Does emotional labor affect nurses suffering from workplace violence? A moderated mediation model

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Abstract

Purpose – *This paper aims to investigate the relationship between emotional labor and workplace violence based on the social exchange theory. Drawing on the social exchange theory, this paper aims to investigate the relationship between emotional labor and workplace violence. Specifically, the authors take a relational approach by introducing positive patient treatment as the mediator. The moderating role of organizational support in the relationship between emotional labor and workplace violence is also considered.*

Design/methodology/approach – *The data of this study encompasses 536 nurses from 10 university hospitals in Turkey. Hierarchical multiple regression analysis was conducted to test the proposed model.*

Findings – *The findings of this study support the negative effect of emotional labor on workplace violence and the mediating effect of patient-positive treatment. Moreover, when organizational support is low, the relationship between emotional labor and workplace violence is strong. In contrast, the effect is weak when organizational support is high.*

Practical implications – *The findings of this study suggest that health-care administrators should offer more training to nurses to help them manage their emotions while interacting with their patients. This leads to positive interpersonal relationships, which, in turn, lowers workplace violence. Moreover, health-care administrators should pay more attention to the buffering role of perceived organizational support for those subordinates with low emotional labor and higher workplace violence.*

Originality/value – *The study provides new insights into emotional labor's influence on workplace violence and the moderating role of organizational support in the link between emotional labor and workplace violence. The paper also offers practical assistance to nurses in the health-care industry interested in building positive patient treatment and trust with their patients and minimizing workplace violence.*

Keywords *Emotional labor, Workplace violence, Positive patient treatment, Organizational support, Nurse, Moderator*

Paper type *Research paper*

1. Introduction

Workplace violence is becoming a global public health concern and a serious occupational hazard (Anderson and Stamper, 2001; Zhang *et al.*, 2022). Workplace violence refers to a sequence of occurrences in which employees are threatened, mistreated or attacked, with explicit or implicit threats to their safety, well-being or health (Anderson and Stamper, 2001). Medical personnel are routinely confronted with workplace violence, a serious hazard to professionals in health-care settings (Zhao *et al.*, 2018). In recent years, workplace violence in nursing has risen dramatically (Zuzelo, 2020). It has been shown to have a variety of adverse outcomes. A decrease in job participation and performance (Lin *et al.*, 2015), higher psychological stress and burnout (Kim *et al.*, 2018), high turnover intentions (Zhao *et al.*, 2018) and poor health-care quality are just a few instances (Zuzelo, 2020). Nurses must work in a pleasant setting to provide high-quality nursing care (Zuzelo, 2020). *The*

Received 2 January 2023
Revised 22 February 2023
Accepted 22 February 2023

Turkish government has implemented new laws and regulations to stop workplace violence as a response to the high prevalence of such occurrences and its detrimental effects. It has also devised a procedure for punishing patients engaged in medical fraud or aggressive behavior. Medical facilities have also been updated to safeguard medical personnel and prevent extreme violence and consequences. To minimize violent interactions induced by nurse–patient conflict, nurses must build a harmonious connection with patients by increasing their service quality. Although there has been much discussion about avoiding workplace violence at the governmental, organizational and individual levels, it is worth noting that few researchers have looked at the influence of emotions on workplace violence in nursing settings. More crucially, nurses are high-risk professional victims subjected to a slew of antisocial actions in the medical workplace by supervisors, patients or their families (Bowling and Michel, 2011; Rodwell and Demir, 2014). To our knowledge, few researchers (Liu *et al.*, 2018; Demir and Rodwell, 2012) focused on workplace violence produced by factors related to organizational shortcomings and individual differences variables within the medical environment.

1.1 Relationships between emotional labor and workplace violence

Emotional labor in early work was defined as "the management of feeling to create a publicly observable facial and bodily display" (Hochschild, 1983, p. 7). It referred to employees' efforts to make their private feelings and/or public emotional displays consistent with the job and organizational requirements. By emotions, we imply discrete emotional occurrences that are shorter in length, more intense than moods and more diffuse affective states with lower intensity and no distinct goal (Frijda, 2004). According to Hochschild's original definition, from a qualitative study of flight attendants and bill collectors, emotional labor refers to efforts undertaken in exchange for wages or other forms of compensation, such as increased tips earned by a restaurant server smiling and smiling and joking with customers. Hochschild uses emotional work and management to characterize comparable activities for private or personal motives other than monetary compensation. This concept is expanded to encompass emotional efforts in meeting perceived or stated individual work-related incentives or expectations that support organizational goals. As a result, it covers emotional labor acts driven by pay incentives (for example, bonuses or sales commissions) and efforts that advance monetary and nonmonetary individual or organizational goals (e.g. performance evaluations, patient/customer retention and myriad others). Individuals are commonly thought to perform emotional labor in two ways: surface acting, in which they display emotions they are not experiencing and are not attempting to feel while suppressing the display of felt emotions, and deep acting, in which they deliberately strive to summon the target emotion and then allow that felt emotion to guide outward expression (Hochschild, 1983; Humphrey, 2012).

