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Examining the Relationship Between Healthcare Workers' Interpersonal Relationship Styles and Social-Emotional Competence Levels and Their Exposure to Violence

Sağlık Çalışanlarının Kişilerarası İlişki Biçimleri ve Sosyal-Duygusal Yetkinlik Düzeyleri ile Şiddete Maruz Kalma Durumları Arasındaki İlişkinin İncelenmesi

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Abstract

The study was conducted to examine the relationship between the interpersonal relationship styles and social-emotional competence levels of healthcare workers and their exposure to violence.

The descriptive study was conducted between January and December 2023. Data were collected using the Introductory Information Form, Interpersonal Relationship Dimensions Scale, and Social-Emotional Competence Scale. Student test and Pearson correlation analysis were used to evaluate the data. Logistic regression analysis was performed with the backward method to predict the exposure to violence.

75.9% of healthcare workers were female and the mean age was 35.3±9.0. 35.5% of healthcare workers stated that they had experienced violence at work during their working lives, 61.1% of whom were subjected to violence by a male patient relative, and 86.4% verbally. It has been reported that violence occurs more during the 16.01-00.00 shift, during treatment and care. It has been determined that there are differences in the exposure of healthcare workers to violence according to their interpersonal relationship styles.

It has been determined that as healthcare workers' empathy, trust in others, and emotional awareness increase in interpersonal relationships, their ability to adapt to different situations (adaptability) also increases. Healthcare workers with lower interpersonal relationship skills (level of trust in others and emotional awareness) are exposed to more violence.

Keywords: Violence, healthcare worker, interpersonal relationship, expertise

Özet

Araştırma, sağlık çalışanlarının kişilerarası ilişki biçimleri ve sosyal-duygusal yetkinlik düzeyleri ile şiddete maruz kalma durumları arasındaki ilişkiyi incelemek amacıyla yapılmıştır.

Tanımlayıcı tipteki araştırma, Ocak-Aralık 2023 tarihleri arasında yürütüldü. Veriler, *Tanıtıcı Bilgi Formu, Kişilerarası İlişki Boyutları Ölçeği (KİBO)* ve *Sosyal-Duygusal Yetkinlik Ölçeği (SDYÖ)* ile toplandı Verilerin değerlendirilmesinde Student-t testi, Pearson korelasyon analizi kullanıldı. Şiddet görme durumunu öngörmek için backward methodu ile lojistik regresyon analizi yapıldı.

Sağlık çalışanlarının %75,9'u kadın ve yaş ortalamaları 35,3±9,0'dır. Sağlık çalışanlarının %35,5'i çalışma yaşamları boyunca iş yerinde şiddeti deneyimlediğini ve bunların %61,1'i erkek hasta yakını tarafından ve %86,4'ü sözel şiddete uğradığını belirtirmiştir. Şiddetin daha çok 16.01-00.00 vardiyasında, tedavi ve bakım sırasında gerçekleştiği bildirilmiştir. Sağlık çalışanlarının, kişilerarası ilişki biçimlerine göre şiddete maruz kalma durumları arasında da fark olduğu saptanmıştır.

Sağlık çalışanlarının kişilerarası ilişkilerde *empati* yeteneği, *başkalarına güven* duyma ve *duygu farkındalığı* arttıkça farklı durumlara uyum sağlama becerilerinin de *(uyumluluk)* arttığı saptanmıştır.

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Kişilerarası ilişki becerileri (başkalarına güven düzeyi ve duygu farkındalığı) daha düşük olan sağlık çalışanları daha fazla şiddete maruz kalmaktadır.

Anahtar Kelimeler: Şiddet, sağlık çalışanı, kişilerarası ilişkiler, yetkinlik

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1. Introduction

Violence is the disproportionate use of force arising from differing opinions, and the use of threats or actions designed to cause traumatic consequences against individuals or groups (Türk Dil Kurumu (TDK), 2023; World Health Organization (WHO), 2020). Worldwide, an average of 1.4 million people die annually due to violence, which corresponds to approximately 3800 people per day (WHO, 2022). In 2019, 475,000 people died due to interpersonal violence. The risk of violence occurring in health institutions is 16 times higher than in other social areas (International Labour Organization (ILO), 2023; Uskun et al. 2022).

