Insider versus Outsider Workplace Mistreatment and their Impact on Affective Ill-being in Healthcare Professionals: Can Personal Resources Act as Buffers?

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Abstract

Aims: Workplace stress can negatively impact healthcare providers' professionalism and quality of care. One source of workplace stress is the experience of workplace mistreatment. Drawing on the Job Demands-Resources theory, this study aimed to (a) investigate the impact of mistreatment frequency experienced by healthcare workers from insider sources (i.e., co-workers, supervisors) and outsider sources (i.e., patients, visitors) on affective ill-being and (b) the potential moderating role of trait resilience and trait self-efficacy, as personal resources, in the mistreatment-illbeing relationship.

Design: Lagged design

Methods: We collected data from 153 Irish healthcare workers between January 2018 – June 2019 via three surveys, separated by 1-week intervals. Personal resources were measured at Time 1, frequency of mistreatment from the two sources was assessed at Time 2, and affective ill-being was assessed at Time 3. We used moderated regression analyses to evaluate the association of mistreatment frequency from the two sources and affective ill-being and the moderating effect of personal resources.

Results: Only insider mistreatment frequency was positively related to affective ill-being. Furthermore, the positive impact of insider mistreatment on affective ill-being was moderated by self-efficacy (but not by trait resilience). In contrast to our expectations, the relationship was stronger at high levels compared to low levels of self-efficacy.

Conclusion: Mistreatment from co-workers and supervisors is linked to higher levels of affective ill-being. Additionally, healthcare workers with high self-efficacy were more vulnerable to the negative consequences of co-worker and supervisor mistreatment as it impacted their affective ill-being.

Impact: These findings extend the literature on workplace mistreatment by integrating insider and outsider perpetrators of mistreatment and examining their differential impact on the employees' affective ill-being. It also highlights mistreatment from organisational

insiders as a significant factor in the relationship between mistreatment and affective ill-being.

Keywords: Workplace Mistreatment, Self-efficacy, Resilience, Affective Ill-being.

Patient or public contribution: No patient or public contribution

What does this paper contribute to the wider global community?

- The findings underscore the detrimental impact of workplace mistreatment on the well-being of healthcare professionals.
- The study findings of higher frequency of insider mistreatment being associated with increased affective ill-being call for action, with line managers and supervisors being critical to achieving respective changes in healthcare workers' environment.
- The findings have implications for policymakers interested in developing a framework to support healthcare professionals in addressing workplace mistreatment, enabling them to effectively fulfil their role as care providers.

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1. Introduction

Hospitals and health institutions are integral to society as they provide access to quality healthcare (WHO, 2022). However, healthcare settings may be conducive breeding grounds for workplace mistreatment because of high workload, emotional demands, constant interpersonal interactions, and low job resources (Vagharseyyedin, 2016). Currently, the Irish Nurses and Midwives Organisation (INMO) reported that the Irish health sector is experiencing staff shortages and hospital patient overcrowding (Connor, 2021). Additionally, at least five nurses a day experienced verbal, physical, and sexual assault during a single month (INMO, 2022). Mistreatment in the workplace comprises various forms of interpersonal misconduct that differ in severity, persistence, motivation, and source (Hershcovis, 2011). We examined two forms of mistreatment, which are particularly prevalent in the healthcare context compared to other settings (Arnetz *et al*., 2018). Verbal aggression refers to the act of using communication or gestures to cause offence, intimidation, or threats (Farrell *et al*., 2006). In contrast, workplace incivility is a low-intensity deviant behaviour with a vague intention to cause harm (Andersson & Pearson, 1999).

Indeed, healthcare workers have a high risk of experiencing disrespectful conduct as they go about their work (Karaeminogullari *et al*., 2018). Situations such as patients addressing healthcare workers inappropriately, patients and consultants having unrealistic perceptions of nurses' workload or unjust behaviours of some managers and colleagues are examples of mistreatment within these settings (Vagharseyyedin, 2016). Previous research indicated that workplace mistreatment adversely impacts employees' well-being as it leads to rumination (Demsky *et al*., 2018), high levels of work-related stress (Hannan *et al*., 2018), and anxiety (Reknes *et al*., 2016). Reasons behind mistreatment in healthcare settings include

disputes over task accountability, role ambiguity, lack of communication between workers, patients' long waiting times, and dissatisfaction with services (Bambi *et al*., 2018). This research aimed to provide a more in-depth understanding of experienced mistreatment among healthcare professionals in their line of work. We examined (a) the impact of the frequency of these encounters on health professionals' affective ill-being and (b) the role of personal resources, namely self-efficacy, and resilience, in potentially mitigating the effect of mistreatment on affective ill-being. Thus, the current research makes two notable contributions to the extant workplace mistreatment literature.

First, we examined the frequency of workplace mistreatment (incivility and verbal aggression) from two different sources and their influence on the affective well-being of healthcare workers. Previous investigations suggest that verbal aggression from patients relates to burnout (Hanson *et al*., 2015), while rude customer treatment triggers negative emotions (Bani-Melhem *et al*., 2020). Co-worker mistreatment is a significant predictor of impaired well-being (Sliter *et al*., 2012), job stress (Foster *et al*., 2021), and turnover intentions (Lim *et al*., 2008). These studies focused only on one source and have not tested the differential effects of these sources of mistreatment on employee well-being. To overcome these limitations, we adopted a comprehensive approach by distinguishing two categories of mistreatment sources in the healthcare setting. We grouped the sources of mistreatment according to insider (i.e., co-workers and supervisors) and outsider (i.e., patients and their visitors) sources, in line with past research which adopted similar categorisations (e.g., Hanson *et al*., 2015; Sliter *et al*., 2012).

Examining these two sources' differential effects on healthcare employees' well-being has critical theoretical and practical implications. From a theoretical perspective, it would be inaccurate to assume that mistreatment from either source would have an equivalent negative effect on employee well-being. On the one hand, healthcare workers may regard instances of

mistreatment from patients as an inherent aspect of their professional responsibilities (Hochschild, 1983) and thus, might be minimally impacted. On the other, mistreatment from co-workers may elicit a sense of injustice (Caza & Cortina, 2007), considering the prevailing norms of professionalism among workers. Hence, examining these two sources simultaneously can help us determine which source of mistreatment is more taxing to healthcare workers' well-being. One can also argue that the severity of the impact informs employees regarding how they should deal with the mistreatment, how they conserve their resources, and devise specific strategies to cope with these behaviours. From a practical standpoint, it could aid practitioners in developing specific interventions that they can implement in the workplace. Moreover, we respond to an increasing chorus of calls (Han *et al*., 2021; Schilpzand *et al*., 2016) to simultaneously examine these sources of mistreatment in a single study to provide a deeper understanding of their differential effects on employee well-being.

Second, this research also examines the role of two personal resources (i.e., self-efficacy and resilience) in buffering the adverse effects of mistreatment on healthcare workers' affective ill-being. We considered these two personal resources because they relate to how individuals deal with environmental demands and adversities (Luthans *et al*., 2007). Unlike stable personality traits, they can be learned and improved through training (Maffoni *et al*., 2020). Resilience can protect individuals from adverse reactions to challenging events (Bryan *et al*., 2019), while self-efficacy is an essential personal resource that supports well-being at work and mitigates the influence of perceived stress (Rhee *et al*., 2017). Hence, both personal resources may help health professionals appraise problematic working conditions (e.g., mistreatment) as challenges rather than threats (Maffoni *et al*., 2020). Thus, they may help create a safe working environment for all stakeholders and reduce stress among healthcare employees.

Drawing on the Job Demands-Resources (JD-R) theory (Bakker *et al*., 2023), we propose that healthcare workers appraise workplace mistreatment as job demands that can have a negative association with well-being through a health impairment process. A job demand refers to the work's physical, social, or organisational elements that require employees' continuous physical or psychological effort (Bakker *et al*., 2023). Therefore, exposure to job demands consumes employees' mental and physical resources, which exhausts their energy and might eventually lead to general health problems (Bakker & Demerouti, 2007). We further propose that personal resources may act as buffers in the health impairment process (Bakker *et al*., 2023). Personal resources pertain to individuals' perceptions that they can effectively manage and influence their environment, particularly in challenging circumstances (Xanthopoulou *et al*., 2007). Hence, self-efficacy and resilience may potentially mitigate the effects of mistreatment (insider and outsider sources) on affective ill-being in environments characterised by low job resources, such as healthcare settings, and without a certain prospect of increasing them.