Although there is emerging evidence that individual differences variables are a crucial predictor of many forms of workplace violence, little is known about the relationship between employees' emotional labor and workplace violence from patients, their relatives or both. In this regard, nurses' emotional labor will benefit nurses and their workplaces (i.e. hospitals). However, there is scant evidence between emotional labor and workplace violence against nurses. According to Wang and Chang (2016), improving a nurse's patient orientation is critical for patient satisfaction. To give a good service, service providers must respect their patients/customers by expressing suitable emotions (Fu, 2013; *Lee and Kim,* 2016). Several researchers have investigated the relationship between emotional labor, patient-oriented behavior and satisfaction. Empirical investigations have revealed that the emotional labor of hospital staff favorably promotes patient satisfaction (Wang and Chang, 2016). Employees are frequently asked to exhibit positive sentiments when interacting with patients. The right emotional expression of nurses relaxes patients and their relatives, which is beneficial to good medical treatment.

The emotional contagion theory offers an additional rationale on why emotions are transferred from one person to another. According to this very theory, emotional projections from others are ''caught'' by individuals in an instinctive, rapid and ephemeral process that is viewed as a multiple-determined family of psychophysiological, behavioral and social phenomena (Hatfield et al.*, 1994). Doherty (1997) elaborates on this idea, arguing that individuals constantly and unconsciously mimic the transient emotional expressions of others to whom they are paying attention and synchronize their own facial, verbal, postural and instrumental expressions in alignment with those expressions. People who are highly attuned to the emotions of others around them, who tend to mimic visual, verbal and postural expressions, and whose conscious emotional experience is heavily impacted by peripheral feedback are especially susceptible to emotional Contagion (Hatfield* et al.*, 1994).* Some research has confirmed emotional contagion's influence (Hatfield *et al.*, 1993; Wang and Chang, 2016). When nurses and patients engage with each other, the latter is influenced by the nurses' emotions. *Patients will feel more at ease with the service offered if nurses exhibit more positive emotions and repress negative emotions due to emotional contagion.* When people are happy with the service and the treatment of the service providers, they are more likely to exhibit less or no workplace violence against them. *Moreover, patients and their relatives can develop negative feelings and attitudes toward nurses who cannot effectively manage emotional labor. Consequently, these feelings and attitudes may lead patients and their relatives to display behaviors negatively perceived by nurses. This, in turn, may develop more negative feelings and attitudes toward patients and their relatives and show ineffective emotional labor, leading to more workplace violence.* As a result, we are attempting to investigate the following study hypothesis:

H1. Emotional labor negatively affects nurses' exposure to workplace violence.

1.2 The mediating role of positive patient treatment

Researchers (e.g. Grandey, 2000; Kim and Jang, 2019; Ni *et al.*, 2021; Tuna and Baykal, 2017; Vinson and Underman, 2020) assert that employees' displays of positive emotions result in favorable organizational outcomes, including a higher positive relationship between employee and customer, higher prosocial service behavior, employee performance and patient satisfaction. We predict that nurses' emotional labor will positively affect patient treatment. The positive patient treatment represents the high-quality interpersonal treatment that patients receive from nurses (Zhan *et al.*, 2016), such as treating the patient with respect and friendliness and understanding the patient's condition. Such treatment may be seen as pleasant and an indication of a positive experience for nurses. According to social exchange theory, individuals aim their reciprocation efforts toward the source of benefits (Blau, 1964; Emerson, 1976). When an individual obtains favor from others through service relationships or interactions, the individual is obligated to return likewise. To discharge this obligation, recipients furnish benefits to the favor-providers (Blau, 1964). In line with this reasoning, we propose that positive patient treatment creates obligations among patients to repay nurses by offering highly favorable treatment as a reciprocal response, which, in turn, leads to less negative verbal and physical behaviors (workplace violence from patients, relatives or both) creating a more peaceful environment without causing harm to others (Bowen *et al.*, 2011). Therefore, we attempt to explore the following research hypothesis:

H2. Positive patient treatment mediates the relationship between emotional labor and exposure to workplace violence.

