

**ORIGINAL RESEARCH:
EMPIRICAL RESEARCH – QUANTITATIVE**

Mediating effects of workplace violence on the relationships between emotional labour and burnout among clinical nurses

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Email: jisu80@cau.ac.kr**Abstract****Aims:** To test a model of the relationship between nurses' burnout and emotional labour using structural equation modelling to identify the mediating effects of workplace violence.**Background:** Nurses are a group that experiences high emotional labour and are exposed to various types of violence in the clinical setting. Burnout is related to emotional labour and exposure of workplace violence, but alternatives to reduce burnout in the context of emotional labour (e.g., reduction in workplace violence) have not been extensively investigated.**Design:** This study adopted a cross-sectional design.**Methods:** A convenience sample comprising 400 nurses from four university hospitals in Korea was selected from 10 to 30 October 2016. Data on nurses' level of emotional labour, burnout and workplace violence were collected from participants. A composite-indicator structural equation model was used to examine the mediation model.**Results:** Overall, 356 nurses (89.0%) returned the completed questionnaires. Burnout was significantly and positively associated with emotional labour and workplace violence. In addition, workplace violence mediated the relationship between emotional labour and burnout related to the nursing job.**Conclusion:** The findings suggest that, to alleviate burnout in clinical nurses due to emotional labour, various programs and policy measures should be adopted to prevent their exposure to workplace violence and to enhance the organizational management of violence.**KEYWORDS**

burnout, emotional labour, nurses, structural equation modelling, workplace violence

1 | INTRODUCTION

Burnout is a response to unmanageable stress characterized by various physical and psychological symptoms, including a negative self-concept and work attitude, loss of interest and so forth (Maslach & Schaufeli, 1993). Nurses working in medical facilities must interact with numerous people daily, including patients and their caregivers,

other medical staff and administrative employees, in addition to providing nursing services. This means that they are often exposed to stressful situations, which, when prolonged, can cause them to experience burnout. Burnout can not only cause physical and psychological disorders, but also reduce work motivation and efficiency, thereby lowering the quality of nursing services and increasing the chances of nursing accidents (Zhang & Feng, 2011). Furthermore, it

can lead to frequent absences from work and a high turnover rate. Burnout in individual nurses can spread to other nurses around them, triggering severe problems with nursing personnel management and the provision of quality care (June & Byun, 2009). Accordingly, it is essential to prevent burnout and enhance the well-being of clinical nurses, and promote the development of the organization as a whole.

1.1 | Background

Numerous researchers have explored nurses' burnout in the context of emotional labour, nearly all of which have concluded that emotional labour is an influencing factor of burnout. Emotional labour refers to the effort that members of an organization make to control their emotion according to the organization's specific norms for emotional expression, to perform their work more effectively or adapt to the organization, when there is a gap between how they actually feel during work and how they are supposed to express their feelings (Hochschild, 1983). Early research on emotional labour focused on service workers, such as flight attendants, hotel employees, or call centre operators, but the research scope has been gradually expanded to embrace professionals such as nurses, teachers and social workers (Brotheridge & Grandey, 2002). Clinical nurses are a representative group of workers who must engage in emotional labour. As care providers, they are required to sympathize with patients' feelings and express positive emotions only, while hiding their negative ones. For instance, Edward, Hercelinskyj, and Giandino (2017), who examined the mental health nurses and Cheng, Bartram, Karimi, and Leggat (2013), who focused on nurses in Australia, found that emotional labour is an influencing factor of burnout and asserted that there should be organizational efforts to manage nurses' emotional labour to prevent burnout. With the generally improved quality of life among domestic consumers and advances in medical technology, the quality of nursing services has similarly improved, but this has inadvertently forced clinical nurses to engage in even greater levels of emotional labour than before.