2. Background

2.1 Mistreatment as a workplace demand

Research on employee well-being has identified various forms of workplace mistreatment as the predominant source of stress (e.g., Foster *et al*., 2021). For instance, Sommovigo and colleagues (2019) found that customer incivility and verbal aggression positively related to emotional exhaustion and cynicism. In an experimental study, Sommovigo *et al*. (2020) showed that customer mistreatment can elicit negative emotions and impair cognitive functioning. Likewise, Rafaeli and colleagues (2012) demonstrated that verbally aggressive customers impaired cognitive performance, leading to more errors in their shifts. These findings underline that episodes of workplace mistreatment are resource-depleting events, particularly in service industries. As Koopmann *et al*. (2015) stated, employees must engage in emotional and behavioural regulation to comply with their

organisation's service rules that stipulate dealing with customers professionally. In line with the JD-R theory (Bakker *et al*., 2023), one can argue that workplace mistreatment is a daily social job demand (Sliter *et al*., 2010). Healthcare professionals appraise these uncivil and verbally aggressive encounters as stressors as they must expend psychological effort in dealing with these interactions.

2.2 Mistreatment and healthcare worker well-being

In the healthcare setting, interpersonal interactions are necessary to carry out tasks and attain goals. However, interpersonal exchanges are not always regarded as positive, and individuals often experience affective feelings for every issue they encounter (Barsade & Gibson, 2007). As Plutchik (1989) stated, emotions serve an adaptive function as individuals react to environmental events that may have ramifications for their survival. Warr (1990) conceptualised affective well-being as feelings about everyday life or affect associated with a specific context. Hence, job-related affective well-being pertains to employees' positive or negative responses to perceptions, experiences, and outcomes related to work (Van Katwyk *et al*., 2000). This study focused on job-related affective well-being because it is one of the essential psychological well-being indicators (Diener & Larsen, 1993). Additionally, emotional experiences function as fundamental mechanisms that link work and non-work domains (e.g., Meier *et al*., 2016). Weiss and Cropanzano (1996) further stated that significant workplace events trigger emotional responses from employees and can have implications for various work behaviours. Thus, mistreatment is an emotionally charged event that may generate adverse affective reactions and have severe implications for well-being and performance (Penhaligon *et al*., 2013). In the context of this study, being exposed to misbehaving patients, family members, and co-workers can elicit negative affective experiences (i.e., affective ill-being).

Experiencing workplace mistreatment is an unpleasant occurrence. For instance, Lanctôt and Guay (2014) found that healthcare workers exposed to mistreatment felt anger,

sadness, fear, and disgust. Additionally, daily exposure to workplace incivility has been found to predict hostility amongst employees, which led to angry behaviours at home, indicative of a spillover effect (Lim *et al*., 2018). Moreover, Tremmel and Sonnentag (2018) found in their diary study that co-worker incivility was indirectly related to evening negative affect via negative affect at the end of the workday, whereas customer incivility was indirectly associated with next-morning negative affect via negative affect at the end of the workday and in the evening. Along the same lines, Zhou *et al*. (2019) showed that burnout mediated the relationship between weekly experiences of co-worker and outsider incivility and work-to-family conflict. They found that suppressing negative emotions during uncivil interactions strengthened the positive relationship between outsider incivility and burnout.

Comparing the influence between the two mistreatment sources on affective ill-being, one can surmise that insider mistreatment will have a stronger impact. This is based on the understanding that interpersonal relations among healthcare workers tend to be less transient and necessitate more frequent interactions than patients and visitors (Andel *et al*., 2022). As previously stated, mistreatment from a colleague might evoke feelings of injustice (Caza & Cortina, 2007) because it violates the norms of professionalism. In contrast, healthcare workers may perceive mistreatment from patients and visitors as part of their role as care providers (Hochschild, 1983).

2.3 The role of personal resources

Recently, scholars have examined the buffering role of personal resources in the relationship between workplace mistreatment and well-being (e.g., Rhee *et al*., 2017). Personal resources are positive self-evaluations characterised by individuals' perception of their capacity to govern and influence their surroundings effectively (Bakker *et al*., 2023). JD-R theory states that similar to job resources, personal resources assist individuals in achieving their goals and protect them from threats, and thus, minimise the associated physiological and psychological costs (Bakker *et al*., 2023). Hence, individuals with more

personal resources have greater access to job resources, and vice versa (Xanthopoulou *et al*., 2007).

2.3.1 Self-efficacy

Self-efficacy is the belief that one can effectively perform the necessary actions to produce desired outcomes (Bandura, 1977). In challenging situations where healthcare workers are exposed to mistreatment, their efficacy expectations play a role in how they interpret events and how long they will persist in dealing with these stressful experiences (Bandura, 1977). Low levels of self-efficacy are related to high psychological and physical strain (Jex & Bliese, 1999). Thus, individuals with low self-efficacy respond to stressors more negatively (Goussinsky, 2012). Conversely, highly efficacious individuals view challenges as manageable, which drives them to exert effort and maximal use of their competencies (Avey *et al*., 2009). For instance, Rhee and colleagues (2017) found that employees' self-efficacy attenuated the influence of co-worker incivility on emotional exhaustion, suggesting that the positive relationship is weak for those high in self-efficacy compared to employees low in self-efficacy. Self-efficacy also minimised the effect of perceived incivility at home on negative emotions (Naeem *et al*., 2020) and buffered the negative association between workplace incivility and health outcomes (Fida *et al*., 2018). Consequently, we propose that for healthcare workers with higher levels of self-efficacy, the frequency of exposure to mistreatment will be less strongly associated with their affective ill-being than those with lower levels of self-efficacy.

2.3.2 Resilience

Resilience is "a dynamic process encompassing the capacity to maintain regular functioning through diverse challenges or to rebound through the use of facilitative resources" (Bryan *et al*., 2019, p. 77). Further, resilience can be described as positive adaptation and growth in response to adversity (Hartmann *et al*., 2020). Adversity comprises situations that have the potential to disrupt or harm the normal functioning of an individual's

well-being (Hoegl & Hartmann, 2021). Hence, highly resilient individuals are characterised as emotionally stable and flexible to changing demands (Avey *et al*., 2009), leading to better well-being and optimal work outcomes (Luthans *et al*., 2006).

Research has demonstrated that resilience buffers the effects of mistreatment on well-being. For instance, Sommovigo *et al*. (2019) found that working students with low and moderate levels of resilience were at high risk of experiencing impaired ability to resolve service failures and tackle customers' discontent compared to those with high levels of resilience. Similarly, Al-Hawari *et al*. (2020) found that for frontline workers with low resilience, experienced customer incivility was positively associated with emotional exhaustion, which in turn related to a lesser ability to satisfy customers. In contrast, these relationships were absent for frontline workers high in resilience. However, other studies have proposed that resilience has limitations and can only get an individual so far. Trent and Allen (2019) found that resilience buffers the incivility-burnout relationship among volunteer workers. However, it only attenuated burnout at low levels of experienced incivility. In contrast, Lin *et al*. (2019) found that resilience only played a protective role for physical but not psychological strains among medical students. Despite the mixed findings, most studies highlight the buffering role of resilience and its influence on well-being. Within the healthcare sector, it has been shown that resilience among nurses is positively associated with psychological well-being and helps minimise the impact of mental distress (Delgado *et al*., 2021).

3. The study

Figure 1 depicts the conceptual framework. Considering the theoretical implications and our review of the literature, we predict that the frequency of insider (i.e., co-workers and supervisors) and outsider (i.e., patients and visitors) mistreatment is positively associated with affective ill-being of healthcare workers, to which insider mistreatment has a stronger

impact. We also propose that resilience and self-efficacy can potentially mitigate the adverse outcomes of workplace mistreatment. Therefore, we hypothesise the following:

Hypothesis 1: *Insider mistreatment is positively related to affective ill-being one week later.*

Hypothesis 2: *Outsider mistreatment is positively related to affective ill-being one week later.*

Hypothesis 3: *Insider mistreatment significantly influences affective ill-being more than outsider mistreatment.*

Hypothesis 4a: *Self-efficacy will moderate the relationship between insider mistreatment and affective ill-being such that the relationship will be weaker as self-efficacy increases.*

Hypothesis 4b: *Self-efficacy will moderate the relationship between outsider mistreatment and affective ill-being such that the relationship will be weaker as self-efficacy increases.*

Hypothesis 5a: *Resilience will moderate the relationship between insider mistreatment and affective ill-being such that the relationship will be weaker as resilience increases.*

Hypothesis 5b: *Resilience will moderate the relationship between outsider mistreatment and affective ill-being such that the relationship will be weaker as resilience increases.*

4. Methodology

4.1 Design

We recruited healthcare professionals across various settings in Ireland via flyers and internet platforms (e.g., Facebook and LinkedIn) to partake in the time-lagged study, consisting of three waves of data collection. Considering previous studies that adopted similar designs (e.g., Taylor *et al*., 2017), we employed weekly surveys to capture the temporal relationships between workplace mistreatment and affective ill-being. Additionally, our sample did not have a fixed working schedule that allowed them to interact regularly with patients and patients' family members.

