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Workplace Violence Is Home Now for Healthcare Workers: Spillover Theory Perspective

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ABSTRACT

In recent years, workplace violence has become an escalating concern, particularly within the healthcare sector. Healthcare workers, who dedicate their lives to caring for others, are increasingly facing violence within their workplaces as evidenced by existing studies. However, literature overlooks complex associations between workplace violence, workplace stress, and domestic violence and stress. This article explores the phenomenon of workplace violence among healthcare workers through the lens of Spillover Theory and investigates impact of workplace violence on domestic stress with single and sequential mediation of workplace stress and domestic violence. Our findings of *MEDTHREE* analysis of time-lagged data indicate that individuals who experience workplace violence are more likely to exhibit stress, which ultimately becomes a cause of domestic violence. The study highlights how spillover theory can help to explain how workplace violence can trigger violence and stress in the home environment. The research highlights the need for a support system and targeted interventions to address the issue of workplace violence to mitigate its spillover effects into domestic violence. With the help of the findings, the organisational decision makers can develop comprehensive strategies to mitigate the harmful consequences of the workplace violence to provide safe and healthy environment at work and home settings.

1 | Introduction

Workplace violence represents a significant concern in organisations, particularly in high demanding services sectors for example, health sector, as it directly impacts the health and safety of individuals. Its association with employee well-being, organisational success, and productivity emphasises the critical need for addressing this issue in the workplace (Dionisi and Dupré 2023; Shahrour et al. 2022). Workplace violence is a negative-sum game for the employer, employees, co-workers, and the family; it detracts substantially from a safe and healthy work and family life. Indeed, workplace violence has been reported as one of the major sources of stress at work (Gragnano, Simbula, and Miglioretti 2020; Magnavita 2014; Saleh et al. 2020; Wang et al. 2024). Although workplace violence is a significant issue for all workers, healthcare workers are at highest risk among all other occupations (Rossi et al. 2023) due to their close contact with distressed patients and their relatives (Aytac, Dursun, and Akalp 2016; Martino 2003). The healthcare workers are 87% more exposed to any kind of violence, either verbal or physical at the workplace, because of the highly sensitive nature of their job—making them one of the most vulnerable groups (Erkol et al. 2007).

Workplace violence in healthcare settings can be defined as an act of intimidation, vandalisation, aggression, and abuse including but not limited to physical, verbal and sexual abuse (L. Lim and Khor 2022; Mambrey, Ritz-Timme and Loerbroks 2023). Recent

literature has identified violence as the act of yelling, rudeness, ignoring or abuse, holding or hiding behaviour between two co-workers (Beattie et al. 2019; Mambrey, Ritz-Timme, and Loerbroks 2023).

Research on workplace violence has made substantial contributions by examining critical antecedents and outcomes, along with the adverse consequences linked to both individuals and organisations (Di-Martino 2003; Rasool et al. 2020; Laeeque et al. 2018). As a domestic being, we spend most of our time either at work or at home, therefore, encountering violent behaviours and taking the resulting stress to either of these settings is inevitable (Bilal et al. 2015). While existing literature offers a great deal of understanding on the topic, it downplays the possible spillover effects of workplace violence to the other settings—for example, domestic environment (Carrington and Williamson 2022; Dheensa et al. 2023; Kowalenko et al. 2012; Laeeque, Saeed and Bilal 2022; Maple and Kebbell 2024; Versola-Russo and Russo 2009).

While numerous studies have examined the prevalence and consequences of workplace violence, few have delved into the intricate relationship between work and home environments. For example, Whyte et al. (2011) examined the prevalence and impact of stalking and examined the care received at workplace and other personal social factors which contributed toward the spillover effect. Similarly, Gentile et al. (2002) examined stalking by clients both within the workplace as well as outside the work domain. However, the existing knowledge is limited in terms of the spillover effect where the violence at workplace exclusively spills over to the domestic domain. Recently, Vranjes et al. (2021) reported that stress and aggression encountered at work can be displaced onto partners in the form of online aggression. This finding highlights the direct pathway through which workplace stressors can influence domestic interactions. Similarly, Sanz-Vergel et al. (2015) illustrated how work-related stress not only affects the individual but can also spill over into their partner's experiences, exacerbating domestic conflicts. Shah and Huang's (2024) study sheds light on how nurses' workplace violence exposure can deplete their life partners' emotional resources, however, it overlooks a crucial link between workplace stress and domestic violence. Furthermore, Li and Lin's (2024) study investigate the spillover of workplace 'cold violence' into family life but misses the opportunity to explore how such stressors might escalate into domestic stress. The study by Liu et al. (2023) found that health professionals faced compounded mental health issues, because of violent attacks, though it is limited by not exploring spillover effects in other settings. While these studies have expanded the literature on the spillover effects of workplace violence, their scope was limited. In this quest, our study aims to bridge this gap by comprehensively investigating the role of workplace violence and its ramifications on the domestic sphere.

By exploring the internal mechanism through which this spillover takes place, this study will help the practitioners to understand the internal mechanism which drives the workplace violence through to the domestic domain. We consider that workplace violence is inevitable, particularly in the highly sensitive sectors, for example, the health care facilities (Rossi et al. 2023). However, steps could be taken to reduce the intensity of these violences incidents as well as their spillover to the domestic domains, which helps the employees create a balance between workplace violence and the domestic quality family life.