1.3 The moderating effect of organizational support

The level at which workers believe their contributions are valued and the organization cares about their well-being at work is known as perceived organizational support (POS) (Rhoades and Eisenberger, 2002). Employees feel positive emotions because the organization values them

(Kurtessis *et al.*, 2017). During emotional labor, this positive emotion can aid in recharging workers' emotional resources (Hur *et al.*, 2015). According to earlier research, high-POS encourages proactive behavior, work engagement and job satisfaction (Caesens *et al.*, 2016; Caesens and Stinglhamber, 2014). An important outside resource for employees is organizational support. Access to these resources helps with emotional recovery and partially compensates for resource depletion brought on by emotional labor, modulating the relationship between emotional labor and outcome factors (Kahn, 1990).

Additionally, prior research has demonstrated that POS may reduce negative emotions as well as the discrepancy between employees' actual emotions and those necessary for work, lowering emotional dissonance (Wen *et al.*, 2019). It follows that nurses' resources for emotional labor will increase when their perception of organizational support is strong. The notion of resource conservation states that when workers continuously exert themselves to display positive emotions for resources or patients, they progressively deplete their energy and become job burnout owing to a lack of sufficient internal or external resources (Brotheridge and Lee, 2002). External resources, such as the perception of organizational support, might lessen the stress and the perceived exhaustion induced by emotional labor. By increasing internal resources, this augmentation of outside resources can support the positive effects of emotional labor on workplace violence. As a result, the POS might weaken the negative relationship between emotional labor on workplace violence. Therefore, we propose the following hypothesis:

H3. Organizational support moderates the relationship between emotional labor and exposure to workplace violence.

Figure 1 envisions the hypothesis.

2. Aims

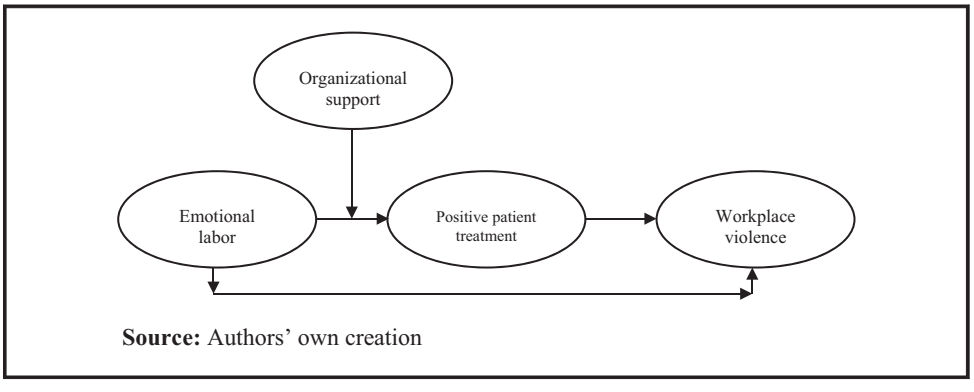
This study aimed to assess the current status of Turkish nurses' exposure to workplace violence; identify the cluster of interrelationships between emotional labor, positive patient treatment, organizational support and workplace violence in the nursing setting; examine the mediating role of positive patient treatment in the relationship between emotional labor and workplace violence; and identify the moderating role of organizational support in the relationship between these variables, to address these knowledge gaps.

3. Methods

3.1 Participants and procedures

Ten university hospitals were chosen randomly from a list of 68 universities across Turkey's seven geographical regions to participate in this study. Five of the hospitals were public,

Figure 1 Proposed moderated-mediation model



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while the remaining five were private. *The health-care sector was our initial choice because both public and private hospitals are well-suited to the surge in workplace violence.* The sample was chosen using the cluster random sampling method. First, all university hospitals in Turkey were divided into seven strata based on their geographical regions. A random cluster sampling was then used to choose hospitals proportionally from each stratum; the study sample was comprised of nurses employed by the selected hospitals.

