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ARAŞTIRMA MAKALESİ / RESEARCH ARTICLE

EXAMINATION OF THE RELATIONSHIPS BETWEEN EXPOSURE TO VIOLENCE AND OCCUPATIONAL BURNOUT AMONG HEALTH CARE WORKERS*

ŞİDDETE MARUZ KALMA DURUMU İLE SAĞLIK ÇALIŞANLARINDA MESLEKİ TÜKENMİŞLİK ARASINDAKİ İLİŞKİLERİN İNCELENMESİ

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ABSTRACT

The primary aim of the study is to examine the relationship between exposure to violence and occupational burnout among healthcare workers. Additionally, a secondary objective of the research is to investigate differences in perceptions of exposure to violence and occupational burnout across demographic groups. The study adopts a relational research design, a type of quantitative methodology. Data are collected from 361 individuals working in both private and public sectors in Bolu, Düzce, and Zonguldak through a survey technique. The collected data are analysed using the SPSS and AMOS software package programmes and frequency analysis, factor analysis, normality tests, t-tests, ANOVA, and chi-square tests are made. According to the findings of the frequency analysis, the most commonly reported forms of violence experienced are verbal harassment and mobbing/bullying. The factor analysis reveals four factors related to occupational burnout: depersonalization, emotional exhaustion, personal accomplishment, and empathy. The results of difference analyses indicate significant differences between exposure to violence and the dimensions of occupational burnout, with the greatest differences occurring between emotional exhaustion and depersonalization. Furthermore, the chi-square analysis reveals significant associations between exposure to violence and certain demographic characteristics.

Keywords: Exposure to Violence, Occupational Burnout, Healthcare Workers.

JEL Classification Codes: M12, I12.

ÖZ

Bu çalışmanın temel amacı şiddete maruz kalma durumu ile sağlık çalışanlarında mesleki tükenmişlik arasındaki ilişkilerin incelenmesidir. Ayrıca demografik gruplar arasında şiddete maruz kalma durumuna ve mesleki tükenmişliğe yönelik algılar arasından farklılıkları incelemek araştırmanın alt amaçlarındandır. Çalışmada nicel araştırma yöntemlerinden ilişkisel araştırma deseni kullanılmıştır. Anket tekniği ile Bolu, Düzce ve Zonguldak illerinde özel ve kamuda çalışan 361 kişiden veriler toplanmıştır. Toplanan veriler SPSS ve AMOS paket programı kullanılarak frekans analizi, faktör analizi, normallik testi, t-testi, ANOVA ve ki-kare testleri uygulanmıştır. Yapılan frekans analizi bulgularına göre en fazla şiddete maruz kalma durumunun mobing/zorbalık ve sözel taciz olduğu ortaya çıkmıştır. Yapılan faktör analizi bulgularına göre mesleki tükenmişlik ile ilgili dört boyut ortaya çıkmıştır. Bunlar duyarsızlaşma, duygusal tükenme, empati ve kişisel başarıdır. Yapılan farklılık analizi bulgularına göre şiddete maruz kalma durumu ile mesleki tükenmişlik boyutları arasında anlamlı farklılıklar tespit edilmiştir. En fazla farklılık duygusal tükenme ile duyarsızlaşma boyutu arasında gerçekleşmiştir. Yapılan ki-kare analizi bulgularına göre de şiddete maruz kalma ile demografik özellikler arasında ilişkiler tespit edilmiştir.

Anahtar Kelimeler: Şiddete Maruz Kalma, Mesleki Tükenmişlik, Sağlık Çalışanları.

JEL Sınıflandırma Kodları: M12, I12.

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EXTENDED SUMMARY

Purpose and Scope:

Healthcare services play a crucial role in the functioning of society, as they involve constant interaction with people, urgency, pain, and the delicate nature of the human body. In this regard, one of the most significant and increasingly prevalent issues in healthcare institutions today is violence (Estryn-Behar et al., 2008; Kahriman, 2014; Yaşayancan et al., 2015; Mento et al., 2020; Ünal et al., 2021). Exposure to violence has been shown not only to increase levels of stress, depression, and anxiety among employees, but also to cause to psychological issues such as low self-esteem and reduced focus at work (Kaukiainen et al., 2001; Hegney et al., 2010). Accordingly, the primary aim of the study is to examine the relationship between exposure to violence and professional burnout among healthcare workers. A secondary objective is to explore whether perceptions of exposure to violence and levels of burnout differ across demographic groups. A review of the literature reveals that several survey-based studies investigate the prevalence of violence experienced by healthcare workers (Taş & Çevik, 2006; Çoşkun & Öztürk, 2010; Kahriman, 2014; Akbaş et al., 2016; Cenk & Karahan, 2019; İkışık et al., 2021). Moreover, previous research explores associations between exposure to violence and various factors such as job satisfaction (Bahar et al., 2015), lifestyle (Yaşayancan et al., 2015), personality traits (Ünal et al., 2021), propensity for violence (Yağcan, 2022), and anxiety levels (Gökçe & Dündar, 2008). As for professional burnout, it is a widely studied topic in the healthcare field (De Hert, 2020; Woo et al., 2020; Shah et al., 2021; Izdebski et al., 2023). However, research specifically examining the relationship between exposure to violence and professional burnout among healthcare workers remains limited. Where such studies exist, they typically focus on specific clinical settings (e.g., emergency departments) or professional groups (e.g., nurses). The study, by contrast, investigates both public and private hospital employees, encompassing a broader range of healthcare professions. It seeks to determine which dimensions of professional burnout are most strongly associated with exposure to violence. The findings aim to provide practical insights for healthcare administrators, helping them identify the areas in which interventions are most needed to improve employee motivation and well-being.

Design/methodology/approach:

Considering the purpose and subject of the research, the relational (correlational) research design from quantitative research methods is thought to be the most appropriate method. The correlational research method involves either exploratory studies, which aim to identify potential relationships between variables, or predictive studies**,** which seek to explain changes in a dependent variable based on one or more independent variables (Büyüköztürk et al., 2018, p. 17). Based on the literature review, it is hypothesized that there may be a relationship between exposure to violence and occupational burnout. It is also hypothesized that perceptions of exposure to violence and perceptions of occupational burnout differ across demographic groups. The study population consisted of healthcare workers employed in both the public and private sectors. Using a convenience sampling method, data are collected through an online survey administered in the provinces of Bolu, Düzce, and Zonguldak. After excluding incomplete or erroneous responses from 380 surveys received, analyses are conducted on 361 valid cases. In the study, data are collected using the survey technique. The data are collected between January 23 and February 23, 2025. The obtained data are analysed using the SPSS and AMOS software packages, applying frequency analysis, factor analysis, normality test, t-test, ANOVA, and chi-square tests.

Findings:

According to the results of the frequency analysis, the most common forms of exposure to violence are mobbing/bullying and verbal harassment. The findings of the factor analysis revealed four dimensions of professional burnout. These are depersonalization, emotional exhaustion, personal accomplishment, and empathy. The results of the difference analysis indicate significant variations between exposure to violence and the dimensions of professional burnout, with the greatest differences observed in the emotional exhaustion and depersonalization dimensions. Furthermore, the chi-square analysis shows significant relationships between exposure to violence and demographic characteristics.

Conclusion and Discussion:

According to the findings of the factor analysis, four dimensions emerge in the study. These are depersonalization, emotional exhaustion, personal accomplishment, and empathy. While the Maslach Burnout Inventory (Maslach & Jackson, 1981) consists of three dimensions, the results of the exploratory factor analysis conducted in the study identify a fourth dimension, named “empathy.” The items included in the personal accomplishment factor are divided into two sub-dimensions in the factor analysis. According to the results of the t-test conducted between exposure to violence and the dimensions of professional burnout, emotional exhaustion and depersonalization are found to be more strongly associated with professional burnout. The analysis reveals no significant relationship between personal accomplishment and professional burnout. The results reveal a significant relationship between the empathy dimension and exposure to verbal harassment. These results are consistent with the findings of Looff et al. (2018). Significant differences are found between exposure to violence and demographic characteristics. The findings indicate that physical violence is more frequently associated with male participants, whereas mobbing/bullying is more frequently associated with female participants. These results are consistent with the findings of Estryn-Behar et al. (2008). It may be suggested that psychological rehabilitation programs should be developed for healthcare workers who are exposed to violence. Considering that individuals prone to violence often have lower levels of education (Bahar et al., 2015), it is also recommended to provide training for employees in this regard and to increase the number of support staff.