This study offers three theoretical contributions to the existing body of knowledge. First, existing literature is fragmented in terms of the existence of the organisational systems in place which are more sophisticated in the western part of the world, where we have evidence (Honarvar et al. 2019; Saleh et al. 2020; Martino 2003; Ramlee et al. 2016) that workplace violence affects the workplace stress despite the extended level of support available in the facilities. We offer these unique insights from the developing context, where the resilient level is relatively higher as compared to the most developed context and show how this workplace violence contributes to the workplace stress. Second, this study contributes to the understanding of the spillover effect of the workplace violence into the domestic violence in the healthcare industry, where the professionals are more trained in their profession by having higher level of empathy and bear the workplace violence. This study adds more insights to the existing studies (e.g., Havaei and MacPhee 2021; Havaei et al. 2023; Hegney et al. 2010; Kaukiainen et al. 2001; Schat and Kelloway 2000; Shahrour et al. 2022; Sun et al. 2021), which provided insights about the diverse industrial settings. Third, we offered more clear understanding of the internal mechanism through which the workplace violence spillover to the domestic violence in the healthcare professionals. We already know that violent and stressed employees are more prone to become violent spouses/partners causing the family environment stressful, particularly in the different professions. However, this study contributes toward this end by exploring this mechanism in the healthcare professionals, which are more trained, particularly having more empathy and more relevant rigorous training. This contribution is important, which gives insights, that how the external factors such as workplace violences are internalised in the form of workplace stress and how they are subsequently externalised through exhibiting domestic violence. We examine this through MEDTHREE analysis to establish the serial mediation between workplace violence and the domestic violence. These insights are important because past research has shown the violence and stress are closely related and have significant implications on healthcare workers' job-related outcomes. However, very scarce research is available to know the implications of the workplace factors on the domestic factors. This is particularly important in the context of the spillover theory (Edwards and Rothbard 2000), which contends that a person carries feelings and emotions from one domain to the other domain. However, it is very important to understand how this transition is logistically carried out. The present study is only one of a few that links workplace violence with domestic violence.

In the following sections, we provide literature review on the topic and explain the overarching theory that is, spillover theory, followed by the hypotheses development. Next section explains the methodology of the study followed by the results. Finally, we provide the discussion of the study including them managerial implications and future research directions.

2 | Literature Review and Hypotheses

2.1 | Workplace Violence

The US National Institute for Occupational Safety and Health defines workplace violence as violent acts, such as physical assaults and threats of assaults, directed toward persons at work or on duty (Wyatt, Anderson-Drevs and Van-Male 2016). Workplace stress is the adverse effect of workplace demands and excessive pressure of work especially in case of healthcare workers (Beehr, Bowling and Bennett 2010; Shahrour et al. 2022). Domestic violence is defined as violent or aggressive behaviour within the home, typically involving the violent abuse of a spouse or partner (Oram et al. 2013). Domestic stress is defined as a state of mental or emotional strain or suspense caused by, and related to, the domestic situation (Hobfoll 2002). Healthcare workers face violence in different forms, including verbal and emotional abuse, bullying, aggression, harassment, and physical violence; or perpetrators, such as patients, patients' relatives and visitors, coworkers, and others in the healthcare sector (Chen et al. 2016).

The healthcare profession is emotionally and psychologically more challenging than any other profession (Garcia et al. 2014; McGrath et al. 2024). Nurses and doctors have more contact with patients, who can make health professionals' work environment taxing and stressful and more demanding (Al-Youbi and Jan 2013). Employees suffering from workplace stress can retaliate by becoming violent toward their partner and other family members domestically (Maple and Kebbell 2024; Sun et al. 2021). The literature indicates that a stressed employee has more chances of becoming aggressive, abusive, and violent toward the people within his or her close circle (MacGregor et al. 2016). The spillover theory (Edwards and Rothbard 2000) also contends that participation in one domain, that is, work, is likely to impact participation in another domain (e.g., family).

2.1.1 | Spillover Theory

Drawing on Spillover theory (Edwards and Rothbard 2000), which is derived from the theory of work-life balance (Clark 2000) and conflict theory (Frone 2003), we frame our research and develop our hypotheses. The theory suggests that experiences and emotions from one area of life, such as work, can spill over into other areas, like personal or family life, and vice versa. This concept is often used to explain the interaction between work and non-work domains (Wilensky 1960). It further argues that the effect in one domain can be either positive or negative, suggesting that the spillover effect may also exhibit similar characteristics (Edwards and Rothbard 2000; Lacasse 2016).

The Spillover theory provides a valuable framework for understanding the mechanisms through which workplace violence and stress influence domestic violence and stress (Maple and Kebbell 2024; Thompson, Kirk and Brown 2005). According to this theory, the emotions, stressors, and behaviours that individuals experience in one domain of their lives—such as the workplace—can transfer or 'spill over' into another domain, such as the home environment. The theory helps explain how the negative experiences associated with workplace violence—such as heightened stress, anger, or frustration—can seep into the domestic sphere, leading to increased tension, aggression, or even violence at home. This process can be particularly pronounced when individuals work in high demanding environments, like healthcare (Jimmieson, Tucker and Walsh 2017). Supporting this theoretical perspective, Vranjes et al. (2021) demonstrated in their daily diary study of dual-earner couples that stress and aggression encountered at work can be displaced onto partners in the form of online aggression. This finding highlights the direct pathway through which workplace stressors can influence domestic interactions. Similarly, Sanz-Vergel et al. (2015) explored the spillover and crossover of daily conflicts between work and home, illustrating how work-related stress not only affects the individual but can also spill over into their partner's experiences, exacerbating domestic conflicts. These studies emphasise the critical role that Spillover theory plays in explaining the link between workplace violence and domestic stress or violence. By incorporating this framework, our research seeks to deepen the understanding of how workplace violence can extend beyond the confines of work, negatively impacting the home environment and contributing to a cycle of stress and violence.

The literature on violence and stress in healthcare infers two key points. First, workplace violence contributes significantly to healthcare employees' stress levels, and stressed employees are likely to carry hostile feelings toward those around them, creating a violent and stressful environment. Second, there have been very few papers and models that have identified the relationship between violence and stress both at workplace and at home, especially in Pakistan. Therefore, identifying and addressing such factors is valuable to limit violence and stress.

