



Are Health Fatalism and Styles of Coping with Stress Affected by Poverty? A Field Study

**Hatice Durmaz¹, Cantürk Çapık²*

1. Department of Psychiatric Nursing, Ataturk University Faculty of Nursing, Erzurum, Turkey
2. Department of Public Health Nursing, Ataturk University Faculty of Nursing, Erzurum, Turkey

*Corresponding Author: Email: haticedurmaz_25@hotmail.com

(Received 19 Jun 2022; accepted 10 Sep 2022)

Abstract

Background: Fatalism is an important parameter that affects individuals' understanding of health. In addition, stress and economic status, such as fatalism, are important factors that affect an individual's understanding of health. In this context, there may be an important link between stress, economic situation and fatalism. This study was conducted to determine whether health fatalism levels and styles of coping with stress are affected by poverty.

Methods: This cross-sectional field study involved participants consisted of 382 individuals living in the two-Family Health Center regions in Turkey in 2018. The data collection phase continued for approximately three months. Collecting the data were used, namely demographic introduction form, Health Fatalism Scale, Styles of Coping with Stress Scale, and Individual Poverty Index. The data were analysed using SPSS 22 package program.

Results: The difference between the average health fatalism score in poor and non-poor individuals was statistically significant ($P < 0.05$). There was a weak, positive, and significant relationship between health fatalism score and optimistic, helpless, and submissive approach scores in both poor and non-poor individuals ($P < 0.05$).

Conclusion: While individuals' health fatalism level was affected by poverty, their style of coping with stress was not affected. Still, there was a significant relationship between health fatalism level and their style of coping with stress.

Keywords: Health fatalism; Coping with stress; Poverty; Nursing; Turkey

Introduction

Health problems are increasing day by day. In addition to medical advancements, social variables are also of great importance in dealing with these difficulties. As stated in the World Health Organization definition, being healthy requires not only the absence of physical illness but also a complete state of well-being in social and psychological terms (1). In this context, social determinants affecting individuals' health perceptions, treatment choices, and psychological conditions are of great

importance (2). Cultural factors including religious elements among these determinants constitute the main area of interest in this study.

Religious beliefs are important parameters that affect individuals' attitudes and behaviors related to health, illness, and death. The effects of these parameters can be positive or negative (3). While the relationship between religious beliefs and health behaviors may be positive, religious beliefs prevent positive health behaviors (4, 5). In a meta-analysis, which included 46 studies dealing with



the relationship between fatalism and health behaviors, there was a positive correlation between higher levels of fatalism and health-threatening behaviors (6). Similarly, in a qualitative study on cholera perception and vaccine acceptance, participants who mentioned that God's will is at the root of cholera were less likely to accept the vaccine (7).

Fatalism is the belief that everything an individual may encounter in his life is determined against his will and that this destiny cannot be changed by effort. In a fatalistic attitude, individuals believe that they cannot control their lives and that there is no point in making choices (8). Fatalism is a response to overwhelming threats that seem uncontrollable (9). Fatalism is a common way of thinking in Turkey due to the dominant cultural characteristics and the religious tendencies of most of society. As a result of an international comparative study about fatalism in Turkey, half of the community adopted fatalism and believed that they could do little to change their own lives (10). In this respect, the understanding of fatalism is a critical issue that Turkey needs to research.

One of the psychosocial factors that affect the individual's understanding of health, such as fatalism, is stress. Lazarus and Folkman defined stress as an interaction that limits the individual's adaptation to society, disrupts the organism's balance, decreases their strength against problems, and forces the individual (11). Stress causes various physiological and psychological symptoms in individuals, such as fatigue, insomnia, loss of appetite, and internal distress (12). Nevertheless, stress does not always lead to negative emotions and situations. Manageable and correctly directed short-term stress prepares the organism to cope with problems (13). In this context, there may be an essential link between stress and fatalism. Because although coping with stress makes the individual more robust, many situations exceed human beings' competence. At some point, the individual realizes that s/he is limited and temporary as a human besides his/her power. At this very point, religious understanding guides individuals. In other words, religious belief defines some non-religious

coping methods against the limitations of the individual's powers (14).

