

 Ozden Guduk

İstinye University, Faculty of Economics, Department of Administrative and Social Sciences, İstanbul, Türkiye

Received: 19 February, 2026

Accepted: 24 March, 2026

Published: 26 March, 2026

Corresponding Author: Ozden Guduk, İstinye University, Faculty of Economics, Department of Administrative and Social Sciences, İstanbul, Türkiye
Email: ozdenguduk@gmail.com

CITATION

Guduk O. The relationship between exposure to violence, perceived safety, and confidence, and burnout among healthcare workers: A moderation analysis. Atlantic J Med Sci Res. 2026;6(2):112-20. DOI: 10.5455/atjmed.2026.01.011

Content of this journal is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License.



INTRODUCTION

Violence is “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm,

maldevelopment, or deprivation” (1). Workplace violence is defined as violence experienced by employees in relation to their work or at the workplace, including the time spent commuting to work. The healthcare sector is recognized as one of the most vulnerable to workplace violence due to the nature of patient care and frequent interpersonal interactions (2-4).

The relationship between exposure to violence, perceived safety, and confidence, and burnout among healthcare workers: A moderation analysis

Abstract

Aim: This study examines the prevalence and types of violence healthcare workers experience, analyzing their distribution by demographic and occupational variables. It also assesses perceptions of safety, confidence, burnout levels, and the relationship between safety, confidence and burnout, considering exposure to violence as a moderating factor.

Materials and Methods: This cross-sectional study surveyed healthcare workers in direct patient contact at two public hospitals in Istanbul. A total of 410 volunteers participated, recruited through convenience sampling. Data collection tools included a sociodemographic form, questions about experiences of violence, the Health Professionals' Safety and Confidence Scale Against Violence, and the Burnout Scale-Short Form. Data were analyzed using SPSS 25.0 and Jamovi 2.6.22 software. Analyses included descriptive statistics, the chi-square test, Spearman correlation analysis, and regression-based moderator analyses using the bootstrap method ($p < 0.05$).

Results: The mean participant age was 29.8 ± 7.31 years; 74.4% were female. Of the participants, 34.6% had experienced violence at least once during their working life. Verbal violence was the most frequently reported type. No significant difference was found between overall violence experience and sociodemographic variables. However, bullying-type violence was more common among women, college graduates, nurses/midwives/emergency medical technicians, and operating room staff ($p < 0.05$). Higher perceived safety-confidence was linked to lower burnout (unstandardized $b = -0.12$; $p = 0.03$). Exposure to violence was positively associated with burnout and moderated the relationship between perceived safety and confidence and burnout, reducing the buffering role of perceived safety and confidence ($p = 0.047$).

Conclusion: Workplace violence among healthcare workers is associated with higher burnout. Perceived safety and confidence mitigate burnout, but this effect is weaker for those previously exposed to violence. Strengthening institutional security, organizational support, and providing psychological support for affected employees are critical to reducing burnout and promoting a safer work environment.

Keywords: Burnout, confidence, healthcare workers, hospital, moderation analysis, safety, workplace violence

Violence against healthcare workers is a widespread problem worldwide. As stated in joint report by the International Labour Organization (ILO) and World Health Organization (WHO), 63% of healthcare workers globally are exposed to some form of violence in the workplace (5). Between 8% and 38% of healthcare workers experience physical violence at some point in their careers, while many more experience verbal abuse or harassment (6). Meta-analyses conducted across different countries also support these findings. Studies report that the prevalence of violence against healthcare workers ranges from approximately 18% to 79% (7-10). This wide range reflects differences in study methodologies, definitions of violence, and regional reporting practices. In Türkiye, studies indicate that 30% to 61% of healthcare workers experience workplace violence during their professional lives (11-14). Overall, these figures suggest that the prevalence of violence against healthcare workers in Türkiye is broadly comparable to global rates, though differences in reporting and study design may contribute to some variation.

Violence in the healthcare sector can manifest in various forms and is generally categorized as physical and psychological violence. Physical violence refers to the use of physical force against an individual, resulting in bodily harm or injury. In contrast, psychological violence includes non-physical behaviors such as verbal abuse, mobbing, sexual harassment, and threats intended to intimidate or harm the individual. These behaviors may negatively affect the physical, mental, or social well-being of those exposed to violence (12,15). Verbal violence is reported as the most common type of violence in healthcare settings (16-18).

