

DENYING FULL HUMANITY TO PATIENTS AND NURSES' WELL-BEING: THE MODERATING ROLE OF ATTACHMENT SECURITY

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The present study aimed to investigate the relationship between patient dehumanizing perceptions and nurses' well-being, by testing the hypothesis that this relationship may be moderated by secure attachment orientation. A cross-sectional study was conducted, surveying Italian nurses through a questionnaire. Humanity attributions to patients and nurses were assessed using uniquely human and non-uniquely human traits; well-being was assessed using job burnout and work engagement measures. Results showed patient infrahumanization effects, with nurses perceiving patients as less defined by uniquely human characteristics than nurses. A moderating effect of attachment security was found for work engagement, indicating that nurses defined by low security may be more inclined to resort to patient infrahumanization to improve well-being at work than their high-security colleagues. Practical implications of findings for the nursing profession and healthcare organizations are discussed.

Keywords: Patient dehumanization; Nursing; Burnout; Work engagement; Secure attachment.

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Recent psychosocial research has shown that healthcare professionals do not assign a fully human status to patients (for reviews, see Capozza, Falvo, et al., 2016; Capozza et al., 2020). Furthermore, it has been discovered that patient dehumanization may be used as a strategy to cope with stress resulting from daily exposure to patients' suffering (see Trifiletti et al., 2014; Vaes & Muratore, 2013). In nursing, the emotional costs of delivering compassionate care in everyday interactions with patients may be particularly high. This study aims to analyze the link between the attribution of lower human status to patients and nurses' well-being. In addition, we aim to explore the moderating role of attachment security, modeled as a dispositional variable, in this relationship (adult attachment theory; Mikulincer & Shaver, 2007a). Nurses with higher secure orientation may be less prone to dehumanize patients to attenuate work stress than nurses with lower secure orientation. They are qualified by positive representations of themselves and other people, and by the ability to effectively manage stressful situations (for reviews, see Mikulincer & Shaver, 2016). The contribution of this work is novel because the role of attachment security as a moderator of the relationship between patient dehumanization and nurses' well-being has never been explored.

PATIENT DEHUMANIZING PERCEPTIONS AND NURSES' WELL-BEING

Largely investigated over the last two decades, dehumanization has been defined as the act of perceiving or treating other people (persons or groups) as not fully human (Haslam & Stratemeyer, 2016). According to modern conceptualizations, outgroup dehumanization is a pervasive bias that may occur even in the absence of overt conflicts or hostility (see Haslam & Loughnan, 2014) and characterize any intergroup relation. The humanity bias, generally detected using subtle or implicit measures, can take different forms. Infrahumanization (Leyens et al., 2007) is the tendency to assign a lower human status to the outgroup: the other group is perceived as less defined by uniquely human (secondary) emotions (e.g., admiration, regret), or uniquely human traits, such as morality and rationality than one's group (for traits, see Capozza et al., 2013; Costello & Hodson, 2010). Animalistic dehumanization occurs when uniquely human characteristics – traits or emotions – are denied to the target. In contrast, when human nature traits, capturing the core of humanity, such as relational skills, curiosity, and warmth, are denied, the target is viewed as a mechanical entity (mechanistic dehumanization) (for the conceptual distinction between the two modes of dehumanization, see Haslam, 2006). The distinction between mechanistic and animalistic dehumanization is supported by behavioral data (e.g., Loughnan & Haslam, 2007) and neuroscientific evidence (Jack et al., 2013; Morris et al., 2018).

Not surprisingly, infrahumanization and dehumanization have detrimental effects. They diminish empathy and helping behaviors (e.g., Cuddy et al., 2007), and increase avoidance inclinations (Capozza et al., 2019; Capozza, Di Bernardo, et al., 2016), discrimination, and aggressive behaviors (e.g., Goff et al., 2008; Viki et al., 2013).