In healthcare institutions, the inability of patients' relatives to control their anger and impulse control or being in contact with individuals who are involuntarily brought to the healthcare institution in mandatory situations is a great source of risk for violence (Pınar & Pınar, 2013). Workplace violence negatively affects employees' physical and mental health, work performance, and quality of service (Çabuk & Menteş, 2023; Lin et al., 2015; Mento et al., 2020;). Interpersonal relationships based on mutual trust in the health sector are also important for treatment and care service delivery (Ekinci et al. 2010; Taylor et al. 2023).

Effective communication and acceptance of an empathic and patient-centered approach are of great importance in healthcare institutions (Ertekin, 2017; Okay, 2012). Negative interactions and limited communication skills are important causes of aggression and violence (Duxbury & Whittington, 2005). Effective interpersonal relationships can increase patient satisfaction and prevent negative outcomes such as possible cases of violence and prolonged hospitalization (Kumar et al. 2019)

Social-emotional competence is a skill that affects the interaction style and continuity of individuals. A high level of this competence reduces burnout and has an important role in preventing violence by increasing the ability of healthcare workers to cope with stressful situations and problem solving skills (Görgens-Ekermans & Brand, 2012; Stamouli & Gerbeth, 2021).

In light of this information, interpersonal communication styles and social-emotional competence levels of healthcare workers may be two important factors in preventing violence in healthcare. However, no study evaluating the effect of these two variables on exposure to. In this context, this study was conducted to examine the relationship between healthcare workers' interpersonal relationship skills social-emotional competencies and their exposure to violence. The following questions will be examined within the scope of the research.

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1. *Do healthcare workers' views on the predisposing factors of violence affect their exposure to violence?*
2. *Do the total and subscale mean scores of the Interpersonal Relationship Dimensions Scale (SIRD) of healthcare workers affect their exposure to violence?*
3. *Do the total and subscale mean scores of the Social-Emotional Expetise Scale (SEES) of healthcare workers affect their exposure to violence?*

2. Method

2.1. Type and Time

The descriptive (cross-sectional) and analytical (correlational) study was conducted between January and December 2023.

2.2. Population and Sample of the Study

The study was conducted with healthcare workers (N=225) working in a district state hospital in western Turkey. No sample selection was made and 166 healthcare workers (73.7% of the population) participated in the study. Of the participants, 54.2% (n=90) were nurses, 17.5% (n=29) were physicians, 16.9% (n=28) were midwives, and 11.4% (n=19) were other health professionals (medical secretaries, health officers).

2.3. Data Collection and Data Tools

In the study, the views and experiences of healthcare workers (physicians, nurses, midwives, etc.) on the predisposing factors of violence, interpersonal relationship styles, and social-emotional competence levels constituted the independent variables, and the exposure of healthcare workers to violence constituted the dependent variable.

Three measurement tools were used to obtain research data.

2.3.1 Introductory Information Form: The first part of the form, which consisted of two parts, included questions prepared by the researcher about sociodemographic and occupational characteristics, while the second part included questions containing data on the individual's exposure to violence. It consisted of a total of 30 open-ended and closed-ended questions.

2.3.2 Scale of Interpersonal Relationship Dimensions (SIRD): The validity, reliability, and development of the SIRD, which is used to evaluate Scale of Interpersonal Relationship Dimensions, was conducted by İmamoğlu (2009). In the reliability analyses, Cronbach's Alpha internal consistency coefficients for the sub-dimensions of the SIRD were found between 0.78 and 0.85. The scale consists of 53 5-point Likert-type questions. The scale has four dimensions. These are Consent Dependency (15 items), Empathy (9 items), Trust in Others (15 items), and Emotion Awareness (14 items) (İmamoğlu & Aydın, 2009). The scale is evaluated based on the mean scores of the subscales. For this sample group, the Cronbach's Alpha reliability values for the sub-dimensions of the scale were 0.87, 0.83, 0.72, and 0.88, respectively.

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2.3.3. Social Emotional Expertise Scale (SEES): The social-emotional concept was developed by McBrien, Wild, and Bachorowski (2018). The scale was adapted to Turkish, and its validity and reliability were conducted by Ay and Temel (2021). In the reliability analyses, Cronbach's Alpha internal consistency coefficients for the sub-dimensions of the SEES were found between 0.74 and 0.85. The 25-item scale consists of two sub-dimensions. The “adaptability” sub-dimension measures the ability to adapt to different situations; the “expressiveness” sub-dimension measures the ability to express one's feelings towards others (Ay & Temel, 2021). The Cronbach Alpha reliability values for the total and sub-dimensions of the scale for this sample group were 0.92, 0.88, and 0.83, respectively.

