	8	9	10

SUBJECTIVE HIERARACHY SCALE (SHiS)

Aşağıdaki 1 ve 10 arasındaki ölçekte 1 hiyerarşinin en altı ve 10 hiyerarşinin en üst noktası olarak düşünüldüğünde, işyerinizde çalışan bütün herkesin içinde sizin konumunuzun nerede olduğunu lütfen en uygun değeri seçerek belirtiniz.

1 2 3 4 5 6 7 8 9 10

En Altı

1	2	3	4	5	6	7	8	9	10

TEN- ITEM PERSONALITY INVENTORY SCALE (TIPI)

Aşağıda size uyabilecek ya da uymayabilecek bazı kişilik özellikleri bulunmaktadır. Lütfen her bir özelliğin sizi GENEL OLARAK ne kadar yansıttığını ya da yansıtmadığını ölçek üzerinde belirtiniz. (1 = Hiç yansıtmıyor, 7 = Tamamen yansıtıyor)

1 ..... 2 ..... 3 ..... 4 ..... 5 ..... 6 7

Hiç yansıtmıyor — Tamamen yansıtıyor

1. Dışa dönük, hevesli	1	2	3	4	5	6	7
2. Eleştirel, geçimsiz	1	2	3	4	5	6	7
3. Güvenilir, disiplinli	1	2	3	4	5	6	7
4. Tedirgin, kolay üzülen	1	2	3	4	5	6	7
5. Yeni deneyimlere açık, kompleks	1	2	3	4	5	6	7
6. Çekingen, sessiz	1	2	3	4	5	6	7
7. Sempatik, sıcak	1	2	3	4	5	6	7
8. Dağınık, dikkatsiz	1	2	3	4	5	6	7
9. Sakin, duygusal olarak dengeli	1	2	3	4	5	6	7
10. Geleneksel, yaratıcı değil	1	2	3	4	5	6	7

IDENTIFICATION SCALE

Aşağıda bazı ifadeler sunulmuştur. Lütfen her cümleyi dikkatlice okuyunuz ve sizin için ne derece doğru olduğunu belirtmek için cümlenin yanındaki (1'den 7'ye kadar olan) rakamlardan size göre en doğru olan rakamı işaretleyiniz.

1. Sağlık çalışanları ile aramda güçlü bağlar olduğunu hissediyorum.	1	2	3	4	5	6	7
2. Kendimi diğer sağlık çalışanları ile özdeşleştiriyorum.	1	2	3	4	5	6	7
3. Çoğu yönden diğer sağlık çalışanları gibiyim	1	2	3	4	5	6	7
4. Sağlık çalışanlarına bağlı olduğumu hissediyorum.	1	2	3	4	5	6	7
5. Sağlık çalışanları grubunun bir parçası olmaktan memnunum	1	2	3	4	5	6	7

MODES OF RELATIONSHIP QUESTIONNAIRE (MORQ)

Bu çalışmada çalıştığınız işyerindeki insanlarla kurduğunuz ilişkiler hakkındaki düşüncelerinizi öğrenmek istiyoruz. Bu nedenle sizden işyerinizdeki bir şekilde etkileşimde olduğunuz bazı kişilerle olan ilişkilerinizi değerlendirmenizi istiyoruz. Anketi tamamlamanız yaklaşık 15 dakika sürecektir.

Bunu yapabilmeniz için öncelikle **işyerinizde çalışan ve sizin bir şekilde etkileşimde olduğunuz** herkesi düşünmenizi ve aklınıza geldiği sırayla **ilk 15 kişiyi** (ismini ya da sizin için tanımlayıcı herhangi bir sıfat) bir kağıda ya da dosyaya yazmanızı istiyoruz. Örneğin, 1. Ayşe, 2. X asistanı, 3. doktor hanım, 4. Elif Hanım, 5. Hasan, ... vb gibi bir liste hazırlayabilirsiniz.

Listeyi hazırladığınızda lütfen diğer sayfaya geçiniz.

Şimdi lütfen hazırladığınız 15 kişilik listedeki **1, 4, 7, 10, 13 ve 15 inci** kişileri aşağıya yazın.

1. Kişi	
4. Kişi	
7. Kişi	
10. Kişi	
13. Kişi	
15. Kişi	

Bir sonraki sayfada hazırladığınız listedeki 1., 4., 7., 10., 13. ve 15. sırada olan kişilerle olan ilişkinizi ayrı ayrı verilen ölçekte değerlendirmenizi isteyeceğiz.