The University of Iowa Injury Prevention Research Center classifies workplace violence into four categories: 1) incidents involving perpetrators with no connection to the workplace (e.g., theft or robbery); 2) violence by service recipients, such as patients, relatives, or visitors in healthcare settings; 3) violence between employees; and 4) incidents stemming from employees' personal relationships, including partners or former partners (19). In healthcare organizations, workplace violence most commonly originates from patients and their relatives (4,16,17,20). Understanding the type of perpetrator helps in tailoring prevention strategies and reporting systems specific to each context.

The presence of workplace violence in healthcare negatively affects employees' psychological and physical well-being (6). Studies indicate that such incidents reduce productivity and job satisfaction, contributing to burnout and increasing intentions to leave the job (3,16,17). Exposure to aggressive behaviors also elevates stress levels and disrupts sleep (17), and may lead to low morale, depression, loss of self-esteem, irritability, difficulty concentrating, and reliving traumatic experiences (4). These outcomes can compromise patient safety by impairing healthcare worker-patient interactions, increasing medical errors, and reducing the overall quality of care (3,10,17,21). From a broader

perspective, such incidents result in substantial financial losses for healthcare institutions (6,20). Overall, stress induced by aggressive or violent interactions appears to mediate the pathway from employee well-being to patient safety and organizational outcomes.

In addition to all these negative effects, the sense of safety and confidence of healthcare workers exposed to violence in the workplace is also undermined. Studies indicate that healthcare workers who have experienced violence during their professional lives report a greater fear of being exposed to violence again, reflecting the impact of actual exposure (14,15). In contrast, even among those without prior experience of violence, many employees report concerns about being attacked at work and perceive existing security measures as inadequate, highlighting the role of perceived risk (3). Fear of violence or feeling unsafe, like experiencing violence itself, reduces organizational commitment and increases professional alienation (22). Another study reveals the partial mediating effect of fear of violence on reduced work performance (23).

Research shows that higher levels of safety and confidence against workplace violence are associated with greater psychological capital, resilience, hope, and self-efficacy among healthcare workers (24). Conversely, exposure to violence can undermine healthcare workers' sense of safety and confidence, which in turn may contribute to increased burnout. Despite these established relationships, few studies have examined how perceived safety, confidence, and actual exposure to violence jointly influence burnout, highlighting a critical gap in the literature. Therefore, research should not only investigate healthcare workers' experiences of violent incidents but also their perceptions of safety and confidence in coping with such threats."

Job burnout is a psychological syndrome resulting from chronic workplace stress, typically characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment, as described in the classical Maslach Burnout framework (25,26). In healthcare workers, burnout manifests as physical and emotional fatigue, negatively impacting well-being, job satisfaction, commitment, and performance (26-28). Considering the negative consequences of burnout for both individuals and organizations, interventions to prevent it are essential. Maintaining employee well-being, engagement, and productivity is particularly important in labor-intensive sectors such as healthcare.

Burnout is a critical concern among healthcare workers, often exacerbated by exposure to workplace violence. This study had two primary aims. The first was to examine the prevalence and types of workplace violence according to demographic and professional characteristics, and to assess healthcare workers' perceptions of safety and confidence. The second aim was to investigate the relationship between perceived safety and confidence (independent variable) and burnout (dependent variable), as well as the moderating role of violence exposure

(moderator). It was hypothesized that higher perceived safety and confidence would be associated with lower burnout, that exposure to violence would be associated with higher burnout, and that violence exposure would weaken the protective effect of safety and confidence on burnout. By explicitly examining how violence exposure moderates the relationship between perceived safety and confidence and burnout, this study addresses a significant gap in the literature and provides evidence to inform interventions aimed at enhancing workplace safety and employee well-being. Notably, this is the first study to apply moderation analysis in this context.

MATERIALS AND METHODS

This is a cross sectional study. The population of the study is healthcare workers at two public hospitals in Istanbul. The sample was obtained through convenience sampling. The study included professional groups with direct patient contact (e.g., physicians, nurses, midwives, health officers, emergency medical technicians (EMTs), radiology and anesthesiology technicians, and patient registration, reception, consultation, and referral staff), while personnel from technical services, cleaning, and cafeteria units were excluded. Participants were asked to self-report whether they had ever been exposed to any type of workplace violence-verbal, physical, sexual, or bullying-regardless of the source (patient, patient relative, coworker, or supervisor). Responses were recorded in a simple yes/no format, with no time restrictions applied. While this approach allowed efficient data collection from frontline staff, the use of convenience sampling may introduce selection bias and limit the generalizability of the findings.