2.4. Ethical Aspects of the Research

The study protocol was conducted in accordance with the Declaration of Helsinki. Data were collected after obtaining permission for the measurement tools used in the study from the scale authors, the Non-Interventional Research Ethics Committee of a university (dated 26.01.2023, Decision No. 0025 and No. 0029), and the institutional administration. In addition, the healthcare professionals who participated in the study were informed that the information would remain confidential and would not be used anywhere else except for the rise.

2.5. Limitations of the Study

The fact that the study was conducted with healthcare professionals working in a single state hospital in a district is a limitation that leads to the conclusion that the results cannot be generali

2.6. Analysis and Evaluation of Data

Statistical Package for Social Sciences (SPSS) 20.0 package program was used to evaluate the data. In descriptive statistical evaluations, categorical variables were presented as numbers, and continuous variables were presented as mean, standard deviation, and median (minimum-maximum). The conformity of the variables to normal distribution was examined using visual and analytical methods. Pearson chi-square test was used to compare categorical variables in independent groups. Student-t test was used in the evaluation of independent groups with normal distribution. Pearson correlation analysis was performed to evaluate the relationships of continuous variables and correlation coefficients (r) were evaluated as 0.0-0.19 “very weak”, 0.20-0.39 “weak”, 0.40-0.59 “moderate”, 0.60-0.79 “strong”, 0.80-1.00 “very strong”. Logistic regression analysis was performed with the backward method to predict the level of violence. In this study, the statistical significance level was accepted as $p<0.05$.

3. Results

According to Table 1, 75.9% of the healthcare workers were female and 65.1% were married. Of the healthcare workers who participated in the study, 44.0% were undergraduate graduates and 54.2% were nurses. 33.1% of the healthcare workers work in inpatient services and 36.1% in emergency services, 83.7% of the healthcare workers work day and night, and 71.7% work 40-56 hours a week.

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Table 1. Distribution of Healthcare Workers According to Their Sociodemographic and Occupational Characteristics, Their Views on Risk Factors for Violence and Their Experience of Violence During Their Working Life

		n	(%)
Age	Ort ± Standart Sapma Medyan (Min-Max)	35.3 ± 9.0 33 (21-57)	
Gender	Woman	126	75.9
	Male	40	24.1
Education Status	High School	47	28.3
	License	73	44.0
	Associate Degree	14	8.4
	Postgraduate	32	19.3
Marital Status	Single	58	34.9
	Married	108	65.1
Number of Children	No	73	44.0
	1 Child	41	24.7
	2 Children	40	24.1
	3 Children	11	6.6
	4 Children	1	0.6
Duration of employment at the hospital (years)	Mean ± Standard Deviation Median (Min-Max)	7,5 ± 6,8 5 (0,5-39,0)	
Profession	Physician	29	17.5
	Nurse	90	54.2
	Midwife	28	16.9
	Other	19	11.4
Worked Unit	Inpatient wards	55	33.1
	Emergency service	60	36.1
	Polyclinic	23	13.9
	Other (intensive care, operating room...)	28	16.9
Mode of Operation	Daytime only	27	16.3
	Only Night	-	-
	Day-Night	139	83.7
Weekly Working Hours	40 hours	24	14.5
	40-56 hours	119	71.7
	56 hours and above	23	13.9
Perception of Self	I am a cheerful-happy person	73	44.0
	I am a calm-patient person	60	36.1
	I am a stressed-tense person	20	12.0
	I am anxious-anxious	11	6.6
	I am an angry person	2	1.2
Smoking Status	Not using	91	54.8
	Using	75	45.2

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Table 1. Distribution of Healthcare Workers According to Their Sociodemographic and Occupational Characteristics, Their Views on Risk Factors for Violence and Their Experience of Violence During Their Working Life (continued)