The study was completed between May 2022 and August 2022. A group of two doctoral students visited 10 university hospitals. Following permission from the hospital's head doctors, they provided the certified nurses with information pertinent to the study's goal during their initial visit. They were told that the study's information was to compile data on workplace violence and emotional labor in the health-care industry. They maintained that participation was voluntary and that they had obtained private guarantees. Nurses interested in participating in this research were invited to provide the names and departments of the research team through email. All respondents were invited during the second visit (10 days later), and questionnaires were given out, filled out and collected immediately. This research included 750 front-line nurses as participants. The sample size was decreased due to incomplete questionnaires to 536 individuals, yielding a response rate of 71%. *The questionnaires filled in by participating nurses were not checked for completeness to avoid offending them in an environment where their managers and colleagues could be present. The voluntary participation and the confidentiality of the participants were other reasons why the questionnaires were not checked immediately. Later, some of the distributed questionnaires were left out of the evaluation because they were mostly left blank.*

The research conformed to the principles embodied in the Declaration of Helsinki. The research was conducted in compliance with the ethical guidelines of the Ethics Committee of the Institutional Review Board of Nevsehir University (Decision no: 205 and date: 30.05.2022). However, owing to the anonymous survey approach, written informed consent was obtained from each participant on the questionnaire's front page.

By doing a multivariate analysis of variance (MANOVA) test on demographic variables, including age and organizational tenure, potential nonresponse bias was evaluated. No significant variations were discovered between respondents and nonrespondents, indicating minimal, if any, nonresponse bias in the sample based on these factors.

3.2 Measures

3.2.1 Emotional labor. Nurses' emotional labor was measured using the Emotional Labor Scale for Nurses, developed by Hong and Kim (2019). This scale contains 16 items. Sample items include "I try to be kind to patients genuinely from my heart," "I suppress my anger when patients' words and behaviors are unfair" and "I exaggerate expressions of interest in patients." Each item is rated on a five-point Likert scale ranging from 1 (not at all) to 5 (very true). Higher scores on the scale indicate higher levels of emotional labor. The scale in this study showed good internal consistency with Cronbach's alpha of 0.83.

3.2.2 Workplace violence. Exposure to workplace violence caused by patients, their relatives or both was assessed by a seven-item measure (Ding *et al.*, 2016). Nurses were asked: "During the past year, have you found yourself in any of the following situations caused by a patient and/or their relatives?" A six-point Likert scale was used (1 = never, 6 = every day). Sample items include the following:

- verbal violence;
- made difficulties;
- smear reputation;
- mobbing behavior;

- intimidating behavior;
- physical violence; and
- sexual harassment.

According to the coding criteria, "never" and "rarely" were coded as not having experienced workplace violence from patients, relatives or both and were assigned a "0" score. Others were assigned a "1" to indicate that the nurses had experienced that sort of violence. *The response option "rarely" was coded as 0 with the "never" option because some participants in the study stated that violence incidents encountered in the last year were almost as rare as if they had never existed. This dichotomy was frequently used in studies on workplace violence* (*Johnson, 2006*; *Zhang et al., 2022*). Cronbach's alpha of this scale was 0.88.

Positive patient treatment. *It was accessed using three items from Zhan et al.'s (2016) scale, which measures negative and positive treatment. Only the positive treatment part of their scale was used in this study*. Nurses rated positive patient treatment based on their actual experiences. Three items are "Today, patients appreciated my service," "Today, patients treated me politely" and "Today, patients expressed understanding of the difficulty in my job." The average α of the scale across the ten days was 0.96.

3.2.3 Organizational support. Consistent with previous research (Moorman *et al.*, 1998), we used the shortened nine-item version of Eisenberger *et al.*'s (1986) POS scale, which measures employee perceptions of the extent to which an organization cares about employees and values their contributions. *Organizational support may come from managers and coworkers, role clarity and resource access* (*Joiner and Bakalis, 2006*). *These areas have been shown to contribute to an employee's overall perception of organizational support. In this study, organizational support by managers is focused upon because managerial support is an important factor that causes effective management of emotional labor* (*Lai et al., 2020*). Sample item of POS includes "Help is available from my superior when I have a problem" (a = 0.91).

3.3 Data analysis

The main statistical methods included descriptive statistical analysis to describe the participants' demographic information and the status of workplace violence – and Pearson correlation, which was generated to estimate the correlations between emotional labor, organizational support, positive customer treatment and workplace violence. We performed a hierarchical linear regression analysis to test these variables' relations, mediating and moderating effects. The mediator was tested by calculating bias-corrected 95% confidence intervals using bootstrapping, with n = 5,000 resamples via the PROCESS procedure for SPSS 26.0 (Hayes, 2013).

4. Results

Nurses comprising the final sample worked in one of the following seven departments:

1. Cardiology (26%);
2. Neurology (23%);
3. Gynecology (16%);
4. Gastroenterology (10%);
5. Orthopedics (8%);
6. Ear, nose and throat (8%), microbiology (6%); and
7. Intensive care unit (3%).