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GENİŞLETİLMİŞ ÖZET

Amaç ve Kapsam:

Sağlık hizmetleri toplumun işleyişinde önemli yere sahiptir. Çünkü insanlarla sürekli etkileşimin, aciliyetin, ağrının ve insan bedeni hassasiyetinin yüksek olduğu bir çalışma alanıdır. Bu doğrultuda günümüzde sağlık kurumlarında artış gösteren problemlerden en önemlisi şiddettir (Estryn-Behar vd., 2008; Kahriman, 2014; Yaşayancan vd., 2015; Mento vd., 2020; Ünal vd., 2021). Şiddete maruz kalmanın, çalışanlar arasında stres, depresyon ve kaygı düzeylerini artırmakla kalmayıp, aynı zamanda düşük özsaygı ve işte azalmış odaklanma gibi psikolojik sorunlara da yol açtığı gösterilmiştir (Kaukiainen vd., 2001; Hegney vd., 2010). Bu kapsamda çalışmanın temel amacı şiddete maruz kalma durumu ile sağlık çalışanlarında mesleki tükenmişlik arasındaki ilişkilerin incelenmesidir. Ayrıca demografik gruplar arasında şiddete maruz kalma durumuna ve mesleki tükenmişliğe yönelik algılar arasından farklılıkları incelemek araştırmanın alt amaçlarındandır. Literatür incelendiğinde sağlık çalışanları ile ilgili şiddete maruz kalma durumuna yönelik tarama çalışmalarının olduğu görülmektedir (Taş ve Çevik, 2006; Çoşkun ve Öztürk, 2010; Kahriman, 2014; Akbaş vd., 2016; Cenk ve Karahan, 2019; İkiışık vd., 2021). Ayrıca şiddete maruz kalma durumu ile iş doyumu (Bahar vd., 2015), yaşam biçimi (Yaşayancan vd., 2015), kişilik özellikleri (Ünal vd., 2021), şiddet eğilimi (Yağcan, 2022), kaygı düzeyi (Gökçe ve Dündar, 2008) arasında ilişkilerin incelendiği görülmektedir. Mesleki tükenmişlik ile ilgili olarak sağlık sektöründe tarama çalışmalarının sıkça çalışıldığı görülmektedir (De Hert, 2020; Woo vd., 2020; Shah vd., 2021; Izdebski vd., 2023). Fakat sağlık çalışanlarında şiddete maruz kalma ile mesleki tükenmişlik arasında ilişkinin incelendiği çalışmalar nadirdir. Sağlık sektöründe şiddete maruz kalma ile tükenmişlik arasındaki ilişki belli klinik (acil servis gibi) veya meslek (hemşire) düzeyinde incelenmiştir. Bu çalışma ile hem özel hem de kamu hastaneleri çalışanları üzerinde inceleme yapılmıştır. Ayrıca sağlık çalışanlarının meslekleri daha geniş bir şekilde ele alınarak incelenmiştir. Sağlık çalışanlarının şiddete maruz kalma durumlarının mesleki tükenmişlik boyutlarından hangisi/hangileri ile ilişkili olduğu önem arz etmektedir. Bu çalışmanın sonuçları uygulayıcılara çalışanların hangi alanda motive edileceği konusunda rehber niteliğindedir.

Yöntem:

Araştırmanın amacı ile konusu dikkate alındığında nicel araştırma yöntemlerinden ilişkisel araştırma deseninin en uygun yöntem olacağı düşünülmüştür. İlişkisel araştırma yöntemi bir veya daha çok bağımsız değişkene bağlı olarak bağımlı değişkendeki değişmeleri açıklamaya yönelik yordayıcı ilişkisel araştırma ya da değişkenler arası olası ilişkileri belirlemeye yönelik keşfedici ilişkisel araştırmalardır (Büyüköztürk vd., 2018, s. 17). Literatür incelemesi sonucunda şiddete maruz kalma ile mesleki tükenmişlik arasında ilişkilerin olabileceği düşünülmüştür. Ayrıca demografik gruplar arasında şiddete maruz kalma durumuna yönelik algılamanın ve mesleki tükenmişliğe yönelik algılamanın farklılık gösterdiği düşünülmüştür. Çalışmanın evrenini kamu ve özel sektörde faaliyet gösteren sağlık çalışanları oluşturmaktadır. Kolayda örneklem yönteminin kullanıldığı araştırmada dijital araçlar kullanılarak Bolu, Düzce ve Zonguldak illerinden anket tekniği ile veriler toplanmıştır. Toplanan 380 anketten eksik ve hatalı olanlar çıkarıldıktan sonra 361 veri üzerinden analizler yapılmıştır. Araştırmada anket tekniği yöntemi kullanılarak veriler toplanmıştır. Veriler 23 Ocak-23 Şubat 2025 tarihleri arasında toplanmıştır. Toplanan verilere AMOS ve SPSS paket programı kullanılarak frekans analizi, faktör analizi, normallik testi, t-testi, ANOVA ve ki-kare testleri uygulanmıştır.

Bulgular:

Yapılan frekans analizi bulgularına göre en fazla şiddete maruz kalma durumunun mobbing/zorbalık ve sözel taciz olduğu ortaya çıkmıştır. Yapılan faktör analizi bulgularına göre mesleki tükenmişlik ile ilgili dört boyut ortaya çıkmıştır. Bunlar duyarsızlaşma, duygusal tükenme, empati ve kişisel başarıdır. Yapılan farklılık analizi bulgularına göre şiddete maruz kalma durumu ile mesleki tükenmişlik faktörleri arasında anlamlı farklılıklar tespit edilmiştir. En fazla farklılık duygusal tükenme ile duyarsızlaşma boyutu arasında gerçekleşmiştir. Yapılan ki-kare analizi bulgularına göre de şiddete maruz kalma ile demografik özellikler arasında ilişkiler tespit edilmiştir.

Sonuç ve Tartışma:

Yapılan faktör analizi bulgularına göre bu çalışmada dört faktör ortaya çıkmıştır. Bunlar duyarsızlaşma, duygusal tükenme, kişisel başarı ve empatidir. Maslach Tükenmişlik ölçeğinde (Maslach ve Jackson, 1981) üç boyut bulunurken bu çalışmada yapılan açıklayıcı faktör analizi sonuçlarına göre dördüncü faktör "empati" boyutu olarak isimlendirilmiştir. Kişisel başarı faktörü içerisinde yer alan ifadeler faktör analizinde iki alt boyut olarak ayrılmıştır. Şiddete maruz kalma ile mesleki tükenmişlik boyutları arasında yapılan t-testi bulgularına göre duygusal tükenme ve duyarsızlaşma boyutlarının mesleki tükenmişlik ile daha fazla ilişkili olduğu anlaşılmaktadır. Kişisel başarı ile mesleki tükenmişlik arasında herhangi bir ilişkiye rastlanmamıştır. Empati boyutu ile sözel tacize maruz kalma arasında anlamlı ilişki çıkmıştır. Bu sonuçlar ile de Looff vd. (2018) çalışması benzerlik göstermektedir. Şiddete maruz kalma durumu ile demografik özellikler arasında anlamlı farklılıklar ortaya çıkmıştır. Bulgular incelendiğinde fiziksel şiddet ile erkeklerin daha fazla ilişkili olduğu, mobbing/zorbalık şiddet türünde ise kadınların erkeklere göre daha fazla ilişkili olduğu anlaşılmaktadır. Bu sonuçlar Estryn-Behar vd., (2008) çalışması ile benzerlik göstermektedir. Şiddete maruz kalan sağlık çalışanlarına yönelik psikolojik rehabilitasyon programlarının geliştirilmesi önerilebilir. Şiddete meyilli kişilerin eğitim düzeyinin düşük olduğu göz önüne alındığında (Bahar vd., 2015) çalışanların bu yönde eğitilmesi ve yardımcı personel sayısının arttırılması önerilebilir.