4.2 Data Collection

We conducted data collection between January 2018 to June 2019. Participation was voluntary, and participants were informed of the nature of the research. Participants were given the option to complete the surveys online via Qualtrics or through paper-and-pencil surveys since some participants would not routinely use a computer while working. Those participants who preferred the paper-and-pencil version were given the surveys labelled *week 1*, *week 2*, and *week 3*, with an envelope for each week. Respondents were instructed to place the completed surveys at the end of each working week in a secured storage box set in their respective manager's offices, which was collected by the first author at the end of each week. For participants who preferred to complete the surveys online, the survey links were distributed to their working e-mails at the end of each working week.

4.3 Inclusion criteria

The study's lagged design meant that the outcome, predictors, and moderator variables were measured at different time points. To be eligible in the final sample, a respondent had to: (a) work as part of a team; (b) be supervised by managers; (c) have direct contact with patients and visitors, (d) complete all three weekly surveys, and (e) provide informed consent. In total, 254 respondents completed the time 1 (T1) survey, 176 (69%) answered the time 2 (T2) survey, and 153 (60%) completed the time 3 (T3) survey. Therefore, the final sample did not include respondents who dropped out after the T1 and T2 surveys. Female respondents accounted for 77.7% of the sample. The age ranged between 21 – 64 years (M = 41.04, SD = 10.38). The average percentage that worked in direct contact with patients and visitors was 76.63 (SD = 25.46). Moreover, the respondents came from various areas of the health sector, including care of the elderly, allied health, emergency services, mental health, and community care.

4.4 Sample

We used G*Power (Faul *et al*., 2009) to assess the required sample size to provide adequate power. The sample size required to achieve significant findings was calculated for

both small and medium effects. Given an estimated power of 0.8, probability of .05, and small effect size of 0.1, G*Power recommended 143 participants, while a medium effect size of 0.25 with the same estimated power (0.8) and probability (.05) recommended a sample size of 62. Thus, the final sample size of 153 is acceptable based on the expectation of effect sizes for the dependent variables being small and medium effects and previous studies that applied similar methodology (e.g., Taylor *et al*., 2017).

4.5 Validity and reliability of measures

We measured *trait resilience* at T1 using the 10-item Conor-Davidson Resilience Scale (Campbell-Sills & Stein, 2007). A sample item was "*I am able to adapt to change*." Participants responded on a 5-point Likert scale (0 = almost always false; 4 = almost always true). Previous studies have indicated that the scale has sound psychometric properties (e.g., Lauridsen *et al*., 2017). This included construct and longitudinal validity among hospital workers. In the current study, the reliability coefficient was acceptable (α = .78) and similar to prior research (α = .77; Sommovigo *et al*., 2019).

We used the Generalised Self-Efficacy Scale (Schwarzer & Jerusalem, 1995) to assess *trait self-efficacy* at T1. A sample item was "*I am confident that I could deal efficiently with unexpected events*." Participants responded on a 4-point Likert Scale (1 = not all true; 4 = exactly true). In a series of multicultural validation studies, it was found that the scale was related to other constructs such as self-regulation and well-being (Luszczynska *et al*., 2005). Furthermore, the Cronbach's alphas in samples from 23 nations ranged from .76 to .90 (Schwarzer & Jerusalem, 1995). The reliability coefficient for the present study was good (α = .84).

We considered the previous work of scholars (e.g., Cortina & Magley, 2003; Rodwell *et al*., 2013) in creating the two sources of mistreatment variables, that is, insider (co-workers, supervisors) and outside sources of mistreatment (patients, visitors). In measuring the *frequency of mistreatment*, we first asked respondents whether they had been exposed to

uncivil acts and verbal aggression. Consistent with previous studies (e.g., Zhu & Tan, 2019) and given that the definition of mistreatment can be subjective, we provided examples of uncivil (e.g., rude, demeaning remarks about you) and verbal aggressive behaviours (e.g., abusive or obscene comments, and warning of intent to injure) to help participants identify or classify a mistreatment event over the previous week at T2. Respondents who answered '*yes*' to these questions were asked to indicate the frequency from each source, namely co-workers, supervisors, patients, and visitors, on a 4-point Likert scale (0 = never; 3 = more than three times). We created the mistreatment variable by summing up the frequencies of both experienced incivility and verbal aggression from co-workers and supervisors. We applied the same procedure for outsider sources mistreatment variable. Moreover, this operationalisation allowed us to distinguish between uncivil acts from diverse sources (e.g., insiders versus outsiders), which is relevant as there is evidence that incivility from different sources might be differentially associated with health-related outcomes (e.g., Zhou *et al*., 2019).

Finally, we measured respondents' *affective ill-being* using the mean score of the Low Pleasure items of the Job-related Affective Well-being (Van Katwyk *et al*., 2000) at T3. Sample items include "*My work made me angry*". Participants responded on a 5-point Likert Scale (1 = very slightly or not at all; 5 = extremely). Basinska *et al*. (2014) tested the multidimensional scaling of the scale among Polish police officers and showed that the theoretical circumplex model of emotions was satisfactorily reproduced. In the current study, the reliability coefficient was exceptional (α = .91) and lower than that reported in the validation paper (α = .95; Van Katwyk *et al*., 2000).

4.6 Data Analyses

Before testing our hypotheses, we first conducted confirmatory factor analyses using M*plus* version 8.5 (Muthen & Muthen 1998-2020) to confirm the discriminant validity of our measures and ensure the common method variance was not an issue. The preliminary and

descriptive analyses, internal consistencies, correlations, and hypotheses testing were performed using the IBM-SPSS 26.0 program. To test our hypotheses, we conducted moderated regression analyses in IBM-SPSS 26.0, using the macro-PROCESS (Model 2; Hayes, 2013). We controlled for gender (0= male; 1= female) given that previous research found that female employees experience greater frequencies of incivility than men (e.g., Montgomery *et al*., 2004). Additionally, compared with men, women tend to experience more intense emotional responses (Deng *et al*., 2016), especially for negative emotions (Brody & Hall, 2000), thereby being more vulnerable to affective ill-being. We further controlled for age as younger employees often become the target of uncivil acts at work (e.g., Torkelson *et al*., 2016). We also controlled for the estimated percentage of working time involving contact with patients and visitors and measured it as a continuous variable.

4.7 Ethical considerations

Informed consent was obtained at the beginning of the survey at Time 1, and no identifying information was collected. Moreover, this study was approved by the Research Ethics Committee from the Kemmy Business School Research Ethics Committee at the University of Limerick on 25 October 2017 (Application No.: 2017_10_KBS_01).

5. Results

5.1 Preliminary analyses

Due to the attrition rate, we conducted dropout analyses using a *t*-test to compare participants who answered all three surveys with those who responded to only one or two (combined into one group) using the variables measured at time 1. We found no significant differences regarding resilience ($t(252) = 0.1$, $p = .92$), self-efficacy ($t(200.11) = -0.14$, $p = .89$), and the estimated percentage of working time involving contact with patients and visitors ($t(208) = -1.46$, $p = .15$).

Since there were two modes of completion in this study (paper-and-pen versus online), we conducted a series of *t*-tests to see if there were differences between these two

modes of completion among the study variables. There were no significant differences found regarding resilience ($t(120.5) = -1.11$, $p = .27$) and self-efficacy ($t(136.88) = -0.64$, $p = .52$). In contrast, a significant difference was found for the estimated percentage of working time involving contact with patients and visitors ($t(207.98) = 8.23$, $p < .001$), which suggests that participants who opted for the paper-and-pen version ($M = 91.94$; $SD = 7.87$) were more in contact with their patients and visitors than those who answered the surveys online ($M = 72.1$; $SD = 27.08$). A significant difference was also found for affective ill-being ($t(151) = 2.94$, $p = .004$) such that participants who responded via paper-and-pen had higher affective ill-being ($M = 2.2$; $SD = 0.57$) than those who completed the survey online ($M = 1.8$; $SD = 0.85$).