Other studies on nurses' burnout have reported that exposure to workplace violence is another factor influencing burnout (Chen, Lin, Ruan, Li, & Wu, 2016; Choi & Lee, 2017; Erdur et al., 2015; Waschgl, Ruiz-Hernández, Llor-Esteban, & García-Izquierdo, 2012; Yoon & Sok, 2016; Zafar, Khan, Siddiqui, Jamali, & Razzak, 2015). Several papers suggested that medical professionals are frequently exposed to violence. For instance, 88.1% of medical staff at an Israeli mental health centre (Itzhaki et al., 2015) and 80.4% of medical professionals in public hospitals in Palestine (Kitaneh & Hamdan, 2012) were found to have experienced violence at work. A retrospective study in New South Wales, Australia also showed that 71% and 29% of its participants had been exposed to verbal and physical abuse, respectively (Cashmore, Indig, Hampton, Hegney, & Jalaludin, 2012). In addition, a study by Li et al. (2017) on 2,400 employees at a children's hospital in Beijing reported that 70.7% of them had experienced workplace violence during their day shifts and that the violence most often occurred in the emergency room. Taken

Why is this research needed?

- Burnout can cause physical and psychological disorders in nurses and reduce work motivation and efficiency, leading to lower quality nursing services and a greater chance for nursing accidents.
- New contributions explaining the dynamic relationship between emotional labour and burnout are required to find pathways to decrease workplace violence.

What are the key findings?

- Emotional labour has a direct effect on clinical nurses' burnout.
- Exposure to workplace violence has a mediating effect on the relationship between emotional labour and occupational burnout from their nursing work.

How should findings be used to influence policy/practice/research/education?

- To reduce nurses' burnout, qualified tools such as the Hospital Aggressive Behaviour scale should be used in clinical settings to regularly measure and evaluate nurses' level of violence exposure.
- Nurses require education on dealing with violent situations (e.g., calling security personnel) and in-hospital violence prevention committees should be established to analyse violence risk factors and introduce preventative measures.
- Violence prevention programs should be developed and implemented to create a safe hospital environment and help not only nurses, but also all hospital employees, feel less burnout.

together, this body of research shows that healthcare workers are victims of violence and this violence has increased to serious levels that can put patients at risk, leading to medical malpractice and medical accidents.

Nurses, in particular, often encounter conflicts and tension with many groups of people (e.g., patients and their families, other medical staff), which increases exposure to numerous violent situations. More than 70% of nurses who experienced workplace violence in the past suffer from anger, irritation, depression, tension throughout their body, palpitations, difficulty in focusing on work due to shaking, anxiety, loss of motivation, a desire to quit their job, headache, an easy startle response, sleeplessness and fear of other people (Kim, Eom, Oh, & Ahn, 2007). When these symptoms are prolonged, nurses might end up experiencing burnout (Roche, Diers, Duffield, & Catling-Paull, 2009).

Despite the seriousness of this problem, many hospitals have not yet introduced adequate measures or legal systems to protect their

nurses from violence. In one study, 88.4% of nurses answered that they had not received any training on how to deal with violence, while 70.1% said that they did not know how they could legally handle violent situations (Yang & Jung, 2009). Zafar et al. (2015), examined emergency departments in Pakistan and reported that the prevention of workplace violence should take priority over other healthcare policies to lessen employee burnout. A study by Waschgler et al. (2012) of nurses working in 11 public hospitals of Murcia, Spain, similarly suggested that workplace violence, along with the occupational satisfaction and psychological health, is related to burnout. These findings suggest a need for further research on exposure to workplace violence and organizational management of this issue to reduce nurses' burnout.

Emotional labourers are frequently exposed to violence in their interactions with customers and emotional labour is known to be highly associated with workplace violence experience (Chang, 2014; Grandey, Kern, & Frone, 2007; Joo & Rhie, 2017; Mayhew, 2003). However, there is relatively little empirical research on the relationship between emotional labour and workplace violence for clinical nurses. Therefore, we want to examine the mediating effects of violence in the workplace on the relationship between emotional labour and burnout to extend the current field of research.