Aşağıda verilen herbir ifadenin, söz konusu kişi ile ilişkinizi ne oranda tanımladığını, aşağıdaki 7 aralıklı ölçekte değerlendiriniz. (1: Bu ilişki için kesinlikle doğru değil, 7: Bu ilişki için kesinlikle doğru)

1.	Bu kişi ile beraber bir karar almaya çalışırken mutlaka herkesin sözü eşittir.	1	2	3	4	5	6	7
2.	Bu kişiden ne aldığınız o kişiye ne kadar verebileceğinizle doğrudan ilişkilidir/orantılıdır	1	2	3	4	5	6	7
3.	Bu kişi ile birbirinize karşı nezaket ve yakınlığınızı ahlaki bir görev olarak hissediyorsunuz.	1	2	3	4	5	6	7
4.	Beraber yapılan bir işi ikinizden biri doğrudan idare ederken diğeri büyük ölçüde kendisine söyleneni yapar	1	2	3	4	5	6	7
5.	Eğer biriniz diğeriniz için çalışıyor olsaydı çalıştığı süre ve yaptığı iş oranında para alırdı.	1	2	3	4	5	6	7
6.	İkiniz tek bir takım gibi birbirinize aitsiniz.	1	2	3	4	5	6	7
7.	Gerektiğinde aynı şekilde karşılık verebilmek için birbirinize ne verdiğinizi takip edersiniz. Böylece bir eşitsizlik olursa bunu ikiniz de anlarsınız.	1	2	3	4	5	6	7
8.	Biriniz karar verir, diğeriniz ise genellikle buna uyar.	1	2	3	4	5	6	7
9.	Her zaman, her ne varsa aynı boyutta paylara bölersiniz.	1	2	3	4	5	6	7
10.	Biriniz diğerini bir rehber ve rol modeli olarak görüyor.	1	2	3	4	5	6	7
11.	Yapılacak bir iş varsa genellikle bunu dengeli bir şekilde paylaşırsınız.	1	2	3	4	5	6	7
12.	Bu kişiyle ilişkinizde elde edeceğiniz fayda ve ödeyeceğiniz bedeli dikkate alarak karar verirsiniz	1	2	3	4	5	6	7
13.	Her ikiniz de benzer tutum, tavır ve değerleri geliştirme egilimindesiniz.	1	2	3	4	5	6	7
14.	Biriniz lider, diğeriniz ise onun sadık takipçisidir.	1	2	3	4	5	6	7
15.	Bu ilişkiye verdiğinizin karşılığını adil olarak alma hakkınız vardır.	1	2	3	4	5	6	7
16.	İkinizi de benzer kılan ortak bir özelliğinizin olduğunu düşünüyorsunuz.	1	2	3	4	5	6	7
17.	Biriniz hiyerarşik olarak bir şekilde diğerinin üstü bir konumdadır.	1	2	3	4	5	6	7
18.	Eğer biriniz diğerinin bir isteğini yaparsa, bir sonraki seferde de diğerinin isteği yapılmalıdır	1	2	3	4	5	6	7
19.	Bu kişi ile ilişkiniz tam anlamı ile rasyonel; her ikiniz de çıkarlarınızı hesaplayarak davranıyorsunuz.	1	2	3	4	5	6	7
20.	Bu kişi ile beraber bir karar almaya çalışırken mutlaka herkesin sözü eşittir.	1	2	3	4	5	6	7

DAILY DIARY HIERARCY QUESTIONS

Aşağıda insanların çalıştıkları yerlerde yaygın olarak kurdukları ilişki biçimlerinden birisini tarif eden iki kısa paragraf okuyacaksınız. Lütfen her iki paragrafı okuduktan sonra tarif edilen türde ilişkiyi bugün kaç kez kurduğunuzu/deneyimlediğinizi düşünün ve altındaki soruyu yanıtlayınız.

1. Bu ilişkide siz "kontrolü elinde tutma" ve inisiyatif alma diğeri ise takip etme eğilimindedir. Kararların çoğunu siz verirsiniz, diğeri ise bu kararları kabul eder. Kararı veren kişi olarak siz, istediğiniz gibi davranır ve işlerin sorumluluğunu üstlenirsiniz. Diğer kişi bu ilişkide takipçidir ve sizin arkanızda yardımcı olarak durur ve ihtiyacı olduğunda sizin kendisini koruyup kollayacağına güvenir.

