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Not All Resources Are Equal: Testing Job and Personal Resources as Buffers in the Despotic Leadership–Emotional Exhaustion Nexus using JD-R Theory

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Abstract

The persistence of despotic leadership in public sector healthcare settings raises serious concerns about employee well-being and organizational sustainability. Drawing on the Job Demands–Resources (JD-R) theory, this study examines how despotic leadership operates as a job demand that escalates emotional exhaustion, which in turn fosters withdrawal behavior among junior nurses. The research further investigates the buffering role of perceived organizational support as a contextual resource and psychological capital as a personal resource. Data were collected through a cross-sectional survey from 428 junior nurses employed in four major public hospitals in Lahore, Pakistan: Jinnah Hospital, Mayo Hospital, Services Hospital, and General Hospital. Established scales were employed, and the data were analyzed using SPSS and Hayes' PROCESS Macro. Preliminary analyses confirmed reliability, validity, and absence of common method bias, while structural testing revealed that emotional exhaustion significantly mediated the despotic leadership–withdrawal relationship. Both perceived organizational support and psychological capital moderated the stressor–strain link, attenuating the adverse effects of leadership toxicity. These findings highlight that leadership styles not only influence immediate job attitudes but also trigger broader strain processes that undermine workforce stability in high-pressure environments, such as public healthcare. The study enriches JD-R theory by extending its application to destructive leadership contexts and integrating both organizational and personal resources as dual buffers. Practically, it suggests that healthcare administrators must foster supportive climates and invest in developing nurses' psychological capital to mitigate leadership-induced stress. Limitations and directions for future inquiry are discussed.

Keywords: Despotic leadership, Emotional exhaustion, Withdrawal behavior, Perceived organizational support, Psychological capital, JD-R theory

Introduction and Background

Healthcare is a profession where small decisions can have profound consequences, often made under intense pressure. Nurses occupy a central role in this system but are also among the most vulnerable, particularly junior nurses who face steep professional learning curves in hierarchical, high-stress environments. In public hospitals within developing countries, chronic overcrowding, underfunding, and resource scarcity exacerbate these challenges (Shah et al., 2021). Junior nurses must manage long hours, emotionally demanding care, and expectations from doctors and senior staff, often with little organizational support. Under such conditions, leadership behaviors strongly shape whether they can

sustain their professional commitment (Alharbi et al., 2020).

Despotic leadership (DL) is especially damaging. Defined by "authoritarianism, exploitation, and disregard for subordinates' welfare (Aronson, 2001; De Hoogh & Den Hartog, 2008), DL corrodes morale and fosters fear, helplessness, and alienation among nurses" (Ahmad & Gao, 2018). Unlike directive leadership, which may provide clarity in a crisis, DL serves leaders' self-interest and suppresses subordinates. For junior nurses on temporary or probationary contracts, this form of leadership is particularly harmful, stripping them of dignity and agency at a stage when they are least equipped to resist.

Nursing itself compounds these risks. Widely recognized as one of the most stressful professions (Poghosyan et al., 2010), it demands simultaneous physical endurance, emotional sensitivity, and cognitive agility. In public hospitals, shortages of staff and supplies often mean excessive patient loads, reliance on outdated equipment, and limited resources (Nishtar, 2019). Nurses are repeatedly exposed to pain, suffering, and death, experiences that gradually erode psychological resilience (Xie et al., 2020). These systemic demands already heighten the risk of exhaustion; when despotic leadership is added, the likelihood of burnout and disengagement escalates dramatically.

The Job Demands–Resources (JD-R) model provides a useful framework for understanding these dynamics. JD-R theory distinguishes between job demands, which consume energy and cause strain, and job resources, which help achieve goals and buffer against demands (Bakker & Demerouti, 2007, 2017). DL constitutes a social demand that drains emotional resources and contributes directly to emotional exhaustion, the core of burnout (Maslach & Jackson, 1981). Exhaustion, in turn, predicts withdrawal behaviors such as absenteeism, disengagement, and turnover (Schaufeli, 2017). For junior nurses, this process is particularly acute. They lack autonomy, have limited coping resources, and must adjust simultaneously to clinical demands and hierarchical relationships (Roche et al., 2015). Psychological withdrawal—lateness, absenteeism, reduced initiative, or diminished commitment—may thus become a self-protective response rather than evidence of laziness (Krishnan et al., 2018).