1. INTRODUCTION

Health services have an important place in the functioning of society, as they involve constant interaction with individuals, high levels of urgency, pain, and sensitivity related to the human body. In this direction, the most important problem that is increasing in health institutions today is violence (Estryn-Behar et al., 2008; Kahriman, 2014; Yaşayancan et al., 2015; Mento et al., 2020; Ünal et al., 2021). Violent incidents in the health sector can obstruct the delivery of essential health services for society (Ünal et al., 2021). Reports titled *"Workplace Violence in the Health Sector"* by the World Health Organization (WHO), the International Council of Nurses (ICN) and the International Labor Organization (ILO, 2002), indicate that more than 50% of healthcare professionals have been exposed to violence at some point during their careers (Er, 2021). Although employees in all sectors may encounter workplace violence, it is well-documented that healthcare workers are disproportionately affected (Calnan, 2012). Research has shown that healthcare professionals often perceive such incidents as a routine part of their job and only categorize severe physical harm as actual violence (Batmaz et al., 2022). Departments with the highest reported rates of violence include the Emergency Department (54.9%), Psychiatry (54.5%), Neurology (39.5%), Geriatrics (39.7%), and Pediatrics (32.3%) (Hıdıroğlu et al., 2019). Violence not only increases stress, depression, and anxiety among healthcare workers but also contributes to psychological issues such as low self-esteem and decreased concentration (Kaukiainen et al., 2001; Hegney et al., 2010).

Violence in healthcare settings leads to a range of negative consequences for professionals, one of the most significant being occupational burnout. Burnout syndrome is a critical issue across various professions (Calnan, 2012). Originally introduced by Freudenberger in 1974, burnout is defined as the depletion of an individual's internal resources due to failure, frustration, unmet expectations, and loss of energy or strength (Kırılmaz et al., 2003). It is characterized by mental, emotional, and physical exhaustion resulting from prolonged stress and excessive workload (Tuğrul & Çelik, 2002), and can lead to symptoms such as reduced motivation, decreased work performance, and unfavorable self-comparisons.

The primary aim of this research is to examine the relationship between exposure to violence and occupational burnout among healthcare workers. A secondary aim is to explore differences in perceptions of exposure to violence and burnout across various demographic groups. The literature review reveals that there are a significant number of studies examining healthcare workers' exposure to violence (Taş & Çevik, 2006; Çoşkun & Öztürk, 2010; Kahriman, 2014; Akbaş et al., 2016; Cenk & Karahan, 2019; İkışık et al., 2021). In addition, researchers have investigated the relationship between exposure to violence and variables such as job satisfaction (Bahar et al., 2015), lifestyle (Yaşayancan et al., 2015), personality traits (Ünal et al., 2021), propensity for violence (Yağcan, 2022), and anxiety levels (Gökçe & Dündar, 2008). Similarly, extensive research has been conducted on occupational burnout in the healthcare sector (De Hert, 2020; Woo et al., 2020; Shah et al., 2021; Izdebski et al., 2023). However, studies specifically addressing the relationship between exposure to violence and burnout among healthcare workers are relatively scarce. Where such studies exist, they tend to focus on particular clinical departments (e.g., emergency services) or specific professions (e.g., nurses). In contrast, the present study examines both private and public sector healthcare professionals across a variety of occupational roles. Identifying which dimensions of burnout are most closely related to exposure to violence is critical. The findings aim to inform practitioners and policymakers about strategies to support and motivate healthcare employees more effectively.

2. LITERATURE

2.1. Exposure to Violence

Violence is defined as any situation in which employees are threatened, abused, attacked or subjected to other aggressive behaviors in connection with their work (Mento et al., 2020; Hoşgör & Türkmen, 2021). WHO defines violence as "a situation that results in, or is likely to result in, injury, death, psychological harm, maldevelopment, or deprivation to the exposed person as a result of the deliberate application of physical force or power, in the form of a threat or act, against another person" (WHO, 2021). A more comprehensive definition describes workplace violence as any incident or behavior in which employees are abused, threatened, or assaulted—including during their commute to or from work—or that involves an explicit or implicit threat to their safety, well-being, or health (Richards, 2003).

When examining the types of violence, they include verbal and sexual abuse, physical violence and threats, murder, behaviors that create an environment of fear, stalking, bullying—whether among employees or between managers

and employees—behaviors involving violence in the workplace that cause stress or avoidance, and mobbing (psychological violence) (Mayhew & Chappell, 2001). Di Martino (2003) categorizes violence into two main forms: physical and psychological. According to this classification, the types of violence include assault, threats, abuse, harassment, and mobbing.

One of the sectors most severely affected by workplace violence is the healthcare sector. Research has consistently shown that employees working in healthcare institutions are frequently subjected to verbal and physical assaults. In fact, studies indicate that healthcare workers are exposed to violence up to 16 times more often than employees in other sectors (Hoşgör & Türkmen, 2021). Violence in healthcare is defined as any incident that involves threatening verbal abuse, behavior or assault by a patient or others that poses a risk to the healthcare professional. (Saines, 1999, p. 8–12; Bahar et al., 2015). The main types of violence encountered in the healthcare setting include psychological violence, verbal abuse, sexual harassment, and physical assault (Mento et al., 2020). According to a report published by WHO in 2021, between 8% and 38% of healthcare workers have been exposed to physical violence—primarily in the form of threats and verbal abuse—from patients and visitors (WHO, 2021).

According to a study conducted on nurses in ten European countries, violence was reported to occur most frequently in psychiatric units, geriatric care, and emergency departments (Estryn-Behar et al., 2008). Similarly, a systematic literature review found that the highest incidence of violence was observed in emergency services, psychiatric and geriatric units, as well as in outpatient clinics and waiting rooms (Mento et al., 2020).

A study conducted with 112 emergency healthcare workers in Gaziantep revealed that 86.8% of participants had experienced verbal violence, and 69.7% reported having been exposed to at least one form of violence during their careers (Özdemir, 2018).

In a study on pediatric nurses in Konya, 68% of participants reported exposure to verbal violence (Bahar et al., 2015). Likewise, a study involving physicians at a training and research hospital in Istanbul found that 79.4% had been subjected to verbal violence, while 49.3% stated they had experienced some form of violence at least once in their professional lives (İkışık et al., 2021).

Research conducted in a public hospital demonstrated that nearly all nurses had encountered at least one form of workplace violence during their careers, with verbal violence being the most common type (Cerit et al., 2017).

Another study from a hospital in Istanbul found that 86% of nurses had been exposed to verbal violence, and 50.4% to physical violence. The most frequent forms of verbal violence included insults, swearing, threats, humiliation, and verbal sexual abuse, while physical violence commonly involved pushing, slapping, object throwing, punching, kicking, biting, and sexual harassment (Çoşkun & Öztürk, 2010).

A study conducted with research assistants at the Faculty of Medicine of Gaziosmanpaşa University indicated that the emergency department was the setting where violence occurred most frequently. Participants attributed the primary cause of violence to systemic issues in the healthcare system, and suggested that empathy and the presence of security personnel could help prevent such incidents (Yaşayancan et al., 2015).

Similarly, a study conducted in a private hospital in Sakarya concluded that verbal violence was the most commonly experienced form, followed by physical violence (Ünal et al., 2021).

2.2. Occupational Burnout

Burnout is defined as a state of failure, emotional exhaustion, depletion of energy and strength, and a sense of inadequacy that arises from unmet expectations and internal frustration. It is also described as a process that develops when interpersonal relationships at work become increasingly difficult, leading individuals to believe that something is inherently wrong in their professional environment. The concept of burnout was first introduced by Freudenberger in 1974. Today, burnout is increasingly recognized as not only an occupational hazard but also a broader social issue (Sart et al., 2018, p. 123–124).

Occupational burnout is defined as “a state in which individuals are unable to perform their duties due to factors such as excessive workload, stress, and job dissatisfaction” (Önsal, 2017, p. 508). The Turkish Language Association (TDK) defines burnout as “a state of losing one’s strength and ceasing to make an effort” (TDK, 2024). Moreover, occupational burnout is widely recognized as a process that develops within the work

environment and can reach severe levels if early symptoms are not addressed in a timely manner (Budak & Sürgevil, 2005).