		n	(%)
Factors Affecting Service Delivery Negatively	No	42	25.3
	Yes	124	74.7
	Inadequate physical conditions of the hospital	-	-
	Excessive workload	20	12.0
	Excessive working time	12	7.2
	Material shortage	8	4.8
	Intense and stressful working environment	44	26.5
	High number of patients per health worker	30	18.1
	Relationship between team members	3	1.8
	Other	7	4.2
Individual Factors Preventing Communication	No	24	14.5
	Yes	142	85.5
	Tense, anxious (pain, etc.), distressed patients and their relatives	33	19.9
	The patient and the patient's relatives making impossible requests	64	38.6
	I am reluctant to communicate	15	9.0
	I don't feel tired, sleepless, exhausted	22	13.2
	Having personal problems	3	1.8
	Insufficient job satisfaction	5	3.0
Environmental Factors	No	-	-
	Yes	166	100.0
	Excessive noise and stimuli	45	27.2
	Non-distance environment	39	23.5
	High number of patients receiving service	51	30.7
	Long working hours	17	10.2
	High number of break and rest hours	-	-
	Shift working conditions	10	6.0
Exposure to Violence	Not subjected to violence	107	64.5
	Subjected to violence	59	35.5
Number of Exposure to Violence	1 time	34	57.6
	2 times	16	27.1
	3 or more times	9	15.3
Perpetrator of Violence	Patient relatives	33	55.9
	Patient	21	35.6
	Hospital employee	3	5.1
	I don't remember	2	3.4
Gender of the Perpetrator	Female	19	32.1
	Male	36	61.1
	Both sexes	4	6.8
Age of Perpetrator	Mean ± Standard Deviation	36.0 ± 8.8	
	Median (Min-Max)	35 (20 - 60)	

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Table 1. Distribution of Healthcare Workers According to Their Sociodemographic and Occupational Characteristics, Their Views on Risk Factors for Violence and Their Experience of Violence During Their Working Life (continued)

		n	(%)
Type of Violence	Verbal violence	51	86.4
	Verbal discussion	28	47.5
	Threatening	12	20.3
	Swearing	6	10.2
	Humiliation	5	8.5
	Physical violence	4	6.8
	Don't shoot	*2*	*3.4*
	With object	*1*	*1.7*
	Other	*1*	*1.7*
	Emotional violence	4	6.8
Estimated Time Interval of Violence	08.01-16.00	21	35.6
	16.01-00.00	33	55.9
	00.01-08.00	5	8.5
Waiting Time of the Perpetrator	Mean ± Standard Deviation	9.8 ± 32.9	
	Median (Min-Max)	15 (0 - 240)	
The Procedure in Place at The Time of The Violence	Treatment and care	24	40.7
	Patient examination	14	23.7
	Resting-eating	9	15.3
	Invasive interventions	7	11.9
	Examination procedures (x-ray etc.)	3	5.1
	Other	2	3.4
Reaction After Violence	I didn't fight back	29	49.2
	I reciprocated	23	39.0
	Other	7	11.9
Emotions After Violence	Fear	6	10.2
	Anger	33	55.9
	Concern	13	22.0
	I didn't feel anything	7	11.9
Managing the Aftermath of Violence	The person spontaneously walked away	27	45.8
	I gave a code white	16	27.1
	The hospital police intervened.	2	3.4
	A report was filed, I filed a complaint	5	8.5
Measures Taken by the Institution After the Violence	Security guard stationed at the unit	26	44.1
	Hospital police came for regular check-up Security cameras installed in the unit	3	5.1
	Panic button made (for code white)	2	3.4
	Nothing was done	2	3.4
TOTAL		166	100

As seen in Table 1, 44.0% of healthcare workers describe themselves as cheerful-happy, 36.1% as calm-patient, 12.0% as stressed-tense, 6.6% as anxious-anxious, 1.2% as angry, and 54.8% do not smoke. 74.7% of healthcare workers think that there are factors that negatively affect service delivery; 26.5% listed intense and stressful working environments, 18.1% listed excessive number of patients,

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12.0% listed workload, 4.8% listed long working hours, 4.8% listed insufficient materials, and 1.8% listed the relationship between team members as factors that negatively affect service delivery (Table 1).

When healthcare workers were asked whether there are individual and environmental factors that prevent communication with patients and their relatives in the environment where they work, 85.5% stated that there are and all of them stated that there are environmental factors that prevent communication. 38.6% of the healthcare workers stated that impossible requests of patients and their relatives, tension (19.9%), fatigue (13.2%), reluctance (9.0%), low job satisfaction (3.0%), and personal problems (1.8%) were the individual factors preventing communication and 30.7% listed an excessive number of patients, 27.2% listed noise, 23.5% listed lack of social distance, 10.2% listed long working hours and 6.0% listed shift working conditions as environmental factors hindering communication (Table 1).