1.2 | Hypothetical model

A model was developed based on empirical evidence from previous studies (Figure 1). The model was used to explore the relationships between emotional labour, workplace violence and burnout and particularly suggests that emotional labour influences burnout through its effect on workplace violence. In previous studies related to burnout, greater emotional labour (Cheng et al., 2013; Edward et al., 2017) and workplace violence experience (Chen et al., 2016; Choi & Lee, 2017; Erdur et al., 2015; Waschgler et al., 2012; Yoon & Sok, 2016; Zafar et al., 2015) were found to be associated with higher burnout. Although the focus was not on nurses, previous research has found that there was an association between the study of hotel workers and the relationship between language violence and emotional labour (Jung, Kim, & Lee, 2015). In a study by Yoon and Kim (2016), workplace violence was found to be a factor that regulates the relationship between emotional labour and the mental health of social workers. Further research identified the presence of a relationship between emotional labour and workplace violence (Joo & Rhie, 2017). Based on this body of work, workplace violence might be a mediator between emotional labour and burnout.

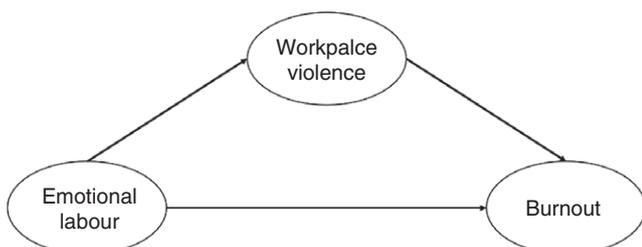


FIGURE 1 Conceptual framework

2 | THE STUDY

2.1 | Aims

The purpose of this study is to identify ways of managing burnout in clinical nurses. More specifically, we aimed to: (a) confirm the relationships between clinical nurses' emotional labour, workplace violence and burnout; (b) and determine whether workplace violence mediate the relationship between emotional labour and burnout.

2.2 | Design

This study adopted a cross-sectional study design.

2.3 | Participants

Nurses participating in this study all had more than a year of work experience in university hospitals. Data were gathered from four university hospitals in three regions of South Korea through convenience sampling.

2.4 | Data collection

A total of 400 questionnaires were distributed to four hospitals; data from 356 individuals were collected from 10 to 30 October 2016. The researcher visited the nursing departments to explain the purpose of the study and to distribute the questionnaires. Nurses who understood the study purpose and gave written consent to participate then completed the questionnaires. One copy of consent form was returned to the participant and the completed questionnaires were sealed in an envelope. According to Jöreskog and Sörbom (1989), our model required a sample size greater than 200 responses for less than 12 measurement variables. Therefore, more than 200 responses were collected to ensure the stability of the model.

2.5 | Ethical considerations

To ensure ethical protection for participants, this study was granted an exemption from IRB review. Participation was voluntary, and all participants were provided with information on the background, purpose and procedure of the study. The participants were also advised that they could cease participation at any time during the response process. Moreover, they were told that all data relating to the personal information of the participant would be kept confidential and destroyed after the study.

2.6 | Measurement

The variables included in this study were emotional labour, workplace violence and burnout. Each variable comprised 2–3 factors. To measure these factors, a total of 32 items taken from various tools were used in the survey.

2.6.1 | Emotional labour

Emotional labour was measured using a tool developed by the Occupational Safety and Health Research Institute (OSHRI), under the Korea Occupational Safety & Health Agency (KOSHA; Jang et al., 2014). This tool is open-access and publicly available in a report on the KOSHA website. Emotional labour could be divided into three subscales: emotional demands and regulation (5 items); overload and conflict in customer service (3 items); and emotional disharmony and harm (6 items). All items were measured on a 4-point scale (1 = never, 2 = rarely, 3 = sometimes, 4 = often). The total score was converted into a scale out of 100 using the KOSHA guideline: (conversion score = (sum of scores given in each item – number of items) / (possible maximum total point – number of items) × 100). Higher scores indicated a higher magnitude of emotional labour. At the time of tool development, the Cronbach's α values for these subscales were 0.795, 0.854 and 0.904, respectively (Jang et al., 2014), while the Cronbach's α values in this study were 0.743, 0.813 and 0.866.