We also ran a series of *t*-tests to assess if the variables of interest differed according to gender. No significant differences between males and females for resilience ($t(222) = -0.97$, $p = .33$), self-efficacy ($t(222) = -1.72$, $p = .09$), and affective ill-being ($t(145) = -0.67$, $p = .50$). However, analyses showed significant differences for the estimated percentage of working time involving contact with patients and visitors ($t(101.5) = -2.73$, $p = .01$), suggesting that male healthcare professionals ($M = 84.06$; $SD = 19.96$) were more in contact with their patients and visitors than females ($M = 74.34$; $SD = 26.59$). Finally, one-way analyses of variance showed that resilience ($F(4,217) = 2.64$, $p = .04$) and self-efficacy ($F(4,217) = 3.34$, $p = .01$) differed significantly across age groups. Specifically, Tukey HSD post hoc analyses highlighted that the 40-49 age group ($M = 3.21$, $SD = 0.56$) had higher resilience than the 20-29 age group ($M = 2.93$, $SD = 0.44$). Likewise, the 40-49 age group ($M = 3.33$, $SD = 0.39$) had higher self-efficacy than the 20-29 age group ($M = 3.09$, $SD = 0.38$).

Table 1 presents the results of the confirmatory factor analyses (CFA), using Full Information Maximum Likelihood in M*plus* (version 8.5). Analyses indicated that the target

three-factor model showed a better fit (χ^2 (387) = 571.08, $p < .001$, CFI = .89, TLI = .88, RMSEA = .06, SRMR = .08) than the alternative models.

The results of Harman's single-factor test indicated that the single factor explained only 19.49% of the variance. Additionally, the hypothesised three-factor model yielded a better fit to the data after the inclusion of the unmeasured latent method factor. Moreover, the unmeasured latent method factor explained 8.2% of the total variance, which is less than 25%, the average method of variance observed in self-report research (Podsakoff *et al*., 2012). This suggests that common method variance was unlikely to be a major concern in this study.

Table 2 presents the means, standard deviations, and correlation coefficients for all study variables. Age was positively correlated to resilience ($r_{(220)} = 0.20$, $p = .003$), self-efficacy ($r_{(220)} = 0.14$, $p = .03$), and insider mistreatment ($r_{(99)} = -0.21$, $p = .03$). Gender was positively related to the estimated percentage of working time involving contact with patients and visitors ($r_{(207)} = 0.16$, $p = .02$). As expected, resilience was positively correlated to self-efficacy ($r_{(247)} = 0.54$, $p < .001$). Insider mistreatment positively correlated to affective ill-being ($r_{(89)} = 0.25$, $p = .02$), while affective ill-being was negatively associated with resilience ($r_{(151)} = -0.16$, $p = .04$) but not with self-efficacy ($r_{(149)} = -0.02$, $p = .80$). Outsider mistreatment was negatively correlated to insider mistreatment ($r_{(99)} = -0.24$, $p = .02$).

5.2 Hypotheses Testing

Moderation analyses using SPSS macro-PROCESS (Model 2; Hayes, 2013) based on 95% confidence intervals with 10,000-sample bias-corrected bootstrapping analysis (*BC CI_{95}*) was used to test the hypotheses. We conducted two tests, one for each predictor. Hence, as seen in Tables 3 and 4, each test included the predictor, two moderators, two interactions, and the control variables. In the event of a significant interaction, simple slope tests were conducted to analyse the conditional effects using high and low levels of the moderator as

one standard deviation above and below the mean score. We mean centred the predictor variables and the moderators to minimise multicollinearity (Aiken & West, 1991).

5.2.1 Mistreatment Frequency from Insider and Outsider Sources

Hypothesis 1 proposed that insider mistreatment frequency would be positively related to affective ill-being. As can be seen in Table 3, while controlling for age, gender, and estimated percentage of working time involving contact with patients and visitors, we found that insider mistreatment frequency was positively associated with affective ill-being (*ß* = 0.43, $p = .02$). Hence, Hypothesis 1 was accepted.

Hypothesis 2 predicted that outsider mistreatment frequency would also be positively related to affective ill-being. As can be seen in Table 4, while controlling for age, gender, and estimated percentage of working time involving contact with patients and visitors, we found that, in contrast to our expectations, outsider mistreatment frequency had no significant effect on affective ill-being (*ß* = -0.14, $p = .26$). Therefore, Hypothesis 2 was rejected.

Hypothesis 3 proposed that insider mistreatment frequency has a more significant influence on the affective ill-being of healthcare workers than outsider mistreatment. Comparing the beta values of the two mistreatment sources and considering the rejection of Hypothesis 2, Hypothesis 3 was accepted.

5.2.2 The Buffering Role of Self-Efficacy on the Relationship between Insider Mistreatment Frequency and Affective Ill-being

Hypothesis 4a predicted that self-efficacy would moderate the impact of insider mistreatment frequency on affective ill-being such that the positive relationship would be weaker as the self-efficacy of healthcare professionals increased. As can be seen in Table 3, while controlling for age, gender, and estimated percentage of working time involving contact with patients and visitors, we found that self-efficacy was not significantly associated with affective ill-being (*ß* = 0.28, $p = .33$). However, the interaction of self-efficacy and insider mistreatment frequency was significant (*ß* = 2.22, $p < .001$). As depicted in Figure 2, the simple slopes test showed that there were no significant relationships for both healthcare

professionals low on self-efficacy (ß = -0.24, p = .37) and healthcare professionals with average self-efficacy (ß = 0.37, p = .06). However, for health professionals with high self-efficacy, there was a positive significant relationship between insider mistreatment frequency and affective ill-being (ß = 0.97, p < .001), such that the positive relationship between insider mistreatment frequency and affective ill-being was stronger for healthcare professionals with high self-efficacy levels than those with average and low self-efficacy levels, which was contrary to our expectations.

5.2.3 The Buffering Role of Self-Efficacy on the Relationship Between Outsider Mistreatment Frequency and Affective Ill-Being

Hypothesis 4b predicted that self-efficacy would moderate the impact of outsider mistreatment frequency on affective ill-being. Specifically, the positive relationship would be weaker for healthcare professionals with high compared to those with low self-efficacy levels. As can be seen in Table 4, while controlling for age, gender and estimated percentage of working time involving contact with patients and visitors, we found that self-efficacy did not significantly predict affective ill-being (ß = 0.24, p = .44). In addition, the interaction between mistreatment frequency from patients and visitors and self-efficacy was marginally significant (ß = -0.76, p = .05). Therefore, Hypothesis 3b was also rejected. Due to the *p-value* being very close to significance, we tested the nature of the interaction. As illustrated in Figure 3, simple slopes test showed that there was a positive relationship for healthcare professionals low on self-efficacy (ß = 0.02, p = .92). However, for healthcare professionals with average (ß = -0.14, p = .27) and high self-efficacy (ß = -0.30, p = .08), the relationship between outsider mistreatment frequency and affective ill-being was negative.

5.2.4 The Buffering Role of Resilience on the Relationship Between Insider Mistreatment Frequency and Affective Ill-Being

Hypothesis 5a predicted that resilience would moderate the impact of insider mistreatment frequency on affective ill-being such that the positive relationship would be weaker as resilience increased. As can be seen in Table 3, while controlling for age, gender

and estimated percentage of working time involving contact with patients and visitors, we found that resilience negatively predicted affective ill-being (*ß* = -0.59, $p < .01$). However, the interaction of resilience and frequency of insider mistreatment was not significant (*ß* = -0.20, $p = .65$). Therefore, Hypothesis 4a was rejected.

5.2.5 The Buffering Role of Resilience on the Relationship Between Outsider Mistreatment Frequency and Affective Ill-Being

Finally, Hypothesis 5b predicted that resilience would moderate the impact of outsider mistreatment frequency on affective ill-being such that the positive relationship would be weaker as resilience increased. As can be seen in Table 4, while controlling for age, gender and estimated percentage of working time involving contact with patients and visitors, we found that resilience negatively predicted affective ill-being (*ß* = -0.47, $p = .03$). However, the interaction of resilience and frequency of outsider mistreatment was not significant (*ß* = 0.28, $p = .26$). Therefore, Hypothesis 4b was also rejected.

6. Discussion

This study examined the healthcare workers' experiences of mistreatment from organisational insiders and outsiders and their differential impact on affective ill-being. In line with the JD-R theory (Bakker *et al*., 2023), workplace mistreatment represents a job demand because healthcare professionals engage in cognitive and emotional efforts in these interactions, and thus can have physiological and psychological costs (e.g., Sommovigo *et al*., 2020). The study also tested whether personal resources, such as self-efficacy and resilience, would buffer the positive relationship between mistreatment and affective ill-being. Personal resources entail positive self-evaluations about one's sense of capability to control and impact their work settings successfully (Xanthopoulou *et al*., 2007). Thus, they could potentially mitigate the effects of work mistreatment on healthcare workers' affective ill-being (i.e., strain). The findings indicate that among the two sources of mistreatment, only insider sources predicted affective ill-being. In testing the buffering roles of the two personal resources, self-efficacy interacted with insider sources of mistreatment in predicting affective

ill-being. However, the effect was contrary to what we hypothesised. Specifically, we found that the positive relationship between insider mistreatment and affective ill-being was stronger among health workers with high levels of self-efficacy. There was no significant interaction found for resilience.