The average age of nurses was 29.81 years. Out of the 536 nurses, 98% were female. *This is consistent with the female: male ratio for the nursing field in Turkey because the nursing profession is historically female-dominated, as most nurses (91%) in Turkey are female.* Furthermore, the average organizational tenure for the nurses was 9.04 years.

Out of the 536 nurses sampled, 79.48% reported having experienced made difficulties within the last year, the most prevalent type of workplace violence in Turkish hospitals. As shown in Table 1, the other prevalence of workplace violence from highest to lowest is intimidation behavior (79.10%), smear reputation (77.99%), verbal violence (75.93%), physical violence (0.6%), mobbing behavior (0.6%) and sexual harassment (0.4%).

We aggregated the experience of the various types of workplace violence to ascertain the total number of incidents within the previous year. Table 2 shows that 54.66% of the participants reported having encountered one or more types of workplace violence within the last year.

We presented the mean, standard deviation and Pearson's correlation coefficients of all continuous variables in Table 3. All study variables are significantly intercorrelated, indicating that each variable could be used in the subsequent regression analyses. For nurses, the average score of study variables was 3.34 for emotional labor, 3.40 for positive patient treatment, 3.61 for organizational support and 3.32 for workplace violence.

In Table 3, emotional labor was found to have significant positive correlations with both positive patient treatment and organizational support (0.51 and 0.57, $p < 0.01$, respectively) and a negative correlation with workplace violence (–0.46, $p < 0.01$).

As far as the average exposure to workplace violence of nurses working in public and private hospitals (3.53 and 3.11, respectively) is concerned, violence experienced by nurses working in public hospitals is higher. This is mainly because the number of patients treated in public hospitals is much higher than those treated in private hospitals, and therefore, the probability of being exposed to violence is higher.

Table 1 Prevalence of different types of workplace violence against nurses

Violence types	*Never*	*Rarely*	*Occasionally*	*Often*	*Frequently*	*Everyday*	*Rate* N *(%)*	*Rank*
Made difficulties	52 (9.7)	58 (10.8)	200 (37.3)	226 (42.2)	0 (0)	0 (0)	426 (79.48)	1
Intimidation behavior	17 (3.2)	95 (17.7)	201 (37.5)	223 (41.6)	0 (0)	0 (0)	424 (79.10)	2
Smear reputation	101 (18.8)	17 (3.2)	0 (0)	10 (1.9)	227 (42.4)	181 (33.8)	418 (77.99)	3
Verbal violence	102 (19.0)	27 (5.0)	0 (0)	7 (1.3)	194 (36.2)	206 (38.4)	407 (75.93)	4
Physical violence	274 (51.1)	259 (48.3)	0 (0.0)	0 (0)	3 (0.6)	0 (0)	3 (0.6)	5
Mobbing behavior	327 (61.0)	206 (38.4)	0 (0.0)	0 (0)	1 (0.2)	2 (0.4)	3 (0.6)	6
Sexual harassment	332 (61.9)	202 (37.7)	0 (0.0)	0 (0)	1 (0.2)	1 (0.2)	2 (0.4)	7

Source: Authors' own creation

Table 2 Prevalence of accumulated types of exposure to workplace violence against nurses

Accumulated violence	N	%
Never	243	45.34
Made difficulties	158	29.48
Intimidation behavior	80	14.92
Smear reputation	34	6.34
Verbal violence	17	3.17
Physical violence	2	0.37
Mobbing behavior	1	0.19
Sexual harassment	1	0.19

Source: Authors' own creation

Table 3 Correlations between study variables

Variables	*Mean*	*SD*	*1*	*2*	*3*	*4*	*5*	*6*
1. Age	29.81	3.23	1					
2. Gender	1.98	0.15	0.02	1				
3. Tenure	9.04	2.53	0.85**	0.07	1			
4. Emotional labor	3.34	1.07	–0.07	–0.04	–0.07	1		
5. Positive patient treatment	3.40	1.43	–0.03	0.01	–0.05	0.51**	1	
6. Organizational support	3.61	1.45	–0.00	–0.03	0.01	0.57**	0.49**	1
7. Workplace violence	3.32	0.71	–0.01	0.02	–0.03	–0.46**	–0.40**	–0.45**

Notes: Gender coded as 1 for male and 2 for female. **Correlation is significant at the 0.01 level (two-tailed). $N = 536$
Source: Authors' own creation

Table 4 summarizes the independent sample t-tests for emotional labor, workplace violence, positive patient treatment and organizational support variables between male and female nurses. Levene's test for equality of variances was insignificant; therefore, the equal variance was assumed. The insignificant value of t-test indicated that there were no differences found in the emotional labor, workplace violence, positive patient treatment and organizational support between male and female nurses.