2.6.2 | Workplace violence

Workplace violence was measured using another tool developed by OSHRI under the guidance of the KOSHA (Jang et al., 2014). This tool is also open-access and publicly available in a report on the KOSHA website. This tool comprises two subscales: 4 items assessed the experience of psychological and sexual violence from customers and 4 items assessing the experience of psychological and sexual violence from supervisors or co-workers. All items were measured on a 4-point scale (1 = never, 2 = rarely, 3 = sometimes, 4 = often). The total score was converted into a scale out of 100 based on the KOSHA guideline: (conversion score = (sum of scores given in each item – number of items) / (possible maximum total point – number of items) × 100). Higher scores indicated higher levels of exposure and experience of workplace violence. At the time of tool development, the Cronbach's α values for the lower-order subscales were 0.740 and 0.745, respectively (Jang et al., 2014) and in this study, they were 0.815 and 0.792.

2.6.3 | Burnout

Burnout was measured using the Professional Quality of Life scale developed by Stamm (2002); the tool is available in Korean and was freely accessible with permission for its use in the current study. This comprises three subscales: compassion satisfaction, burnout and secondary traumatic stress. In this study, we used only the burnout subscale, which contains 10 items rated on 5-point scales (1 = never, 2 = rarely, 3 = sometimes, 4 = often, 5 = very often). Higher scores indicate higher levels of burnout. The Cronbach's α at the time of tool development was 0.75 (Stamm, 2002). The validity testing in this study (see below) showed that the burnout scale could be divided into two factors; the Cronbach's α values of these factors were 0.762 and 0.724.

The results of the factor analysis for validity testing showed that burnout could be divided into two factors ($\chi^2 = 850.240$, $df = 45$, $p < 0.001$). More specifically, factor 1 contained 5 reverse scored items related to emotional status (*I am happy, I feel connected to others, I have beliefs that sustain me, I am the person I always wanted to be and I am a very caring person*), while factor 2 contained 5 items examining negative feelings related to the nursing job (*I am not as productive at work because I am losing sleep over traumatic experiences related to a person I nurse, I feel trapped by my job as a nurse, I feel worn out because of my work as a nurse, I feel overwhelmed because my nursing case load seems endless and I feel bogged down by the system*). Because the correlation coefficient between these two factors was only 0.164, or close to 0 (Table 1), they were analysed separately for the analysis.

2.7 | Data analysis

We used SPSS Statistics 23.0 for Windows and SPSS AMOS 23.0 for data coding, cleaning and analysis. First, the validity of the measurements was tested using principal component analysis, specifically the varimax rotation method, which minimizes the number of factors. The number of extracted factors was determined by checking the explained variance—that is, the total number of factors had to explain 50% or more of the cumulative variance (Lee, 2012). None of the items from the original tools were eliminated. Finally, the reliability of the proposed factors was tested using Cronbach's alpha. Second, general characteristics of participants were analysed using descriptive statistics. Third, exploratory factor analysis was conducted to test the validity of the tools before conducting the structural equation modelling. Finally, structural equation modelling was used to test the relationships among the variables and the bootstrapping method was adopted to test the mediating effects of the violence variables. The model was estimated using the maximum likelihood method, which assumes multivariate normality. The model's goodness of fit was assessed through several incremental fit indices, including the Comparative Fit Index (CFI), Tucker-Lewis Index (TLI), Incremental Fit Index delta 2 (IFI delta 2) and Parsimony Normed Fit Index (PNFI), alongside three absolute goodness-of-fit indices, including the chi-square statistic, root mean square error of approximation (RMSEA) and chi-square/degrees of freedom ratio (CMIN/df; Zhang & Feng, 2011).

TABLE 1 Means, standard deviations (SDs), and correlations of emotional labour, workplace violence and burnout

	Mean	SD	1	2	3	4
1. Burnout 1 (emotional status)	15.14	3.14	1			
2. Burnout 2 (nursing job)	15.07	3.23	0.164**	1		
3. Emotional labour	69.98	14.75	0.176**	0.426**	1	
4. Workplace violence	20.36	14.40	0.113*	0.352**	0.277**	1

Note. * $p < 0.01$, ** $p < 0.05$.