When the opinions of health workers regarding their experiences of violence throughout their working lives are examined, 35.5% of healthcare workers stated that they had experienced violence at the workplace during their working life and 42.4% of them had been subjected to violence more than once. 55.9% of healthcare workers have been subjected to violence by patient relatives, 35.6% by patients, 5.1% by hospital staff; 61.1% have been subjected to violence by a female, and 32.1% by a male individual. 86.4% of healthcare workers have been subjected to verbal violence, 6.8% to physical violence, and 6.8% to emotional violence. 55.9% of healthcare workers stated that the incidents of violence against healthcare workers occurred between 16.01-00.00 and 35.6% between 8.01-16.00, 40.7% during treatment and care, 23.7% during the examination, 15.3% during rest-meal, 11.9% during the invasive intervention and 5.1% during the examination, and the perpetrators of violence waited for an average of 9.8±32.9 minutes. 55.9% of healthcare workers stated that they felt anger, 22.0% felt anxiety, 10.2% felt fear and 49.2% did not respond in any way after the violence. After the violence, 45.8% stated that the perpetrator spontaneously left, 27.1% gave a white code, 15.3% reconciled, 8.5% filed a report and 3.4% stated that the hospital police intervened. After the violence, 44.1% stated that measures such as security guards, 5.1% hospital police control, 3.4% security cameras, and 3.4% panic buttons were taken in the unit where they work. In addition, 44.1% stated that no measures were taken (Table 1).

There was a significant positive moderate correlation (r_E=-0,343, $p<0.01$) between the mean score of the Compatibility subscale of the SEES and the mean score of the Empathy subscale of the SIRD, and a significant positive mild correlation (r_{TO}=0,172, $p<0.05$; r_{EA}=0,188, $p<0.05$) between the mean scores of the Trust in Others and Emotion Awareness subscales. There was a significant positive and moderate correlation (r_E=-0,381, $p<0.01$) between the mean scores of the Narrativism subscale of the SEES and only the mean scores of the Empathy subscale of the SIRD (Table 2).

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Table 2: The Relationship Between the Total and Subscale Scores of the Scale of Interpersonal Relationship Dimensions (SIRD) and Social-Emotional Expertise Scale (SEES) of Healthcare Workers

TOTAL AND SUBSCALE DIMENSIONS			Scale of Interpersonal Relationship Dimensions (SIRD)					Social-Emotional Expertise Scale (SEES)		
			KİBÖ Toplam	Consent Addiction	Empathy	Trust in Others	Emotion Awareness	SEESTotal	Compatibility	Narrativism
Scale of Interpersonal Relationship Dimensions (SIRD)	Consent Addiction	r		1	0.067	**-0.342****	**-0.422****	0.002	-0.021	-0.038
		p			0.391	**0.000**	**0.000**	0.981	0.785	0.623
		N			166	**166**	**166**	166	166	166
	Empathy	r			1	**0.346***	**0.234***	**0.376****	**0.343****	**0.381****
		p				**0.001**	**0.002**	**0.000**	**0.000**	**0.000**
		N				**166**	**166**	**166**	**166**	**166**
	Trust in Others	r				1	**0.639***	**0.157***	**0,172***	0.113
		p					**0.001**	**0.044**	**0.027**	0.146
		N					**166**	**166**	**166**	166
	Emotion Awareness	r					1	0.143	**0.188***	0.055
		p						0.066	**0.016**	0.485
		N						166	**166**	166
Social-Emotional Expertise Scale (SEES)	SEESTotal	r							**0.970****	**0.923****
		p						1	**0.001**	**0.001**
		N							**166**	**166**
	Compatibility	r							**1**	**0.802****
		p								**0.001**
		N								**166**
	Narrativism	r								1
		p								
		N								

p<0,05, ** p<0,001

It was found that there was a difference between the exposure to violence according to the opinions of healthcare workers and that there were individual factors that prevented communication with patients and their relatives in the unit where they worked (p<0.05) (Table 3).