According to 2024 Ministry of Health statistics, the total number of healthcare professionals in Istanbul is 153,176 (29). However, as this figure does not differentiate between public and private sectors or levels of service, the exact study population is unknown. Despite this limitation, it represents the most suitable available estimate and was therefore accepted as the population size. The minimum sample size was calculated using Cochran's formula (30), which is suitable for estimating a proportion in a large population with a specified confidence level and margin of error. A 95% confidence level and a 5% margin of error were applied. In the absence of prior prevalence data, a conservative estimate of $p=0.5$ was used to maximize the required sample size, ensuring adequate statistical power. Based on these assumptions, the theoretical target sample size was determined to be 384.

Approval was obtained from the Bartın University Social and Human Sciences Ethics Committee prior to the study (Date: 10.12.2025 and Decision Number: 22/1). All procedures were conducted in accordance with the ethical standards of the Declaration of Helsinki.

A researcher-developed questionnaire was distributed to healthcare workers via Google Forms, and written information was provided prior to participation. Participants were reached through social media groups and data were collected from

410 voluntary participants. The questionnaire comprised 31 items.

The first section included seven questions addressing participants' sociodemographic and professional characteristics (age, gender, marital status, education level, profession, years of professional experience, and unit of employment). This was followed by seven items concerning experiences of workplace violence, including the type of violence, the perpetrator, and any resulting injuries. The second section consisted of the "Safety and Confidence Scale of Healthcare Professionals," and the third section included the "Burnout Scale-Short Form."

Safety and Confidence Scale of Healthcare Professionals: The Turkish validity and reliability of the scale originally developed by Kowalenko et al. were established by Şengül et al. (12). The instrument comprises two subscales: a three-item Safety subscale and a four-item Confidence (Violence Management) subscale. All items are rated on a 10-point Likert scale, yielding total scores ranging from 7 to 70, with higher scores indicating greater perceived safety, confidence, and competence in managing violence. In the Safety subscale, the second and third items were reverse-coded in accordance with the original scale.

Cronbach's alpha coefficient for the Turkish version was 0.85 for the overall scale, 0.81 for the Safety subscale, and 0.84 for the Confidence subscale. In this study, the reliability levels of the safety ($\alpha=0.71$), confidence ($\alpha=0.86$), and safety-confidence total score ($\alpha=0.73$) were calculated.

Burnout Scale-Short Form: Originally developed by Pines and Aronson and adapted into Turkish by Çapri, this scale assesses employees' burnout levels (31). It consists of 10 items rated on a 7-point Likert scale ranging from 1 (Never) to 7 (Always). Higher scores indicate greater burnout. Mean scores of 2.4 or below reflect very low burnout; 2.5-3.4 indicate warning signs; 3.5-4.4 correspond to burnout; and 4.5-5.4 signify a severe level of burnout. Cronbach's alpha coefficients for this study was $\alpha=0.94$, indicating excellent internal consistency.

Data analysis was performed using IBM Statistical Package for the Social Sciences (SPSS) Statistics (v.25.0) and Jamovi (v.2.6.22) software. Categorical variables were summarized as frequency (n) and percentage (%), while continuous variables were summarized as mean $\pm$ standard deviation or median (IQR: interquartile range) according to their distribution characteristics. Minimum and maximum values for continuous variables were also reported. The normality assumption for continuous variables was assessed using the Shapiro-Wilk test.

Differences between groups according to sociodemographic variables were examined using the chi-square test. Relationships between variables were assessed using Spearman's rank correlation coefficient (Spearman's rho). Moderation analysis was conducted using linear regression, including an interaction term (violence exposure $\times$ safety-confidence), with 5,000 bootstrap samples. Unstandardized regression coefficients (b)

and bias-corrected 95% confidence intervals were reported. In all analyses, the statistical significance level was set at $p < 0.05$.

RESULTS

A total of 410 individuals participated in the study; the majority were female (74.4%), single (54.4%), and held an associate degree (40.7%). Most participants were nurses and related health staff (41.0%) and worked in inpatient wards (39.3%). The mean age was 29.83 ± 7.31 years, and the mean professional

experience was 6.91 ± 6.69 years (Table 1).