3 | FINDINGS

3.1 | Descriptive statistics and correlation analysis

The participants of this study were 29.12 (SD 5.42) years old on average; 65.9% were 20–29 years old, 24.6% were 30–39 years old and 9.5% were 40–49 years old. In terms of total work experience, participants had worked as clinical nurses for the median of 4 years, 1st quartile was 2 years and 3rd quartile was 8 years. As for position, most (73.1%) were staff nurses and 51.2% had a bachelor's degree.

The inter-correlations of all latent variables were next calculated to test their significance. Means, standard deviations and inter-correlations for all variables are presented in Table 1. Burnout 1 (which related to emotional status) was associated with burnout 2 (which related to the nursing job; $r = 0.164, p < 0.05$), emotional labour ($r = 0.176, p < 0.005$) and workplace violence ($r = 0.113, p < 0.005$). Burnout 2 (nursing job) was associated with emotional labour ($r = 0.426, p < 0.005$) and workplace violence ($r = 0.352, p < 0.005$). Workplace violence was related with emotional labour ($r = 0.277, p < 0.005$).

3.2 | Measurement model

Evaluating the suitability of the measurement model to the sample data required confirmatory factor analysis. As shown in Figure 2,

two latent constructs (emotional labour and workplace violence) and seven observed variables were included in the measurement model. All the fit indices for the measurement model indicated that it was a suitable fit to the data: RMSEA = 0.049, CMIN/df = 1.847, TLI = 0.971, IFI delta 2 = 0.991 and CFI = 0.990.

The composite reliability was higher than the standard value of 0.7 (Franklin, Burns, & Lee, 2014; emotional labour, 0.772 and workplace violence, 0.727) and the average variance extracted was greater than the standard of 0.5 (emotional labour, 0.541; and workplace violence, 0.602; Pu, Wu, Chiu, & Huang, 2016). Together, these results indicated that the observed variables were strong representatives of the latent constructs.

3.3 | Structural model

For the first step, the direct effect of the predictor variable (emotional labour) on the dependent variables (burnout 1 and burnout 2) without the mediators was tested. The direct standardized path coefficients were significant, $\beta = 0.151 (p = 0.010)$ and $\beta = 0.392 (p < 0.001)$, respectively. Then, a partial mediation model that contained workplace violence as mediators and a direct path from emotional labour to burnout was tested (Figure 3). This model showed a very good fit to the data, RMSEA = 0.047, CMIN/df = 1.766, TLI = 0.974, IFI delta 2 = 0.989 and CFI = 0.989.