2.2 | Workplace Violence and Workplace Stress

Healthcare workers are at the highest risk of workplace violence among all occupations as the nature of their work allows no mistakes at all (Martino 2003; Yeboah et al. 2016). Healthcare workers are 87% more exposed to any kind of violence, either verbal or physical at the workplace, because of the most sensitive and demanding nature of their job (Erkol et al. 2007). Havaei and MacPhee (2021) found among 551 medical-surgical nurses in British Columbia that workplace violence is a significant factor contributing to psychological stress, which negatively affects nurses' health and well-being, suggesting a strong correlation between exposure to workplace violence and adverse mental health outcomes. Previous research has concluded that the highest risk of workplace violence is in occupations where there is intensive interaction inside or outside the business (Thompson, Kirk and Brown 2005). Contextually, healthcare employees are at higher risk of being exposed to violence as compared to other sectors (Martino 2003; Park, Cho and Hong 2014). Studies have reported that workplace violence adversely affect the employees as they suffer from anxiety (Hegney et al. 2010), psychological distress (Hanson et al. 2015; Shirom and Melamed 2005), lack of work concentration (Kaukiainen et al. 2001), and emotional exhaustion (Grandey, Kern,

and Frone 2007). Workplace violence has been shown to have a direct relationship with workplace stress, as evidenced by studies conducted by Gates, Gillespie, and Succop (2011) and Hanson et al. (2015). According to Mayhew and Chappell (2007), workplace violence is a strong predictor of employee stress. Previous research also supports this notion among the healthcare workers in China (Aytac, Dursun, and Akalp 2016; Lei, Hee and Dong 2010; Yeboah et al. 2016). Therefore, it is hypothesised that:

H1. *Workplace violence has a significant positive impact on workplace stress in the healthcare industry.*

2.3 | Workplace Stress and Domestic Violence

According to Spillover Theory, healthcare workers exposed to workplace stress are more likely to exhibit domestic violence due to the emotional and psychological strain that carries over from their professional environment (Pluut et al. 2022). Several studies have identified stress as a source of violence (Kop, Euwema and Schaufeli 1999). A study by MacGregor et al. (2016) examined 2831 individuals who experienced domestic violence and highlighted that domestic violence is increasingly recognised as a workplace issue, significantly impacting both stress levels and productivity, suggesting that personal experiences of violence can extend into professional environments and affect workplace dynamics. Studies in Pakistan have also revealed that most of the time females (spouses) are soft targets and a working person may bully the non-working family member (Bilal et al. 2015). Boundaries of work and family life are blurring because of the integral nature of both settings (Schrank 2006) and people easily transition between the roles of employee and family member (Ashforth, Kreiner, and Fugate 2000; Clark 2000). According to Mayhew and Chappell (2007) workplace stress may cause domestic violence. Rayner-Thomas (2013) concluded that domestic violence has positive relationship several factors outside the domestic sphere; workplace violence is one of them. Therefore, we hypothesise that:

H2. *Individuals working in the healthcare industry, who are subject to workplace stress are more likely to be violent domestically.*

2.4 | Workplace Violence, Domestic Violence and Domestic Stress

Workplace violence can give rise to family problems (Aytac, Dursun, and Akalp 2016). Ashforth (2001) suggested that we undergo micro and macro role transitions daily while shifting our role from the specified family member to the role of employee. In addition, macro transitions are permanent whereas micro transitions involve shifting between currently held roles. It is evident that employees can take violence from either of the settings to the other by indulging in the same thoughts and activities. An online study was conducted in Canada, and it was reported that workers take domestic violence to the workplace and vice versa in the form of preoccupation with the same thoughts, stalked by the perpetrator and continuation of the argument even at workplace by texting, emailing or any means possible to contact (Wathen, MacGregor and MacQuarrie 2015). One of the phone surveys conducted in America (2005) concluded that 44% of full-time employees experience the effects of workplace violence at home (Workplaces Respond website; CAEPV Website n.d.). The blurring of work and family border, facilitated by the advancement in telecommunications and the on-call nature of healthcare workers, workplace concerns are likely to cause greater stress in personal life (Chesley, Moen, and Shore 2001; Schrank 2006). According to DeFrank (2012) workplace violence is highly and persistently positively correlated with domestic stress throughout literature. Any violent incident can be traumatic for the person involved, which has long lasting effect on the victims that they try to reduce the feelings of guilt and inferiority by transferring the role of perpetrator to their victim (Pelto-Piri, Warg and Kjellin 2020). This results in inflicting the same pain on other co-workers, making them the victims of workplace violence. As suggested by spillover theory, in return these victims will take this feeling of stress and anxiousness to their home and other social settings and a vicious cycle will continue to operate (Versola-Russo and Russo 2009). Domestic violence is defined as violent or aggressive behaviour within the home, typically involving the violent abuse of a spouse, a partner or a family member (Howard et al. 2013). Domestic stress is defined as a state of mental or emotional strain or suspense caused by and related to domestic situation (Hobfoll 2002). Research across various healthcare and public service sectors consistently demonstrates that workplace violence, such as harassment and mobbing, contributes to heightened occupational stress (Rasool et al. 2020; Shahrour et al. 2022), which can negatively impact work performance and well-being (Havaei and MacPhee 2021; Samma et al. 2020). Similarly, domestic violence has been increasingly recognised as a workplace stressor, influencing productivity (Oh et al. 2022; MacGregor et al. 2016). This suggests a potential link between domestic and workplace stressors that collectively exacerbate psychological distress and job-related burnout (Pariona-Cabrera et al. 2024; Wang et al. 2024). Healthcare workers face violence in different forms, like verbal and emotional abuse, bullying, aggression, harassment, and physical violence; or perpetrators, such as patients, patients' relatives and visitors, coworkers, and others in the healthcare sector (Chen et al. 2016). The violence faced at the workplace is carried to the home environment causing domestic violence (Jonge 2016). The existing research demonstrates that domestic violence is positively related with stress specifically after violent incidents at home (Jones, Hughes and Unterstaller 2001). Based on these empirical grounds, we hypothesised:

H3. *Workplace violence has a positive significant impact on domestic violence in the healthcare industry.*