Table 3: Distribution of Healthcare Workers' Exposure to Violence According to Total and Subscale Scores of Scale of Interpersonal Relationship Dimensions (SIRD) and Social-Emotional Expertise Scale (SEES)

TOTAL AND SUBSCALE DIMENSIONS		Exposure to Violence		
		Exposed	Not Exposed	p
		X ± Ss	X ± Ss	
Scale of Interpersonal Relationship Dimensions (SIRD)	Consent Addiction	47.4 ± 10.8	47.3 ± 9.9	0.957
	Empathy	34.0 ± 5,9	35.1 ± 5.7	0.270
	Trust in Others	47,3 ± 8.0	50.6 ± 6.3	**0.003***
	Emotion Awareness	44.5 ± 11.4	48.4 ± 8.1	**0.012***
Social-Sensory Expertise Scale (SEES)	SEESTotal	93.9 ± 12.5	95.9 ± 11.9	0.314
	Compatibility	60.2 ± 8.1	61.5 ± 7.7	0.299
	Narrativism	33.7 ± 5.1	34.4 ± 4.9	0.405

N=166, *p<0,05, *p<0,001

There is a significant difference between the mean scores of the Trust in Others, Emotion Awareness subscale scores total scale scores of the SIRD, and the exposure to violence (p<0.05). The logistic regression model of the factors affecting exposure to violence showed that a 1-unit increase in the

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“Trust in Others” sub-dimension score of the SEES decreases the risk of violence by 6 units (CI: 2%-11%) and this was statistically significant (p<0.05). According to the results of the analysis, health workers' trust in others explains 10.3% of the factors affecting exposure to violence (R^2=0.103) (Table 4).

Table 4: Logistic Regression Model of Factors Affecting Health Workers' Exposure to Violence

	Unstandardized Beta Coefficient	Standard Deviation	Wald	p	OR	OR (%95 GA)	
						Min	*Max*
Fixed	1,691	1,302	1,688	0,194			
Trust in others	-0,067	0,024	7,584	**0,006**	0,94	0,89	0,98
Individual factor preventing communication (ref: none)	1,116	0,582	3,671	0,055	3,05	0,98	9,56

4. Result

The healthcare workers who participated in the study were female, had undergraduate or graduate degrees, and the mean age was 35.3±9.0 years. Most the healthcare workers work 40-56 hours per week in day and night shifts in units where there is direct contact with patients; 13.9% of them work more than 56 hours per week (Er et al., 2021). According to the Civil Servants Law No. 657, the weekly working time of civil servants is 40 hours and according to Law No. 2368, the working time of healthcare professionals is 45 hours per week (Official Gazette, December 31, 1980, Issue: 17207 Repeated, Ministry of Health). It is stated that the maximum working time suitable for human physiology is 7.5 hours per day and 45 hours per week (Er et al., 2021). In line with this information, it can be said that long working hours increase the risk of violence by increasing fatigue and stress, triggering burnout and depression (Shemtob et al., 2022; Afonso et al., 2017). In support of this idea, healthcare professionals also stated that long working hours, high number of patients and workload, and intense and stressful work environments negatively affect healthcare service delivery.

The majority (76.1%) of the healthcare workers who participated in the study described themselves as cheerful-happy, calm-patient, while 19.2% described themselves as stressed, tense, anxious-anxious, and angry. In addition, similar to the studies in the literature, almost half of them (45.2%) stated that they smoked (Yılmaz and Onan 2021). This finding may be noteworthy in terms of evaluating the relationship between personality traits and smoking, which may pose a risk for violence, and v

Approximately one-third of the healthcare workers who participated in the study have been subjected to violence at least once usually by a male patient or patient relative. The mean age of the perpetrators was 36.0±8.8 years. In the literature, the rates of exposure to violence among healthcare workers vary between 30% and 95% (Aydemir et al., 2020; Uskun et al, 2022; Üzümcü, 2019). Similar to the findings of the study, young and male patient relatives are considered a risky group in terms of violence against healthcare workers in the literature (Hatunoğlu et al., 2014; Şahiner et al., 2018; Bekar & Çevik, 2021; Edward et al., 2016).

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Most of the healthcare workers (86.4%; n=51) who stated that they had been exposed to violence were mostly exposed to verbal violence (in the form of arguing, threatening, swearing, insulting), and to a lesser extent to physical (hitting, using objects, etc.) and emotional violence. In the literature, it is stated that healthcare workers are mostly exposed to verbal violence and to a lesser extent to physical violence and that this violence often occurs in inpatient wards, emergency services, and outpatient clinics (Üzümcü, 2019; Bekar &Çevik, 2021). In this study, a large proportion of healthcare workers stated that they work in inpatient wards, emergency departments, and outpatient clinics. Accordingly, it can be said that the cases of violence in the field of health occur in units where there is direct contact with the patient and it is important to start intervention studies to prevent workplace violence in the field of health primarily in inpatient wards, emergency departments and outpatient clinics.