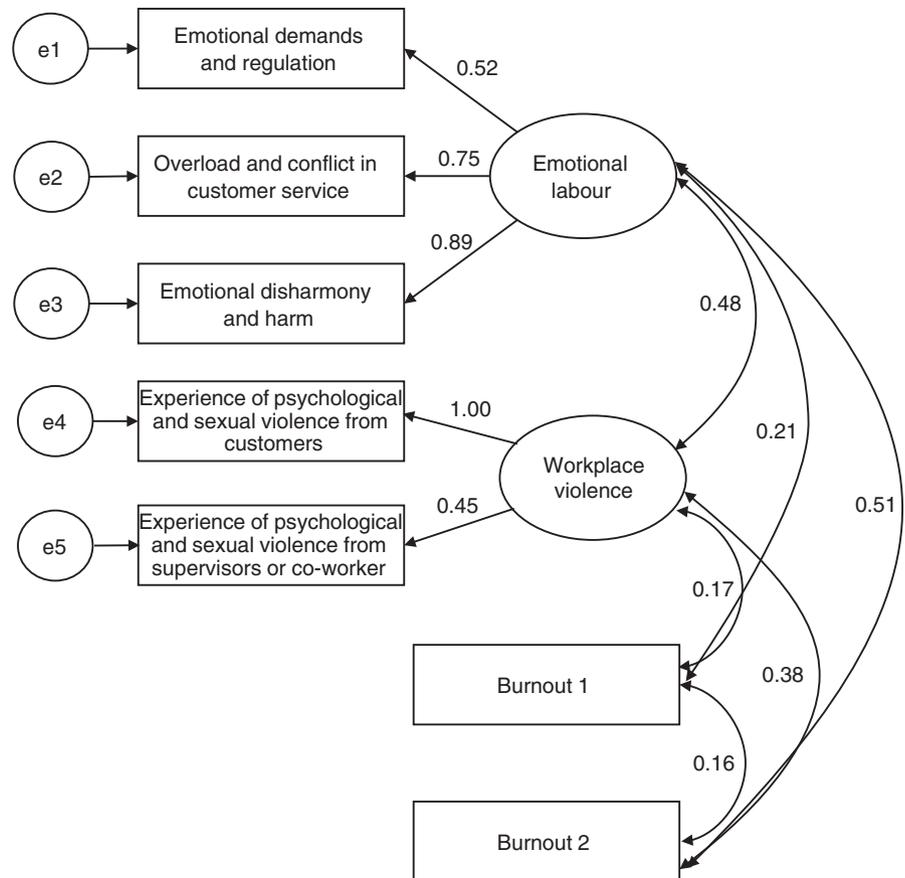


FIGURE 2 The measurement model

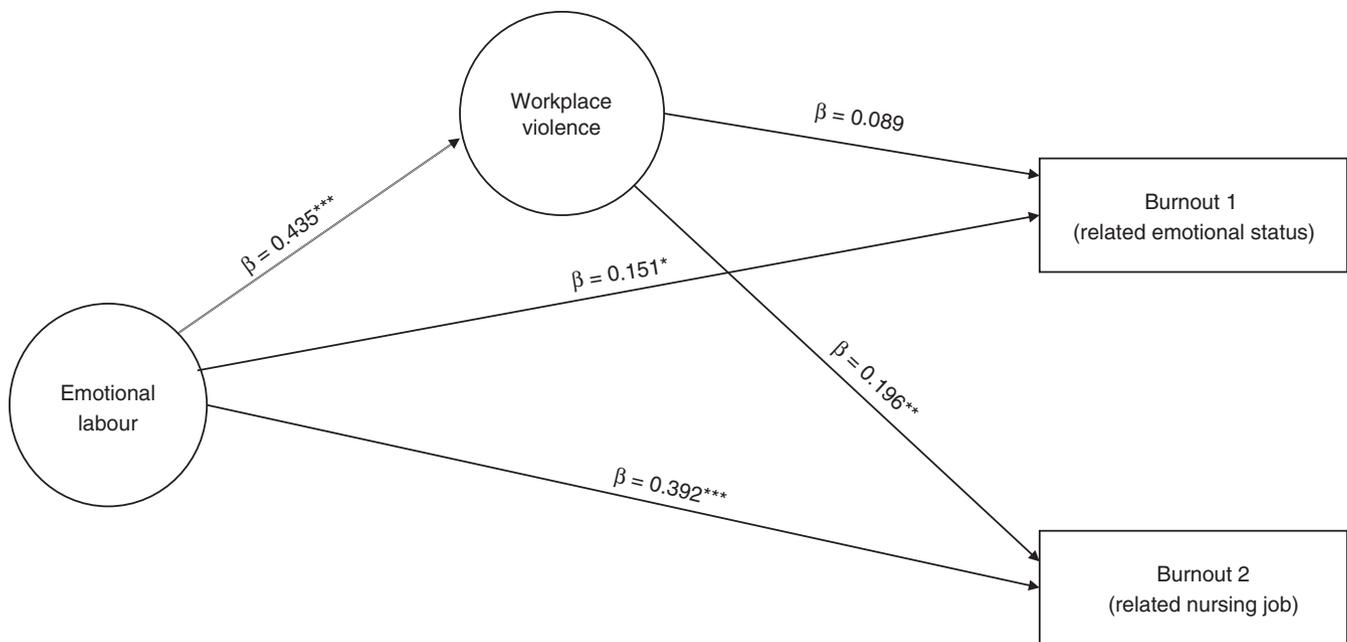


FIGURE 3 The final structural model

3.4 | Direct and indirect effects

First, the direct effects of exposure to workplace violence on emotional labour and burnout were tested for significance using the bootstrap estimation procedure (a bootstrap sample of 1,000 was specified). Table 2 shows the direct and indirect effects of the final model. As shown in Table 2, emotional labour had a significant direct effect on burnout 1 (emotional status) and 2 (nursing job), $\beta = 0.151$ ($p = 0.010$) and $\beta = 0.392$ ($p < 0.001$), respectively. Furthermore, the indirect effect of emotional labour on burnout 1 (emotional status) through exposure to workplace violence was not significant $\beta = 0.039$ ($p = 0.170$). However, the indirect effect of emotional labour on burnout 2 (nursing job) via exposure to workplace violence was significant, $\beta = 0.085$ ($p = 0.003$).

4 | DISCUSSION

Recently, there are a growing number of clinical nurses engaged in emotional labour (Martínez-Iñigo, Bermejo-Pablos, & Totterdell, 2018) and who report having experienced workplace violence worldwide (Duncan et al., 2001). Given that the global challenge of emotional labour and workplace violence contributing to nurse burnout, the findings of this study add knowledge to the growing body of literature that is focused on identifying alternatives for reducing and preventing burnout among clinical nurses. Specially, Korean nurses who are directly faced with the challenges of various departments, patients and caregivers and who carry out three shifts and have large workloads, can be said to be as severe emotional workers as they are classified as 3D (dirty, dangerous and demanding) job and the main cause of burnout. A relatively large number of young

nurses are working in hospitals, due to the number of Korean nurses who have stopped working after acquiring many years of experience. Moreover, a high percentage of young nurses are exposed to workplace violence because of cultural characteristics (Jiao et al., 2015; Park, Cho, & Hong, 2015). Korean nurses are frequently exposed to hospital workplace violence, with almost 75% reporting experiencing violence from patients and their guardians. Moreover, 98.3% and 23.4% of all nurses have experienced verbal and physical abuse, respectively (Bae & Lee, 2015).