Emotional exhaustion serves as the psychological hinge in this sequence. DL strips meaning and dignity from work, leaving nurses "drained" and undermining their capacity for compassionate care (Dyrbye et al., 2020). Exhausted nurses are more prone to errors, jeopardizing patient safety and lengthening recovery times (Shanafelt et al., 2015). For junior nurses, the consequences are magnified by their lack of coping strategies and institutional power. Yet JD-R theory also highlights that resources can moderate these effects. At the organizational level, Perceived Organizational Support (POS), "the belief that one's organization values and supports employees" (Eisenberger et al., 1986), is especially critical. Even in resource-constrained hospitals, practices such as fair scheduling, recognition, and supervisor empathy can mitigate the harm of abusive leadership (Rhoades & Eisenberger, 2002; Caesens et al., 2017). Such signals of support reassure nurses that, despite toxic leaders, the broader organization cares for their well-being (Tepper et al., 2000).

At the personal level, Psychological Capital (PsyCap), "comprising hope, efficacy, resilience, and optimism, equips employees to withstand adversity" (Luthans et al., 2007). Nurses with strong PsyCap may reinterpret despotic behaviors as temporary setbacks, sustain motivation through optimism, and recover quickly from stressors through resilience. Evidence consistently links PsyCap to lower burnout and higher job satisfaction among nurses (Avey et al., 2011). In this way, PsyCap acts as an individual buffer that weakens the pathway from DL to exhaustion.

Structural challenges in public hospitals underscore the urgency of these buffers. Unlike private institutions with greater resources and flexibility, public hospitals often operate under rigid bureaucracies and chronic shortages (World Health Organization, 2020). Junior nurse attrition is thus especially costly, representing lost investments in training and further burdening remaining staff. Some argue that hierarchical leadership is necessary in high-pressure contexts, where decisiveness may aid coordination (Wong et al., 2013). However, DL differs fundamentally from directive leadership: it is characterized by arrogance, coercion, and disregard for subordinates (Aronson, 2001). Such behaviors erode trust and psychological safety, which are essential for collaborative care and error reporting. What may appear efficient in the short term proves destructive in the long run.

By focusing on junior nurses in public hospitals, this study addresses a critical gap. Senior nurses often have experience, networks, and strategies to cope with toxic leadership. Junior nurses, however, stand at the most precarious point in their careers—balancing clinical demands, relational hierarchies, and professional insecurity (Roche et al., 2015). They are both most exposed to DL and least able to resist it. Examining how DL fosters exhaustion and withdrawal not only extends JD-R theory into toxic leadership contexts but also generates urgently needed practical insights.

This study develops a moderated mediation model in which DL increases emotional exhaustion, which in turn drives withdrawal behaviors. POS and PsyCap are hypothesized as buffers at the organizational and personal levels, respectively. The model contributes theoretically by extending JD-R theory to healthcare leadership and practically by highlighting strategies to reduce nurse withdrawal in under-resourced hospitals. The stakes are profound: each junior nurse lost to exhaustion weakens already fragile systems, and unchecked despotic leadership threatens both employee well-being and patient safety. Addressing these dynamics is therefore both an academic imperative and a societal necessity.

Theoretical background and hypotheses development

Leadership in organizational psychology has traditionally been studied through a positive lens, emphasizing inspiring, supportive, and empowering leader behaviors (Avolio & Bass, 1995; Yukl, 2013). Yet, in the last two decades, a countertrend has gained traction, highlighting the destructive, exploitative, and toxic forms of leadership that inflict considerable psychological harm on employees (Einarsen et al., 2007; Schyns & Schilling, 2013). Among these, despotic leadership has emerged as a particularly pernicious variant—"marked by arrogance, authoritarianism, and disregard for the well-being of subordinates" (Aronson, 2001; De Hoogh & Den Hartog, 2008). Scholars argue that despotic leaders create climates of fear, suppress autonomy, and push employees into states of chronic stress and withdrawal (Naseer et al., 2016; Thoroughgood et al., 2018).

Despotic Leadership as a Job Demand

Leadership research has long centered on constructive behaviors that inspire and support employees (Avolio & Bass, 1995; Yukl, 2013). In contrast, recent work emphasizes destructive leadership forms that harm employee well-being (Einarsen et al., 2007; Schyns & Schilling, 2013). Among these, despotic leadership—defined as self-serving, arrogant, and authoritarian behavior that disregards subordinates' welfare (Aronson, 2001; De Hoogh & Den Hartog, 2008)—has emerged as especially damaging. Such leaders foster climates of fear, suppress autonomy, and intensify stress and withdrawal (Naseer et al., 2016; Thoroughgood et al., 2018).

Within the Job Demands–Resources (JD-R) framework (Bakker & Demerouti, 2007, 2017), despotic leadership can be conceptualized as a chronic social job demand that depletes energy and undermines resilience. Unlike episodic stressors such as long shifts, despotic supervision is persistent and relational, leaving employees few avenues for escape. Studies link despotic leadership to job stress, disengagement, and turnover intentions (Khan et al., 2018; Schyns & Schilling, 2013), and in healthcare, such climates may reduce both care quality and staff well-being (Abbas et al., 2020).