H4. *Workplace violence has a positive significant impact on domestic stress in the healthcare industry.*

H5. *Domestic violence has a positive significant impact on domestic stress in the healthcare industry.*

2.5 | Workplace Stress and Domestic Violence as Sequential Mediators

Stress has multiple sources including many physical, psychological, and social stressors related to personal and work life (Yeboah et al. 2016). According to Magnavita (2014) workplace violence is positively associated with workplace stress which can disrupt personal relationships (Kristensen et al. 2005). Research indicates that workplace violence causes employee stress (Martino 2003) and a stressed employee is more likely to be violent at home (Magnavita 2014). According to Martino (2003), stress was the most important cause behind the violent behaviour of healthcare workers against their co-workers, patients, family members as well as the other visitors. In a study of spillover effect, Williams and Alliger (1994) used experience sampling methodology to examine mood-related spillover on a daily basis; their findings suggest that working parents in their sample were more likely to bring work-related emotions home than they were to transfer family related emotions to the workplace. Workplace violence has been shown to directly trigger occupational stress, as evidenced by Shahrour et al. (2022), who found that psychiatric nurses experiencing workplace violence reported elevated stress levels, with no mitigating effect from social support. Similarly, Rasool et al. (2020) demonstrated that workplace violence, including harassment and ostracism, increases workplace stress, which negatively impacts job performance in healthcare settings. MacGregor et al. (2016) and Oh et al. (2022) further highlighted that domestic violence exacerbates stress and reduces productivity, suggesting that stress originating from workplace violence can extend into personal lives and manifest as domestic stress. Nam et al. (2024) supported this by showing that workplace violence heightened psychological distress, increasing turnover intention, indicating that stress from workplace violence may sequentially mediate the relationship between workplace violence and domestic stress through its effects on domestic life. These findings collectively suggest that workplace stress and domestic violence sequentially mediate the relationship between workplace violence and domestic stress in the healthcare industry. Therefore, we hypothesise:

H6. *Workplace stress mediates the relationship between workplace violence and domestic stress in the healthcare industry.*

H7. *Domestic violence mediates the relationship between workplace violence and domestic stress in the healthcare industry.*

H8. *Workplace stress and domestic violence sequentially mediates the relationship between workplace violence and domestic stress in the healthcare industry.*

The hypothesised research model of our study based on the above hypotheses is provided in Figure 1. In addition, to summarise the hypotheses development section, we provide the list of the relevant important studies to support the hypotheses of the study (see Table 1).

3 | Methods

In this section we have explained the data collection procedure, sample size and the contextual information about our population.

We collected data from employees in Pakistan's healthcare sector, which has 354,524 registered employees (Pakistan Medical and Dental Council 2024). The healthcare sector is recognised for its high levels of workplace violence, with healthcare workers frequently facing physical assaults, verbal abuse, and harassment from patients, their families, or colleagues (Bilal et al. 2015; Laeeque et al. 2018; Shahzad and Malik 2014). This occupational stress can spillover into their personal lives, increasing the risk of domestic violence and compounding overall stress levels. The spillover effect, where stress and violence experienced at work affect home life, is particularly pronounced in healthcare workers due to the emotional demands of their profession, including caring for patients under high-pressure conditions (Laeeque et al. 2018). Understanding these dynamics is essential not only for safeguarding the well-being of healthcare workers but also for ensuring the quality of care they provide. High levels of workplace stress and violence have been linked to burnout, reduced job satisfaction, and potentially compromised patient care, making this an important public health issue (Mento et al. 2020). There are government interventions to overcome this problem and to provide remedial steps to avoid workplace violence. For example, the Senate of Pakistan passed a bill to amend the Pakistan Penal Code (1860) and the Pakistan Code of Criminal Procedure (1898) against sexual harassment and violence within the workplace (Bilal et al. 2015). However, even with strict and well-defined measures taken by the Pakistani judicial system, several violent incidents are occurring in various Pakistani hospitals (Bilal et al. 2015; Shahzad and Malik 2014). Furthermore, a recent systematic review concluded that the prevalence of workplace violence against healthcare workers ranges from 25% to 100%, highlighting the persistent nature of this issue (Rehan et al. 2023). Therefore, including healthcare workers in this study offers valuable insights into the broader implications of workplace stress and violence, with

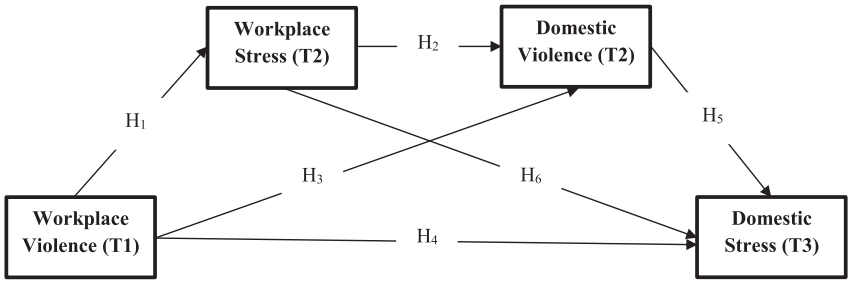

FIGURE 1 | Theoretical framework.

TABLE 1 | Summary of empirical studies for hypotheses.