There is growing evidence that patient dehumanization/infrahumanization is a widespread, albeit largely unconscious, phenomenon among healthcare professionals. The humanity bias has been found in a variety of healthcare settings by examining, for instance, physicians and nurses in oncology wards (Capozza et al., 2015), nurses working in different hospital wards (e.g., cardiology, hemodialysis, surgery; see Trifiletti et al., 2014), educators of people with intellectual and developmental disabilities (Capozza, Di Bernardo, et al., 2016). These dehumanizing perceptions might explain why patients are often target of negative behaviors that can undermine their dignity and deteriorate the caregiving relationship. Dehumanizing perceptions are also observed in the general population. They concern, for instance, people with mental illness (Martinez et al., 2011; for autistic people, see Cage et al., 2019), people with dementia (Miron et al., 2017), individuals with intellectual disabilities (Falvo et al., 2014), and people in a vegetative state (Gray et al., 2011).

Concerning the consequences of patient dehumanization in healthcare contexts, research is still in its infancy. One negative outcome is that the humanity bias is associated with spontaneous avoidance responses among caregivers (Capozza, Di Bernardo, et al., 2016). It can also be associated with lower adherence to one's physician's therapeutic prescriptions (see Falvo et al., 2019). However, the denial of full humanity to patients can be functional for healthcare providers, being a useful coping strategy to alleviate stress symptoms and burnout perceptions¹ (for further functional aspects of patient dehumanization, see Haque & Waytz, 2012; see also Capozza, Falvo, et al., 2016).

Some studies have highlighted that, under certain conditions, patient dehumanization is associated with lower burnout perceptions and reduced stress symptoms. Vaes and Muratore (2013) examined health professionals (e.g., nurses, physicians, psychologists), operating in oncological centers. They discovered that the attribution of secondary (uniquely human) emotions to an imagined cancer patient presented in a clinical scenario, that is, humanizing her suffering, was positively related to burnout, especially for

healthcare workers who reported more frequent contact with patients. In addition, the attribution of primary (non-uniquely human) emotions, that is, dehumanizing the target's suffering, was positively related to higher work engagement and higher perceptions of professional efficacy.² Trifiletti et al. (2014) found that the perception of patients as not fully defined by humanity was associated with lower stress symptoms, among nurses with a high affective commitment to the organization or to patients (see the three-component model of commitment and its different targets, Meyer & Herscovitch, 2001). Stress reduction was achieved by both denying uniquely human traits to patients and assigning them non-uniquely human traits. In a study surveying nurses (Di Gilio, 2015), the ascription of non-uniquely human traits to patients was related to lower levels of burnout for nurses with lower abilities to read other people's minds (assessed via the Reading the Mind in the Eyes Test; Baron-Cohen et al., 2001; see also Vellante et al., 2013), but it was related to higher levels of burnout for nurses with higher mentalizing skills. Finally, relevant results come from experimental studies by Cameron et al. (2016). Examining Amazon's Mechanical Turk participants, they showed that anticipating affective costs of helping causes dehumanization of members of a stigmatized outgroup. Therefore, self-protective motives can lead to dehumanizing others.

Healthcare providers denying full humanity to patients may avoid the emotional overload that derives from patients' suffering, thus releasing cognitive and emotional resources useful for clinical task performance; they may feel more energetic and competent and, thus, more capable of delivering efficient care. Taken together, these findings offer initial support for the functional aspects of patient dehumanization for healthcare workers' well-being. Interestingly, the association between patient dehumanization and reduced burnout (or improved well-being) was found to be moderated by several variables (i.e., contact with patients, organizational and patient commitment, capacity to read other people's minds). However, other healthcare professionals — such as, people with low attachment security — may use dehumanization as a coping strategy.

ATTACHMENT SECURITY

Based on the original formulation by Bowlby (1982), adult attachment theory (see Mikulincer & Shaver, 2007a) argues that social relationships established in adulthood are strongly affected by those developed with primary caregivers during infancy. According to Bowlby, an innate attachment behavioral system drives individuals to search for availability and responsiveness of protective others (attachment figures). When caring and safety are consistently met, a sense of security is built, promoting learning and exploration of social and physical environment (Belsky, 1999). In contrast, the lack or inconsistency of these supporting experiences may generate a sense of insecurity in interpersonal relations. Thus, individual differences in attachment system in adulthood derive from internalization of previous experiences with attachment figures (see e.g., Ainsworth et al., 1978; Bowlby, 1973; Mikulincer & Shaver, 2007a). Individuals characterized by secure attachment orientation hold positive self- and other representations; they easily develop close relationships, rely on others when in need, and can effectively cope with environmental challenges by using adaptive ways of affect regulation. Anxious individuals are characterized by negative self-representations, though judging other people positively; they are afraid of rejection and search for approval, constantly seeking attention and support. Finally, individuals with an avoidant orientation have negative evaluations of other people, whom they perceive as unreliable; they tend to rely on themselves when in threatening situations and feel emotionally distant from others.