Hypothesis 1: Despotic leadership is positively related to emotional exhaustion among junior nurses.

Emotional Exhaustion as a Mediator

JD-R theory identifies emotional exhaustion—the depletion of emotional resources—as the central strain mechanism through which demands impair health (Maslach & Jackson, 1981; Schaufeli & Bakker, 2004). In nursing, exhaustion is the most salient burnout dimension, tied to absenteeism, reduced care quality, and turnover (Leiter & Maslach, 2009; Van Bogaert et al., 2014).

Despotic leadership amplifies exhaustion by eroding psychological safety (Edmondson & Lei, 2014), undermining fairness and recognition (Cropanzano et al., 2017), and modeling hostility that spreads cynicism (Tepper, 2007; Thoroughgood et al., 2018). Empirical evidence confirms these links: Naseer et al. (2016) found despotic leadership predicted exhaustion via job stress, while Xu et al. (2021) reported similar effects for authoritarian leadership among Chinese nurses.

Hypothesis 2: Emotional exhaustion is positively related to withdrawal behavior among junior nurses.
Hypothesis 3: Emotional exhaustion mediates the relationship between despotic leadership and withdrawal behavior.

Withdrawal Behavior as an Outcome

Withdrawal behaviors—lateness, absenteeism, reduced effort, disengagement—reflect coping responses when demands overwhelm resources (Hanisch & Hulin, 1990; Bakker & Demerouti, 2017). Exhausted nurses may emotionally detach, limit patient interactions, or reduce effort (Leiter & Maslach, 2009). Despotic leadership accelerates this trajectory, increasing turnover intentions, lowering citizenship behaviors, and fostering withdrawal (Tepper, 2000; Harvey et al., 2007; Schyns & Schilling, 2013).

Perceived Organizational Support as a Buffer

JD-R theory emphasizes that resources can mitigate the harmful effects of demands (Bakker & Demerouti, 2007). Perceived organizational support (POS), "the belief that the organization values and cares for employees (Eisenberger et al., 1986), is a key protective resource". POS reduces burnout and strengthens commitment (Rhoades & Eisenberger, 2002) and buffers the effects of abusive supervision (Zhang & Akhtar, 2013; Caesens & Stinglhamber, 2014). In healthcare, high POS predicts lower exhaustion and greater satisfaction (Van der Heijden et al., 2019). For nurses, POS may signal that despotic behaviors reflect individual failings rather than institutional neglect (Kurtessis et al., 2017).
Hypothesis 4: Perceived organizational support moderates the relationship between despotic leadership and emotional exhaustion, such that the relationship is weaker when POS is high.

Psychological Capital as a Buffer

Personal resources also shape stressor–strain dynamics (Xanthopoulou et al., 2007). Psychological Capital (PsyCap), "encompassing hope, efficacy, resilience, and optimism (Luthans et al., 2007) enables employees to interpret stressors more optimistically and recover more effectively" (Avey et al., 2011). High psychological capital (PsyCap) reduces burnout, sustains satisfaction, and supports performance under pressure (Avey et al., 2010; Youssef-Morgan & Luthans, 2013).
For nurses, PsyCap may blunt despotic leadership's effects by providing internal coping capacity, complementing organizational resources such as POS. Together, these dual resource reservoirs align with JD-R's resource-based logic.
Hypothesis 5: Psychological capital moderates the relationship between despotic leadership and emotional exhaustion, such that the relationship is weaker when PsyCap is high.

Integrating the JD-R Framework

The JD-R model provides a comprehensive lens for situating despotic leadership within stressor–strain–outcome processes. Despotic leadership operates as a chronic social demand that fuels exhaustion, which in turn drives withdrawal. Organizational (POS) and personal (PsyCap) resources buffer these effects, illustrating the dual health-impairment and motivational pathways (Bakker & Demerouti, 2017; Xanthopoulou et al., 2009). By positioning despotic leadership as a job demand and tracing its effects on emotional exhaustion and withdrawal among junior nurses, this framework highlights the mechanisms through which toxic supervision undermines healthcare work and the conditions under which its impact may be mitigated.