Professional burnout is described as a state in which an individual becomes disconnected from the essence, meaning, and purpose of their profession and no longer genuinely cares about the people they serve (Maslach, 2003). According to Maslach and Jackson (1981), professional burnout consists of three dimensions: emotional exhaustion, depersonalization, and reduced personal accomplishment. Emotional Exhaustion refers to feelings of being emotionally overwhelmed and depleted at work. Individuals experiencing this dimension may feel disillusioned with their job and mentally drained after work**.** Depersonalization involves developing a detached or indifferent attitude toward clients or patients. It can manifest as harsh behavior, emotional distance, or blaming others for problems. Reduced Personal Accomplishment is defined as a decline in feelings of competence and success in one's professional role. This dimension may also include a lack of empathy and diminished ability to understand others' emotions. In addition to the Maslach Burnout Inventory (MBI), alternative tools are also used to measure burnout. One such instrument is the Copenhagen Burnout Inventory (CBI)**,** developed by Kristensen et al. (2005). The CBI also includes three dimensions: personal burnout, work-related burnout, and client-related burnout (Yıldırım & İçerli, 2010).

As a result of occupational burnout and its effects on individuals, various adverse outcomes may occur, such as economic difficulties, deterioration of mental and physical health, loss of personal peace and happiness, post-traumatic stress disorder, and a lack of energy to sustain daily life. These outcomes are observed more frequently in the healthcare sector compared to other industries. Physical and psychological consequences, emotional suppression, and unaddressed feelings often lead to learned helplessness, withdrawal from the work environment, increased sick leave, absenteeism, deviant workplace behavior, and a heightened intention to resign (Agervold & Mikkelsen, 2004). As occupational burnout increases, life satisfaction tends to decrease. Due to factors such as high-stress environments and excessive workloads, it is anticipated that healthcare workers are more likely to experience burnout than individuals in other sectors (Uzun & Tortumlu, 2022). Therefore, ensuring that physicians and healthcare professionals work in safe, violence-free environments is essential to prevent burnout, maintain their professional performance, and ensure the continuity of healthcare services (İkiışık et al., 2021). Increased workload has been shown to negatively affect both job satisfaction and productivity among healthcare professionals (Yaşayancan, 2015). In order to enhance the quality of service in healthcare institutions and achieve organizational goals, healthcare workers must operate willingly, effectively, and efficiently (Bahar et al., 2015).

2.3. The Relationship Between Exposure to Violence and Occupational Burnout

In recent years, violence against employees in various institutions has been increasing and has become a serious issue affecting professionals across all sectors (Bahar et al., 2015). Studies in the literature have indicated that violent incidents occurring in the healthcare sector are associated with factors such as occupational burnout, job dissatisfaction, stress, fear, anger, and low motivation (Kahriman, 2014). A selection of relevant research findings is presented below.

According to the findings of research conducted on nurses in ten European countries (Belgium, Slovakia, Germany, Italy, England, France, Norway, Finland, the Netherlands, and Poland), exposure to moderate and high levels of violence was found to significantly cause to high levels of occupational burnout. The research also revealed that exposure to violence was associated with an increased intention to transfer to another institution or leave the nursing profession entirely. Additionally, the findings indicated that younger nurses, male nurses, and nursing assistants were at a higher risk of experiencing violence compared to older nurses, female nurses, and specialized nurses (Estryn-Behar et al., 2008).

A systematic literature review revealed that exposure to violence leads to feelings of anger, guilt, insecurity, and burnout. It was also reported that, between 2004 and 2015, doctors and nurses in the United States experienced the highest rates of verbal abuse (Mento et al., 2020).

In a study conducted on forensic psychiatric nurses, physical violence was found to be associated with emotional exhaustion and depersonalization (de Looff et al., 2018).

According to the results of one study, 44.4% of healthcare workers who were exposed to violence reported experiencing professional burnout, and 27.0% stated that their perspective on the profession had changed (Özdemir

et al., 2018). Another study indicated that 12.8% of nurses exposed to violence expressed a desire to leave the profession (Kahriman, 2014).

In the research by Bahar et al. (2015), it was found that pediatric nurses exposed to verbal violence had a more negative perception of job satisfaction compared to other nurses.

In the study conducted by Coşkun and Öztürk (2010), it was established that single nurses had more night shifts in the working schedule, and nurses working during the day perceived the work environment as safer than those working night shifts. Additionally, those with longer tenures in the profession and hospital were more likely to work daytime shifts, and this difference was found to be statistically significant.

Yaşayancan et al. (2015) concluded that research assistants exposed to violence at the faculty of medicine experienced a decline in professional performance, psychological problems, and considered resigning or changing departments. The study also found that more than half of the research assistants had considered resigning at least once, despite stating that the medical faculty they chose was among their top five preferences.

In the research by Ünal et al. (2021), it was found that male employees were exposed to more violence than females, doctors more than nurses, older individuals more than younger ones, employees with longer work experience more than those with fewer years of service, and individuals with higher education levels more than those with lower education levels.

Based on the literature review, it is suggested that there may be relationships between exposure to violence, occupational burnout, and demographic variables. The main hypotheses formulated in this context are as follows:

H_1: There is a significant difference between participants' exposure to violence groups (yes/no) and their perception of professional burnout.

H_2: There are significant differences between participants'demographic characteristics and their perceptions of exposure to violence.

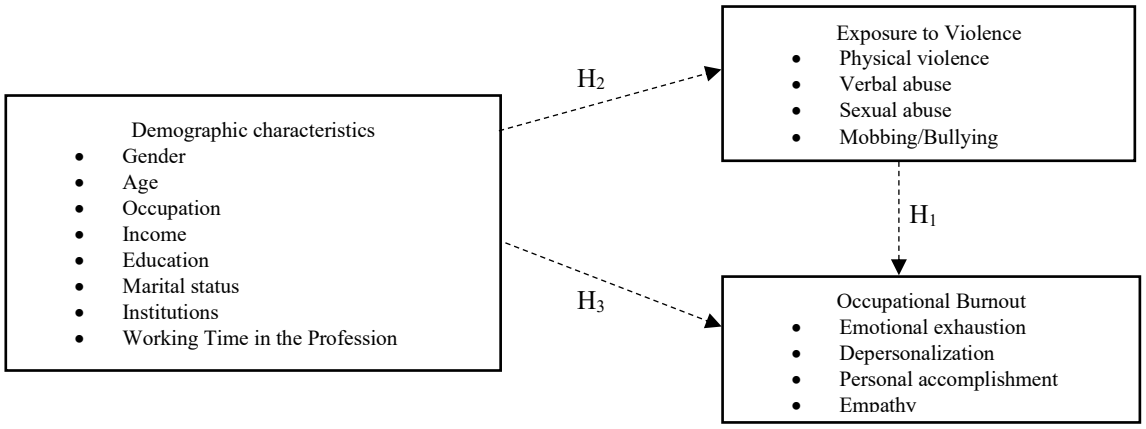
H_3: There is a significant relationship between participants' demographic characteristics and their perceptions of exposure to violence.

3. METHOD

3.1. Aim and Model of the Research

The primary objective of this research is to investigate the effect of exposure to violence on occupational burnout among healthcare workers. In line with this objective and the scope of the research, the correlational research design, a subtype of quantitative research methods, was deemed most appropriate. Correlational research can be classified as predictive, which aims to explain changes in a dependent variable based on one or more independent variables, or exploratory, which seeks to identify the relationships between variables (Büyüköztürk et al., 2018, p. 17). The research model is shown in Figure 1.

Figure 1. Research model



3.2. Hypotheses

As a result of the literature review, it is thought that there may be a relationship between exposure to violence and occupational burnout (Estryn-Behar et al., 2008; Çoşkun & Öztürk, 2010; Kahriman, 2014; Bahar et al., 2015; Yaşayancan et al., 2015; de Looff et al., 2018; Özdemir et al., 2018; Mento et al., 2020; Ünal et al., 2021). In addition, it is thought that the perception of exposure to violence and the perception of occupational burnout differ among demographic groups. The hypotheses to be tested in the study are as follows;

Main and sub-hypotheses:

H_1: There is a significant difference between the participants' exposure to violence groups (yes/no) and their perception of professional burnout.