Another essential factor in this study is the poverty situation. Estimating and revising the international poverty line; national poverty lines, purchasing power parity, consumer price index and household surveys are used (15). An individual is defined as poor if he cannot meet his needs with the resources and opportunities he has (16). Since health problems are significantly intertwined with socioeconomic structure, poverty is a factor that can affect fatalism. Protecting and improving people's health is directly related to any individual, cultural and socioeconomic conditions (12). For instance, poor people may have less education, and a low education level may lead them to take a more fatalistic approach (17, 18). Thus, while poverty directs individuals to fatalism, it also affects their stress response. Because the weaknesses of the individual (e.g., economic inadequacy) can make them ineffective in dealing with stress (19, 20). Poverty significantly increases the risk of toxic stress (21). Nurses should be aware of poor individuals' values and needs that affect their health status health fatalism is a critical issue that needs to be considered. In addition, fatalism is a common way of thinking in Turkey due to the dominant cultural characteristics and the religious tendencies of most of society. In this respect, this research is regarded as an important study in presenting cultural data. There is no study in literature in which fatalism and coping with stress are examined in terms of the poverty parameter.

This study was conducted to determine whether the level of health fatalism and styles of coping with stress are affected by poverty and whether there is a relationship between health fatalism levels and styles of coping with stress.

Methods

Research Design

This cross-sectional study was carried on individuals registered in two Family Health Center (FHC) regions. FHC are health centers in Turkey, where essential health services are provided. The first FHC region was chosen to collect data from

poor individuals, and the second FHC region to collect data from non-poor individuals. In selecting these family health centers, the regions where poor and non-poor individuals live were considered. These regions were determined by reference from xxx Metropolitan Municipality. The study was completed between 1 Jan-15 Oct 2018. The study population consists of individuals over the age of 30 who live in two related FHC regions and have no psychiatric diagnosis.

Study Area and Sample

Overall, 7250 individuals are registered in both FHC Regions. Still, the total number of poor households is unknown as the number of low-income families in the FHC regions is not registered. Thus, the number of participants was determined by applying the sample formula for the unknown universe cases. According to this formula, 384 individuals should be included in the study, and the sample size was stratified according to FHC populations. According to this stratification, 210 individuals were included in the first FHC region study, and 174 individuals from the second FHC region. Two participants were excluded from the study due to missing data, and the study was completed with 382 individuals. Each of these 382 individuals lived in different households, and in total, 1716 individuals lived in these 382 households.

Measures

Four forms were used: demographic introduction form, Health Fatalism Scale, Styles of Coping with Stress Scale, and Individual Poverty Index.

Demographic form: It consists of 6 questions questioning age, gender, marital status, income status, and the number of people living at home.

Health Fatalism Scale: Bobov and Çapık made the scale's validity and reliability in Turkish in 2020 (17). Franklin, Schlundt, and Wallston developed it in 2008 (22). The scale consists of 17 questions and is a 5-point Likert type. The Turkish version of the scale consists of a single factor

structure and can be filled in 5-10 minutes. Increasing the score on the scale indicates that fatalism is rising. This scale is suitable for all social classes. The authors developed the scale to identify a pattern between health fatalism and preventative health behaviors. In the Turkish version of the scale, the Cronbach α coefficient was determined as 0.91 (17, 22). In this study, this value was calculated as 0.913.

Styles of Coping with Stress Scale: Folkman and Lazarus developed it in 1980 (23). It measures the coping mechanisms associated with symptoms such as depression, loneliness, and psychosomatic problems. Adapted into Turkish by Şahin and Durak, the scale consists of 30 items and five subscales (24). The scale measures two main styles of coping with stress. These are "Problem-oriented/active" and "Emotion-oriented/passive" styles. Active styles show "seeking social support," "optimistic approach," and "self-confident approach" subscales, passive styles show "helpless approach" and "submissive approach" subscales. It is believed that those who can effectively cope with stress use the "confident and optimistic approach," and those who cannot cope with stress use the "submissive and desperate approach" more. The higher the scores, the more the person uses that style. The Cronbach α coefficient of the Turkish version of the scale was determined between 0.45-0.80 (19). In this study, this value was calculated between 0.699 and 0.824.

Individual Poverty Index: This index, previously applied in a study of Çapık and Bahar, is a chart showing how many Turkish Liras (TL) the poverty line will be accepted according to the number of individuals living in the household (25). For instance, if there are six family members, the amount of monthly income required for a family of 6 people was examined from the chart to determine whether the household is in the poor class (25).