Conceptual Framework

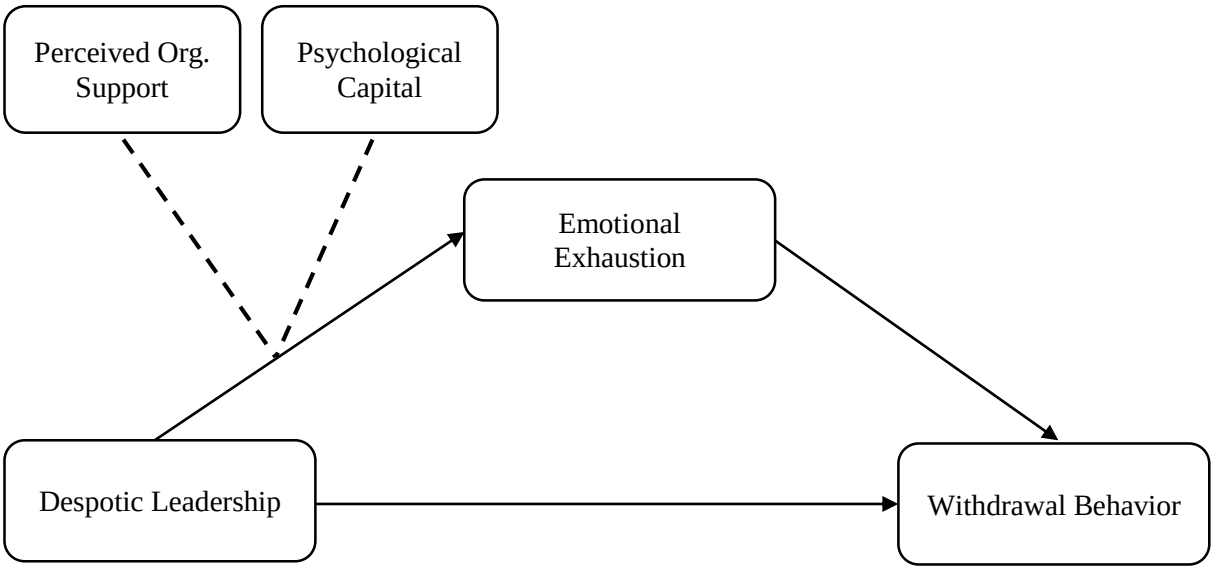

Figure 1: Conceptual model of the study

Materials and Methods

Research philosophy and ontological position

This study adopts an objectivist–positivist stance: social phenomena are treated as measurable constructs that exist independently of individual interpretation (Crotty, 1998), and hypotheses are tested using empirical methods designed to produce generalizable inferences (Creswell, 2014; Saunders, Lewis, & Thornhill, 2019). Within this frame, despotic leadership, emotional exhaustion, withdrawal behaviors, perceived organizational support (POS), and psychological capital (PsyCap) are operationalized with validated psychometric instruments and analyzed quantitatively, consistent with positivist commitments to replicability and observable evidence (Bryman, 2016).

Research design

A cross-sectional, survey-based quantitative design was employed to test the JD-R–informed moderated-mediation model relating despotic leadership to withdrawal via emotional exhaustion, and the buffering roles of POS and PsyCap (Levin, 2006; Spector, 2019). Although longitudinal designs offer stronger causal leverage, a cross-sectional approach is appropriate for theory testing when combined with robust statistical mediation and moderation techniques (Hayes, 2018).

Population and setting

The sampling frame comprised junior nurses employed in four large public tertiary hospitals in Lahore (Jinnah, Mayo, Services, and General Hospital). These institutions serve high patient volumes under constrained resources and therefore constitute a relevant context for studying leadership effects on nurse well-being (Shahzad et al., 2017). Junior nurses were selected because their limited decision latitude and proximity to supervisory authority render them particularly susceptible to deleterious leadership behaviors (Laschinger et al., 2012).

Sampling strategy and sample size

Given operational constraints in public hospitals (rotational shifts, limited availability), purposive sampling was used to target nurses meeting the study's inclusion criteria (Etikan, Musa, & Alkassim,

2016; Palinkas et al., 2015; Robinson, 2014). Data were collected across the four hospitals to mitigate single-site idiosyncrasies (Shadish, Cook, & Campbell, 2002). The final usable sample comprised 428 junior nurses. This sample size exceeds commonly recommended thresholds for complex mediation and moderated-mediation analyses (Kline, 2015; Wolf et al., 2013) and aligns with guidance for advanced multivariate procedures (Hair et al., 2019), thereby affording adequate statistical power for detection of small to medium effects (Cohen, 1992). Achieving this sample is notable given typical constraints on participation in healthcare settings (Polit & Beck, 2017).

Data collection procedure

Data collection took place over eight weeks following formal permission from hospital administrations and nursing superintendents. Trained research assistants approached nurses during non-clinical intervals, explained the study, obtained informed consent, and distributed paper questionnaires in sealed envelopes to preserve confidentiality. To mitigate common method bias, item blocks for independent, mediator, and moderator constructs were counterbalanced across questionnaires, and instructions stressed candid, anonymous responses (Podsakoff et al., 2003). Completed surveys were returned in sealed envelopes and stored securely.