Incidents of violence against healthcare workers occurred frequently between 16.01-00.00 hours, during treatment-care, patient examination, invasive interventions, examination procedures, and resting-dining. According to health workers, the perpetrator of violence waited an estimated average of 9.8 (±32.9) minutes for the intervention to be performed. Similarly, in different studies in the literature, it is stated that more violence occurs when patients wait too long during examinations, treatments, and examinations, when there is a delay in accessing services, and when there is limited number of employees during meal times and visits (İlhan et al., 2013; Öz, 2020; Hoşgör & Türkmen, 2021). In line with these data, the risk of violence is higher during interventions where healthcare workers come into contact with the patient and in situations that cause prolonged waiting time (such as eating, resting, and visiting). The inviolability of the human body is constitutionally protected (Article 17 of the Constitution: ...Except in cases of medical necessity and as prescribed by law, the bodily integrity of the person cannot be touched; he/she cannot be subjected to scientific and medical experiments without his/her consent) (Constitution of the Republic of Turkey 1982. Official Gazette of the Republic of Turkey. November 9, 1982. Article 17). Healthcare workers are one of the limited professional groups that have the right to touch a person's bodily integrity. However, even though a professional has such a right, touching a person's bodily integrity requires a relationship of trust, in other words, a bond between the service provider (physician, nurse) and the service recipient (patient, patient's relatives). This requires healthcare professionals to be attentive and have some special skills prior to the intervention. Although health professionals acquire these competencies through both professional and in-service training, these competencies of health professionals may be disabled in acute situations where the life of the service recipient is endangered, or the bonding necessary for a relationship of trust may lose its priority. In this case, situations such as danger, unknown, uncertainty, etc. experienced by service recipients increase anxiety. Similarly, every minute that the service recipient (patient, patient's relatives) cannot get information increases this uncertainty and anxiety even more. This may further increase the likelihood of violence against healthcare workers (Lim et al. 2022; McGuire et al. 2021). For this reason, it is important to take the necessary measures and improvements in areas that harbor all these risks (insufficient number of healthcare workers, excessive workload, long waiting time, etc.) in the units where healthcare service delivery takes place in order to prevent violence against healthcare workers.

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When the process after the violence was evaluated, about half of the healthcare workers who were exposed to violence reacted to the perpetrator after the violence, while the other half stated that they did not react at all. When healthcare workers were asked what they felt after the violence they experienced, similar to previous studies (Arnetz & Arnetz, 2001; Gerberich et al., 2004; Lanctôt & Guay, 2014), they stated that they felt “anger”, “anxiety”, and “fear” respectively, and approximately one in ten (11.9%) stated that they did not feel anything. When analyzing how they managed the process after the incident of violence, a significant proportion of health professionals (64.5%; n=38) did not exhibit a proactive attitude (the person walked away on their own, the person was reconciled with the person, the hospital police intervened) and showed a more passive-silent approach in the face of violence, while a relatively smaller proportion (36.5%; n=21) exhibited an entrepreneurial attitude (giving a code white, filing a report-complaint). When asked whether the organization they were working for took any measures after the incident of violence, approximately half of them stated that security measures were increased in the unit they were working in, while the other half stated that no measures were taken. In similar studies, it was determined that health professionals manage the process after violence in a similar way, and very few of them prefer to resort to legal remedies due to their belief that they cannot get legal results (Aydemir et al. 2020; Er et al., 2021). Not doing anything or adopting a passive attitude after each experience of violence will give hope for the repetition of the violence. For this reason, the reasons why healthcare workers cannot exhibit a more entrepreneurial approach after experiencing violence should be further investigated and comprehensive training structured with a multidisciplinary team approach (consisting of law enforcement officers, lawyers, etc.) should be planned to help them manage the post-violence process more effectively.