Determining the poverty line: The approach of \$4.3 per day, applied in determining the international poverty lines and accepted for the countries

including Turkey, was taken as a basis to determine the poverty line. According to this approach, households that cannot earn \$4.3 per person per day are considered poor (15, 16). According to the Central Bank dollar rate data on 10 Feb 2017, in Turkey, the poverty limit for a family of 4 is 2466 TL, calculated from 1 dollar, 4.78 TL. The minimum amount of income that should be earned monthly was determined by applying the individual poverty index if more than four people are living in a household. Households that earn less than this specified income are estimated low-income families, and those with an income above deemed non-poor households (25). The households named here as non-poor households should not be understood as wealthy households.

Data Collection Method

The interviewer made home visits and asked questions to an available individual from the house who agreed to participate in the study to collect the data. The data collection phase continued for approximately three months. Before the data was collected, a short training was given to the pollsters about the study.

Variables: Health fatalism score and scale of coping with stress score were dependent variables.

Age, gender, marital status, income status, number of people living at home were independent variables.

Statistical Methods

The data were analyzed with SPSS 22 package program (IBM Corp., Armonk, NY, USA). The individuals' demographic characteristics were analyzed applying descriptive statistics, *t*-test in independent groups for comparison of paired groups, and Pearson correlation analysis for relational inferences. The Cronbach α coefficient was calculated and the data distribution was evaluated with the Shapiro Wilk test to determine the scales' internal consistency coefficient

Ethics Approval

Permission was obtained from the Ethics Committee of Faculty of Health Sciences, Atatürk University for the study (2017-3/8). Verbal consent was taken from all participants while collecting the data. They could quit the study at any time. All stages of the study have complied with the Declaration of Helsinki.

Results

The demographic characteristics of the participants are presented in Table 1.

Table 1: Distribution of demographic characteristics of participants

Variable		Poor individuals (n=209)		Non-poor individuals (n=173)	
		n	%	n	%
Gender	Man	63	30.1	68	39.3
	Woman	146	69.9	105	60.7
Marital Status	Single	152	72.7	104	60.1
	Married	57	27.3	69	39.9
Home Ownership	My own home	144	58.9	119	68.8
	Rent	65	31.1	54	31.1
Family Type	Nuclear family	166	79.4	167	96.5
	Extended family	43	20.6	6	3.5
Education Level	Primary education	47	22.5	25	14.5
	High school	38	18.2	34	19.7
	University graduates	124	59.3	114	65.9
		Mean	Sd.	Mean	Sd.
Age (yr)		27.11	9.66	27.91	9.49
Monthly income (TL)		2163.99	818.37	3523.99	1606.55
Average number of people in the house		5.36	1.65	3.86	1.25

69.9% of the poor individuals were women, 72.7% were single, 58.9% lived in their own house, 79.4% lived in a nuclear family, and 59.3% were university graduates. The average age of the poor participants was 27.11 ± 9.66 . The average monthly income was 2163.99 ± 818.37 TL, and the average number of people in the house they lived in was 5.36 ± 1.65 (Table 1).

60.7% of the non-poor individuals were women, 60.1% were single, 68.8% lived in their own home, 96.5% lived in a nuclear family, and 65.9% were university graduates. The average age of the non-poor participants was 27.91 ± 9.49 . The average monthly income was 3523.99 ± 1606.55 TL, and the average number of people in the house they lived in was 3.86 ± 1.25 .

Table 2: Comparison of health fatalism and styles of coping with stress scores in poor and non-poor individuals

Variable	n	Health Fatalism		Confident Approach		Optimistic Approach		Desperate Approach		Submissive Approach	
		Mea	Sd.	Mea	Sd.	Mea	Sd	Mea	Sd	Mea	Sd
		n		n		n	.	n	.	n	.
Poor individuals	209	56.87	13.85	14.98	4.18	9.96	3.13	11.35	4.72	7.21	3.68
Non-poor individuals	173	53.90	14.40	15.17	4.17	9.71	3.19	10.99	4.52	7.21	3.74
Testing and Significance		t=2.050, P=0.041		t=-0.446, P=0.656		t=0.772, P=0.441		t=0.758, P=0.449		t=-0.006, P=0.995	

As seen in Table 2, the difference between the health fatalism score averages of poor and non-poor individuals was statistically significant ($P<0.05$). The health fatalism score average of

poor individuals was higher. The difference between the mean scores of poor and non-poor individuals in all sub-dimensions of the Styles of Coping with Stress Scale was not significant.