Study	Context	Results
Shahrour et al. (2022)	195 psychiatric nurses from two governmental mental health hospitals	Workplace violence predicted nurses' stress, and social support did not moderate the relationship
Havaei and MacPhee (2021)	551 medical-surgical nurses in British Columbia	Workplace violence triggers psychological stress with negative effects on nurses' health and well-being
Sun et al. (2021)	Chinese Sixth National Health Service Survey among 1371 healthcare workers	Work stress was directly related to workplace violence, while psychological demands and social approval indirectly influenced workplace violence through stress
Rasool et al. (2020)	345 healthcare workers in Pakistan	Workplace violence (harassment, mobbing, ostracism and stalking) negatively impacted work performance by increasing occupational stress
MacGregor et al. (2016)	2831 individuals who experienced domestic violence	Domestic violence increasingly seen as a workplace issue, influencing both stress and productivity
Wang et al. (2024)	Study on Chinese correctional officers assessing stress	Stress played mediating roles in the effect of workplace violence on job burnout
Pariona-Cabrera et al. (2024)	Data from 225 aged care workers in Australia and 136 healthcare workers in China across multiple waves	Job stress mediated the relationship between workplace violence and the quality of care provided
Lu, Jian, and Yang (2024)	734 Taiwanese police officers	Specialisation in domestic violence prevention reduced the exposure to trauma and associated stress among officers
Oh et al. (2022)	Korean children and youth panel survey	Domestic violence experiences were positively associated with increased stress
Nam et al. (2024)	308 nurses working during COVID-19 in Korea	Workplace violence increased turnover intention, with psychological distress acting as a mediator
Samma et al. (2020)	Healthcare workers from 15 hospitals in Pakistan	Workplace violence reduced sustainable work performance, mediated by occupational stress

potential applications for interventions in other high-stress professions.

3.1 | Procedure

The approval to conduct the present study was obtained from the author's institution (SZABIST, Pakistan). The printed questionnaires were personally provided to respondents which contained a cover letter explaining the purpose of the survey and significance of participation while ensuring confidentiality of the responses. Considering that all the registered healthcare workers were highly qualified and possessed a strong command of the English language, the instrument was developed in English. Surveys were administered to healthcare workers on day, evening and night shifts for both weekdays and weekends to capture a comprehensive view of the workforce. Although healthcare employees work in different occupations, the data specifically have been collected from hospital and healthcare-centre employees.

After the respondents agreed to fill in the questionnaire, they were requested to sign the informed consent for their voluntarily participation. At the time of data collection, the respondents were residing with their family members, including spouses, parents, or siblings. The data are cross-sectional, and time lagged, segregated for different variables, through a survey-based questionnaire. We used the time-lagged data collection to maintain the temporal antecedence of the causal variables over mediating variables and subsequently over the dependent variable. For workplace violence, we contacted healthcare employees/workers (at T1, 510 responses), and for the workplace stress and domestic violence they were contacted 3 months after the first survey (at T2, 460 responses) and finally for the domestic stress they were contacted again after another 3 months (at T3, 423 responses). To enhance response rates, we employed the strategy of follow-up reminders at each data collection point. After three reminders, no further reminders were sent. The target number of responses was set at 510, with a final sample size of 423 achieved. A personal code was assigned to link the three waves of time-lagged data and to ensure data anonymity to eliminate common method bias (Podsakoff et al. 2003).

3.2 | Measures

Workplace violence was measured with six related items ($\alpha = 0.877$) scale developed by Rogers and Kelloway (1997), and Schat and Kelloway (2000). The items included statements like 'someone threatened you at the workplace', and 'someone tried to hit you or has someone pushed you with force'. *Workplace stress* was measured using four items scale ($\alpha = 0.785$) developed

by Parker and DeCotiis (1983). The measure contained statements such as 'I feel fidgety or nervous at the workplace', and 'sometimes I feel like crying at workplace'. *Domestic violence* was measured using five items scale ($\alpha = 0.879$) developed by Richardson et al. (2002). The measure contained statements such as 'I try to control my family members', 'I shout or scream, and become very aggressive at home', and 'sometimes, I feel I may be involved in physical assault at home'. *Domestic stress* was measured through a five items scale ($\alpha = 0.832$) developed by Weathers et al. (1993). The scale included statements such as 'you been upset because of something that happened unexpectedly', 'you were unable to control the important things at home', 'you often feel nervous and stressed at home', 'sometimes you feel you could not cope with domestic issues', and 'you get angry, because of things not in your control'. The scale is provided in Supporting Information S1: Appendix 1.

3.3 | Control Variables

Employees' gender, age, daily patient contact in hours, department, tenure, and education level were modelled as control variables. Gender was coded as 1 = female and 2 = male, age and job tenure were measured in the number of years. Patient contact was measured in daily number of hours. Department was coded as 0 for emergency and 1 for inpatient or outpatient. The educational level was measured in the number of years such as 12 (intermediate), 14 (Bachelor), 16 (Master) and 21 (PhD).

3.4 | Reliability and Validity Analysis

We conducted exploratory factor analysis and evaluated the reliability of the constructs used in our study, estimating Cronbach's alpha coefficient and composite reliability (CR). The results are provided in Table 2; all the loadings are within an acceptable range (i.e., > 0.510). Although there were some low loadings, the overall average variance explained (AVE) was within an acceptable range (i.e., > 0.50); therefore, we retained all the above items in further analysis. The Cronbach's alpha as well as the composite reliability values were much above their threshold (i.e., > 0.70), thus indicating that all measures were internally consistent (Gliem and Gliem 2003). We established convergent validity, that is, through AVE (i.e., > 0.505) for all constructs (Ping 2005). To establish discriminant validity, we used criteria suggested by Fornell and Larcker (1981), that is, square root of AVE for each construct was higher than their inter correlation with other constructs, therefore, discriminant validity of all the constructs was established (see Table 3).

3.5 | Data Analysis

We analysed the data using SPSS software. We used *MEDTHREE analysis* for the calculation of indirect effects to test simple and sequential mediation hypotheses (Hayes and Preacher 2010) through bootstrapping method with model 6, using a Process-Macro in SPSS. Model 6 of the PROCESS Macro,

TABLE 2 | Reliability analysis.