As the empathy ability of healthcare professionals increases, their ability to express their feelings towards others (expressiveness), adaptation to different situations, and social sensory expertise increase. In addition, as their trust in others and emotional awareness increase, their ability to adapt to different situations and their social sensory expertise also increase. This creates a safer and more open communication environment while establishing interpersonal relationships with patients, allowing health professionals to do their jobs more efficiently and effectively (Moudatsou et al., 2020; DiBlasio and Barazandeh 2020). Healthcare professionals with high empathy and emotional awareness (interpersonal skills) were also found to have higher social-emotional competencies and adaptability. Although no direct relationship was found between social-emotional competence and exposure to violence, a negative correlation was found between interpersonal skills (especially trust in others) and exposure to violence. This suggests that interpersonal relationship style plays a mediating role in the relationship between social-emotional competence and exposure to violence. Furthermore, in the literature, it is stated that good communication skills reduce the rate of exposure to violence (İnanıcı et al., 2020). In addition, it is stated that healthcare workers who trust others have higher anger control and manage their emotions better in times of crisis (Mert et al., 2019). According to the regression analysis, it was determined that a 1-unit change in trust in others caused a 6-unit change in exposure to violence, and trust in others explained 10% of the exposure to violence. Changes in the healthcare system in recent years have brought about some challenging working conditions (overwork, overpatient load, lack of equipment, an intense and stressful working environment with noise and

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excessive stimuli, insufficient autonomy, low job satisfaction, physical and mental burnout, etc.) as expressed by healthcare workers. All these conditions increase the feeling of worthlessness in healthcare workers from time to time, reduce trust in others, attachment (taking responsibility), and future expectations, and may lead to loss of empathy tolerance and intolerance (Di Prinzio et al., 2022; Volger et al., 2018). When the healthcare worker experiencing intolerance and burnout and the anxious patient or patient's relatives who are uncertainty come face to face, the possibility of violence may be inevitable for the healthcare worker providing treatment and care services. Therefore, this finding is valuable in terms of revealing that developing a sense of trust in healthcare workers is an effective factor in reducing workplace violence.

5. Conclusion

It was determined that the interpersonal relationship skills and social-emotional competencies of the healthcare professionals participating in the study were at a good level in a positive direction. It was determined that healthcare workers who are empathic, trust others and have emotional awareness have higher adaptability (agreeableness), and healthcare workers with high empathy skills have a better emotional expression (expressiveness). Sociodemographic and occupational characteristics of healthcare workers and their views on the predisposing factors of violence do not affect their exposure to violence. Only a smaller proportion of healthcare workers who think that there are individual factors that prevent them from communicating with patients and their relatives in the unit where they work are exposed to violence. While health workers' exposure to violence does not change according to their social-emotional competencies, their interpersonal relationship skills affect their exposure to violence. Healthcare workers who trust others and have higher emotional awareness are exposed to violence less frequently. Healthcare workers' exposure to violence varies negatively with their views on the existence of individual factors that prevent them from communicating with patients and their relatives in the unit where they work, their trust in others, and their emotional awareness.

According to the results obtained from the study conducted to examine the relationship between interpersonal relationship skills and social-emotional competencies of healthcare workers and their exposure to violence, the level of trust in other healthcare workers was found to be a risk factor for exposure to violence. Accordingly, it is necessary to conduct qualitative studies that examine in depth the interpersonal relationship skills that cause health workers to be exposed to violence, to create interventions to improve health workers' sense of trust in others in both vocational training and in-service training programs in order to prevent violence against health workers, to develop interventions to improve individual and environmental factors (long working hours, high number of patients, high workload, inadequate materials, an intense and stressful working environment with noise and excessive stimuli, being physically and mentally exhausted, low job satisfaction, etc.) that cause a decrease in the sense of trust in others in health workers.), interventions need to be developed. In addition, in units where violence against health workers is more likely to occur (especially in inpatient services, emergency departments, and outpatient clinics), serious security measures should be established or existing security measures should be increased for people (especially young adults (average age 36) and male patient relatives) and situations that are more likely to commit violence

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against health workers, It is recommended to provide training on protection from the types of violence (especially verbal violence) that health care workers are more frequently exposed to, to provide information to health care workers on situations where the risk of violence is high (such as treatment-care, patient examination, invasive interventions, examination procedures and prolonged waiting time of the patient/patient's relatives due to resting and eating) and how to manage a possible risk of violence that may arise in these situations and where they can apply. In addition, it is recommended that health workers who have been exposed to violence should be provided with professional support when necessary to manage the emotions (anger, anxiety fear, etc.) they feel during and after the violence; empathy, trust in others and emotional awareness should be developed in interpersonal relationships in order to increase the social cohesion of health workers in their working environments; and research should be conducted to examine the relationship between their ability to manage emotions and their exposure to violence

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Conflict of Interest

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