Table 3: Investigation of the relationship between the Health Fatalism Scale score and the Styles of Coping with Stress Sub-Dimension scores

Variable	Health Fatalism	
	Poor individuals	Non-poor individuals
Confident Approach	r	0.082
	P	0.237
Optimistic Approach	r	0.159
	P	0.022
Desperate Approach	r	0.297
	P	0.000
Submissive Approach	r	0.385
	P	0.000

As seen in Table 3, there was a weak, positive and significant relationship between health fatalism score and optimistic, helpless, and submissive approach scores in both poor and non-poor individuals ($P<0.05$). As the health fatalism score increases in both groups, the optimistic, desperate,

and submissive approach scores also increased. There was no significant relationship between the self-confident approach score and poor individuals' health fatalism score. However, there was a weak, positive, and significant relationship between self-confident approach, score, and health

fatalism score in non-poor individuals ($P < 0.05$). As the health fatalism score increased in non-poor individuals, the self-confident approach score also increased.

Discussion

It is possible to find traces of the culture of poverty in Turkey and all over the world. An example of this is that arabesque music culture, which contains quite a fatalistic discourse, is generally embraced in regions with low economic levels (26). As a result of this study poor individuals' average health fatalism score was higher (Table 2). In Turkey, individuals whose income is less than their expenses have higher fatalism levels (17). Extremely poor and poor individuals had high fatalism scores (27). Similarly, in developed countries in the European Union, people typically share a fatalistic perception of the causes of poverty (28). Again, in another study, a negative relationship between fatalism and poverty was discovered (29). Our study determined that poor individuals' average health fatalism score was significantly higher than that of non-poor individuals and it is compatible with the literature. In this sense, poor individuals adopt fatalism as a defence mechanism against social inequality. Indeed, fatalistic thinking is about poverty (30). Individuals who define themselves as poor have more fatalistic approaches (31). In Anthropology and Sociology, which studies human and society, the understanding of fatalism is an issue that is dealt with within the context of poverty culture. Poverty is actually the effort of the class below a specific social order to comply with the conditions and reactions (32). In other words, fatalism can be said to be one of the main features of the culture of poverty. In this context, fatalistic belief becomes a protective factor in the face of events that people do not seem to be able to cope with. This can also be beneficial in controlling stress and maintaining mental health. Therefore, the increased fatalism score in poor individuals was compatible with the basic expectation of this study.

On the other hand, another significant finding of our study is that poor and non-poor individuals do not differ in their styles of coping with stress (Table 2). In other words, whether individuals are poor or not does not change their way of coping with stress. The factor that determines the styles of coping with stress is the characteristics/strengths of the individual (33). People practice strategies such as hiding, suppressing, believing in supernatural powers, using social support, or fatalism, considering their characteristics (18). According to this assumption, regardless of the individual's income level, he/she is exposed to different types of stress in one way or another. In Turkey, individuals use problem-focused coping style if it is possible to change their life events, and if it is not possible, they use emotion-focused coping style. This behaviour is also a natural tendency to relieve tension (14). There is another study that supports this opinion. In that study, comparing the styles of coping with stress between working and non-working women, significant results were obtained between socioeconomic level and coping styles. Individuals who defined their economic situation as bad had higher mean scores for helpless approach, and those who stated medium had higher submissive approach scores than others (34). In other words, the individual determines a style of coping with stress appropriate to his or her economic status. There is an emphasis here on the existence of stress at every economic level, not at which economic level.

The increase in the optimistic approach, helpless approach and submissive approach scores in poor individuals also causes a significant increase in fatalism scores (Table 3). Normally, it is unexpected that both coping styles (optimistic and submissive) are used together. However, in this study, there are poor people in the sample group and they may have different coping strategies. Already, in this study, we are trying to clarify this issue. When we thought about this issue in more detail, we were able to find a logical explanation in the light of the existing literature. Individuals may tend to avoid responsibilities in order to protect themselves against problems that they cannot overcome. This