Overall, 34.6% of participants ($n=142$) reported experiencing workplace violence. Among those exposed (participants who reported at least one incident), verbal violence was the most common type (56.3%). When all reported incidents were considered, including multiple types per participant, verbal violence remained the most frequent (65%), followed by bullying (17%) and physical violence (16%), while sexual violence was rare (2%) (Table 2).

Table 1. Distribution of participants' demographic and professional characteristics (N=410)

Variable	n	Percentage (%)
Gender		
Female	305	74.4
Male	105	25.6
Marital Status		
Single	223	54.4
Married	187	45.6
Education level		
Primary/secondary/high school	64	15.6
Associate degree (2-year)	167	40.7
Bachelor's degree	143	34.9
Postgraduate degree	36	8.8
Profession		
Physician	55	13.4
Nurses, midwives, health officers, EMTs	168	41.0
Lab technician, radiology technician, anesthesia technician	58	14.1
Patient services staff	129	31.5
Department		
Inpatient clinic	161	39.3
Outpatient clinic	67	16.3
Administrative unit	23	5.6
Intensive care unit	36	8.8
Emergency department	12	2.9
Hospital common/service areas	28	6.8
Operating room	51	12.4
Other	32	7.8
	Mean$\pm$SD	Median
Age	29.83 $\pm$ 7.31	28
Years of work experience	6.91 $\pm$ 6.69	5

EMT: emergency medical technician

Table 2. Participants' exposure to violence and distribution of violence types (N = 410)

Exposure to violence ¹	n	Percentage (%)
Not exposed	268	65.4
Exposed	142	34.6
Type of violence experienced ²	n	Percentage (%)
Physical	32	16
Verbal	130	65
Bullying	34	17
Sexual	4	2
Combined violence types per individual ³	n	Percentage (%)
Physical	7	4.9
Physical + Verbal	21	14.8
Physical + Verbal + Bullying	3	2.1
Physical + Verbal + Bullying + Sexual	1	0.7
Verbal	80	56.3
Verbal + Bullying	22	15.5
Verbal + Bullying + Sexual	3	2.1
Bullying	5	3.5

¹: Percentages for exposure to violence were calculated based on the total sample (N=410). ²: In the section "Multiple Types of Violence Experienced Simultaneously," the total number of reported violence types was used rather than the number of individuals (n=200). ³: Percentages in the section "Type of Violence by Individual" were calculated only among participants who were exposed to violence (n=142). Participants may report more than one type of violence; therefore, percentages may exceed 100%

There was no statistically significant difference between the incidence of violence and demographic variables (gender, marital status, education, occupation, and department) ($p>0.05$). When types of violence were examined, statistically significant differences were found in terms of bullying based on gender, educational status, occupation, and department ($p<0.05$). This suggests that the rate of bullying is higher among women. Associate degree graduates experienced less bullying compared to other education levels, with bachelor's degree graduates reporting the highest rates. Approximately two-thirds (67.6%) of participants who experienced bullying were nurses, midwives, or emergency medical technicians (EMTs). Among work units, employees in the operating room reported the highest prevalence of bullying (23.5%), whereas those working in inpatient wards reported the lowest (Table 3).

The participants' mean safety score was 16.6 ± 6.64 (median=15.0; IQR=9.0), the average confidence score was 27.3 ± 9.03 (median=28.0; IQR=14.8), and the total safety and confidence score was 43.9 ± 11.4 (median=44.0; IQR=16.0). The average burnout score was 32.6 ± 12.9 , with a median value of 32.0 (IQR=16.0). Score ranges were 3–30 for safety,

4–40 for trust, 8–70 for the total safety and confidence score, and 8–70 for burnout (Table 4).

When examining the relationships between participants' demographics and their total scores for safety, and confidence, as well as burnout, it was found that the relationships between age, gender, marital status, education level, and occupation variables and the relevant scale scores were not statistically significant ($p>0.05$) (Table 5).

The moderating role of exposure to violence on the effect of safety-confidence scores on burnout was examined. According to the analysis results, safety-confidence significantly and negatively predicts burnout ($b=-0.12$, 95% CI: $-0.22 - -0.02$, $p=0.025$). Exposure to workplace violence was positively associated with burnout ($b=10.92$, 95% CI: $8.49-13.18$, $p<0.001$). Most importantly, the interaction between safety-confidence and the presence of violence is statistically significant ($b=0.23$, 95% CI: $-0.001 - 0.45$, $p=0.047$); This finding indicates that the experience of violence moderates the relationship between perceived safety and confidence and burnout, weakening the buffering effect of safety and confidence (Table 6).