$H_{1a,b,c,d}$: There is a significant difference between the participants' perception of emotional exhaustion and a) exposure to physical violence, b) exposure to verbal harassment, c) exposure to sexual harassment, d) mobbing/bullying.

$H_{1e,f,g,h}$: There is a significant difference between the participants' perception of depersonalization and e) exposure to physical violence, f) exposure to verbal harassment, g) exposure to sexual harassment, h) mobbing/bullying.

$H_{1i,j,k,l}$: There is a significant difference between the participants' perception of personal accomplishment and i) exposure to physical violence, j) exposure to verbal harassment, k) exposure to sexual harassment, l) mobbing/bullying.

$H_{1m,n,o,p}$: There is a significant difference between participants' perception of empathy and m) exposure to physical violence, n) exposure to verbal harassment, o) exposure to sexual harassment, p) mobbing/bullying.

H_2: There are significant differences between participants' demographic characteristics and their perceptions of exposure to violence.

$H_{2a,b,c,d,e,f,g,h}$: There is a significant relationship between participants' the perceptions regarding occupational burnout according to their a) gender, b) age, c) marital status, d) education, e) income status, f) profession, g) institution, h) years of working in the profession.

H_3: There is a significant relationship between participants' demographic characteristics and their perceptions of exposure to violence.

$H_{3a,b,c,d,e,f,g,h}$: There is a significant relationship between participants' the perceptions regarding exposure to violence according to their a) gender, b) age, c) marital status, d) education, e) income status, f) profession, g) institution, and h) years of working in the profession.

3.3. Sampling

The population of the study consists of healthcare workers employed in both the private and public sectors. Utilizing the convenience sampling method, data were collected through digital tools and a survey technique in the provinces of Bolu, Düzce, and Zonguldak. Following the elimination of incomplete and erroneous responses from the 380 surveys collected, analyses were carried out on a final sample of 361 valid responses. According to Karagöz and Kösterelioğlu (2008, p. 85), the sample size should typically be between 5 and 10 times the number of variables.

3.4. Data Collection Tools

Ethical approval for the present study was obtained from the Scientific Research and Publication Ethics Committee of Düzce University (Meeting No: 1, Decision No: 2025/39, Date: 23/01/2025). Data were collected between January 23 and February 23, 2025, using a survey technique.

The scales used in the study are valid and reliable instruments frequently utilized in the literature. The Exposure to Violence Scale was adapted from Bahar et al. (2015) and consists of four items: physical violence, verbal abuse, sexual abuse, and threats/psychological violence. Responses were recorded using a dichotomous format (1 = Yes, 2 = No).

The Maslach Burnout Inventory (MBI), developed by Maslach and Jackson (1981), was used to measure occupational burnout. The scale was adapted into Turkish by Ergin (1992) in the study titled *"Burnout in Doctors and Nurses and Adaptation of the Maslach Burnout Scale."* The inventory consists of 22 items and measures three

dimensions: Emotional exhaustion**,** depersonalization**,** and personal accomplishment. A 5-point Likert-type scale was used for responses (1 = Never, 5 = Always). The collected data were analyzed using the AMOS and **SPSS** software. Descriptive statistics, exploratory factor analysis (EFA), confirmatory factor analysis (CFA), normality tests, independent samples t-tests, chi-square tests, and one-way ANOVA were conducted.

3.5. Limitations of the Study

The primary limitation of this study is that the data were collected cross-sectionally during January and February 2025, which prevents causal interpretations. Additionally, the use of a convenience sampling method restricts the generalizability of the findings to a broader population. Another limitation is the focus solely on healthcare workers, excluding other occupational groups. Moreover, the research sample was limited to participants from three provinces—Bolu, Düzce, and Zonguldak—which may further affect the representativeness of the results.

4. FINDINGS

This section presents the analysis results of the study data conducted using the SPSS software. It includes the findings of frequency analysis, followed by factor analysis, normality testing, and difference analyses.

4.1. Demographic Findings

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

Table 1. Demographic Findings

Demographic information		n	%	Demographic information		n	%
Gender	Male	113	31.3	Occupation	Doctor	22	6.1
	Female	248	68.7		Nurse	118	32.7
Age	18-25	67	18.6		Midwife	29	8.0
	26-33	148	41.0		Administrator	14	3.9
	34-41	63	17.5		Administrative personnel	63	17.5
	42-49	57	15.8		Health technician	54	15.0
	≥50	26	7.2		Emergency Medical Technician	46	12.7
Marital status	Married	227	62.9		Others	15	4.2
	Single	134	37.1	Institution	Public hospital	303	83.9
Educational level	High school and below	33	9.1		Private hospital	58	16.1
	Associate degree	89	24.7	Working Time in the Professior	<1 year	18	5.0
	Undergraduate	202	56.0		1-5 year	114	31.6
	Postgraduate	37	10.2		6-10 year	74	20.5
Income	≤20,000 TL	35	9.7		11-15 year	61	16.9
	20,001-50,000 TL	126	34.9		≥16 year	94	26.0
	≥50,001 TL	200	55.4				
	Total	361	100.0		Total	361	100.0

Upon examination of Table 1, it is evident that the majority of survey participants are women (68.7%). This finding is consistent with broader trends in Turkey and globally, where women constitute the majority of healthcare professionals (Çelik, 2024). Regarding age distribution, the 26–33 age group represents the largest portion of participants (41%). When combined with the 18–25 age group (18.6%), it can be concluded that most respondents are relatively young. The data also indicate that a majority of participants are married (62.9%). In terms of educational background, most respondents hold a university-level degree, including associate degrees (24.7%), bachelor's degrees (56%), and postgraduate degrees (10.2%). When examining income levels, more than half of the participants (55.4%) report earning 50,000 TL or more. Analysis of occupational distribution reveals participation across a wide range of roles within healthcare institutions. The most represented occupational groups are nurses, administrative personnel, and health technicians, respectively. The "other" category includes physiotherapists, anesthesiology technicians, psychologists, technicians, audiometrists, and laboratory personnel. The "management" group comprises hospital managers, assistant managers, and unit managers, while the

"administrative" group includes civil servants, secretaries, and support staff. The majority of participants are employed in the public sector (83.9%). Given the relatively young age profile, it is not surprising that a large proportion of respondents have 1–5 years of professional experience (31.6%). Meanwhile, 26% have 16 or more years of experience, suggesting that the sample includes both early-career and seasoned professionals.

4.2. Descriptive Findings on Exposure to Violence

Descriptive statistics related to exposure to violence, which serves as the independent variable in this study, are presented in Table 2.

Table 2. Descriptive Findings on Exposure to Violence

		n	%
Exposure to physical violence	Yes	51	14.1
	No	310	85.9
Verbal abuse	Yes	191	52.9
	No	170	47.1
Sexual abuse	Yes	15	4.2
	No	346	95.8
Mobbing/Bullying	Yes	217	60.1
	No	143	39.6

When Table 2 is examined, it is observed that the survey participants are generally exposed to violence. The most common types of violence reported are "mobbing/bullying" (60.1%) and "verbal abuse" (52.9%). In contrast, the least frequently reported types of violence are "sexual abuse" (4.2%) and "physical violence" (14.1%).

4.3. Occupational Burnout Factor Analysis Findings (CFA and DFA)

The factor analysis findings related to occupational burnout, which constitutes the dependent variable of this study, are presented in Table 3.