Research has extensively documented the positive effects of secure attachment, both as an individual predisposition and as a contextually activated factor (see Mikulincer & Shaver, 2007b). Security, for instance, leads to helping behaviors (see, e.g., Capozza, Colledani, & Falvo, 2021; Mikulincer et al., 2005), reduces intergroup prejudice (Mikulincer & Shaver, 2001), and facilitates the use of effective strategies to cope with stressful events (e.g., Mikulincer & Florian, 1995). In general, security provides a basis for desirable psychological states (Shaver et al., 2017). Initial studies have shown that attachment security is also linked to humanizing perceptions of the outgroup. Capozza et al. (2018) discovered that secure attachment, as a dispositional variable, was positively associated with humanity attributions to people with intellectual and developmental disabilities. Outgroup humanization was also observed when using different methods of security priming (see Capozza, Falvo, & Di Bernardo, 2021; Zhang et al., 2015). In Capozza, Falvo, and Di Bernardo (2021), outgroup targets were people who are homeless and the Roma.

OVERVIEW OF THE CURRENT STUDY

In the present study, we surveyed a sample of hospital nurses through a questionnaire assessing: the attributions of uniquely human (UH) and non-uniquely human traits (NUH) to patients and nurses (see Capozza et al., 2013); burnout and work engagement; attachment orientations conceptualized as dispositional variables (using a scale adapted from Hazan & Shaver, 1987). We predicted that patients would be ascribed a not fully human status; in other words, nurses should perceive patients as more characterized by NUH than UH traits (dehumanization), and less characterized by UH traits (infrahumanization) than nurses (Hypothesis 1). We also predicted that patient dehumanization/infrahumanization would be positively related to nurses' work engagement and negatively related to burnout (Hypothesis 2). Finally, we predicted that nurses qualified by higher levels of secure attachment would be less prone to use patient dehumanization (or infrahumanization) to increase their well-being than less secure nurses. The former, in fact, are more able to face threatening situations and to employ adaptive strategies to regulate their emotions, when dealing with patients' suffering and death (for the relationship between secure attachment and reduced burnout among nurses, see Falvo et al., 2012). Thus, we hypothesized a moderating effect of secure attachment: the association of the humanity bias with work engagement and burnout should be stronger, or significant, for nurses with a lower level of secure attachment (Hypothesis 3).

In this study, we focused on burnout and work engagement. Regarding work engagement in nursing, research has highlighted its positive outcomes: for instance, it increases nurses' personal initiative and reduces hospital mortality rates (see Bargagliotti, 2012; for reviews on antecedents and outcomes of work engagement in nursing, see García-Sierra et al., 2016; Keyko et al., 2016).

METHOD

Participants and Procedure

A total of 102 nurses took part in the cross-sectional study. They worked in two organizations located in a central region of Italy: 81.4% were employed in a hospital (cardiology, surgery, orthopedics, internal medicine, and intensive care wards) and 18.6% in a nursing home for the elderly. Questionnaires were delivered to participants in envelopes by the head nurse of the ward. The envelope contained the

questionnaire and an instruction letter, clarifying that participation was anonymous and voluntary. Respondents were informed about the aim of the study, the duration of the task, and the possibility of withholding their consent by not accepting to participate, or not returning the questionnaire (response rate was 63.8%). Completed questionnaires were placed inside boxes located in common areas of the ward. Data were collected between January and May 2018. The study was approved by the local Ethical Committee for Psychological Research.

Most respondents (65 women and 35 men; two missing values) were aged between 31 and 50 years (66.7%); 10.8% were aged up to 30 years, and 21.6% were between 51 and 60 years (one missing value). As to the length of service, 21.6% of participants had a seniority up to 5 years, 16.7% between 6 and 10 years, 43.1% between 11 and 20 years, and 15.7% had a seniority of over 20 years (three missing values).