Multiple linear regression analyses were performed to examine the hypotheses. The relationships between emotional labor, positive customer treatment, organizational support and workplace violence after adjusting for gender, age and job tenure were tested. Such variables were regarded as the control variables. Positive patient treatment was tested as a potential mediator of the relationship between emotional labor and workplace violence. We tested the mediator via the PROCESS procedure for SPSS 26.0 (Hayes, 2013) by calculating bias-corrected 95% confidence using bootstrapping with $n = 5{,}000$ resamples. Emotional labor was positively related to positive patient treatment ($\beta = 0.37$, $p < 0.001$) and negatively related to workplace violence ($\beta = -0.23$, $p < 0.01$); *H1* and *H2* were supported, as shown in Table 5. According to the suggestions by Aiken and West (Aiken and West, 1991), the data were centered (subtracting its average value). It showed that organizational support significantly moderated the relationship between emotional labor and workplace violence. Results displayed in Table 5 and Figure 2 confirm the *H3* hypothesis. *Figure 2 graphically shows the interactional emotional labor and workplace violence relationship moderated by organizational support, for which high and low levels are depicted as one standard deviation above and below the mean, respectively. As predicted, when employees perceived high levels of organizational support, the relationship between emotional labor and workplace violence was weaker. On the contrary, it was found that low organizational support strengthened the negative relationship between emotional labor and workplace violence. The negative relationship between emotional labor and workplace violence was more pronounced when an employee's perceived organizational support was low.*

Table 4 Independent sample *t*-tests for the variables of emotional labor, workplace violence, positive patient treatment and organizational support between male and female nurses

	Levene's test for equality of variances			
Variables	F	Sig.	t	Sig. (two-tailed)
Emotional labor	0.35	0.55	0.81	0.52
Workplace violence	0.10	0.98	–1.08	0.68
Positive patient treatment	0.30	0.59	–0.15	0.88
Organizational support	2.77	0.60	0.74	0.56

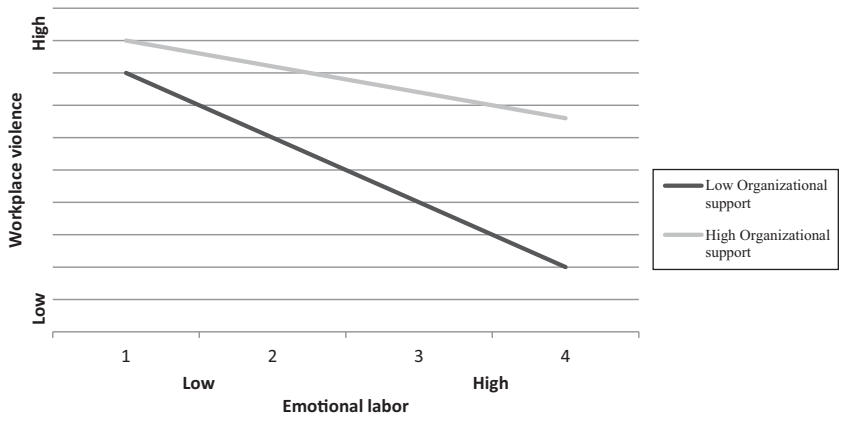
Source: Authors' own creation

Table 5 Hierarchical multiple regression model

Variables	*Positive patient treatment*	*Workplace violence* *Hypothesis 1*	*Hypothesis 2*	*Hypothesis 3*
Control variables				
Age	0.04	–0.03	–0.01	–0.02
Gender	0.05	–0.05	–0.02	–0.03
Tenure	0.11*	–0.03	–0.01	–0.01
Mediator				
Positive patient treatment			0.21**	
Moderator				
Organizational support				–0.19**
Interaction				
Emotional labor X Organizational support				–0.13*
Independent variable				
Emotional labor	0.37***	–0.23**	–0.19**	–0.21**
F	15.12**	12.11**	18.18**	11.12**
R	0.31**	0.27**	0.36**	0.29**
R-square	0.11**	0.10**	0.14**	0.09**

Notes: *,** and ***Correlations are significant at the 0.05, 0.01 and 0.001 levels, respectively (two-tailed)
Source: Authors' own creation

Figure 2 Interaction of emotional labor and organizational support on workplace violence



Source: Authors' own creation

5. Discussions

According to the present study, workplace violence was a problem for most Turkish nurses. The most common types of violence, ranging from high to low frequency, were verbal violence, smear reputation, made difficulties, intimidation behavior, physical violence, mobbing behavior and sexual harassment. The results support that workplace violence in nursing is widespread and serious. Overwhelmingly, workplace violence against nurses is becoming a serious concern. The higher-than-average prevalence of workplace violence against nurses might be due to several factors. One factor is that several modifications to the health system have not sufficiently addressed long-standing nurse-patient conflicts. The nursing industry's declining employment opportunities and high job demands may also be factors for workplace violence. The following discussion looks at nursing emotional labor. This factor has not been included in previous studies as a potential reason for nurses not being exposed to workplace violence.