6.1 Theoretical Implications

First, the study contributes to the current literature on workplace mistreatment in healthcare workers by adopting a broad approach that considers two different sources of mistreatment. Mistreatment in healthcare settings comprises multiple actors, consisting of organisational insiders (e.g., co-workers, supervisors) and outsiders (e.g., patients and visitors). In contrast to the findings of Tremmel and Sonnentag (2018) and Zhou *et al*. (2019), who found that both co-worker and customer incivility were positively related to end-of-workday negative affect and strain reactions, respectively, the current study demonstrated that only mistreatment from organisational insiders influenced affective ill-being. The findings from our research and their previous work suggest that negative effects of interpersonal interactions among colleagues or managers impact participants' affective well-being not only on the day they experienced but for at least one week. However, our findings indicate that the negative effects of outsider mistreatment do not seem to last long. This may point to relationship quality as being a crucial factor.

Care provision depends on a multidisciplinary approach, which requires effective teamwork and collaboration among colleagues (Manser, 2009). Taking this into account, along with the implementation of policies that underscore professionalism and dignity at work, meant that experiencing mistreatment from organisational insiders is a breach of trust and violates the norms of mutual respect (Andersson & Pearson, 1999), and can then elicit feelings of injustice (Caza & Cortina, 2007). This leads us to the explanation as to why mistreatment from co-workers and supervisors resulted in feelings of anger and discouragement more so than misbehaving patients and their visitors. Consequently, the

adverse effect of insider mistreatment on well-being is more pronounced than outsider sources. Additionally, the relationship with co-workers and managers tends to be more enduring than with patients (Andel *et al*., 2022) and, thus, may be more important to employees.

Concerning the non-significant findings between mistreatment frequency from patients/visitors and healthcare workers' affective ill-being, one possible explanation was that healthcare professionals are accustomed to their patients' misbehaviours. Simply put, because of the repetitive and continuous exposure to mistreatment, healthcare professionals may have developed habituation effects (Choi *et al*., 2022) which act to reduce its impact on affective ill-being. It could also be the case that participants consider these interactions part of their job, and they are expected to deal with such behaviours effectively by regulating their response toward their clients (Hochschild, 1984). In contrast to organisational insiders, one could posit that healthcare professionals are less prone to developing habituation effects toward them, as mistreatment from colleagues is less accepted as being part of the job. Finally, it is plausible that healthcare workers attributed their patients' and their visitors' mistreatment as a form of discontent with the health services or they are aware of the difficult circumstances surrounding their patients and families. Therefore, instead of being affected, healthcare workers may sympathise with their patients and demonstrate professionalism by not being offended by their rude conduct (Koopmann *et al*., 2015).

Nevertheless, mistreatment from co-workers and supervisors is considered a social job demand (Bakker *et al*., 2023; Foster *et al*., 2021; Sliter *et al*., 2010), is associated with negative affect (Lanctôt & Guay, 2014; Lim *et al*., 2018; Tremmel & Sonnentag, 2018) and may stimulate unwanted reactions (e.g., rumination), which can then have an undesirable impact on the well-being of employees (Demsky *et al*., 2018; Hannan *et al*., 2018; Sliter *et al*., 2012). Episodes of mistreatment are work conditions that are perceived as a threat and

can potentially disrupt employees' emotional conditions in such a way that the employees depart from normal functioning (Bakker *et al*., 2023). Hence, scholarly work in this area is essential, as it underscores the negative impact of social stressors on employees' well-being and work outcomes and enlightens practitioners in finding ways to minimise the propagation of such behaviours at work.

With regard to the buffering roles of resilience and self-efficacy, we found no evidence to suggest that these personal resources have such an effect, in contrast to previous studies (e.g., Fida *et al*., 2018; Rhee *et al*., 2017; Sommovigo *et al*., 2019). Instead, we either found that they had none (in the case of trait resilience) or the opposite effect (in the case of self-efficacy). Although this finding was initially a surprise for us, it could be the case that having rigid high levels of self-efficacy may lead to feelings of helplessness when attempting to establish control and being confident about one's ability to manage the situation in the face of uncontrollable or unexpected events (Schiaffino *et al*., 1991). It is also possible that highly efficacious employees who perceive work challenges as malleable (Avey *et al*., 2009; Bandura, 1977) invest more effort to manage and control workplace demands. However, for an uncontrollable demand like mistreatment, they perceive the interaction as a result of their incompetency or lack of work effort. Previous studies show that mistreatment, like incivility, can elicit undesirable reactive behaviours like rumination (Demsky *et al*., 2018), which may deplete resources and lead to higher affective ill-being. Moreover, while there is a substantial body of research indicating that self-efficacy serves as a cognitive mechanism that offers protection (e.g., Goussinsky, 2012; Naeem *et al*., 2020; Rhee *et al*., 2017), other investigations have proposed that this perspective may not provide a comprehensive understanding of the phenomenon (Schönfeld *et al*., 2017). They stated that a significant disparity exists in the number of studies that substantiate the protective benefits of self-efficacy compared to the minimal evidence that indicates a lack of positive impacts or even

detrimental outcomes. As for resilience, we can classify workplace mistreatment as a form of workplace adversity (Hoegl & Hartmann, 2021). The current investigation found that resilience reduces affective ill-being. However, it does not appear to protect healthcare workers from the harmful impacts of mistreatment from the two groups of sources.

6.2 Implications for policy and practice

Organisations' primary responsibility is to set the proper tone for respect and dignity at work and identify acceptable and respectful behaviours. Therefore, healthcare institutions need to consider how to improve the interpersonal interactions of their workers. Although most organisations have formal mechanisms to address worker-to-worker mistreatment, these procedures often offer limited levels of protection (Klein & Martin, 2011). Therefore, workplaces with high levels of mistreatment, such as healthcare settings, need robust policies compounded with evidence-based interventions to tackle these issues with a particular focus on organisational insiders. For instance, training and intervention programs are designed and implemented to diffuse workplace mistreatment and educate staff members on effectively dealing with these antisocial workplace behaviours (e.g., Laschinger *et al*., 2012). Moreover, such programs may encourage healthcare professionals to report these incidents, as only through reporting can these issues be highlighted. More importantly, training and interventions would significantly contribute to achieving a safe and pleasant working environment for current and future healthcare workers as they delineate acceptable and unacceptable behaviours (Dimarino, 2011).

In light of this, healthcare organisations could consider using clinical simulation training (e.g., Watters *et al*., 2015). In this simulation, healthcare workers were trained interprofessional communication using computer-generated scenarios in clinical situations. The simulation led to an improvement in their perceived abilities related to communication and teamwork (Watters *et al*., 2015). Additionally, management can collect critical incidents from employees that involve uncivil and verbally aggressive interactions and form a

taxonomy of unprofessional behaviours (Cullen *et al*., 2021). This could be a potential learning opportunity for practitioners and employees to reflect upon and draw strategies to communicate professionally with colleagues and respond rationally rather than reacting emotionally. Furthermore, workplace civility workshops and cultural change initiatives, such as the Civility, Respect, and Engagement in the Workplace (CREW) programs, could be helpful tools to promote respectful behaviours among team members (Leiter *et al*., 2011).

Finally, we found no evidence to suggest that personal resources can act as effective buffers in the relationship between mistreatment and well-being. Specifically, we found an opposite effect for self-efficacy. Nevertheless, this highlights the critical roles of line managers and supervisors in promoting and maintaining professionalism in the workplace. For instance, line managers and supervisors can cultivate social support in the team or in the wards. Social support can lessen the frequency of mistreatment between workers and can also improve one's confidence in handling social stressors like incivility and verbal aggression.

6.3 Strengths, limitations and recommendations for further research

The present study offers valuable insights by examining the experienced mistreatment by healthcare workers from different sources within the healthcare settings and their differential impact on affective ill-being. Furthermore, in work contexts where job resources are critically low, this study investigated whether personal resources would mitigate the impact of mistreatment on affective ill-being. However, the generalisability of these results is subject to certain limitations. First, there are issues associated with single-source and self-report methodology, which raises concerns about common method bias (Podsakoff *et al*., 2012). We controlled this by separating the measurement of the predictor and criterion variables one week apart and by checking that common method bias was not a substantial issue in our data. Our study utilised a lagged design, where the outcome variable was measured in the third survey and not at the same timepoint as the main predictors. Therefore, we recommend that replications be carried out utilising intensive longitudinal studies and

integrating self-reports alongside other reported (e.g., supervisor ratings) and objective (e.g., performance) data. Doing so would enable us to examine whether the instability or inertia exhibited by individuals with high self-efficacy can elucidate the circumstances under which this personal resource can act as either a vulnerability or a protective factor against the adverse consequences of workplace mistreatment.