Table 3. Association between demographic characteristics and exposure to workplace violence* N=410

Variable	Not Exposed (n, %)	Exposed (n, %)	P (Exposure vs no exposure)	Physical (n=32)	Verbal (n=130)	Bullying (n=34)	Sexual (n=4)	P (by violence type)
Gender			0.930					0.020*
Female	106 (74.7)	199 (74.3)		23 (71.9)	96 (73.9)	31 (91.2)	4 (100)	
Male	36 (25.4)	69 (25.8)		9 (28.1)	34 (26.2)	3 (8.8)	-	
Marital Status			0.051					0.110
Single	68 (47.9)	155 (57.8)		20 (62.5)	63 (48.5)	14 (41.2)	2 (50)	
Married	74 (52.1)	113 (42.2)		12 (37.5)	67 (51.5)	20 (58.8)	2 (50)	
Education Level			0.160					0.010*
Primary/Secondary/High school	24 (16.9)	40 (14.9)		6 (18.8)	18 (13.9)	7 (20.6)	-	
Associate degree (2-year)	51 (35.9)	116 (43.3)		14 (43.8)	50 (38.5)	5 (14.7)	-	
Bachelor's degree	49 (34.5)	94 (35.1)		12 (37.5)	46 (35.4)	15 (44.1)	3 (75)	
Postgraduate degree	18 (12.7)	18 (6.7)		-	16 (12.3)	7 (20.6)	1 (25)	
Profession			0.310					0.010*
Physician	13 (9.2)	42 (15.7)		-	13 (10.0)	1 (2.9)	-	
Nurses, midwives, health officers, EMTs	63 (44.4)	105 (39.2)		17 (53.1)	55 (42.3)	23 (67.7)	4 (100)	
Lab/radiology/anesthesia technicians	21 (14.8)	37 (13.8)		3 (9.4)	18 (13.9)	6 (17.7)	-	
Patient services staff	45 (31.7)	84 (31.3)		12 (37.5)	44 (33.9)	4 (11.8)	-	
Department			0.660					0.010*
Inpatient ward	56 (39.4)	105 (39.2)		12 (37.5)	51 (39.2)	6 (17.7)	1 (25)	
Outpatient clinic	18 (12.7)	49 (18.3)		4 (12.5)	17 (13.1)	4 (11.8)	-	
Administrative unit	10 (7.1)	13 (4.9)		1 (3.1)	9 (6.9)	4 (11.8)	1 (25)	
Intensive care unit	13 (9.2)	23 (8.6)		5 (15.6)	11 (8.5)	5 (14.7)	-	
Emergency department	5 (3.5)	7 (2.6)		1 (3.1)	5 (3.9)	2 (5.9)	-	
Hospital common/service areas	7 (4.9)	21 (7.8)		1 (3.1)	7 (5.4)	-	-	
Operating room	20 (14.1)	31 (11.6)		4 (12.5)	18 (13.9)	8 (23.5)	-	
Other	13 (9.2)	19 (7.1)		4 (12.5)	12 (9.2)	5 (14.7)	2 (50)	

* p<0.05 considered statistically significant, - : No cases observed

Table 4. Distribution of burnout, safety, and confidence scale scores (N=410)

Statistic	Safety	Confidence	Total safety-confidence	Burnout
Mean	16.6	27.3	43.9	32.6
Median	15.0	28.0	44.0	32.0
SD	6.6	9.1	11.4	12.9
IQR	9.0	14.8	16.0	16.0
Minimum	3.0	4.0	8.0	8.0
Maximum	30.0	40.0	70.0	70.0

Safety: 3-30, Confidence: 4-40, Total: 7-70, Burnout: 10-70, IQR: interquartile range, SD: standard deviation

Table 5. Participants' demographic characteristics and relationship between burnout, safety against violence, and confidence (N=410)

r	Safety	Confidence	Total safety-confidence score	Burnout
Age	-0.001	0.08	0.07	0.03
Gender	-0.05	0.06	0.02	0.07
Marital status	0.03	0.05	0.05	0.01
Education level	-0.01	0.03	0.03	0.06
Profession	-0.05	-0.08	-0.09	0.08

r: Spearman's rho correlation coefficient, * p<0.05 considered statistically significant, Categorical variables were coded numerically for correlation analysis