Table 3. Occupational Burnout Factor Analysis Findings

Dimensions	Items	Factor loads	Standardized Regression Weights	AVE	CR	Eigenvalue	Variance Explained	Cronbach' Alpha
Emotional exhaustion	EE2	0.816	0,769	0,58	0,92	6.932	34.661	0.917
	EE3	0.807	0,768					
	EE1	0.801	0,789					
	EE5	0.798	0,810					
	EE4	0.726	0,868					
	EE8	0.709	0,740					
	EE6	0.696	0,631					
	EE7	0.672	0,719					
Depersonalization	D11	0.784	0,605	0,52	0,84	2.670	13.350	0.839
	D10	0.772	0,612					
	D12	0.738	0,818					
	D13	0.678	0,855					
	D14	0.605	0,692					
Personal accomplishment	PA21	0.732	0,459	0,28	0,60	1.580	7.898	0.597
	PA 18	0.631	0,576					
	PA 22	0.619	0,561					
	PA 20	0.454	0,495					

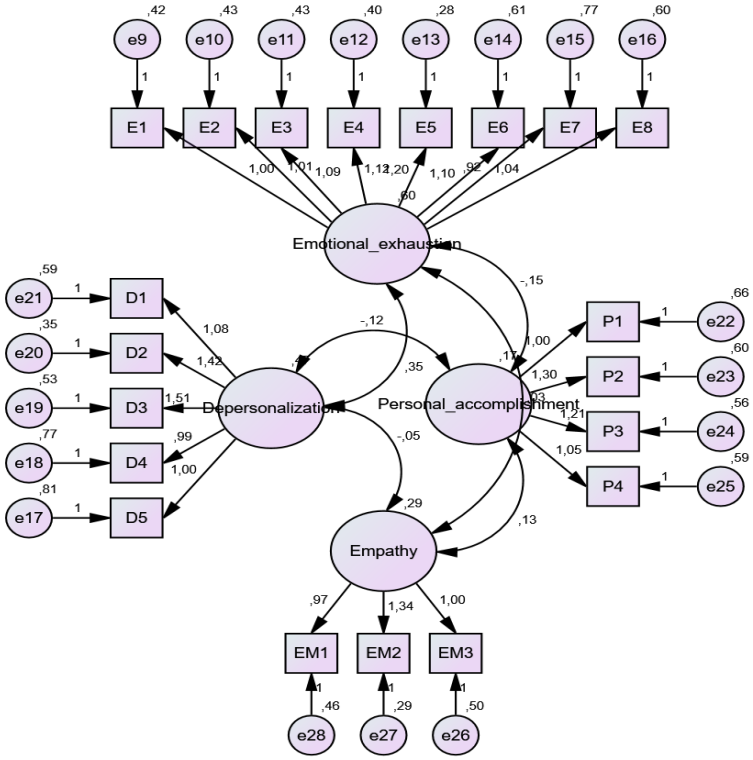
Dimensions	Items	Factor loads	Standardized Regression Weights	AVE	CR	Eigenvalue	Variance Explained	Cronbach' Alpha
	E16	0.813	0,603					
Empathy	E15	0.789	0,798	0,46	0,71	1.037	5.183	0.697
	E17	0.593	0,610					

KMO: 0.905, p: 0.000, Bartletts Test: 3,362.975, Rotation Method: Varimax, Extraction Method: Principal Components
Total Variance Explained: 61.091, Cronbach's Alpha: 0.833

When Table 3 is examined, the KMO value of 0.905 falls within the acceptable range of 0.5 to 1.0 (Altunışık et al., 2010), indicating that the sample size is adequate for factor analysis. Bartlett's test yielded a p-value of 0.000 ($p < 0.001$), demonstrating that the correlations among variables are sufficiently strong. The Cronbach's Alpha value of 0.832, which falls within the range of 0.8 to 1.0, indicates that the scale has high internal consistency and reliability (Yıldız & Uzunsakal, 2018). Items 9 and 19 were excluded from the analysis due to cross-loading on two factors. Item 9 ("I feel like I have come to the end of the road") and item 19 ("I create a comfortable environment between myself and the people I encounter in my job") did not clearly load onto a single factor. As a result of the factor analysis, the occupational burnout scale was grouped under four distinct factors: emotional exhaustion, depersonalization, personal accomplishment, and empathy. The total variance explained by these four factors was 61.091%, indicating that the model sufficiently captures the construct of occupational burnout. No item was found to have a negative impact on the scale. An analysis of the eigenvalues shows that the factor emotional exhaustion (6.932) contributes the most to explaining occupational burnout, followed by depersonalization (2.670), personal accomplishment (1.580), and empathy (1.037), respectively.

As seen in Table 3, the AVE and CR values indicate the model's convergent validity. The AVE values exceed the threshold of 0.50, and the CR values are above 0.70. These results confirm the presence of convergent validity (Fornell & Larcker, 1981, p. 382–388). Below, Figure 2 presents the fit indices obtained from the CFA analysis. These fit indices demonstrate the structural validity of the model.

Figure 2. Confirmatory Factor Analysis



RMR=,0607 CMIN=436,756 DF=164 CMIN/DF=2,663 GFI=,885 AGFI=,853 RMSA=,068

Based on the analysis results, the model demonstrates good fit as indicated by the following indices: CMIN/DF = 2.663 (< 5), RMR = 0.0607 (< 0.08), GFI = 0.885 (> 0.85), AGFI = 0.853 (> 0.85), and RMSEA = 0.068 (< 0.08). These values suggest that the model has acceptable fit, supporting its construct validity (Kline, 2011; Cole, 1987; Schermelleh-Engel et al., 2003).

4.4. Normality Test Findings

As a general rule, parametric tests require that the data be normally distributed. To assess normality, kurtosis and skewness values were considered. According to Tabachnick et al. (2013), kurtosis and skewness values between -1.5 and +1.5 indicate that the data are approximately normally distributed. The results of the normality test are presented in Table 4.

Table 4. Skewness and Kurtosis Values of The Factors

Dimensions	n	Mean	Standard Deviation	Skewness	Kurtosis	Min.	Max.
Emotional exhaustion	361	2.94	0.860	-0.063	-0.482	1.00	5.00
Depersonalization	361	2.22	0.892	0.442	-0.581	1.00	5.00
Personal accomplishment	361	3.57	0.615	-0.303	0.214	1.50	5.00
Empathy	361	3.76	0.695	-0.874	1.084	1.33	5.00

When Table 4 is examined, it is observed that the kurtosis and skewness values fall within the acceptable range of -1.5 to +1.5. Therefore, it can be concluded that the data meet the assumption of normality, and parametric tests such as the t-test and ANOVA can be applied.

4.5. Difference Analysis Findings

To examine group differences, t-tests, ANOVA, and chi-square analyses were conducted. According to the t-test results, no significant differences were found in occupational burnout perceptions based on gender, marital status, type of institution, or income groups. However, t-test results revealed significant differences in occupational burnout perceptions between participants who were exposed to violence and those who were not. The results of these analyses are presented in Table 5.

Table 5. The Relationship Between Exposure to Violence and Occupational Burnout

Have you been subjected to physical violence?		**n**	**Mean ($\bar{x}$)**	**Sig.**
Emotional Exhaustion	Yes	51	3.19	**0.022**
	No	310	2.89	
Depersonalization	Yes	51	2.51	**0.013**
	No	310	2.18	
Have you been subjected to verbal abuse?		**n**	**Mean ($\bar{x}$)**	**Sig.**
Emotional Exhaustion	Yes	191	3.20	**0.000**
	No	170	2.64	
Depersonalization	Yes	191	2.43	**0.000**
	No	170	1.99	
Empathy	Yes	191	3.85	**0.013**
	No	170	3.67	
Have you been subjected to sexual abuse?		**n**	**Mean ($\bar{x}$)**	**Sig.**
Depersonalization	Yes	15	3.17	**0.000**
	No	346	2.18	
Have you been subjected to mobbing/bullying?		**n**	**Mean ($\bar{x}$)**	**Sig.**
Emotional Exhaustion	Yes	218	3.18	**0.000**
	No	143	2.56	
Depersonalization	Yes	218	2.43	**0.000**
	No	143	1.91	

When Table 5 is examined, significant differences are observed between exposure to violence and the perception of occupational burnout. In particular, significant differences are found between exposure to physical violence and the emotional exhaustion and depersonalization dimensions. The findings indicate that individuals exposed to physical violence have higher mean scores in the emotional exhaustion dimension (Yes, $\bar{x}$ = 3.19) compared to those not exposed (No, $\bar{x}$ = 2.89). Similarly, those exposed to physical violence (Yes, $\bar{x}$ = 2.51) show higher depersonalization scores than those not exposed (No, $\bar{x}$ = 2.18). Based on these results, hypotheses H_{1a} and H_{1e} are supported.