SORU: Bugün çalıştığınız kurumda içinde bulunduğunuz bütün ikili ilişkileri ve grup içi etkileşimleri düşündüğünüzde tarif edilen türde bir ilişki bu ilişkilerin yüzde kaçını oluşturuyordu?

2. Bu ilişkide siz "takip eden" ve diğerini izleyen kişisiniz, diğeri ise kontrolü elinde tutma ve inisiyatif alma eğilimindedir. Kararların çoğunu diğer kişi verir, siz ise bu kararları kabul edersiniz. Kararı veren kişi, istediği gibi davranır ve işlerin sorumluluğunu üstlenir. Siz bu ilişkide takipçisinizdir ve diğerinin arkasında yardımcı olarak durursunuz ve ihtiyacınız olduğunda sorumlu kişinin sizi koruyup kollayacağına güvenirsiniz.

SORU: Bugün çalıştığınız kurumda içinde bulunduğunuz bütün ikili ilişkileri ve grup içi etkileşimleri düşündüğünüzde tarif edilen türde bir ilişki bu ilişkilerin yüzde kaçını oluşturuyordu. Lütfen rakam olarak yazınız.

APPENDIX B: ETHICS COMMITTEE APPROVAL

Sayı : 17162298.600-385
Konu : Tez Çalışması

27 NİSAN 2020

İlgili Makama

Üniversitemiz Sosyal Bilimler Enstitüsü Sosyal Psikoloji Tezli Yüksek Lisans Programı öğrencisi Murat Tümer'in Dr. Öğretim Üyesi İlker Dalgar'ın danışmanlığında yürütmekte olduğu "Örgütsel Yapıdaki Hiyerarşik İlişkilerin Hiyerarşinin Farklı Pozisyonlarındaki Bireylerin İyilik Halleri Üzerine Etkileri: Cerrahi Branş Doktorları Örneği" başlıklı yüksek lisans tez çalışması değerlendirilmiş ve yapılmasında bir sakınca olmadığı tespit edilmiştir.
Bilgilerinize saygılarımızla sunarız.

Başkent Üniversitesi Sosyal ve Beşeri Bilimler ve Sanat Araştırma Kurulu

Ad, Soyad	Değerlendirme	İmza
Prof. Dr. M. Abdülkadir Varoğlu	Olumlu/~~Olumsuz~~	
Prof. Dr. Kudret Güven	Olumlu/Olumsuz	
Prof. Ali Sevgi	Olumlu/Olumsuz	
Prof. Dr. Işıl Bulut	Olumlu/Olumsuz	
Prof. Dr. Sadegül Akbaba Altun	Olumlu/~~Olumsuz~~	
Prof. Dr. Can Mehmet Hersek	Olumlu/~~Olumsuz~~	
Prof. Dr. Özcan Yağcı	Olumlu/~~Olumsuz~~	

Prof. Dr. Sadegül Akbaba Altun, Sosyal Bilimler Enstitüsü Sosyal Psikoloji Tezli Yüksek Lisans Programı öğrencisi Murat Tümer'in Dr. Öğretim Üyesi İlker Dalgar'ın danışmanlığında yürütmekte olduğu "Örgütsel Yapıdaki Hiyerarşik İlişkilerin Hiyerarşinin Farklı Pozisyonlarındaki Bireylerin İyilik Halleri Üzerine Etkileri: Cerrahi Branş Doktorları Örneği" başlıklı yüksek lisans tez çalışmasını yapabileceğini; ancak, kullanılacak ölçeklerin sahiplerinden izin alınması gerektiğini iletmişlerdir.

Prof. Dr. Özcan Yağcı ise, Sosyal Bilimler Enstitüsü Sosyal Psikoloji Tezli Yüksek Lisans Programı öğrencisi Murat Tümer'in Dr. Öğretim Üyesi İlker Dalgar'ın danışmanlığında yürütmekte olduğu "Örgütsel Yapıdaki Hiyerarşik İlişkilerin Hiyerarşinin Farklı Pozisyonlarındaki Bireylerin İyilik Halleri Üzerine Etkileri: Cerrahi Branş Doktorları Örneği" başlıklı yüksek lisans tez çalışmasının "iyilik halleri" ne yönelik içeriklendirmeye ve örneklemin özelliklerine bağlı olarak ilgi çekici olacağını düşündüklerini belirtmişlerdir.