	Factor loading of item								
Construct	**#1**	**#2**	**#3**	**#4**	**#5**	**#6**	**α**	**CR**	**AVE**
Workplace violence (T1)	0.75	0.60	0.85	0.71	0.77	0.66	0.87	0.87	0.53
Workplace stress (T2)	0.76	0.59	0.63	0.85			0.78	0.80	0.51
Domestic violence (T2)	0.57	0.79	0.76	0.72	0.72		0.87	0.84	0.51
Domestic stress (T3)	0.51	0.86	0.74	0.75	0.62		0.85	0.83	0.50

Note: Workplace violence (6 items loaded), workplace stress (4 items loaded), domestic violence (5 items loaded), domestic stress (5 items loaded).
Abbreviations: α = cronbach's alpha, AVE = average variance extracted, CR = composite reliability.

TABLE 3 | Correlations.

	1	2	3	4	5	6	7	8	9	10
1. Gender	—									
2. Age	0.10*	—								
3. Patient contact	0.01	−0.09	—							
4. Department	0.07	−0.03	0.27**	—						
5. Tenure	0.10*	0.95**	−0.10*	−0.02	—					
6. Education	−0.05	−0.06	−0.04	−0.04	−0.06	—				
7. WV (T1)	−0.01	−0.08	0.03	−0.02	−0.07	0.03	**0.73**			
8. WS (T2)	−0.06	−0.01	−0.02	−0.06	0.01	−0.00	0.53**	**0.71**		
9. DV (T2)	0.00	−0.01	0.06	−0.00	0.01	−0.04	0.57**	0.46**	**0.72**	
10. DS (T3)	0.06	−0.02	0.02	−0.06	0.01	−0.09	0.57**	0.53**	0.69**	**0.71**

Note: Bold values are the diagonal values which are square root of the AVEs of the main constructs (i.e., WV, WS, DV, DS), which are higher than their inter-correlation with other constructs, therefore, establishes the discriminant validity (Fornell and Larcker 1981).
Abbreviations: DS = domestic stress, DV = domestic violence, WS = workplace stress, WV = workplace violence.
*Correlation is significant at the 0.05 level (2-tailed). **Correlation is significant at the 0.01 level (2-tailed).

developed by Hayes and Preacher (2010), is a statistical tool used to analyse complex mediation models that is, serial multiple mediation. The multiple mediation is one where the effect of an independent variable on a dependent variable is transmitted through a chain of mediators in a specific order. Unlike simple mediation, where the effect of X on Y is mediated by a single mediator (M), serial multiple mediation involves a sequence of mediators. This model allowed us to investigate how an effect is transmitted through a series of variables with estimation of indirect effects and their confidence intervals. We estimated path coefficients at the 95% confidence interval, using 5000 iterations.

4 | Results

4.1 | Descriptive Statistics and Correlation

Descriptive statistics are provided in Table 4. The sample consisted of 78% of male respondents and average age of the respondents was 41.43 years with standard deviation of 11.6. The average patient contact on daily basis was 3.62 h with standard deviation of 1.43. In our sample, 44% of respondents were working in emergency department, while 56% in the inpatient or outpatient departments. Average tenure of respondents was 6.82 years with standard deviation of 2.76. The average educational level of the respondents was 14 years of education.

Table 3 shows correlation matrix and the evidence of discriminant validity. As per Fornell and Larcker (1981) criteria square root of AVEs (provided in diagonal) are higher than the intercorrelation of the constructs with other constructs. Results further show that none of the control variables is significantly related to the main variables of the study. Workplace violence is significantly and positively related to workplace stress ($r = 0.539$, $p < 0.001$), domestic violence ($r = 0.576$, $p < 0.001$) and domestic stress ($r = 0.572$, $p < 0.001$).

4.2 | Mediation Analysis

The direct, indirect, and sequential mediation hypotheses were tested using a bootstrap regression method using *MEDTHRE* analysis (Model 6) with 95% confidence interval and 5000 bootstrapped samples. Results are provided in Tables 5 and 6. The number of bootstrap samples for bias corrected bootstrap confidence intervals was 5000, at the 95% level of confidence for all confidence intervals. The results (see Table 5) of Hypothesis 1 indicate that there is a 29% variation ($R^2 = 0.29$, $F = 172$, $p < 0.001$) in workplace stress because of workplace violence. The results support the hypothesis ($\beta = 0.66$, $t = 13.11$) that workplace violence is positively associated with workplace stress.

The results indicate that a 60% variation ($R^2 = 0.60$, $F = 121$, $p < 0.001$) in domestic violence is explained by workplace stress and workplace violence. The results support Hypothesis 2 ($\beta = 0.70$, $t = 3.29$) that workplace stress is positively associated with the likelihood of domestic violence. Hypothesis 3 has also been accepted ($\beta = 0.65$, $t = 9.90$), indicating that workplace violence is positively associated with domestic violence. Hypothesis 4 is, similarly, supported ($\beta = 0.22$, $t = 4.11$) suggesting that workplace violence is positively associated with domestic stress. Hypothesis 5 is supported ($\beta = 0.43$, $t = 11.96$) that workplace violence is positively associated with domestic violence.

For the simple (Model 4) and sequential mediation (Model 6), the *MEDTHREE* analysis suggested by Hayes and Preacher (2010) was used and the results are presented in Table 6. The analysis showed ($\beta = 0.504$, SE = 0.056, CIs: 0.400, 0.622) that workplace stress mediates the positive relationship between workplace violence and domestic violence. The VAF indicates 28% mediation, supporting Hypothesis 6. Hypothesis 7 is also supported ($\beta = 0.288$, SE = 0.04, CIs: 0.217, 0.374) that domestic violence mediates the relationship between workplace violence and domestic stress conforming 57% mediation (VAF = 57.14). The results of the hypothesis 8 were also significant ($\beta = 0.075$,

TABLE 4 | Descriptive statistics.