Second, the current study only tested combined mistreatment frequency from participants' co-workers and supervisors and the people they work for (e.g., patients and visitors). Future studies could also assess the extent to which mistreatment from each specific source impacts employee well-being and organisational outcomes.

Third, considering that workplace mistreatment in the healthcare sector varies according to workplace context, future research could compare levels of workplace mistreatment between frontline staff and allied health professionals. More research is needed to clarify the differences in the health and work-related outcomes of mistreatment depending upon the source and comparing professional groups that spend different times in contact with patients. Thus, it would be interesting to investigate differences between professionals who work in nursing homes and those who work in psychiatric units, emergency departments, and other domains in the healthcare setting. Comparing settings could give healthcare organisations insights into developing the profile of aggression that healthcare workers receive in these areas, which would help increase the generalisability of findings.

Future investigations can build on the results of this study by examining the mediating role of affective reactions between workplace mistreatment and various employee well-being and organisational outcomes. It would be ideal to use a longitudinal approach to provide insights on short-, mid- and long-term changes over time and investigate reciprocal relationships between workplace mistreatment (e.g., incivility and verbal aggression) and well-being outcomes (e.g., burnout, work engagement).

Finally, future research could also investigate the buffering role of emotion-focused personal resources. They may provide more insights than general self-efficacy and resilience in explaining the link between emotional job demands (e.g., workplace mistreatment) and emotion-related outcomes (e.g., affective well-being). In line with this, a replication should be conducted to examine the moderating role of self-efficacy beliefs on self-regulating negative emotions, specifically concerning the impact of mistreatment on affective well-being.

7. Conclusion

This study demonstrated that a higher frequency of mistreatment from co-workers and supervisors is associated with increased affective ill-being. The findings further showed that, unexpectedly, healthcare employees high in self-efficacy were more sensitive to the effects of mistreatment from their co-workers as it impacted their affective well-being more compared to healthcare employees low in self-efficacy. This suggests that rather than acting as a buffer, self-efficacy intensified the positive relationship between mistreatment and affective ill-being.

Our findings of higher frequency of insider mistreatment being related to increased affective ill-being call for action and changes in the work settings of healthcare workers. In the context of bringing about change and transforming envisioned HR policies (such as those pertaining to dignity, respect, and civility; see Dennehy, 2021) the role of line managers and supervisors is critical (Cunningham & Hyman, 1995). Specifically, management should promote a professional and friendly working atmosphere, especially in busy work settings like healthcare institutions to address and prevent mistreatment among co-workers. This could be done by educating employees on the detrimental effects of workplace mistreatment and through interventions that enhance professionalism.

References

Aiken, L.S., & West, S.G. (1991). *Multiple regression: Testing and interpreting interactions*. Sage

Al-Hawari, M. A., Bani-Melhem, S., & Quratulain, S. (2020). Do frontline employees cope effectively with abusive supervision and customer incivility? Testing the effect of employee resilience. *Journal of Business and Psychology*, *35*(2), 223–240. https://doi.org/10.1007/s10869-019-09621-2

Andel, S. A., Porter, C. O. L. H., Amber, B., & Lukjan, K. P. X. (2022). Differential effects of rude coworkers and patients on nurses' safety performance: An emotional labor perspective. *Journal of Managerial Psychology*, *37*(3), 224–242. https://doi.org/10.1108/JMP-03-2021-0119

Andersson, L. M., & Pearson, C. M. (1999). Tit for tat? The spiraling effect of incivility in the workplace. *Academy of Management Review*, *24*(3), 452–471. https://doi.org/10.5465/amr.1999.2202131

Arnetz, J., Hamblin, L. E., Sudan, S., & Arnetz, B. (2018). Organizational determinants of workplace violence against hospital workers. *Journal of Occupational and Environmental Medicine*, *60*(8), 693–699. https://doi.org/10.1097/JOM.0000000000001345

Avey, J. B., Luthans, F., & Jensen, S. M. (2009). Psychological capital: A positive resource for combating employee stress and turnover. *Human Resource Management*, *48*(5), 677–693. https://doi.org/10.1002/hrm.20294

Bakker, A. B., & Demerouti, E. (2007). The job demands-resources model: State-of-the-art. *Journal of Managerial Psychology*, *22*(3), 309–328. https://doi.org/10.1108/02683940710733115

Bakker, A. B., Demerouti, E., & Sanz-Vergel, A. (2023). Job demands-resources theory: Ten years later. *Annual Review of Organizational Psychology and Organizational Behavior*, *10*, 25–53. https://doi.org/10.1146/annurev-orgpsych-120920

Bambi, S., Foà, C., De Felippis, C., Lucchini, A., Guazzini, A., & Rasero, L. (2018). Workplace incivility, lateral violence and bullying among nurses. A review about their prevalence and related factors. *Acta Biomedica*, *89*(6), 51–79. https://doi.org/10.23750/abm.v89i6-S.7461

Bandura, A. (1977). Self-efficacy: Toward a Unifying Theory of Behavioral Change. *Psychological Review*, *84*(2), 191–215. https://doi.org/10.1037/0033-295X.84.2.191

Bani-Melhem, S., Quratulain, S., & Al-Hawari, M. A. (2020). Customer incivility and frontline employees' revenge intentions: interaction effects of employee empowerment and turnover intentions. *Journal of Hospitality Marketing and Management*, *29*(4), 450–470. https://doi.org/10.1080/19368623.2019.1646180

Barsade, S. G., & Gibson, D. E. (2007). Why does affect matter in organizations? *Academy of Management Perspectives*, *21*(1), 36–59. https://doi.org/10.5465/AMP.2007.24286163

Basińska, B.A., Gruszczyńska, E., & Schaufeli, W.B. (2014). Psychometric properties of the Polish version of the job-related affective well-being scale. *International Journal of Occupational Medicine and Environmental Health*, *27*(6), 993-1004. https://doi.org/10.2478/s13382-014-039-x

Brody, L.R., & Hall, J.A. (2000). Sex and emotion. In M. Lewis & J.M. Haviland-Jones (Eds.), *Handbook of emotions* (pp. 325-414). The Guilford Press.

Bryan, C., O'Shea, D., & MacIntyre, T. (2019). Stressing the relevance of resilience: A systematic review of resilience across the domains of sport and work. *International Review of Sport and Exercise Psychology*, *12*(1), 70–111. https://doi.org/10.1080/1750984X.2017.1381140

Campbell-Sills, L., & Stein, M. B. (2007). Psychometric analysis and refinement of the Connor-Davidson Resilience Scale (CD-RISC): Validation of a 10-item measure of resilience. *Journal of Traumatic Stress*, *20*(6), 1019–1028. https://doi.org/10.1002/jts.20271

Caza, B. B., & Cortina, L. M. (2007). From insult to injury: Explaining the impact of incivility. *Basic and Applied Social Psychology*, *29*(4), 335–350. https://doi.org/10.1080/01973530701665108

Choi, W. D., Kelley, T., Walden, E., McCool, B., & O'Boyle, M. (2022). Emotional dissonance among frontline hospitality employees: An exploratory study examining habituation theory using fMRI. *Journal of Hospitality and Tourism Research*, *46*(1), 174–188. https://doi.org/10.1177/10963480211011633

Connor, D. (2021, October 11). Nurses warn of 'unsafe' conditions due to staff shortages. RTE. https://www.rte.ie/news/business/2021/1011/1253065-nurses-warn-conditions-unsafe-due-to-staff-shortages/

Cunningham, I., & Hyman, J. (1995). Transforming the HRM vision into reality: The role of line managers and supervisors in implementing change. *Employee Relations*, *17*(8), 5-20. https://doi.org/10.1108/01425459510103451.