Measures

Humanity Attributions. To assess humanity attributions, four uniquely human (reasoning, rationality, morality, intellectual abilities) and three non-uniquely human (instinct, drive, impetus) traits were employed (see Capozza et al., 2013). Participants were first asked to rate the outgroup (hospitalized patients) and, then, their professional ingroup (nurses) on each trait, presented in a fixed random order; filler items, such as intelligence and friendliness, were included. The introductory sentence was: "In this hospital, nurses [patients] are characterized by." Answers were given on a 7-step scale (from 1 = *definitely false* to 7 = *definitely true*; 4 = *neither true nor false*). Alpha coefficients, for patients and nurses, were, respectively, .74 and .78, for UH traits, and .61 and .68, for NUH traits.

Attachment Orientation. Individual differences in attachment orientations were assessed through a three-item scale, adapted from Hazan and Shaver (1987). Participants were presented with three paragraphs describing typical ways of experiencing social relations, according to secure, anxious, and avoidant attachment. For secure attachment, for instance, the item was: "I find it relatively easy to get close to others and I am comfortable depending on them and having them depend on me. I don't often worry about being abandoned or about someone getting too close to me." The introductory sentence was: "Consider the following three paragraphs concerning ways of perceiving social relationships, even intimate social relationships. For each paragraph, indicate to what extent it describes your mode of perceiving relationships." Respondents were asked to answer on a 7-step scale ranging from 1 = *strongly disagree* to 7 = *strongly agree* (4 = *neither agree nor disagree*).

Job Burnout. To measure the emotional exhaustion dimension of job burnout, the Maslach Burnout Inventory– General Survey (MBI-GS; Schaufeli et al., 1996) in the Italian version (Borgogni et al., 2005) was applied. Five items were used, for instance: "I feel exhausted by my work"; "Working all day is truly an effort for me." Participants had to indicate, on a 7-step scale (0 = *never*, 1 = *rarely/a few times a year or less*, 2 = *occasionally/once a month or less*, 3 = *regularly/a few times a month*, 4 = *frequently/once a week*, 5 = *very frequently/a few times a week*, 6 = *daily*), how frequently they experienced the feelings or opinions described by the items. Reliability was .89.

Work Engagement. The Italian version (Balducci et al., 2010) of the shortened Utrecht Work Engagement Scale (UWES-9; Schaufeli et al., 2006) was used to assess work engagement. The scale, capturing the three facets of the construct — vigor, dedication, and absorption — included nine items, for instance: "At my job, I feel strong and vigorous"; "My job inspires me"; "I feel happy when I am working

intensely.” Answers were given on a 7-step scale anchored by 0 = *never* and 6 = *daily* (1 = *rarely/a few times a year or less*, 2 = *occasionally/once a month or less*, 3 = *regularly/a few times a month*, 4 = *frequently/once a week*, 5 = *very frequently/a few times a week*). The alpha coefficient was .94.

RESULTS

Humanity Attributions

To detect patient dehumanizing perceptions, a repeated-measure ANOVA 2 (target groups: patients vs. nurses) \times 2 (humanity dimensions: UH vs. NUH) was applied. The two main effects were significant, $F(1,101) = 56.53, p < .001, \eta^2_p = .36$, for humanity dimensions ($M = 4.98$ for UH traits and $M = 4.44$ for NUH traits), and $F(1,101) = 67.44, p < .001, \eta^2_p = .40$, for target groups ($M = 4.96$ for nurses and $M = 4.46$ for patients). Also the interaction was significant, $F(1,101) = 52.88, p < .001, \eta^2_p = .34$. Simple effect analysis showed that nurses assigned more uniquely human traits to their professional group ($M = 5.52, SD = 0.86$) than to patients ($M = 4.45, SD = 0.83$), $F(1,101) = 92.00, p < .001, \eta^2_p = .48$, whereas they did not differentiate the two groups on the non-uniquely human dimension ($M = 4.41, SD = 0.82$ and $M = 4.47, SD = 0.68$, for nurses and patients, respectively), $F(1,101) = 0.46, p = .497, \eta^2_p = .005$. Furthermore, nurses perceived themselves as more characterized by UH than NUH traits, $F(1,101) = 105.86, p < .001, \eta^2_p = .51$, but, for patients, no difference in the attribution of the two dimensions was found, $F(1,101) = 0.04, p = .851, \eta^2_p = .00$. Thus, an infracumanization effect was observed, confirming Hypothesis 1 and replicating the classical pattern in infracumanization research, in which the UH attributes are assigned more to the in-group than to the outgroup, whereas the NUH attributes are not differently assigned to the two groups (Leyens et al., 2007). Patient dehumanization was not detected: patients were not perceived as more characterized by non-uniquely human than uniquely human traits. To test Hypotheses 2 and 3, only patient infracumanization was considered, by computing the difference between the attribution of UH traits to nurses and patients (the higher the score, the more patients are infracumanized).