A total of 54.66% of participants were exposed to workplace violence, whereas 45.34% were never exposed to workplace violence. This is a noteworthy percentage that deserves attention and can be attributed to the precautionary measures taken by the Turkish Ministry of Health in hospitals. Such measures include, amongst others, deterrent and aggravated penalties for those who commit violent behavior against health-care workers (up to two years imprisonment when proven guilty) as well as control measures such as installing barrier protection, metal detectors and security alarm systems. Another set of measures, not to be underestimated, are administrative and work practice controls, including workplace violence response and zero-tolerance policies, establishing a mandatory timely reporting system and services, including traumatic stress counseling.

The findings demonstrated that emotional labor negatively affected Turkish nurses' direct and indirect exposure to workplace violence. In addition, this research demonstrated that emotional labor is favorably connected with patient treatment and minimal workplace violence exposure among nursing staff. Consistent with earlier qualitative research (Najafi *et al.*, 2018), this study discovered that being the target of aggression from patients, their families or both is concurrently associated with workplace violence victims. The emotional labor of nurses is a key predictor of interpersonal interactions with patients and workplace misbehavior (Tepper *et al.*, 2009). Consequently, nurses exhibiting emotional labor may generate good patient treatment, using it to promote nurse–patient reciprocity. The results confirmed the mediating influence of nurse–patient treatment in the negative relationship between emotional labor and workplace violence and supported the four hypotheses in the introduction. In other words, emotional labor can improve nurse–patient interactions, reducing the probability of nurses suffering workplace violence. *A further explanation is the spread of emotional contagions based on the emotional contagion theory. In interactions between nurses and patients, the patients are impacted by the nurses' emotions. They will feel more at ease with the service provided if nurses display more positive emotions and suppress negative emotions due to emotional contagion. Patients are more likely to display less or no workplace violence toward nurses if they are satisfied with the service and the treatment of the service providers.*

The results also showed that the positive patient treatment somewhat lessened the relationship between emotional labor and workplace violence. According to prior research, emotional labor favors nursing personnel's positive patient treatment (Zhao *et al.*, 2018). We found that nurses providing positive patient care occasionally had to cope with little workplace violence from patients, their families or both. Nurses treating patients well are more likely to improve job functioning, which decreases the likelihood of impolite behavior toward patients and the frequency of communication issues – all potential factors for diminished workplace violence, according to Lagerveld *et al.* (2010). Very little research has been done on positive patient treatment as a potential mediator in the relationship between emotional labor and workplace violence. As nurses are seen as departmental representatives, their performance affects how they perceive and value their line of work. Previous studies (Aryee *et al.*, 2007; Kim *et al.*, 2020) have demonstrated significant and positive research on emotional labor. *Nurses who perform more emotional labor at work are more likely to have solid and good relationships with patients, family members or both, making them less vulnerable to workplace violence.* According to prior research, emotional labor may lessen stressful conditions at work and people's negative sentiments, which may lessen workplace violence (Glomb and Liao, 2003). The development of supporting measures is necessary to address workplace violence. Legislators and nursing administrators should consider this study's finding that nurses' emotional labor enhances patient treatment to lessen exposure to workplace violence.

The findings of this research show that there is an inverse relationship between workplace violence and organizational support. The relationship between emotional labor and workplace violence was also demonstrated to be moderated by organizational support. The results show that organizational support moderates the relationship between emotional labor and workplace violence because "exposure to workplace violence" was higher among

nurses who assessed their organizational support as low. The results further highlight the dynamic relationship between workplace violence and organizational support for emotional labor. Results specifically indicate that nurses with weaker organizational support had a higher relationship between emotional labor and exposure to workplace violence. This could be because nurses with less organizational support have more chances to make nursing mistakes or have communication problems than those with more workability.