Cortina, L.M., & Magley, V.J. Raising voice, risking retaliation: Events following interpersonal mistreatment in the workplace. *Journal of Occupational Health Psychology*, *8*(4), 247-265. https://doi.org/10.1037/1076-8998.8.4.247

Cullen, M. J., Zhang, C., Mustapha, T., Tiryaki, E., Benson, B., Konia, M., Sackett, P. R., & Culican, S. M. (2021). Development of a taxonomy of unprofessional behavior in clinical learning environments using learner-generated critical incidents. *Medical Teacher*, *43*(10), 1161–1169. https://doi.org/10.1080/0142159X.2021.1918331

Delgado, C., Roche, M., Fethney, J., & Foster, K. (2021). Mental health nurses' psychological well-being, mental distress, and workplace resilience: A cross-sectional survey. *International Journal of Mental Health Nursing*, *30*(5), 1234–1247. https://doi.org/10.1111/inm.12874

Demsky, C. A., Fritz, C., Hammer, L. B., & Black, A. E. (2018). Workplace Incivility and Employee Sleep: The Role of Rumination and Recovery Experiences. *Journal of Occupational Health Psychology*, *24*(2), 228–240. https://doi.org/10.1037/ocp0000116

Deng, Y., Chang, L., Yang, M., Huo, M., & Zhou, R. (2016). Gender differences in emotional response: Inconsistency between experience and expressivity. *PLoS ONE*, *11*(6). https://doi.org/10.1371/journal.pone.0158666

Dennehy, F. (2021). *A case study into the role of line managers in the management of bullying, harassment and sexual harassment as part of the dignity at work policy* [Masters Thesis, National College of Ireland]. NORMA eResearch NCI Library

Diener, E. & Larsen, R. (1993). The experience of emotional well-being. In M. Lewis and J.M. Havilland (Eds.). *Handbook of emotions*. Guildford Press

Dimarino, T. J. (2011). Eliminating lateral violence in the ambulatory setting: One center's strategies. *AORN Journal*, *93*(5), 583–588. https://doi.org/10.1016/j.aorn.2010.10.019

Farrell, G. A., Bobrowski, C., & Bobrowski, P. (2006). Scoping workplace aggression in nursing: Findings from an Australian study. *Journal of Advanced Nursing*, *55*(6), 778–787. https://doi.org/10.1111/j.1365-2648.2006.03956.x

Faul, F., Erdfelder, E., Buchner, A., & Lang, A.-G. (2009). Statistical power analyses using G*Power 3.1: Tests for correlation and regression analyses. *Behavior Research Methods*, *41*(4), 1149–1160. https://doi.org/10.3758/BRM.41.4.1149

Fida, R., Laschinger, H. K. S., & Leiter, M. P. (2018). The protective role of self-efficacy against workplace incivility and burnout in nursing: A time-lagged study. *Health Care Management Review*, *43*(1), 21–29. https://doi.org/10.1097/HMR.0000000000000126

Foster, K., Roche, M., Giandinoto, J. A., Platania-Phung, C., & Furness, T. (2021). Mental health matters: A cross-sectional study of mental health nurses' health-related quality of life and work-related stressors. *International Journal of Mental Health Nursing*, *30*(3), 624–634. https://doi.org/10.1111/inm.12823

Goussinsky, R. (2012). Coping with customer aggression. *Journal of Service Management*, *23*(2), 170–196. https://doi.org/10.1108/09564231211226105

Han, S., Harold, C. M., Oh, I.-S., Kim, J. K., & Agolli, A. (2021). A meta-analysis integrating 20 years of workplace incivility research: Antecedents, consequences, and boundary conditions. *Journal of Organizational Behavior*, *43*(3), 497–523. https://doi.org/10.1002/job.2568

Hannan, E., Breslin, N., Doherty, E., McGreal, M., Moneley, D., & Offiah, G. (2018). Burnout and stress amongst interns in Irish hospitals: contributing factors and potential solutions. *Irish Journal of Medical Science*, *187*(2), 301–307. https://doi.org/10.1007/s11845-017-1688-7

Hanson, G. C., Perrin, N. A., Moss, H., Laharnar, N., & Glass, N. (2015). Workplace violence against homecare workers and its relationship with workers health outcomes: A cross-sectional study. *BMC Public Health*, *15*(1). https://doi.org/10.1186/s12889-014-1340-7

Hartmann, S., Weiss, M., Newman, A., & Hoegl, M. (2020). Resilience in the workplace: A multilevel review and synthesis. *Applied Psychology*, *69*(3), 913–959. https://doi.org/10.1111/apps.12191

Hayes, A.F. (2013). *Introduction to mediation, moderation, and conditional process analysis: A regression-based approach*. Guilford Press

Hershcovis, M. S. (2011). "Incivility, social undermining, bullying...oh my!": A call to reconcile constructs within workplace aggression research. *Journal of Organizational Behavior*, *32*(3), 499–519. https://doi.org/10.1002/job.689

Hochschild, A.R. (1983). *The managed heart*. University of California Press

Hoegl, M., & Hartmann, S. (2021). Bouncing back, if not beyond: Challenges for research on resilience. *Asian Business and Management*, *20*(4), 456–464. https://doi.org/10.1057/s41291-020-00133-z

Irish Nurses Midwifery Organisation. (2022, July 21). *Nurses make up over 60% of hospital assaults in June*. https://inmo.ie/Home/Index/217/14004

Jex, S. M., & Bliese, P. D. (1999). Efficacy beliefs as a moderator of the impact of work-related stressors: A multilevel study. *Journal of Applied Psychology*, *84*(3), 349–361. https://doi.org/10.1037/0021-9010.84.3.349

Karaeminogullari, A., Erdogan, B., & Bauer, T. N. (2018). Biting the hand that heals: Mistreatment by patients and the well-being of healthcare workers. *Personnel Review*, *47*(2), 572–591. https://doi.org/10.1108/PR-03-2016-0054

Klein, A., & Martin, S. (2011). Two dilemmas in dealing with workplace bullies - False positives and deliberate deceit. *International Journal of Workplace Health Management*, *4*(1), 13–32. https://doi.org/10.1108/17538351111118572

Koopmann, J., Wang, M., Liu, Y., & Song, Y. (2015). Customer mistreatment: A review of conceptualizations and a multilevel theoretical model. *Research in Occupational Stress and Well Being*, *13*, 33–79. https://doi.org/10.1108/S1479-355520150000013002

Lanctôt, N., & Guay, S. (2014). The aftermath of workplace violence among healthcare workers: A systematic literature review of the consequences. *Aggression and Violent Behavior*,*19*(5), 492–501. https://doi.org/10.1016/j.avb.2014.07.010

Laschinger, H. K. S., Leiter, M. P., Day, A., Gilin-Oore, D., & MacKinnon, S. P. (2012). Building empowering work environments that foster civility and organizational trust:

Testing an intervention. *Nursing Research*, *61*(5), 316–325. https://doi.org/10.1097/NNR.0b013e318265a58d

Lauridsen, L.S., Willert, M.V., Eskilden, A., & Christiansen, D.H. (2017). Cross-cultural adaptation and validation of the Danish 10-item Connor-Davidson resilience scale among hospital staff. *Scandinavian Journal of Public Health*, *45*(6), 654-657. https://doi.org/10.1177/1403494817721056

Leiter, M. P., Laschinger, H. K. S., Day, A., & Oore, D. G. (2011). The impact of civility interventions on employee social behavior, distress, and attitudes. *Journal of Applied Psychology*, *96*(6), 1258–1274. https://doi.org/10.1037/a0024442

Lim, S., Cortina, L. M., & Magley, V. J. (2008). Personal and workgroup incivility: Impact on work and health outcomes. *Journal of Applied Psychology*, *93*(1), 95–107. https://doi.org/10.1037/0021-9010.93.1.95

Lim, S., Ilies, R., Koopman, J., Christoforou, P., & Arvey, R. D. (2018). Emotional mechanisms linking incivility at work to aggression and withdrawal at home: An experience-sampling study. *Journal of Management*, *44*(7), 2888–2908. https://doi.org/10.1177/0149206316654544

Lin, Y. K., Lin, C. Der, Lin, B. Y. J., & Chen, D. Y. (2019). Medical students' resilience: A protective role on stress and quality of life in clerkship. *BMC Medical Education*, *19*(1). https://doi.org/10.1186/s12909-019-1912-4

Luszczynska, A., Scholz, U., & Schwarzer, R. (2005). The general self-efficacy scale: Multicultural validation studies. *The Journal of Psychology*, *139*(5), 439-457. https://doi.org/10.3200/JRLP.139.5.439-457

Luthans, F., Avey, J. B., Avolio, B. J., Norman, S. M., & Combs, G. M. (2006). Psychological capital development: Toward a micro-intervention. *Journal of Organizational Behavior*, *27*(3), 387–393. https://doi.org/10.1002/job.373

Luthans, F., Youssef, C. M., & Avolio, B. J. (2007). *Psychological capital: Developing the human competitive edge*. Oxford University Press.