Measures

All study variables were assessed with established instruments on five-point Likert scales (1 = strongly disagree, 5 = strongly agree). Despotic leadership was measured with the six-item scale by De Hoogh and Den Hartog (2008), which captures authoritarian, self-serving, and exploitative leader behaviors. Emotional exhaustion was assessed with the nine-item Emotional Exhaustion subscale of the Maslach Burnout Inventory (Maslach & Jackson, 1981), widely regarded as the benchmark for burnout research. Withdrawal behavior was captured through a five-item scale adapted from Lehman and Simpson (1992), reflecting both cognitive and behavioral forms of withdrawal, such as reduced effort and absenteeism tendencies. Perceived organizational support was measured with the eight-item short form of the Survey of Perceived Organizational Support (Eisenberger et al., 2001), indexing the belief that the organization values employees' contributions and well-being. Psychological capital was assessed with the 12-item Psychological Capital Questionnaire (Luthans et al., 2007), covering hope, efficacy, resilience, and optimism, and modeled as a higher-order construct. Scale scores were computed as item means, with higher values reflecting greater intensity. All measures demonstrated acceptable reliability ($\alpha > .70$; Nunnally & Bernstein, 1994) and have been validated across occupational and cultural contexts (De Hoogh & Den Hartog, 2008; Maslach & Jackson, 1981; Eisenberger et al., 2001; Luthans et al., 2007).

Data screening and data analysis strategy

Questionnaires were screened for completeness and response validity. Cases with substantial missing data, patterned responding (e.g., straight-lining), or otherwise implausible response patterns were excluded from analysis. Prior to hypothesis tests, data distributions were examined for normality; multicollinearity diagnostics (variance inflation factors and tolerance) were evaluated. Harman's single-factor test and procedural remedies (item randomization, anonymity assurances) were used to assess and reduce common method variance (Podsakoff et al., 2003).

Analyses were conducted in SPSS (v.26) and Hayes' PROCESS Macro (v.4.0). Descriptive statistics and Pearson correlations described sample characteristics and bivariate relationships. Mediation was tested using PROCESS Model 4 and moderated mediation with Model 14 (Hayes, 2018). All indirect effects were estimated with bias-corrected bootstrap confidence intervals based on 5,000 resamples (Preacher & Hayes, 2008). Interaction terms were probed using simple slopes and plotted to aid interpretation. Throughout, inferential decisions were guided by bootstrap confidence intervals rather than sole reliance on p-values.

Inclusion and exclusion criteria

To ensure a homogeneous sample relevant to the research questions, inclusion criteria required participants to be: (1) employed as junior (staff) nurses in one of the four selected public hospitals; (2) working either on permanent or contractual terms; (3) having a minimum of six months' continuous tenure under their current immediate supervisor to ensure adequate exposure to supervisory behavior (De Hoogh & Den Hartog, 2008); and (4) willing and able to provide informed consent. Exclusion criteria were applied to remove sources of systematic heterogeneity: nurses in managerial or supervisory positions (whose role expectations and leader–follower dynamics differ markedly), trainees or interns, and respondents whose questionnaires exhibited extensive missingness, obvious inattentive responding, or inconsistent answers across related items. These screening rules preserved internal validity and focused inference on the population most exposed to despotic supervision.

Ethical considerations

The study conformed to institutional and disciplinary ethical standards. Formal permissions were secured from each participating hospital's administration and nursing leadership. Participation was voluntary; all respondents received written information about study aims, data handling, confidentiality, and the voluntary nature of participation before completing the survey. Identifying information was not collected; survey data were anonymized, stored on password-protected drives, and reported only in aggregated form. Given the potentially sensitive topic of supervisory mistreatment, researchers provided participants with contacts for psychological support services and ensured that no individual leader or unit could be identified in any reports. Data retention and destruction followed institutional policies.

Data Analysis and Results

Preliminary Analyses and Assumption Testing

The dataset comprising 428 usable cases was screened for missing values, outliers, and normality before hypothesis testing. Missing values were minimal (<2%) and handled using expectation-maximization procedures, consistent with best practices in survey research (Enders, 2010). Univariate outliers were examined using standardized z-scores, while multivariate outliers were assessed via Mahalanobis distance (Tabachnick & Fidell, 2019). No extreme cases were found that substantially influenced parameter estimates.

Regression assumptions were also tested. The results of Shapiro–Wilk tests and visual inspection of histograms suggested that variables approximated normal distributions, which is acceptable given the robustness of regression to minor violations with large samples (Field, 2018). Multicollinearity was assessed using variance inflation factors (VIFs), all of which were below the threshold of 5 (Hair et al., 2019). Homoscedasticity was evaluated using scatterplots of residuals against predicted values, which showed no systematic patterns. These checks suggested that the dataset met the key assumptions for regression and PROCESS analyses.