Significant differences are observed in the emotional exhaustion, depersonalization, and empathy dimensions in relation to exposure to verbal abuse. The findings indicate that individuals exposed to verbal abuse report higher levels of emotional exhaustion (Yes, $\bar{x}$ = 3.20) compared to those not exposed (No, $\bar{x}$ = 2.64). Similarly, the depersonalization scores are higher among those exposed to verbal abuse (Yes, $\bar{x}$ = 2.43) than those not exposed (No, $\bar{x}$ = 1.99). Furthermore, individuals exposed to verbal abuse (Yes, $\bar{x}$ = 3.85) show higher empathy scores than those not exposed (No, $\bar{x}$ = 3.57). Based on these results, hypotheses H_{1b}, H_{1f}, and H_{1n} are supported.

Among the various types of violence, exposure to sexual abuse is reported at the lowest level (n = 15). A significant difference is found between exposure to sexual abuse and the depersonalization dimension. The results indicate that individuals exposed to sexual abuse (Yes, $\bar{x}$ = 3.17) have higher levels of occupational burnout compared to those not exposed (No, $\bar{x}$ = 2.18). Based on this finding, hypothesis H_{1c} is supported.

A significant difference is found between exposure to mobbing/bullying and the emotional exhaustion and depersonalization dimensions. In terms of emotional exhaustion, individuals exposed to mobbing/bullying (Yes, $\bar{x}$ = 3.18) report higher levels of occupational burnout compared to those not exposed (No, $\bar{x}$ = 2.56). Similarly, in the depersonalization dimension, those exposed to mobbing/bullying (Yes, $\bar{x}$ = 2.43) exhibit higher burnout levels than those not exposed (No, $\bar{x}$ = 1.91). Based on these results, hypotheses H_{1d} and H_{1h} are supported.

ANOVA analysis was performed to identify differences among multiple groups. The results of the ANOVA, which examined variations in occupational burnout dimensions (measured on an interval scale) across different demographic groups (measured on a categorical scale), are presented in Table 6.

Table 6. One-Way ANOVA analysis results

Dimensions	Groups	Sum of Squares	df	Mean Square	F	p	Difference
Emotional Exhaustion	Between Groups	13.754	4	3.439	4.838	**0.001***	Between ≥50 ($\bar{x}$:2.34) and others groups ($\bar{x}$:2.90/3.05/3.08)
	Within Groups	253.025	356	0.711			
	Total	266.779	360				
Depersonalization	Between Groups	22.400	4	5.600	7.548	**0.000***	42-49 ($\bar{x}$:1.93) and ≥50 ($\bar{x}$:1.56) and others groups ($\bar{x}$:2.22/2.37/2.43)
	Within Groups	264.128	356	0.742			
	Total	286.529	360				
Personal accomplishment	Between Groups	8.029	4	2.007	5.575	**0.000***	42-49 ($\bar{x}$:3.71) and ≥50 ($\bar{x}$:4.00) and others groups ($\bar{x}$:3.41/3.52/3.54)
	Within Groups	128.170	356	0.360			
	Total	136.199	360				
Empathy	Between Groups	6.382	3	2.127	4.523	**0.004***	High school ($\bar{x}$:3.39) and undergraduate ($\bar{x}$:3.82) and post graduate ($\bar{x}$:3.90)
	Within Groups	167.894	357	0.470			
	Total	174.276	360				
Depersonalization	Between Groups	11.512	7	1.645	2.111	**0.042***	Emergency medical technician ($\bar{x}$:2.01), administrator ($\bar{x}$:1.74) and other personal ($\bar{x}$:1.92) nurse ($\bar{x}$:2.41)
	Within Groups	275.017	353	0.779			
	Total	286.529	360				
Empathy	Between Groups	8.276	7	1.182	2.514	**0.016***	Doctor ($\bar{x}$:4.07) health technician ($\bar{x}$:3.52) and emergency medical technician ($\bar{x}$:3.97)
	Within Groups	166.000	353	0.470			
	Total	174.276	360				

Dimensions	Groups	Sum of Squares	df	Mean Square	F	p	Difference
Emotional Exhaustion	Between Groups	11.954	4	2.988	4.175	**0.003***	Between ≥16 (x̄:2.68) and 6-10 (x̄:3.20)
	Within Groups	254.826	356	0.716			
	Total	266.779	360				
Depersonalization	Between Groups	24.517	4	6.129	8.328	**0.000***	≥16 (x̄:1.82) and others groups (x̄:2.13/2.30/2.52/2.38)
	Within Groups	262.011	356	0.736			
	Total	286.529	360				
Personal accomplishment	Between Groups	5.572	4	1.393	3.796	**0.005***	1-5 (x̄:3.47) and 6-10 (x̄:3.50) and ≥16 (x̄:3.77)
	Within Groups	130.627	356	0.367			
	Total	136.199	360				

*p<0,05

When Table 6 is examined, significant differences are observed between occupational burnout perceptions and the variables of age, education level, profession, and years of professional experience. The findings indicate that younger age groups report more negative perceptions in the emotional exhaustion and depersonalization dimensions compared to those in the 42–49 and 50+ age groups. However, the opposite trend is observed in the personal accomplishment dimension: individuals aged 42–49 and 50+ report lower levels of personal accomplishment compared to younger age groups. No significant difference is found between age groups in the empathy dimension. Based on these findings, hypothesis H_{2b} is supported.

When the education groups are considered, the average scores for the empathy dimension indicate that high school graduates have a more negative perception compared to those with undergraduate and postgraduate education. No significant differences are found between education level and the depersonalization, emotional exhaustion, and personal accomplishment dimensions. Based on these findings, hypothesis H_{2d} is supported.

When occupational groups are examined, the average scores for the depersonalization dimension suggest that the response tendency leans toward disagreement overall. However, nurses report more negative perceptions in this dimension compared to emergency medical technicians, managers, and other personnel. In the empathy dimension, doctors display more positive perceptions than health technicians. No significant differences are found among occupational groups in the personal accomplishment and emotional exhaustion dimensions. Based on these results, hypothesis H_{2f} is supported.

When working year groups are examined, significant differences are observed in the depersonalization, emotional exhaustion, and personal accomplishment dimensions. The findings indicate that individuals with 6–10 years of work experience report more negative perceptions in the emotional exhaustion dimension compared to those with 16 or more years of experience. Similarly, in the depersonalization dimension, groups with fewer years of work experience show more negative perceptions than the 16+ years group. Additionally, in the personal accomplishment dimension, the 1–5 year and 6–10 year groups exhibit lower levels of personal accomplishment compared to those with 16 or more years. Based on these results, hypothesis H_{2h} is supported.

A chi-square test was conducted to examine the relationships between participants' exposure to violence and demographic groups. Since both variables are measured on a categorical scale, conducting a chi-square analysis is appropriate (Büyüköztürk, 2015). The results of the analysis are presented in Table 7, which includes only the significant relationships identified.