Therefore, this study tested the mediating effects of exposure to workplace violence on the relationship between emotional labour and burnout among clinical nurses. To explore the mediating effect of exposure for workplace violence, we examined the following paths: [emotional labour → exposure to workplace violence], [exposure to workplace violence → burnout 1 and 2] and [emotional labour → burnout 1, 2]. We found that, while the [emotional labour → exposure to workplace violence] and [emotional labour → burnout 1 and 2] paths were significant, [exposure to workplace violence → burnout 1 and 2] was significant only for burnout 2. On the basis of the items, burnout 1 can be seen as burnout that nurses experience because of daily life adversities and burnout 2 refers to occupational burnout, or burnout due to factors in clinical settings. While the emotional labour of clinical nurses might directly influence both burnout 1 and 2, it seems to have an indirect impact on burnout 2 via exposure to workplace violence. These results indicate a partial mediating effect of the exposure to violence on the relationship between emotional labour and burnout 2 and support past findings that emotional labour and exposure to violence might trigger burnout (Chen et al., 2016; Cheng et al., 2013; Choi & Lee, 2017; de Paiva, Canário, de Paiva, & Gonçalves, 2017; Edward et al., 2017; Erdur et al., 2015; Hong & Lee, 2016; Waschglér et al., 2012; Yoon & Sok,

TABLE 2 Direct and indirect effects for the final model

Model pathways	Standardized effect (β)	SE	CR	p
Direct effect				
Emotional labour → burnout 1 (emotional status)	0.151	0.030	2.566	0.010
Emotional labour → burnout 2 (nursing job)	0.392	0.035	5.879	<0.001
Emotional labour → workplace violence	0.435	0.209	6.553	<0.001
Workplace violence → burnout 1 (emotional status)	0.089	0.009	1.578	0.122
Workplace violence → burnout 2 (nursing job)	0.196	0.009	3.721	<0.001
Indirect effects				
Emotional labour → workplace violence → burnout 1 (emotional status)	0.039	0.034	–	0.107
Emotional labour → workplace violence → burnout 2 (nursing job)	0.085	0.026	–	0.003

Note. CR: Critical ratio.