Reliability and Validity of Measures

Reliability was assessed through Cronbach's alpha (α) and composite reliability (CR). All scales exceeded the conventional threshold of 0.70 (Nunnally & Bernstein, 1994). Construct validity was examined through confirmatory factor analysis (CFA). Convergent validity was supported by average variance extracted (AVE) values greater than 0.50 (Fornell & Larcker, 1981). Discriminant validity was tested by comparing the square root of AVE with inter-construct correlations; in all cases, the square root of AVE exceeded corresponding correlations, supporting discriminant validity.

Table.1: Reliability and Validity Statistics of Study Constructs

Construct	Items	α	CR	AVE
Despotic Leadership	6	.91	.92	.61
Emotional Exhaustion	9	.89	.90	.59
Withdrawal Behavior	5	.87	.88	.56
Perceived Organizational Support	8	.90	.91	.60
Psychological Capital	12	.93	.94	.65

Correlation Analysis

Descriptive statistics and correlations are reported in *Table 2*. Despotic leadership showed significant positive correlations with emotional exhaustion ($r = .48$, $p < .001$) and withdrawal behavior ($r = .41$, $p < .001$). Emotional exhaustion correlated positively with withdrawal behavior ($r = .52$, $p < .001$). Both perceived organizational support ($r = –.37$, $p < .001$) and psychological capital ($r = –.40$, $p < .001$) were negatively related to emotional exhaustion, suggesting potential buffering roles.

Table.2: Means, Standard Deviations, and Correlations among Study Variables

Variable	M	SD	1	2	3	4	5
1. Despotic Leadership	2.89	0.77	–				
2. Emotional Exhaustion	3.12	0.82	.48***	–			
3. Withdrawal Behavior	2.67	0.74	.41***	.52***	–		
4. Perceived Org. Support	2.95	0.79	–.35***	–.37***	–.28***	–	
5. Psychological Capital	3.08	0.83	–.32***	–.40***	–.29***	.44***	–

*$p < .001$

Common Method Bias Test

Given the reliance on self-report data, common method bias (CMB) was tested. Harman's single-factor test revealed that the first factor accounted for 28.6% of the variance, below the 50% threshold (Podsakoff et al., 2003). Additionally, a single-factor CFA model was compared with the hypothesized five-factor measurement model. The one-factor model demonstrated poor fit ($\chi^2/df = 8.14$, CFI = .52, RMSEA = .14), whereas the five-factor model exhibited acceptable fit indices ($\chi^2/df = 2.61$, CFI = .93, TLI = .91, RMSEA = .06, SRMR = .05). These results suggest that CMB was not a significant threat.

Confirmatory Factor Analysis (CFA)

The hypothesized five-factor measurement model (despotic leadership, emotional exhaustion, withdrawal behavior, perceived organizational support, psychological capital) was compared against alternative models. The five-factor model provided the best fit, with all fit indices surpassing recommended thresholds (Hu & Bentler, 1999). Factor loadings for all items exceeded .60 and were significant ($p < .001$), supporting convergent validity.

Hypotheses Testing

Hayes' (2018) PROCESS macro (Models 4, 7, and 14) was used to test mediation, moderation, and moderated mediation effects.

1. Direct effect of despotic leadership on withdrawal behavior was significant (β = .29, SE = .06, p < .001), supporting H1.
2. Mediating role of emotional exhaustion: Despotic leadership predicted emotional exhaustion (β = .45, SE = .05, p < .001), which in turn predicted withdrawal behavior (β = .34, SE = .07, p < .001). Bootstrapped indirect effects (95% CI [.09, .21]) confirmed mediation, supporting H2.
3. Moderating role of perceived organizational support: The interaction between despotic leadership and POS on emotional exhaustion was significant (β = –.18, SE = .06, p < .01). Simple slope analysis showed that the relationship between despotic leadership and emotional exhaustion was weaker under high POS, supporting H3.
4. Moderating role of psychological capital: Results indicated that PsyCap buffered the link between emotional exhaustion and withdrawal behavior (β = –.15, SE = .05, p < .01). At high PsyCap, the indirect effect of despotic leadership on withdrawal behavior through emotional exhaustion was weaker, supporting H4.

Table.3: Regression Results for Mediation and Moderated Mediation (Process)

Pathway	β	SE	T	95% CI (LL, UL)
DL → Emotional Exhaustion	.45	.05	9.00***	[.35, .55]
EE → Withdrawal Behavior	.34	.07	4.86***	[.20, .48]
DL → Withdrawal Behavior (Direct)	.29	.06	4.83***	[.17, .41]
DL × POS → Emotional Exhaustion	–.18	.06	–3.00**	[–.29, –.07]
EE × PsyCap → Withdrawal Behavior	–.15	.05	–3.20**	[–.25, –.05]

Note. DL = Despotic Leadership, EE = Emotional Exhaustion, POS = Perceived Organizational Support, PsyCap = Psychological Capital. **p < .01; ***p < .001.