Testing of Moderation Models

To test the moderation hypotheses, PROCESS Model 1 (Hayes, 2017) was applied. Two models were run: in the first, the outcome variable was work engagement, in the second, it was job burnout. In both models, patient infracumanization was the predictor, secure attachment was the moderator variable, and avoidant and anxious attachment were modeled as covariates. As to demographic variables, preliminary multiple regression analyses, evaluating the effects of gender, age, and working seniority on each of the two well-being's indicators, revealed that only gender was related to burnout, with men showing higher levels of emotional exhaustion, $b = -0.88, p = .001$. Therefore, gender was modeled as a further covariate (due to missing values for this variable, moderation analyses were run with $N = 100$). Means and zero-order correlations between the study variables are presented in Table 1. The regression equation, in the moderation model, includes six predictors and it requires a sample of 97 participants to reach a power of .80, with a probability level of .05 and an effect size of $f^2 = .15$ (medium). To avoid multicollinearity, the measures of infracumanization and secure attachment were mean-centered before analysis (Cohen et al., 2003).

TABLE 1
 Means, standard deviations (*SD*), and correlations between the study variables (*N* = 100)

	<i>Mean</i>	<i>SD</i>	1	2	3	4	5	6	7
1. Secure attachment orientation	3.95	1.50	-						
2. Avoidant attachment orientation	3.68	1.52	.24*	-					
3. Anxious attachment orientation	2.98	1.41	.34***	.23*	-				
4. Patient Infrahumanization	1.08	1.15	.11	.07	-.09	-			
5. Work engagement	5.21	1.09	.16	.10	-.13	.24*	-		
6. Job Burnout (exhaustion)	2.99	1.22	-.09	.03	.11	-.21*	-.43***	-	
7. Gender	1.65	0.48	-.01	-.04	-.07	.03	.18	-.31***	-

Note. For gender, 1 = men, 2 = women. Patient infrahumanization was calculated as the difference between the attribution of UH (uniquely human) traits to nurses and patients.

* $p < .05$. *** $p \leq .001$.

Results concerning work engagement as the outcome variable (model statistics: $F[6, 93] = 3.22, p = .006; R^2 = .17$; effect size, $f^2 = .20$) showed a main effect of secure orientation which was positively associated with the outcome ($b = 0.15, t = 2.02, p = .046$). In addition, the interaction between security and infrahumanization was found to be significant, albeit marginally ($b = -0.10, t = 1.94, p = .056$). Simple slope analysis (see Figure 1) highlighted that, when attachment security was low ($-1 SD$), patient infrahumanization had a positive relationship with work engagement ($b = 0.31, t = 2.72, p = .008$). In contrast, when attachment security was high ($+1 SD$), infrahumanization was not associated with the outcome variable ($b = 0.02, t = 0.13, p = .898$).

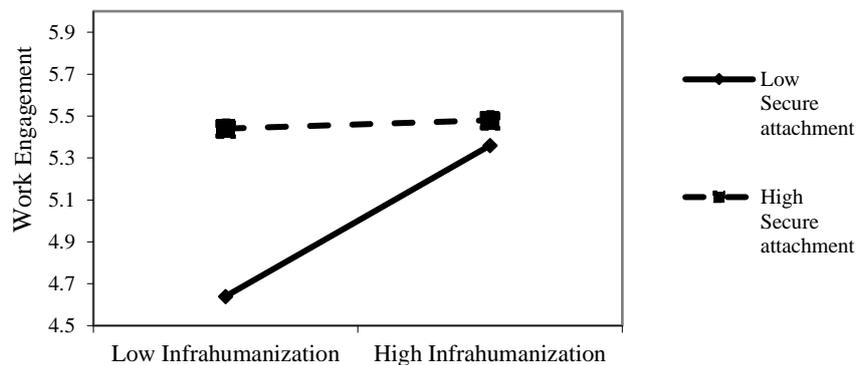


FIGURE 1
 Moderating effect of secure attachment on the relationship between patient infrahumanization and nurses' work engagement.