situation brings with it a strict understanding of fatalism (35). Individuals can develop strategies such as fatalism, acting according to superstitions and believing in supernatural powers in coping with stress (33). In fact, fatalism is a tool that an individual use to manage stress. In fact, fatalism leads individuals not to question and to submit in terms of understanding and interpreting social events (8). The results of this study are compatible with the literature showing the negative relationship between self-efficacy belief and fatalistic tendency (36). The striking finding at the end of the research is that the optimistic approach, which is one of the strategies for problem solving, is used in a meaningful way together with the submissive approach. The fatalism understanding, widely used in Turkish culture, leads to the use of the optimistic thinking technique in individuals (37). Everything will be good and thinking that there can be good in bad events leads people to optimism. Fatalism can provide false comfort by placing the events' responsibility that the individual has difficulty coping with on supernatural power (35). This relaxation is thought to lead to an optimistic approach in individuals. In short, poor individuals seem to use every possible strategy to get rid of the current event. On the other hand, in non-poor individuals, unlike poor individuals, there is a significant relationship between self-confident approach score and fatalism score. This finding may indicate that improvements in the available economic opportunities lead people to cope with stress in a self-confident approach.

Some limitations should be noted in this study. Determining the poverty line is based on individuals' verbal expressions of their financial situations, and the literature on the subject is limited. Moreover, the determination of monthly income according to the statement of the individual is the limitation of this study.

Conclusion

Health fatalism is a concept that will affect initiatives and innovative steps in the health field all over the world. Health problems are closely related to individuals' socioeconomic structures.

This study's most important result is that poor individuals' health fatalism level is higher than non-poor people. Another result is that regardless of poverty, optimistic, desperate, and submissive approach styles are positively associated with fatalism. In addition, all our findings are considered together, poor individuals can use both positive and negative stress coping strategies together. In line with these results, it can be recommended to conduct comparative studies on fatalism in different cultures, to study poverty with different parameters, and to examine the factors affecting fatalism and coping with stress, especially in terms of sociodemographic variables.

Journalism Ethical considerations

The authors have entirely observed ethical issues (Including plagiarism, informed consent, misconduct, data fabrication and falsification, double publication and submission, redundancy, etc.).

Acknowledgements

No financial support was received for the study.

Conflict of interest

The authors declare that there is no conflict of interest.

References

1. World Health Organization (1948). <https://www.who.int/about/governance/constitution>
2. Bahar M, Nartgün Z, Durmus S, Bıçak B (2012). *Traditional-Complementary Measurement and Evaluation Techniques, Teacher's Handbook*. 1st ed. Pegem Publishing House, Ankara.
3. Agorastos A, Demiralay C, Huber CG (2014). Influence of religious aspects and personal beliefs on psychological behavior: focus on anxiety disorders. *Psychol Res Behav Manag*, 7: 93-101.
4. Karakaş SA, Durmaz H (2017). Old age psychological characteristics and morale. *Kocatepe Medical Journal*, 18(1): 32-6.