Maffoni, M., Sommovigo, V., Giardini, A., Paolucci, S., & Setti, I. (2020). Dealing with ethical issues in rehabilitation medicine: The relationship between managerial support and emotional exhaustion is mediated by moral distress and enhanced by positive affectivity and resilience. *Journal of Nursing Management*, *28*(5), 1114–1125. https://doi.org/10.1111/jonm.13059

Manser, T. (2009). Teamwork and patient safety in dynamic domains of healthcare: A review of the literature. *Acta Anaesthesiologica Scandinavica*, *53*(2), 143–151. https://doi.org/10.1111/j.1399-6576.2008.01717.x

Meier, L. L., Cho, E., & Dumani, S. (2016). The effect of positive work reflection during leisure time on affective well-being: Results from three diary studies. *Journal of Organizational Behavior*, *37*(2), 255–278. https://doi.org/10.1002/job.2039

Montgomery, K., Kane, K., & Vance, C. M. (2004). Accounting for Differences in Norms of Respect: A Study of Assessments of Incivility Through the Lenses of Race and Gender. *Group and Organization Management*, *29*(2), 248–268. https://doi.org/10.1177/1059601103252105

Muthén, L.K., & Muthén, B.O. (1998-2020). *Mplus user's guide*. Eight edition. Muthén & Muthén

Naeem, M., Weng, Q., Ali, A., & Hameed, Z. (2020). Linking family incivility to workplace incivility: Mediating role of negative emotions and moderating role of self-efficacy for emotional regulation. *Asian Journal of Social Psychology*, *23*(1), 69–81. https://doi.org/10.1111/ajsp.12391

Penhaligon, N. L., Louis, W. R., & Restubog, S. L. D. (2013). Feeling left out? The mediating role of perceived rejection on workgroup mistreatment and affective,

behavioral, and organizational outcomes and the moderating role of organizational norms. *Journal of Applied Social Psychology*, *43*(3), 480–497. https://doi.org/10.1111/j.1559-1816.2013.01026.x

Plutchik, R. (1989). Measuring Emotions and their derivatives. In R. Plutchik & H. Kellerman (Eds.), *Emotion: Theory, research, and experience: The measurment of emotions* (pp. 1–35). Academic Press.

Podsakoff, P. M., MacKenzie, Podsakoff, N. P. (2012). Sources of method bias in social science research and recommendations on how to control it. *Annual Review of Psychology*, *63*, 539–569. https://doi.org/10.1146/annurev-psych-120710-100452

Rafaeli, A., Erez, A., Ravid, S., Derfler-Rozin, R., Treister, D. E., & Scheyer, R. (2012). When customers exhibit verbal aggression, employees pay cognitive costs. *Journal of Applied Psychology*, *97*(5), 931–950. https://doi.org/10.1037/a0028559

Reknes, I., Einarsen, S., Pallesen, S., Bjorvatn, B., Moen, B. E., & Magerøy, N. (2016). Exposure to bullying behaviors at work and subsequent symptoms of anxiety: The moderating role of individual coping style. *Industrial Health*, *54*, 421–432. https://doi.org/10.2486/indhealth.2015-0196

Rhee, S. Y., Hur, W. M., & Kim, M. (2017). The relationship of coworker incivility to job performance and the moderating role of self-efficacy and compassion at work: The job demands-resources (JD-R) approach. *Journal of Business and Psychology*, *32*(6), 711–726. https://doi.org/10.1007/s10869-016-9469-2

Rodwell, J., Demir, D., & Flower, R. (2013). The oppressive nature of work in healthcare: Predictors of aggression against nurses and administrative staff. *Journal of Nursing Management*, *21*, 888-897. https://doi.org/10.1111/jonm.12086

Schiaffino, K.M., Revenson, T.A., & Gibofsky, A. (1991). Assessing the impact of self-efficacy beliefs on adaptation to rheumatoid arthritis. *Arthritis & Rheumatology*, *4*(4), 150-157. https://doi.org/10.1002/art.1790040404

Schilpzand, P., De Pater, I. E., & Erez, A. (2016). Workplace incivility: A review of the literature and agenda for future research. *Journal of Organizational Behavior*, *37*, S57–S88. https://doi.org/10.1002/job.1976

Schönfeld, P., Preusser, F., & Margraf, J. (2017). Costs and benefits of self-efficacy: Differences of the stress response and clinical implications. In *Neuroscience and Biobehavioral Reviews* (Vol. 75, pp. 40–52). Elsevier Ltd. https://doi.org/10.1016/j.neubiorev.2017.01.031

Schwarzer, R., & Jerusalem, M. (1995). Generalized Self-Efficacy Scale. In J. Weinman, S. Wright, & M. Johnston, *Measures in Health Psychology: A User's Portfolio. Causal and Control Beliefs*. NFER-NELSON.

Sliter, M., Jex, S., Wolford, K., & McInnerney, J. (2010). How rude! Emotional labor as a mediator between customer incivility and employee outcomes. *Journal of Occupational Health Psychology*, *15*(4), 468–481. https://doi.org/10.1037/a0020723

Sliter, M., Sliter, K., & Jex, S. (2012). The employee as a punching bag: The effect of multiple sources of incivility on employee withdrawal behavior and sales performance. *Journal of Organizational Behavior*, *33*(1), 121–139. https://doi.org/10.1002/job.767

Sommovigo, V., Setti, I., & Argentero, P. (2019). The role of service providers' resilience in buffering the negative impact of customer incivility on service recovery performance. *Sustainability (Switzerland)*, *11*(2). https://doi.org/10.3390/su11010285

Sommovigo, V., Setti, I., O' Shea, D., & Argentero, P. (2020). Investigating employees' emotional and cognitive reactions to customer mistreatment: An experimental study. *European Journal of Work and Organizational Psychology*, *29*(5), 707–727. https://doi.org/10.1080/1359432X.2020.1745189

Taylor, S. G., Bedeian, A. G., Cole, M. S., & Zhang, Z. (2017). Developing and Testing a Dynamic Model of Workplace Incivility Change. *Journal of Management*, *43*(3), 645–670. https://doi.org/10.1177/0149206314535432

Torkelson, E., Holm, K., & Bäckström, M. (2016). Workplace incivility in a Swedish context. *Nordic Journal of Working Life Studies*, *6*(2), 3–22. https://doi.org/10.19154/njwls.v6i2.4969

Tremmel, S., & Sonnentag, S. (2018). A sorrow halved? A daily diary study on talking about experienced workplace incivility and next-morning negative affect. *Journal of Occupational Health Psychology*, *23*(4), 568–583. https://doi.org/10.1037/ocp0000100

Trent, S. B., & Allen, J. A. (2019). Resilience only gets you so far: Volunteer incivility and burnout. *Organization Management Journal*, *16*(2), 69–80. https://doi.org/10.1080/15416518.2019.1604199

Vagharseyyedin, S. A. (2016). Nurses' perspectives on workplace mistreatment: A qualitative study. *Nursing and Health Sciences*, *18*(1), 70–78. https://doi.org/10.1111/nhs.12236

Van Katwyk, P. T., Fox, S., Spector, P. E., & Kelloway, E. K. (2000). Using the job-related affective well-being scale (JAWS) to investigate affective responses to work stressors. *Journal of Occupational Health Psychology*, *5*(2), 219–230. https://doi.org/10.1037/1076-8998.5.2.219

Warr, P. (1990). The measurement of well-being and other aspects of mental health. *Journal of Occupational Psychology*, *63*, 193–210. https://doi.org/10.1111/j.2044-8325.1990.tb00521.x

Watters, C., Reedy, G., Ross, A., Morgan, N. J., Handslip, R., & Jaye, P. (2015). Does interprofessional simulation increase self-efficacy: A comparative study. *BMJ Open*, *5*(1). https://doi.org/10.1136/bmjopen-2014-005472

Weiss, H. M., & Cropanzano, R. (1996). Affective events theory: A theoretical discussion of the structure, cause and consequences of affective experiences at work. In B. Staw & L. Cummings (Eds.), *Research in Organizational Behaviour*, (pp. 1–74). Elsevier Science/JAI Press.

World Health Organisation (2022). Health professions networks. https://www.who.int/teams/health-workforce/health-professions-networks

Xanthopoulou, D., Bakker, A. B., Demerouti, E., & Schaufeli, W. B. (2007). The role of personal resources in the job demands-resources model. *International Journal of Stress Management*, *14*(2), 121–141. https://doi.org/10.1037/1072-5245.14.2.121

Zhou, Z. E., Meier, L. L., & Spector, P. E. (2019). The spillover effects of coworker, supervisor, and outsider workplace incivility on work-to-family conflict: A weekly diary design. *Journal of Organizational Behavior*, *40*(9–10), 1000–1012. https://doi.org/10.1002/job.2401

Zhu, G., & Tan, T. K. (2019). Medical student mistreatment by patients in the clinical environment: Prevalence and management. *Singapore Medical Journal*, *60*(7), 353–358. https://doi.org/10.11622/smedj.2019075