Table 6. Moderation analysis: effect of safety-confidence on burnout by exposure to violence (N=410)

Variable	95% confidence interval				Z-value	p-value
	Estimate (b)	Standard error (SE)	95% CI lower	95% CI upper		
Presence of violence**	-10.92	1.22	-13.18	-8.49	-8.96	<0.01**
Safety and confidence	-0.12	0.05	-0.22	-0.02	-2.25	0.03**
Presence of violence × Safety-confidence	0.23	0.12	-0.01	0.45	1.99	0.04**

• Regression-based moderation estimates, ** p<0.05 considered statistically significant, Higher b indicates direction of effect; negative values indicate burnout decreases with increasing safety-confidence

DISCUSSION

The study investigates workplace violence among healthcare workers, their perceptions of safety and confidence, and the impact of these factors on burnout.

According to this study conducted with healthcare workers employed in public hospitals, approximately one-third of participants (34.6%) reported experiencing violence during their professional carrier. The most common type of violence was verbal abuse, while bullying and physical violence mostly occurred alongside verbal abuse, whereas reports of sexual violence were relatively low. Numerous studies in the literature support these findings; approximately one-third to over one-half of healthcare workers experience violence (2,3,9,11,16), with verbal violence being the most common type (2,9,17,32-34).

The study found that, the incidence of violence among healthcare workers did not differ according to demographic variables. However, the incidence of bullying- type violence was significantly higher among women, university graduates, nurses, midwives, emergency medical technicians (EMTs) professional groups, and especially operating room staff. This difference may indicate that the risk of bullying may increase in work environments such as operating rooms, where there is high stress, a pronounced hierarchy, and a need for intense team communication. The literature indicates that women (11,13,16,34) and nurses (11,18,35) are more exposed to violence. However, some studies report that emergency departments and psychiatric units (2,17,18,36) are more at risk for violence.

Evaluation of the scale scores indicated that participants' perceptions of safety and confidence regarding workplace violence were above average but not high. The mean score for the Safety subscale suggests limited perceptions of physical and organizational safety measures, whereas the relatively higher mean score for the Confidence (violence management) subscale reflects stronger self-efficacy in coping with violent situations. These findings are consistent with previous research. Özkan and Ünal (24) reported that emergency department staff demonstrated generally above-average perceptions of safety and confidence, with higher scores in the confidence subdimension than in safety. Similarly, another study found physicians' perceived safety climate to be moderate and their confidence in managing workplace violence to range from moderate to good (36). In contrast, Yural et al. (14) reported low perceptions of safety and moderate perceptions of violence management competence among healthcare workers. Additionally, a study reported that approximately 62% of hospital employees perceived their work environment as unsafe (37). Overall, the literature suggests that healthcare professionals do not feel fully safe in their work settings. This underscores the need for targeted interventions to strengthen both organizational safety measures and staff confidence in handling violent situations.

Mean burnout scores indicated that participants were not experiencing severe burnout; however, their levels were within a risk range requiring attention. Consistent with this finding, studies conducted in Türkiye report moderate burnout levels among hospital healthcare workers (38-40). The study also

demonstrated that burnout decreased as perceived safety and confidence increased. This result suggests that the protective effect of safety and confidence on burnout varies depending on the exposure to violence; that is, the relationship is not at the same level in both groups. However, this protective effect varied according to exposure to violence; the buffering role of safety and confidence was weaker among those who had experienced violence. Specifically, healthcare workers reported lower burnout when they had higher confidence in their institution and felt safe, but this benefit was reduced following violent incidents. Supporting this, Yural et al. (14) found that perceptions of safety declined with increased exposure to violence. Repeated exposure to violence is associated with heightened fear, which creates a sustained psychological burden and reduces job performance (23). Research further shows that workplace violence leads to significant psychological and professional consequences regardless of type. Employees exposed to verbal, physical, or sexual violence frequently report anger, reduced work performance, impaired mental health, and disrupted social relationships. Physical violence, in particular, has a stronger impact on intentions to leave the job, suggesting more severe and long-term consequences as well as a higher risk of staff turnover (35). Fear of violence also decreases organizational commitment and increases professional alienation (22). Conversely, higher perceptions of safety and confidence are positively associated with psychological capital, resilience, hope, and self-efficacy among emergency department staff (33). Overall, the literature indicates that both exposure to violence and feelings of insecurity can be detrimental. Therefore, in addition to preventing workplace violence, healthcare managers should implement concrete policies and interventions that actively promote a safe work environment and strengthen employees' sense of safety and confidence.