5. Joshanloo M (2022). The relationship between fatalistic beliefs and well-being depends on personal and national religiosity: A study in 34 countries. *Heliyon*, 8(6): e09814.
6. Cohn L, Villar OE, Armando O (2015). *Fatalism and health behavior: A meta-analytic review*. Subdirección de Publicaciones, México.
7. Merten S, Schaetti C, Manianga C, et al (2013). Local perceptions of cholera and anticipated vaccine acceptance in Katanga Province, Democratic Republic of Congo. *BMC Public Health*, 13:60.
8. Macit M (2014). *Fatalism in the submission-coping pendulum: A social psychological approach*. Ötüken Publications, İstanbul.
9. Hayes J, Clerk L (2020). Fatalism in the fight against Covid-19: implications for mitigation and mental health. *Res Net*, 12: 201-33.
10. Çarkoğlu A, Kalaycıoğlu E (2009). Religiosity in Turkey: an international comparison. İstanbul: Sabancı University İstanbul Policy Center. http://research.sabanci-univ.edu/13119/1/Rapor_Kamu-din-dar%C4%B1k.pdf
11. Lazarus RS, Folkman S (1984) *Stress, appraisal and coping*. Springer Publishing, New York.
12. Marchlewska M, Green R, Cichocka A, et al (2022). From bad to worse: avoidance coping with stress increases conspiracy beliefs. *Br J Soc Psychol*, 61(2): 532-549.
13. Dhabbar FS (2014). Effects of stress on immune function: the good, the bad, and the beautiful. *Immunol Res*, 58(2-3): 193-210.
14. Ekşi H. A Study on coping, religious coping, and the relationship between mental health [PhD thesis]. Uludağ University Social Sciences Institute. Philosophy and Religious Studies Department, Department of Psychology of Religion, Turkey; 2001.
15. World Bank (2017). Monitoring global poverty, report of the commission on global poverty. <https://openknowledge.worldbank.org/bitstream/handle/10986/25141/9781464809613.pdf>
16. Turkish Statistical Institute (TSI) (2016). Poverty study, Newsletter; Issue:21867 <https://data.tuik.gov.tr/Bulten/Index?p=Income-and-Living-Conditions-Survey-2016-21867>
17. Bobov G, Capik C (2020). The Reliability and Validity of the Religious Health Fatalism Scale in the Turkish Language. *J Relig Health*, 59(2): 1080-95.
18. Ersin F, Capik C, Kissal A, Aydogdu NG, Beser A (2018). Breast cancer fatalism scale: A validity and reliability study in Turkey. *Int J Caring Sci*, 11(2): 783-91.
19. Guo G, Harris KM (2000). The Mechanisms mediating the effects of poverty on children's intellectual development. *Demography*, 37(4): 431-47.
20. Solantaus T, Leinonen J, Punamaki RL (2004). Children's mental health in times of economic recession: replication and extension of the family economic stress model in Finland. *Dev Psychol*, 40(3): 412-29.
21. Kelly MM, Li K (2019). Poverty, toxic stress, and education in children born preterm. *Nurs Res*, 68(4): 275-84.
22. Franklin MD, Schlundt DG, Wallston KA (2008). Development and validation of a religious health fatalism measure for the African-American faith community. *J Health Psychol*, 13(3): 323-35.
23. Folkman S, Lazarus RS (1980). An analysis of coping in a middle-aged community sample. *J Health Soc Behav*, 21(3):219-39.
24. Şahin NH, Durak A (2005). Adapting the scale of stress coping styles for college students. *Turkish Psychological Association*, 10(34): 56-73.
25. Çapık C, Bahar Z (2008). Determination of factors influencing perceived health status among poor and non-poor women in Eastern Turkey. *Int J Caring Sci*, 1(2): 58-65.
26. Öge S. (2014). Arabesque perception of fate - Orhan Gencebay example. *Journal of Atatürk University Faculty of Theology*, 41: 47-76.
27. Cidade EC, Moura JRJF, Nepomuceno BB, et al (2016). Poverty and fatalism: Impacts

- on the community dynamics and on hope in Brazilian residents. *J Prev Interv Community*, 44(1):51-62.
28. da Costa LP, Dias JG (2015). What do European believe to be the causes of poverty? A multilevel analysis of heterogeneity within and between countries. *Soc Indic Res*, 122:1-20.
 29. Powe BD (1995). Cancer fatalism among elderly Caucasians and African Americans. *Oncol Nurs Forum*, 22(9): 1355-9.
 30. Freeman HP (1989). Cancer in the socioeconomically disadvantaged. *CA Cancer J Clin*, 39(5): 266–88.
 31. Babjaková J, Džuka J, Gresty J (2019). Perceived Causes of Poverty and Subjective Aspirations of the Poor: A Literature Review. *Ceskoslovenska Psychologie*, 63(3): 325-36.
 32. Gün S. Children working on the street in the context of the poverty cycle. [PhD thesis]. Ankara University Institute of Social Sciences, Turkey; 2010.
 33. Folkman S, Lazarus RS (1985). If it changes, it must be a process: study of emotion and coping during three stages of college examination. *J Pers Soc Psychol*, 48(1): 150-70.
 34. Barut Y, Özkamalı E, Tıngır S (2010). Ways for working women and non-working women to cope with stress. *International Journal of Social Research*, 3(14): 120-30.
 35. Kuşat A (2000). Self-deception as a psychological phenomenon and its association with religious belief. *Religious Studies*, 3(8): 97- 116.
 36. Kaya A, Bozkur B (2017). Investigating the relationship between tendency of fatalism, self-efficacy and defense styles. *Ege Eğitim Dergisi*, 18(1): 124-45.
 37. Ersari G, Naktiyok A (2012). Role of stress-fighting techniques in the internal and external motivation of employees. *Journal of Atatiirk University Institute of Social Sciences*, 16(1): 81-101.