Variable	Description	Min	Max	Mean	SD	Ske	Kurt
1. Gender	1 = female; 2 = male	1	2		0.41	1.39	−0.06
2. Age	years	23	59	41.43	11	−0.02	−1.31
3. Patient contact	Daily patient contact (hours)	1	6	3.62	1.43	0.01	−1.26
4. Department	0 = emergency; 1 = other	0	1		0.49	−0.26	−1.94
5. Tenure	Years served in healthcare	1	11	6.82	2.11	−0.50	−0.30
6. Education	Number of years	12	21	14.15	2.76	1.05	−0.14
7. Workplace violence (T1)	6 items on 5-point scale	1	4.17	3.45	0.52	−1.18	2.72
8. Workplace stress (T2)	4 items on 5-point scale	1.5	5	3.94	0.64	−0.84	1.11
9. Domestic violence (T2)	5 items on 5-point scale	1	5	3.98	0.75	−0.92	0.93
10. Domestic stress (T3)	5 items on 5-point scale	1.3	5	3.86	0.67	−0.62	0.51

Note: $N = 423$. 12 years of education = Qualification, 14 years of education = Bachelor, 16 years of education = Master, 21 years of education = PhD.
Abbreviations: Kurt = kurtosis, which are in acceptable range, hence, no substantial problem of distribution of the data, SD = standard deviation, Ske = skewness.

TABLE 5 | Results—regression.

	Model-1		Model-2		Model-3	
	Workplace stress		Domestic violence		Domestic stress	
IVs	**Estimate**	***t***	**Estimate**	***t***	**Estimate**	***t***
Gender	−0.05	−0.91	−0.04	−0.82	−0.03	−0.72
Age	−0.01	−0.58	−0.01	−0.69	−0.01	−0.39
Patient contact	−0.02	−0.69	−0.02	−0.58	−0.01	−0.32
Tenure	0.05	0.24	0.04	0.42	0.01	0.69
Education	−0.01	−0.54	−0.01	−0.65	−0.01	−0.79
WV (T1)	0.66*	13.1	0.65*	9.90	0.22*	4.11
WS (T2)			0.70*	3.29	0.21*	5.14
DV (T2)					0.43*	11.96
R^2	0.29		0.60		0.74	
F	172.11		121.3		171.06	

Abbreviations: DS = domestic stress, DV = domestic violence, WS = workplace stress, WV = workplace violence.
*Significant at 1% level of significance.

TABLE 6 | MEDTHREE analysis (total, direct and indirect effects).

Outcome = domestic stress	Effect	Boot (SE)	LLCI	ULCI	VAF %
Total indirect effect (workplace violence, T1)	0.50	0.05	0.40	0.62	—
M1 (workplace stress, T2)	0.14	0.04	0.07	0.22	28.17
M2 (domestic stress, T3)	0.28	0.04	0.22	0.37	57.14
M1 & M2	0.07	0.02	0.04	0.12	14.88

Note: Indirect effects (with bootstrap 95% CI and standard error).
Abbreviation: VAF = variance account for.

SE = 0.020, CIs: 0.041, 0.120) indicating that workplace stress and domestic violence sequentially mediates the relationship between workplace violence and domestic stress, confirming 15% mediation (VAF = 14.88).

5 | Discussion

Objectives of this study were to investigate the relationship between workplace violence and domestic stress through workplace stress and domestic violence among the healthcare workers in Pakistan. Pakistan is the world's 5th most populated country and shares a large portion of world's disease (Ahmad et al. 2022). The insufficient fundings in health sector and shortage of healthcare staff makes Pakistan one of the world's highest patient-to-nurse and lowest physician-to-nurse ratios (Pakistan Healthcare Spending 2023). Consequently, the healthcare employees have to work for long hours, with extended shifts making them susceptible to stress and violent behaviour (Bilal et al. 2015). Under these adverse circumstances, performance of healthcare employees is compromised leading to a low service quality to the patients. Workplace violence leading to a number of negative organisational outcomes is a well-recognised hazard. Despite of the fact that the issue is gaining a lot of attention in research, policy, and practice, yet by year 2013 the incidents of serious workplace violence were four times more common in healthcare than in private industry on average (Blando, Ridenour and Hartley 2020).

In line with these alarming statistics, our results show that workplace violence and stress have a positive relationship with domestic violence and domestic stress. It was found that an employee who faces workplace violence is likely to act violently toward their family members. Several studies (e.g., Hegney et al. 2010, Kaukiainen et al. 2001; Schat and Kelloway 2000) have consistent findings in different organisational settings. According to Mayhew and Chappell (2007) the spillover of the violent feeling is more common in healthcare settings than other industries. Our results show that healthcare workers are more susceptible to facing violence and take these feelings to other settings and act violently. Our results further show significant mediation effect of stress and domestic violence in the relationship between workplace violence and domestic violence. One explanation of this important finding is that the violent and stressed employees are more prone to become violent spouses/partners causing the family environment stressful. Results of H_8 show that workplace stress and domestic violence sequentially mediate the relationship between workplace violence and domestic stress. This indicates that employees who face violence but manage stress are less prone to take violent feelings to their home setting than the employees who cannot manage the workplace stress due to violence. Although past research has shown that violence and stress are closely related and have significant implications on healthcare workers' job-related outcomes, there was scant research, particularly in the context of Pakistan, toward the spillover effects of violence from one domain (work) to the other domain (home).

Our study has three main theoretical contributions: First, existing literature provides evidences from the in the western part of the world, where more investments are made by the organisations for work life balance and more secure working conditions (Honarvar et al. 2019; Saleh et al. 2020; Martino 2003; Ramlee et al. 2016), however, we provide evidence from the developing context, characterised by less secured working establishments, where the resilient level is relatively higher, but our findings show that despite the higher levels of resilience workplace violence a major contributor for the workplace stress and domestic stress. Second, we developed our understanding of spillover theory (Edwards and Rothbard 2000) which contends that a person is likely to spillover feelings and emotions readily from one domain to another domain either consciously or unconsciously. As spouse is the closest person of the family, the chances are more that feelings of stress and violence can be transferred and spillover to spouse than any other family member. Third, we empirically examined how workplace violence contributes to domestic violence by examining mediating role of workplace stress and showed that domestic violence and domestic stress are the outcome of workplace stress and violence. In line with our findings, the prior research has established that violent behaviour within the organisation toward employees is related to occupational stress (Gutsan et al. 2018; Martino 2003; Saleh et al. 2020). We extended this line of research by empirically validating that workplace stress is associated with domestic violence and domestic stress. Therefore, the findings of this study offer valuable theoretical and practical implications for the healthcare industry.