Overall, the results provide strong support for the hypothesized model grounded in JD-R theory. Despotic leadership was associated with higher emotional exhaustion and withdrawal behavior among junior nurses. Emotional exhaustion mediated this relationship, while perceived organizational support and psychological capital functioned as critical buffers at organizational and personal levels, respectively. These findings align with JD-R propositions that both job and personal resources can mitigate strain, even in the presence of demanding leadership conditions.

Discussion and Conclusion

Discussion of Findings

The central aim of this study was to examine how despotic leadership (DL) shapes emotional exhaustion among junior nurses in public sector hospitals, and how this strain process translates into withdrawal behaviors. Anchoring the analysis in the Job Demands–Resources (JD-R) theory (Bakker & Demerouti, 2007; Schaufeli & Taris, 2014), the study further assessed how perceived organizational support (POS) as a job resource and psychological capital (PsyCap) as a personal resource buffer against the adverse effects of despotic leadership.

The findings confirm the hypothesized direct association between despotic leadership and emotional exhaustion. Nurses working under authoritarian and punitive supervisors reported higher levels of psychological strain, which aligns with prior work suggesting that despotic leaders erode autonomy, create climates of fear, and leave subordinates with limited coping strategies (De Hoogh & Den Hartog, 2008; Arain et al., 2015). In public sector hospitals—where work demands are already high

due to chronic underfunding, staff shortages, and overcrowded wards (Ali & Khan, 2020; Shah et al., 2021)—the added stress of despotic supervision appears to intensify exhaustion and hasten the depletion of psychological energy. This supports JD-R's health impairment pathway, which posits that excessive demands combined with low resources accelerate burnout (Bakker & Demerouti, 2017).

The mediating role of emotional exhaustion between DL and withdrawal behaviors was also strongly supported. Exhausted nurses, drained of cognitive and emotional resources, were more likely to disengage from work, arrive late, or reduce discretionary effort—behaviors widely documented as withdrawal in organizational behavior literature (Hanisch & Hulin, 1990; Schaufeli et al., 2009). This mediating mechanism reinforces the argument that negative leadership exerts its most damaging effects not merely through immediate dissatisfaction but through the cumulative psychological depletion it triggers (Zhang & Bednall, 2016).

Importantly, the moderating roles of POS and PsyCap yielded nuanced insights. Perceived organizational support attenuated the impact of despotic leadership on emotional exhaustion, suggesting that institutional care—expressed through fair treatment, recognition, or even supportive HR policies—provides a protective layer against toxic supervisory practices (Eisenberger et al., 2002; Caesens et al., 2017). Psychological capital, characterized by optimism, self-efficacy, hope, and resilience (Luthans et al., 2007), also weakened the stressor–strain link. Nurses with higher PsyCap appeared more capable of reframing adversity, recovering from setbacks, and mobilizing personal strengths to withstand despotic pressure. These findings confirm JD-R's second proposition that resources—both organizational and personal—are not merely supplementary but critical moderators that shape how demands are processed (Xanthopoulou et al., 2007; Bakker & Demerouti, 2018). In short, this study provides evidence that despotic leadership is a potent stressor in healthcare settings, but also demonstrates that supportive organizational structures and resourceful employees can partially shield against its damaging consequences.

Theoretical Implications

The results carry several theoretical contributions for leadership and stress research.

First, the study extends JD-R theory by demonstrating how destructive leadership, rather than the more commonly studied job demands such as workload or emotional labor, can function as a critical demand that fuels emotional exhaustion. By positioning DL within JD-R's framework, this research expands the taxonomy of demands to include toxic relational dynamics, reaffirming that demands are not confined to task characteristics but also reside in social exchanges at work (Schaufeli & Taris, 2014).

Second, the results enrich the literature on stressor–strain mechanisms by confirming emotional exhaustion as a mediator linking despotic leadership to withdrawal. While prior studies have examined burnout broadly (e.g., Lee & Ashforth, 1996), this study isolates emotional exhaustion—the core dimension of burnout most strongly tied to performance deterioration (Maslach et al., 2001). This precision strengthens the explanatory power of JD-R's health impairment process in leadership contexts.

Third, the evidence on POS and PsyCap as moderators reinforces JD-R's dual-pathway assumption that resources buffer the negative impact of demands. By testing both an organizational-level and an individual-level resource, this study highlights the multi-layered nature of resource effects and shows that resilience to destructive leadership is not solely a personal trait but also dependent on institutional practices. This multilevel integration helps answer recent calls to better connect JD-R's micro and meso dimensions (Bakker & Demerouti, 2018).