2016; Zafar et al., 2015). More specifically, this finding suggests that workplace violence might compound on the already severe burden of emotional labour, thus aggravating clinical nurses' burnout.

The fact that a mediating effect of violence exposure was not detected for burnout 1; however, indicates that, even if clinical nurses with high emotional labour are exposed to violence at work, it might not influence their burnout caused by daily life problems. This might be attributable to clinical nurses' strict separation of their working environment from their daily life.

Taken altogether, the findings of this study indicate that clinical nurses might experience greater occupational burnout when they face violence coupled with severe emotional labour. Thus, to reduce burnout in clinical nurses due to emotional labour, their exposure to workplace violence should be reduced.

To reduce the burnout of nurses, before creating an environment safe from violence in the workplace, it will be necessary to raise awareness about the safety of staff and management working at the hospital. Recently, Israeli psychiatric hospitals improved their safety awareness of employees and management after implementing an intervention program for employees to improve their safety environment and reduce violence (Isaak et al., 2017).

To this end, qualified tools such as the Hospital Aggressive Behaviour scale should be used in clinical settings to regularly measure and evaluate nurses' level of violence exposure (Waschler et al., 2012). Furthermore, clinical nurses should be trained on how to react to possible workplace violence to handle the situation immediately, such as calling security personnel or using recording methods, rather than panicking. It would also help to establish violence prevention committees in hospitals to analyse violence risk factors and devise preventative measures. Recently, a violence prevention program based on the middle-range theory of resilience was applied to nurses in the emergency centre of a general hospital in C city, South Korea and proved effective in reducing their burnout (Lee & Sung, 2017). More such violence prevention programs should be developed and implemented to create a safe hospital environment, which might help lessen burnout experienced by not only nurses and but also all employees working in the hospital.

In addition, in a study of Jung et al. (2015) on Korean hospital nurses' experiences of verbal violence, nurses classified the 'impolite

words' (83.0%) as the most experienced form of language violence. This is because in Korean culture, this behaviour is regarded as a 'talk down' and is verbal violence as it displeases the other person's self-concept and causes discomfort. With this context in mind, spreading awareness of honorific language use is one way to further reduce verbal violence and prevent burnout by encouraging respecting others.

4.1 | Limitations

First, although this study is a cross-sectional and embraced nurses as representative subjects of emotional labour, it sampled nurses from only 4 university hospitals. Therefore, the results cannot be generalized to nurses elsewhere, which suggests the need for replication studies that include nurses from other areas and hospitals. Second, there is a need for further research exploring individual and environmental variables that could moderate the relationship between exposure to workplace violence and burnout 1 (related emotional status). Third, since this study used a self-reported survey method based on nurses' own subjective perceptions, future research should include additional sources of data collection, such as in-depth interviews and participant observation to construct a generalized model and develop effective intervention programs. Finally, to develop programs to reduce burnout in clinical nurses, further study is needed to confirm the mediating effect of emotional labour in relation to workplace violence and burnout.

5 | CONCLUSION

This study adds empirical evidence to the burnout literature, particularly by elucidating the importance of workplace violence—namely, that it serves as a mediator of the relationship between emotional labour and burnout in nursing. This study suggests that high emotional labour and workplace violence are critical issues when tackling burnout. Both of these factors negatively affect individuals and organizations. Interventions aimed at reducing nurse burnout should include efforts to decrease emotional labour and workplace violence. Nevertheless, administrators have historically focused only on

personal stress management to decrease nurse emotional labour and reduce burnout. Preventing violence in the workplace and developing a coping program is one way of reducing the burnout of nurses in the workplace.

CONFLICTS OF INTEREST

No conflict of interest has been declared by the authors.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE <http://www.icmje.org/recommendations/>):

- substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

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