5.1 | Managerial Implications

This study offers several significant contributions to the existing literature on workplace violence, stress, and domestic violence, particularly within the healthcare industry. Existing research focuses on settings with sophisticated organisational systems (Honarvar et al. 2019; Martino 2003; Ramlee et al. 2016; Saleh et al. 2020). This study adds unique insights from a developing context where support systems might be less extensive. We explore how workplace violence contributes to stress even with potentially higher employee resilience compared to developed contexts. We contribute to the understanding of spillover theory, examining the transfer of workplace violence experience to domestic violence in healthcare (Havaei and MacPhee 2021; Hegney et al. 2010; Kaukiainen et al. 2001; Schat and Kelloway 2000; Shahrour et al. 2022; Sun et al. 2021). These studies focused on diverse industries. This research offers new insights by examining a specific profession—healthcare—and considering their unique training and empathy.

Previous research suggests stressed and violent employees are more likely to become violent at home (e.g., Geck et al. 2017). However, limited research explores this specific mechanism in highly trained and empathetic professionals like healthcare workers. Our study examines how healthcare professionals internalise workplace violence as stress and then externalise it through domestic violence. We explore this using MEDTHREE analysis, examining the serial mediation process. Past research connects violence and stress to employee well-being (e.g., Beehr, Bowling, and Bennett 2010). However, limited research explores the impact of workplace factors on domestic violence. This study adds to Spillover Theory (Edwards and Rothbard 2000) by examining how emotions are transferred across domains and identifying the internal mechanisms at play. By linking workplace violence to domestic violence in healthcare, this research contributes to a previously understudied area and highlights the importance of addressing workplace violence not just for employee well-being but also for potentially impacting their personal lives.

The workplace violence and employee stress in the healthcare sector accounts for a high proportion of violence at work, that is, healthcare workers are facing 87% more incidents compared to other professions (Erkol et al. 2007). Several studies have established that high levels of violence and stress have a high cost for the employer, for example, in the United States workers in healthcare-related occupations have lost the most time due to violence at work (Llewellyn 2001).

There are several factors that contribute toward violence and stress at the workplace; measuring such factors is a complex task. However, based on our findings, we provide some managerial implications. The study provides evidence of the negative outcomes of violence and stress at workplace (see results of H_1–H_4). Therefore, it is essential for hospital administration to actively reduce incidents of violence and implement stringent measures to ensure effective control. The hospital administration can identify those factors that lead to violence, seeking to exclude violent individuals from workplaces for example, reducing waiting time for patients and introducing real time appointment mechanism (Grot et al. 2023). Healthcare facilities can develop a comprehensive violence prevention programme. The administration can prevent violence by gaining employees' and employers' commitment; to give trainings related to health and safety; to analyse and rectify safety hazards; by keeping accurate and detailed records of the violence incidence. The organisations can also initiate an intensive awareness campaign for healthcare employees, and there must be a well-defined and reasonably anonymised system of reporting any violent incidence. There should be a zero-tolerance policy against violence, and strict decisions should be taken in case a person is found guilty of any violent activity. Hospital managers and administrators can make use of social media to create closed group blogs and Facebook pages, where workers can anonymously talk about their incidents related to violence at workplace and home. However, if it is run in controlled environment through well-defined code of conduct, it can produce meaningful and useful results (La Regina et al. 2021). It will give them an opportunity to express and vent their voice and opinions. They may also share different strategies to deal with violent situations at the workplace and learn from each other the ways to cope with critical incidents. The hospital management can also keep a full record of the violent events, which may indicate employees who are more vulnerable to violent incidents and can be protected from such situations. In addition, this can also facilitate identifying the habitual perpetrators.

5.2 | Limitations and Future Research

The findings of this study are constrained by the following limitations. First, we used exploratory research design and additional research can ascertain the replicability of results in other industries including the mining industry and labour-intensive factories in Pakistan. Second, though violence has multiple dimensions, the study considers only workplace and domestic violence and did not consider the other types, and therefore, future research may examine other dimensions of violence. Third, although dual source data were collected for the present study, the cross-sectional nature of the data limits the explanation of the causality between the variables. Therefore, future research may collect multidimensional and longitudinal data for further validation of the results and to establish the causality between the workplace violence and stress through a carefully designed experimental design. Fourth, we consider the effect of workplace violence and stress on domestic violence and stress, however, examining reverse causality between the variables such as to see the effect of domestic violence on workplace violence through an experimental research design. Finally, for more detailed insights about the factors which contribute to the workplace violence, a qualitative study may garner further insights. Lastly, some key factors that may cause domestic violence and stress are alcoholism, family issues and financial burdens. These have not yet been explored fully in Pakistan.

6 | Conclusion

We contributed to the workplace violence literature by providing theoretical support by empirically testing the links between workplace violence and domestic stress through sequential mediating effect of workplace stress and domestic violence. Our findings extend the emphasis of previous research by indicating that the workplace violence—domestic violence and stress link is not as simple as previously believed. The results indicate that violence within the workplace can often have significant implications for the home life of victims of workplace violence. It is a cyclic process as one setting ultimately effects the other. The study supports the work-life balance and spillover theory, stressing that negative workplace feelings extend into family life, potentially leading to violence and stress in the home environment. The existing research has significantly contributed toward the investigation of the workplace violence and stress; however, the problem cannot be completely eradicated as several factors are responsible for violence and stress at workplace and at home. The pervasive issue of workplace violence cannot be overlooked due to its detrimental consequences for all parties involved. Therefore, by prioritising research and implementing effective interventions, we can create safer and more productive workplaces for all.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The authors have nothing to report.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.