Additionally, prior studies among health-care professionals have demonstrated a strong correlation between stress and a lack of "perceived organizational support" (Kabat-Farr *et al.*, 2019). Therefore, among nurses with higher levels of organizational support, there was a weaker negative significant relationship between emotional labor and the probability of experiencing workplace violence. The reason could be that nurses with higher levels of organizational support may have more experience or psychological resources to draw upon when coping with emotional labor than their colleagues who received lower levels of organizational support. According to this interaction effect, nurses with different degrees of self-perceived workability may experience emotional labor differently from those who do not believe in terms of exposure to workplace violence. Hospital administrators shall consider this new viewpoint as part of future hospital administration. According to recent research (Van Poel *et al.*, 2020), nurses with less organizational support are more prone to experience workplace violence, emphasizing that more attention shall be given to emotional labor and particularly true to elderly nurses, female nurses and nurses with health issues (Kadijk *et al.*, 2019). Combined with earlier studies' findings, strategies to improve nurses' organizational support include encouraging positive coping mechanisms (Kadijk *et al.*, 2019), offering organizational support and providing job resources (Boelhouwer *et al.*, 2020) – which will lessen instances of workplace violence.

6. Conclusions

Violence in the workplace directed toward nurses is frequent in Turkey, with over 95% of nurses reporting that they have experienced more than one kind of workplace violence throughout their careers. From most common to least expected, the following are the types of workplace violence to which nurses are most likely to be exposed:

- mobbing conduct;
- smearing reputation;
- physical violence;
- intimidating behavior; and
- sexual harassment.

Emotional labor and positive patient treatment were shown to be associated with violent behavior in the workplace among Turkish nurses. Within the context of this procedure, positive patient treatment was partly a mediating function. POS of nurses was shown to play a moderating role in the relationship between emotional labor and exposure to workplace violence. It was a previously unrecognized variable and mechanism in the body of prior research. It has been recommended that the management of hospitals shall construct nursing training programs to reduce the number of nurses subject to workplace violence. Nursing managers should be taught to foster organizational support and healthy working interactions. *Moreover, organizations can use various management measures to combat workplace violence against nurses. Staff training programs promoting communication skills and violence de-escalation techniques are the main interventions for managing aggressive behaviors in health-care settings* (*Dafny and Muller*, 2022; *Small et al.*, 2020)*, so nurses can respond to unpredictable environments and implement immediate interventions for their safety. According to Khan* et al. (2021)*, staff training should be more participatory, practical and less theoretical and involve real-life experiences. Finally, security guards, alarms,*

monitoring, safe refuges and access controls help nurses feel more confident when dealing with aggressive patients and their families. Safety committees and advisory boards can also evaluate workplace safety concerns and recommend interventions to reduce workplace violence (*Small et al., 2020*). *Following a violent occurrence, nurses may attend a debriefing session that gives feedback on prevention techniques in a supportive atmosphere and may include follow-up help, such as a referral to a psychologist* (*Small et al., 2020*).

The ramifications for clinical nursing practice include the recognition by health administrators and politicians that nurses are frequently subject to various types of workplace violence. The contact between supervisors and nurses and the nurse–patient connection in the nursing setting are two more factors that contribute to developing a harmonious nursing environment – the more emotional labor, the lower the workplace violence. This study stressed the advantages of emotional labor in the health-care sector and a strategy to break the vicious cycle of workplace violence. Health-care administrators should pay special attention to the impact of emotional labor on workplace violence toward nurses. More attention should be focused on nurses' emotional labor through the adoption of formal standards allowing nurses to prevent occupational health hazards and reduce the likelihood of nursing staff suffering workplace violence and mental health problems.

While this study does fill some gaps in our understanding of emotional labor and workplace violence, it also has several serious flaws that require adjusting. First, collected answers were acquired from nurses recalling their own experiences, which might have caused response bias owing to social desirability or unintended data. Second, we acknowledge that the actual completion rate was low, even if we have shown that the sample is representative of Turkish nurses and that there were no significant discrepancies across the data collecting locations. Furthermore, a cross-sectional study design could not determine the link between emotional labor and violence in the workplace. A longer-term study is needed to reveal deeper impacts in various cultural contexts. *Finally, future emotional labor research might benefit from focusing on the role of several factors in reducing or exacerbating the impact of emotional labor on workplace violence. In line with Huynh et al.'s (2008) caution about the significance of recognizing and incorporating individual differences variables and job-related as well as organizational factors in research, variables such as personalities (e.g. extraversion, neuroticism, etc.), job autonomy, tasks routines, work complexity (job-related factors) and social norms (organizational factor) can have a significant impact on emotional labor and workplace violence.*

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