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https://ror.org/04fjtte88

Table 7. Chi-Square Analysis Results

Have you been subjected to physical violence?			**Yes**	**No**	**Total**	**p-value, x^2 value, df value**
Gender	Male	n	22	91	113	p: 0.049 x^2: 3.87 df: 1
		%	19.5%	80.5%	100.0%	
	Female	n	29	219	248	
		%	11.7%	88.3%	100.0%	
Have you been subjected to mobbing/bullying?						
Gender	Male	n	51	62	113	p: 0.000 x^2: 16.00 df: 1
		%	45.1%	54.9%	100.0%	
	Female	n	167	81	248	
		%	67.3%	32.7%	100.0%	
Have you been subjected to physical violence?			**Yes**	**No**	**Total**	
Age	18-25	n	3	64	67	p: 0.006 x^2: 14.43 df: 4
		%	4.5%	95.5%	100.0%	
	26-33	n	17	131	148	
		%	11.5%	88.5%	100.0%	
	34-41	n	16	47	63	
		%	25.4%	74.6%	100.0%	
	42-49	n	9	48	57	
		%	15.8%	84.2%	100.0%	
	≥ 50	n	6	20	26	
		%	23.1%	76.9%	100.0%	
Have you been subjected to mobbing/bullying?			**Yes**	**No**	**Total**	
Martial Status	Married	n	125	102	227	p: 0.007 x^2: 7.24 df: 1
		%	55.1%	44.9%	100.0%	
	Single	n	93	41	134	
		%	69.4%	30.6%	100.0%	
Have you been subjected to verbal abuse?			**Yes**	**No**	**Total**	
Educational Level	High school	n	10	23	33	p: 0.041 x^2: 8.27 df: 3
		%	30.3%	69.7%	100.0%	
	Associate's degree	n	48	41	89	
		%	53.9%	46.1%	100.0%	
	Undergraduate	n	110	92	202	
		%	54.5%	45.5%	100.0%	
	Postgraduate	n	23	14	37	
		%	62.2%	37.8%	100.0%	

Have you been subjected to verbal abuse?			**Yes**	**No**	**Total**	
Occupation	Nurse	n	79	39	118	p: 0.000 x^2: 33.95 df: 7
		%	66.9%	33.1%	100.0%	
	Midwife	n	9	20	29	
		%	31.0%	69.0%	100.0%	
	Doctor	n	13	9	22	
		%	59.1%	40.9%	100.0%	
	Health technician	n	25	29	54	
		%	46.3%	53.7%	100.0%	
	Emergency medical technician	n	32	14	46	
		%	69.6%	30.4%	100.0%	
	Administrator	n	6	8	14	
		%	42.9%	57.1%	100.0%	
	Administrative personnel	n	24	39	63	
		%	38.1%	61.9%	100.0%	
	Others	n	3	12	15	
		%	20.0%	80.0%	100.0%	
Have you been subjected to physical violence?			**Yes**	**No**	**Total**	
Working Time in the Profession	<1 year	n	1	17	18	p: 0.002 x^2: 17.25 df: 4
		%	5.6%	94.4%	100.0%	
	1-5 year	n	7	107	114	
		%	6.1%	93.9%	100.0%	
	6-10 year	n	10	64	74	
		%	13.5%	86.5%	100.0%	
	11-15 year	n	17	44	61	
		%	27.9%	72.1%	100.0%	
	≥16 year	n	16	78	94	
		%	17.0%	83.0%	100.0%	

When Table 7 is examined, significant relationships are observed between exposure to violence (Yes responses) and gender groups. It is found that men are more likely to be exposed to physical violence than women. Conversely, in terms of exposure to mobbing/bullying (Yes responses), women report higher exposure than men. Based on these findings, hypothesis H_{3a} is supported.

Significant relationships also emerge between age groups and exposure to physical violence, with individuals aged 34 and above showing higher exposure rates. Thus, hypothesis H_{3b} is supported.

There are significant relationships between marital status and exposure to mobbing/bullying, with single individuals reporting higher exposure than married individuals. Accordingly, hypothesis H_{3c} is supported.

A significant association is found between education levels and exposure to verbal abuse. The relationship strengthens with increasing education level, particularly among those with postgraduate education, who show the highest exposure rates. These findings support hypothesis H_{3d}.

Significant relationships are identified between occupational groups and exposure to verbal abuse. Emergency medical technicians, nurses, and doctors are respectively more likely to be exposed to verbal abuse compared to other groups. This supports hypothesis H_{3f}.

Finally, significant relationships are found between length of service and exposure to physical violence. Those with 11–15 years and 16 or more years of service report higher exposure than others, supporting hypothesis H_{3h}.

5. CONCLUSION

The main aim of this research is to investigate the relationship between exposure to violence and occupational burnout among healthcare professionals. Within the scope of the study, data were collected from a total of 361 participants from the provinces of Bolu, Düzce, and Zonguldak using a convenience sampling method. The sample included employees from both public and private hospitals. Frequency analysis results (Table 2) indicate that healthcare professionals are most frequently exposed to mobbing/bullying and verbal abuse, while physical violence and sexual abuse are the least common types of violence encountered. These findings are consistent with previous studies in the literature. Although verbal abuse is generally reported as the most prevalent form of violence, this research also identifies mobbing/bullying as a predominant type. Similar results have been reported in studies by Mento et al. (2020), Bahar et al. (2015), İkiışık et al. (2021), Özdemir et al. (2018), and Kahriman (2014).

According to the factor analysis results (Table 3), four factors emerged in this study: emotional exhaustion, personal accomplishment, depersonalization, and empathy. While the MBI (Maslach & Jackson, 1981) traditionally includes three dimensions, the explanatory factor analysis conducted here revealed a fourth factor—empathy. Additionally, the items within the personal accomplishment factor were divided into two sub-dimensions in the analysis.

According to the t-test results (Table 5) examining the relationship between exposure to violence and occupational burnout dimensions, depersonalization and emotional exhaustion were found to be more strongly associated with occupational burnout. No significant relationship was observed between personal accomplishment and occupational burnout. However, a significant association was identified between the empathy dimension and exposure to verbal abuse. These findings are consistent with those of de Looff et al. (2018).

According to the results of the ANOVA analysis (Table 6), significant differences were found in participants' perceptions of occupational burnout across age, education, profession, and length of service groups. The findings revealed that younger age groups reported more negative perceptions in the emotional exhaustion and depersonalization dimensions compared to older groups. Conversely, the opposite pattern was observed for the personal accomplishment dimension. Regarding education, high school graduates exhibited more negative perceptions than those holding bachelor's and master's degrees. In terms of occupation, nurses reported more negative perceptions of occupational burnout in the depersonalization dimension than emergency medical technicians, managers, and other personnel. Finally, healthcare professionals with fewer years of experience showed more negative perceptions compared to their more experienced counterparts.

According to the findings of the chi-square analysis (Table 7), significant relationships emerged between exposure to violence and demographic variables. The results indicate that men are more frequently associated with physical violence, whereas women are more often associated with mobbing/bullying. These findings are consistent with those of Estryn-Behar et al. (2008). Regarding age, individuals aged 34–41 and those aged 50 and above show higher associations with physical violence, which aligns with the study by Ünal et al. (2021). In terms of marital status, singles were found to be more frequently exposed to mobbing/bullying than married individuals. Given that singles may work more night shifts and longer hours, their exposure to violence might be higher; this is supported by studies such as Çoşkun and Öztürk (2010).

Within the education groups, a positive association was found between higher education levels (associate, undergraduate, and postgraduate degrees) and exposure to verbal abuse. These findings are similar to those reported by Ünal et al. (2021). Among occupational groups, emergency medical technicians, nurses, and doctors were identified as the most exposed to verbal abuse, respectively. Finally, those with 11–15 years and 16 or more years of professional experience showed higher exposure to physical violence, consistent with the findings of Ünal et al. (2021).

It is recommended that psychological rehabilitation programs be developed for healthcare workers who are exposed to violence. Considering that individuals prone to violent behavior often have a low level of education (Bahar et al., 2015), it may also be advisable to provide targeted training for employees and to increase the number of support staff accordingly. The following topics may be explored by future researchers:

- Different types of violence can be examined in greater detail in relation to occupational burnout. For instance, the associations between verbal abuse (e.g., shouting, verbal threats, insults), physical violence (e.g., hitting, kicking, scratching), and burnout levels can be systematically analyzed.
- The relationship between factors such as the type of treatment provided, uncertainty in treatment outcomes, and exposure to violence can be explored. Future studies may investigate which types of treatments are more likely to trigger violent behavior.
- The mediating roles of variables such as personality traits and lifestyle can be examined in the relationship between exposure to violence and occupational burnout.
- Research and training programs can be developed to enhance the quality of communication and interaction between healthcare workers and patients or their relatives, particularly in terms of empathy. By understanding the sensitivities of patients and their families, healthcare workers may adopt more appropriate behaviors, which could potentially mitigate professional burnout.

DECLARATION OF THE AUTHOR

Declaration of Contribution Rate: The author contributes the study on his own.

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Declaration of Ethics: For this study the approval of ethical committee no 2025/39 dated 23.01.2025 was taken from the Ethical Committee, Düzce University.

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