Note. Low and high infrahumanization and low and high secure attachment correspond to 1 SD below and 1 SD above the sample mean. Infrahumanization was calculated as the difference between the attribution of UH (uniquely human) traits to nurses and patients.

Concerning emotional exhaustion (model statistics: $F[6, 93] = 2.92, p = .012, R^2 = .16$; effect size, $f^2 = .19$), results showed a marginally significant main effect of patient infrahumanization ($b = -0.20, t = 1.92, p = .058$), indicating that the more nurses perceived patients as not fully human, the less they reported burnout. A significant main effect of gender was also revealed ($b = -0.77, t = 3.15, p = .002$), replicating findings of our preliminary analyses (men reported more burnout than women). Neither the main effect of attachment security nor the interaction term turned out to be significant.

Two alternative models were tested, in which either work engagement or burnout were the predictor and patient infrahumanization was the outcome variable (secure orientation was the moderator; avoidant and anxious attachment, as well as gender, were used as covariates). In both models, no regression coefficient was found to be significant (models' statistics: $F_s \leq 1.70, p_s \geq .13; R^2 = .07$, for burnout; $R^2 = .10$, for work engagement).

Regression findings partially confirmed our hypotheses: a negative relationship (barely significant) was found between patient infrahumanization and burnout, but patient infrahumanization was not related to work engagement (Hypothesis 2).³ The expected moderating effect of attachment security was observed for work engagement, but not for burnout (Hypothesis 3). Thus, as hypothesized, for nurses with low secure attachment, infrahumanization was associated with increased work engagement; this relation was, in contrast, not significant for nurses with high secure attachment. Regardless of attachment orientation, infrahumanization was negatively related to burnout (all data are available from the first author upon request).

DISCUSSION

The patient-centered approach and the strategy of care humanization (see, e.g., Borbasi et al., 2012; Epstein & Street, 2007) focus mainly on healthcare providers' feelings of empathy and compassion toward patients, relational support, and the goal of meeting patients' needs (Busch et al., 2019). These variables were found to be associated with many positive outcomes for patients, for instance, satisfaction of care, adherence to therapeutic recommendations, and clinical results (e.g., Beach et al., 2005; Pereira et al., 2016). However, research has highlighted the detrimental effects of being emotionally involved with patients' suffering. Negative effects of empathy and emotional investment in helping include risks of burnout, compassion fatigue (i.e., emotional strain from working with traumatized people; Figley, 1995), and stress (see, e.g., Hunt et al., 2017). Impaired nurses' well-being is likely to have adverse consequences not only for the individual worker, but also for the whole organization (e.g., turnover, absenteeism, poor performance, and low quality of patient care; see, e.g., Dyrbye et al., 2019; Poghosyan et al., 2010).

Nurses, therefore, need to employ strategies of emotional regulation when facing suffering in their daily interactions with patients. Drawing upon research on dehumanization in medical contexts, we hypothesized that the attribution of lower human status to patients may be one of these strategies, especially used by nurses with low secure attachment.

Results showed that nurses, working in two different organizations and different wards, perceived patients as less defined by uniquely human traits (infracommunication effect) than their ingroup. We also discovered that patient infracommunication was associated with increased work engagement, but only for nurses with low attachment security. These findings replicate previous research on patient dehumanization (see, for a review, Capozza, Falvo, et al., 2016), and show, for the first time, the moderating effect of secure attachment (Mikulincer & Shaver, 2007a) for the relationship between patient dehumanization and higher well-being.

Thus, not assigning patients a fully human status may help nurses to lessen the emotional overload and to increase energy and involvement while working. This mechanism, which concerns nurses with low secure attachment, however, can have adverse consequences. Patient dehumanization, in fact, can generate negative reactions in patients (e.g., hostility, distrust; see Haque & Waytz, 2012); it can harm communication; in general, it can deteriorate the quality of the therapeutic relationship, ultimately leading to increased stress and burnout among healthcare providers.