Finally, by focusing on public healthcare workers in a South Asian context, the study contributes to cross-cultural validation of JD-R propositions. Much JD-R research has been Western-centric (Bakker et al., 2014). The evidence here indicates that JD-R processes apply even in collectivist, resource-constrained environments, though the salience of support mechanisms may be stronger in these contexts where organizational resources are often scarce.

Practical Implications

The findings also hold pressing implications for hospital administrators and policymakers.

At the leadership level, results suggest the need for stricter selection and training mechanisms for nurse supervisors. Despotic leadership behaviors—arbitrary punishments, disregard for employee well-being, rigid control—are not merely unpleasant but function as psychological demands that impair employee health. Leadership development programs emphasizing ethical conduct, emotional intelligence, and participative management could reduce the prevalence of despotic tendencies (Brown & Treviño, 2006).

At the organizational level, enhancing perceived organizational support emerges as a tangible intervention. Simple practices such as acknowledging nurses' contributions, providing transparent communication, and ensuring fair grievance mechanisms can counteract the harmful influence of despotic leaders. Hospitals operating under chronic resource strain may underestimate the psychological impact of such symbolic gestures, yet this study shows they carry measurable protective weight.

On the employee side, interventions to build psychological capital among nurses could also mitigate the toll of toxic leadership. Evidence-based training modules in resilience, mindfulness, and cognitive reappraisal have been shown to enhance PsyCap (Luthans et al., 2008). Embedding such training into professional development programs could strengthen nurses' personal resources, making them less vulnerable to stress-induced withdrawal.

Finally, these implications are not only organizational but societal. Public hospitals in Pakistan already face challenges of brain drain, absenteeism, and low morale (Shah et al., 2021). Addressing despotic leadership and its psychological fallout may help retain skilled nurses, reduce absenteeism, and ultimately improve patient care quality—a goal of national importance in resource-limited healthcare systems.

Limitations of the Study

Despite its contributions, the study is not without limitations.

The first limitation stems from its cross-sectional design. Although mediation and moderation were tested using PROCESS, causal inferences remain tentative. Longitudinal designs would provide stronger evidence of whether despotic leadership causes emotional exhaustion over time rather than co-occurring with it (Cole & Maxwell, 2003).

Second, data relied exclusively on self-reports, raising concerns of common method variance. Although Harman's single-factor test and CFA diagnostics suggested CMV was not a major issue, the reliance on perceptual data cannot be fully discounted. Future research might triangulate these results with supervisor ratings, peer assessments, or objective attendance data.

Third, the focus on junior nurses in four public hospitals in Lahore limits generalizability. While the choice was deliberate to capture a vulnerable occupational group, findings may not extend to senior medical staff, private hospitals, or other cultural contexts. Comparative studies across sectors and regions would clarify the boundary conditions of the observed effects.

Fourth, the study centered on withdrawal behaviors as the primary outcome. While relevant, DL likely influences other outcomes such as counterproductive work behaviors, errors in patient care, or diminished prosocial service behaviors. Future models could broaden the outcome space to capture the full range of destructive leadership consequences.

Directions for Future Research

Building on these limitations, several avenues warrant exploration.

Longitudinal and diary studies could illuminate how despotic leadership triggers daily fluctuations in exhaustion and performance, thus strengthening causal claims. Multi-source designs should also be pursued, combining surveys with supervisor evaluations or patient satisfaction metrics.

Future work may examine interaction effects among multiple resources. For example, do POS and PsyCap amplify each other in buffering despotic leadership, or are their effects redundant? Such analyses would help refine resource substitution and resource synergy theories within JD-R (Hobfoll et al., 2018).

There is also scope to explore cultural moderators. In collectivist societies where hierarchy is more normalized, despotic leadership may be tolerated to some extent, but the breaking point at which it induces strain may vary. Comparative cross-country designs could advance theory on leadership and stress in diverse settings.

Finally, researchers might investigate intervention studies—designing and testing training programs that explicitly target PsyCap development or POS enhancement, then evaluating their effectiveness in reducing the harms of despotic leadership. Such applied scholarship would bridge the gap between organizational science and healthcare policy.

Conclusion

This study set out to examine how despotic leadership affects the psychological well-being and work behaviors of junior nurses in Lahore's public sector hospitals. By integrating the JD-R framework, it demonstrated that despotic leadership operates as a demand that fuels emotional exhaustion, which in turn drives withdrawal behaviors. Yet it also showed that resources—organizational in the form of POS and personal in the form of PsyCap—can buffer these negative effects.

Theoretical contributions include extending JD-R to destructive leadership, clarifying emotional exhaustion's mediating role, and validating the dual importance of organizational and individual resources. Practically, the findings stress the urgency of curbing despotic practices, institutionalizing supportive systems, and investing in nurse resilience training. While bounded by its methodological constraints, the study offers a meaningful step toward understanding and addressing leadership-driven strain in high-stakes healthcare environments.

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