This study has some limitations. First, the data were based on participants' self-reports. Additionally, due to the cross-sectional design, causal relationships between variables cannot be definitively inferred.

CONCLUSION

This study found that healthcare workers' perceptions of safety and confidence regarding workplace violence were above average, while their levels of burnout were within a risk range that warrants attention. The findings indicate that healthcare workers' perceptions of safety and confidence in relation to workplace violence were associated with their levels of burnout, and that past experiences of violence played a moderating role.

As the literature clearly shows, fear of violence or feelings of insecurity are as significant as exposure to violence itself, leading to considerable negative consequences. Therefore, healthcare managers should not only take measures to prevent violence in the workplace but also create work environments where employees feel safe. Consequently, the factors causing workplace violence should be investigated and addressed, and plans should be developed to protect employees when violent

incidents occur. Furthermore, supportive measures should be implemented to enhance feelings of safety and confidence, including initiatives aimed at empowering healthcare workers. Furthermore, employees exposed to violence should receive psychological support to mitigate the effects of their negative experiences.

For future research, longitudinal studies are recommended to explore the long-term effects of workplace violence on burnout, psychological well-being, and staff retention. Intervention studies should assess the effectiveness of targeted safety programs, training in violence management, and organizational support measures in improving both perceived safety and confidence. Additionally, qualitative research could provide in-depth insights into the experiences, coping strategies, and unmet needs of healthcare workers who face violence in different hospital settings, thereby guiding more tailored preventive and supportive policies.

Conflict of Interests

The authors declare that there is no conflict of interest in the study.

Financial Disclosure

The authors declare that there is no financial support.

Ethical Approval

The study protocol received approval from the Ethics Committee of Bartın University (Date: 10.12.2025 and Decision No: 22/1).

Patient Consent

The link to the questionnaire prepared by the researcher was sent to healthcare workers via Google Forms, and the necessary information was provided in writing prior to the survey.

REFERENCES

1. World Health Organization. Global status report on violence prevention 2014. Geneva: WHO; 2014.
2. Khan MN, Haq ZU, Khan M, et al. Prevalence and determinants of violence against health care workers in Peshawar. BMC Public Health. 2021;21:330.
3. Al-Sayaghi KM. Violence against healthcare workers in emergency departments of Al-Madinah hospitals. J Fam Community Med. 2023;30:307-16.
4. Lim MC, Jeffree MS, Saupin SS, et al. Workplace violence in healthcare settings: risk factors and preventive measures. Ann Med Surg (Lond). 2022;78:103727.
5. World Health Organization. Occupational health: health workers. Available from: <https://www.who.int/news-room/fact-sheets/detail/occupational-health--health-workers>. Accessed January 6, 2026.
6. World Health Organization. Preventing violence against health workers. Available from: <https://www.who.int/activities/preventing-violence-against-health-workers>. Accessed January 2, 2026.
7. Rossi MF, Beccia F, Cittadini F, et al. Workplace violence against healthcare workers: an umbrella review. Public Health. 2023;221:50-9.