The relationship between patient dehumanization and nurses' well-being can be bi-directional: infracommunication/dehumanization may allow higher work engagement and reduced stress or burnout, but, at the same time, lower nurses' well-being may give rise to patient dehumanizing perceptions. Future research should investigate the relationship between humanity attributions to patients and well-being in nursing, using a longitudinal design, thus overcoming the limitations of our cross-sectional study, to establish both causality between constructs and to analyze long-term effects of humanity attributions to patients. In addition, future research should identify other individual difference variables that may moderate the dehumanization-well-being relationship, such as proactivity (see Bateman & Crant, 1993; see also Falvo et al., 2013) and those included in the psychological capital (optimism, self-efficacy, resilience, and hope; Luthans et al., 2007).

Regarding the moderating effect of secure attachment, we discovered that it concerns work engagement but not burnout. We can provide a post-hoc explanation of this finding. Research has highlighted that individuals (nurses) defined by secure attachment, in addition to other qualities (see Mikulincer & Shaver, 2016), may be characterized by creativity (Mikulincer et al., 2011) and environmental exploration

(e.g., Boccato et al., 2015; Feeney & Thrush, 2010; Green & Campbell, 2000). These resources, having a buffering effect on stress elicited by job demands, may allow secure nurses to maintain energy and vigor in their work. Thus, for secure nurses, patient dehumanization may not be necessary to experience work engagement. Creativity and exploration are, instead, not sufficient to curb the daily increment in stress leading to burnout and favoring dehumanization.

Concerning the consequences for the target of dehumanization, it has been found that the denial of human nature (i.e., mechanistic dehumanization) induces sadness and impairs cognitive flexibility; the denial of human distinctiveness (i.e., animalistic dehumanization) induces feelings of shame, besides sadness, and impairs cognitive flexibility, the latter effect characterizing individuals with low self-esteem (Zhang et al., 2017; see Bastian & Haslam, 2011, for further negative effects of being target of dehumanization). Future research should replicate these findings focusing on patients' responses in medical contexts.

Our results are consistent with recent research showing the positive effects of attachment security (either contextually activated or as an individual predisposition) on promoting outgroup humanization (see Capozza et al., 2018; Capozza, Falvo, & Di Bernardo, 2021). As a practical implication, healthcare organizations could consider individual differences in secure attachment to identify a specific type of healthcare professional at risk of using dysfunctional coping mechanisms. Furthermore, it has been consistently found that security can be temporarily elicited, for instance, through the activation of mental representations of supportive figures or interactions, inducing long-term effects. Security activation, therefore, can boost positive outcomes such as more effective emotion-regulation strategies, regardless of individual attachment orientations (for the effects of security priming, see Mikulincer & Shaver, 2007b, 2015). In health organizations, the sense of security can be activated by promoting affiliative teams and encouraging supportive styles of leadership (Ronen & Mikulincer, 2012), thus reducing, in nurses, the use of patient inhumanization to enhance well-being.

Many strategies can be proposed aimed to foster work engagement and its positive outcomes in nursing, such as interventions based on organizational climate and job resources (see the Nursing Job Demands-Resources model by Keyko et al., 2016; see also Knight et al., 2017). Finally, unpublished studies conducted in our laboratory have highlighted that not only nurses' well-being, but also humanizing perceptions of patients are positively related to job resources and negatively related to job demands (see the Job Demands-Resources model by Bakker & Demerouti, 2017), thus indicating the centrality of intervening on organizational factors. As observed by Busch et al. (2019), healthcare professionals themselves perceive favorable work conditions as a key factor promoting the humanization of care.

NOTES

1. According to Maslach et al.'s (2001) definition, burnout is a persistent response to chronic emotional and interpersonal stressors on the job, characterized by three dimensions: exhaustion (depletion of emotional and internal resources), cynicism (distancing oneself from the job and feeling cynical about the value of one's work), and inefficacy (the feeling of being less effective in one's job).
2. Schaufeli et al. (2002) defined work engagement as a work-related state of mind characterized by energy and mental resilience (vigor), deep involvement and enthusiasm (dedication), and joyful immersion in work (absorption).
3. Results from zero-order correlations (see Table 1) are consistent with Hypothesis 2, indicating that the humanity bias was positively related to work engagement and negatively related to burnout

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