8. Lu L, Dong M, Wang SB, et al. Prevalence of workplace violence against health-care professionals in China: a meta-analysis. *Trauma Violence Abuse*. 2020;21:498-509.
9. Ramzi ZS, Fatah PW, Dalvandi A. Workplace violence against healthcare workers during COVID-19: a systematic review. *Front Psychol*. 2022;13:896156.
10. Sahebi A, Golitaleb M, Moayedi S, et al. Prevalence of workplace violence against healthcare workers: an umbrella review. *Front Public Health*. 2022;10:895818.
11. Er T, Ayoglu FN, Acikgoz B. Violence against healthcare workers: risk factors and prevention. *Turk J Public Health*. 2021;19:69-78.
12. Sengul H, Bulut A, Ozgules B. Validity and reliability of the Turkish version of the health and safety scale against violence. *J Int Soc Res*. 2019;12:738-49.
13. Uskun E, Batmaz K, Aydin G. Violence against healthcare workers: a hospital-based study. *Med J SDU*. 2022;29:23-35.
14. Yural B, Acuner D, Cevik Akkus G. Perceptions of safety and confidence against violence among healthcare professionals. *J Health Nurs Manag*. 2024;11:82-90.
15. Kambur B. Relationship between fear of violence and burnout in healthcare workers. *Curr Healthc Manag*. 2025;3:12-22.
16. Bahadir Yilmaz E, Yuksel A, Mutlu H. Evaluation of violence against healthcare workers: a cross-sectional study. *Turk Klin J Forensic Med Forensic Sci*. 2022;19:158-64.
17. Chakraborty S, Mashrekly SR, Dalal K. Violence against physicians and nurses: a systematic review. *J Public Health (Berl)*. 2022;30:1837-55.
18. Civilotti C, Berlanda S, Iozzino L. Workplace violence against healthcare workers in Italy: a scoping review. *Int J Environ Res Public Health*. 2021;18:5860.
19. University of Iowa Injury Prevention Research Center. Violence in the workplace: risk factors and prevention strategies. Iowa: UIIPRC; 2001.
20. Somani R, Muntaner C, Hillan E, et al. Effectiveness of interventions to de-escalate workplace violence. *Saf Health Work*. 2021;12:289-95.
21. Chen S, Lin S, Ruan Q, et al. Workplace violence and burnout among medical staff. *Arch Environ Occup Health*. 2016;71:330-7.
22. Yalim MK, Ozkara B. Impact of fear of violence on organizational commitment. *Gaziantep Univ J Soc Sci*. 2025;24:1439-53.
23. Ugan C, Akbolat M. Mediating role of fear of violence on job performance. *J Organ Behav Stud*. 2023;3:25-37.
24. Ozkan N, Unal O. Psychological capital and safety against violence in healthcare workers. *Curr Healthc Manag*. 2023;1:1-15.
25. Maslach C, Schaufeli WB, Leiter MP. Job burnout. *Annu Rev Psychol*. 2001;52:397-422.
26. Cao Y, Gao L, Fan L, et al. Emotional intelligence and burnout among healthcare workers. *Front Public Health*. 2022;10:892421.
27. Kim S, Kitzmiller R, Baernholdt M, et al. Patient safety culture and workplace violence. *Workplace Health Saf*. 2023;71:78-88.
28. Gimenez Lozano JM, Martinez Ramon JP, Morales Rodriguez FM. Workplace violence and burnout: a systematic review. *Int J Environ Res Public Health*. 2021;18:3280.
29. Ministry of Health of Türkiye. Health Statistics Yearbook 2024. Ankara: General Directorate of Health Information Systems; 2025.
30. Cochran WG. Sampling Techniques. 3rd ed. New York: John Wiley & Sons; 1997.
31. Caprı B. Tükenmişlik ölçeğinin Türkçe uyarlaması: geçerlik ve güvenilirlik çalışması. *Mersin Univ Egit Fak Derg*. 2006;2:62-77.
32. Albay A, Nizam F. Evaluation of violence in health with white code data. *J Med Top Updates*. 2022;1:54-61.
33. Bildik B, Atis SE, Cekmen B, et al. Workplace violence in emergency departments. *Am J Emerg Med*. 2022;59:9-14.
34. Guven O, Kurt BF. Evaluation of violence in health: the case of Kırklareli. *Karya J Health Sci*. 2023;4:47-50.
35. Demirci S, Ugurluoglu O. Violence against healthcare workers in Ankara. *J Forensic Nurs*. 2020;16:E33-41.
36. Chen FL, Hou WH, Chen JH, et al. Organizational factors predicting confidence in handling workplace violence. *Healthcare (Basel)*. 2022;10:637.
37. Yakut HI, Yalcin Burhan B, Ciftci A, et al. Physical abuse and security in healthcare workplace. *Turk J Pediatr Dis*. 2012;6:146-54.
38. Celik T, Guclu A. Burnout in health institutions: a public hospital study. *Eurasian Acad Sci Soc Sci J*. 2021;35:22-41.
39. Atalay M, Cakirel Y. Workload, job satisfaction and burnout among healthcare staff. *J Manag Econ Res*. 2022;20:431-63.
40. Cevik O, Ozbaldi AA. Burnout levels and demographic characteristics of health workers. *Manas J Soc Stud*. 2020;9:1773-87.