

Workplace violence against nurses as a public health issue: a narrative review

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Abstract

Workplace violence (WPV) against nursing staff is a significant and growing problem in healthcare systems, affecting both employee well-being and the quality of patient care. The aim of this study is to present the scale of the phenomenon, its forms, and its consequences for nurses. A review of the literature indicates that WPV is widespread and occurs in various forms, including verbal, psychological, and physical abuse. Verbal violence is the most common form involving insults, threats and humiliation. Research findings show that a substantial proportion of nurses experience WPV repeatedly, leading to negative health outcomes such as stress, burnout, anxiety and depressive symptoms. WPV also affects the quality of patient care by reducing concentration and increasing the risk of errors. Contributing factors include healthcare system overload, staff shortages and inadequate communication with patients. The need for preventive measures is emphasized, including training in managing aggressive behaviour, improving work organization and providing psychological support for staff. Effective prevention of WPV requires systemic solutions and increased awareness of the issue.

Introduction

Workplace violence (WPV) against healthcare workers is a global phenomenon and represents a significant challenge for both staff safety and the quality of patient care. It is estimated that approximately 62% of healthcare workers experience at least one form of occupational violence during their careers (World Health Organization n.d., *Violence and...*). According to the World Health Organization (WHO), violence is defined as the intentional use of physical force or power – whether actual or threatened – against oneself, another person, a group or a community, which results in or has a high likelihood of resulting in injury, death, psychological harm, developmental disorders or deprivation of basic needs (World Health Organization n.d., *Violence Prevention...*). However, it is important to note that this definition primarily focuses on physical violence and may not fully capture non-physical forms that are frequently reported in healthcare settings.

In contrast, the European Agency for Safety and Health at Work defines WPV more broadly as the deliberate use of force – actual or potential – in a work-related context that may result in injury, psychological harm or deprivation of basic needs (European Agency for Safety and Health at Work 2012). WPV is increasingly recognized as a significant issue in the healthcare sector, closely associated with organizational pressure as well as staffing and resource shortages. Cases of WPV increased in number markedly during the COVID-19 pandemic, when increased stress levels, workload overload and social tensions contributed to more frequent manifestations of hostility towards healthcare personnel, including acts of intimidation and stigmatization (Abreu et al. 2026).

In 1996, during the 49th World Health Assembly, Resolution WHA49.25 was adopted, recognizing violence as a major global public health problem. The document emphasized the need to develop monitoring systems and implement effective prevention strategies (World Health Organization 1996). In 2002, the WHO, in collaboration with the International Labour Organization, the International Council of Nurses and Public Services International, published framework guidelines for preventing violence in the healthcare sector (Di Martino 2002).

WPV includes verbal abuse, physical assaults and sexual harassment, all of which negatively affect both healthcare workers and the functioning of healthcare organizations. The consequences of WPV extend beyond the individual level and include systemic impacts such as increased legal costs, compensation payments, higher staff turnover, reduced work efficiency and the need to implement stricter safety procedures (Abdulwehab, Kedir 2025). Attention has also been drawn to the particular vulnerability of healthcare workers, especially those employed in high-risk settings such as emergency departments and psychiatric wards (European Agency for Safety and Health at Work 2012; European Commission 2021). International research data indicate that verbal violence is the most common form

of WPV, followed by emotional, physical and sexual violence. Verbal violence particularly affects nurses (Banga et al. 2023).

The consequences of such incidents can be categorized into physical, professional and organizational outcomes (González-González et al. 2025). The impact of WPV on healthcare personnel and the associated direct and indirect costs for healthcare systems may also increase risks to patient safety. Numerous studies indicate that WPV is associated with reduced quality of care and an increased risk of medical errors. Many researchers also highlight the relationship between WPV and staff turnover. Burnout syndrome resulting from WPV experiences correlates with higher rates of resignation and increased intentions among healthcare workers to leave their current positions. Direct costs related to violence prevention and management are also substantial. Absenteeism is a frequently reported consequence of WPV, and in addition to direct costs, studies indicate significant productivity losses as a result of it (O'Brien et al. 2024). The high prevalence of WPV has a significant negative impact on healthcare workers, leading to stress, job abandonment and the development of post-traumatic stress disorder, which is particularly prevalent among nurses. Research clearly indicates that nurses' health and safety should be a key priority for healthcare administration (González-González et al. 2025).

It is also worth noting that in developing countries, the proportion of workers experiencing WPV may be as high as 88% (Abdulwehab, Kedir 2025). Every year, millions of nurses are exposed to various forms of workplace aggression, demonstrating the high prevalence of this problem in the healthcare sector (Wang et al. 2025). It is estimated that up to 80% of incidents remain unreported, indicating a significant underestimation of the scale of the problem (Mahmoudi et al. 2026).

The aim of this article is to review the literature on patient and visitor violence towards nursing staff and to identify the forms it takes, consequences for healthcare personnel, as well as preventive strategies.

Methods

This narrative review was conducted to synthesize current evidence on WPV against nurses and its association with burnout and related occupational outcomes. A structured search of the literature was performed using the PubMed and Google Scholar databases. The search strategy included combinations of keywords such as “workplace violence”, “nurses”, “nursing staff”, “burnout”, “occupational stress”, “psychological consequences”, “turnover intention” and “patient safety”. Additional searches were conducted using terms related to specific forms of violence, including “physical violence”, “verbal abuse” and “cyberbullying in healthcare”. The review included systematic reviews, meta-analyses, scoping

reviews, integrative reviews and original cross-sectional studies published in English and Polish. Studies focusing on healthcare workers other than nurses were included only if nursing-specific data were clearly reported. Articles addressing WPV in non-healthcare settings were excluded. Editorials, commentaries, conference abstracts without full text, and non-peer-reviewed publications were also excluded. The search covered publications from 2002 to 2026 to capture both foundational and recent evidence on WPV in healthcare settings. The selection of studies was based on relevance to the research topic, with particular emphasis on evidence reporting associations between WPV, burnout, psychological health outcomes and organizational consequences among nursing staff. As this is a narrative review, no formal quality assessment of the studies included was performed. Therefore, the findings should be interpreted with consideration to the potential methodological limitations of the evidence reviewed.

Types of workplace violence and risk factors

WPV can take various forms; therefore, it is important to distinguish between physical and non-physical behaviours. Physical violence involves the use of force against another person and may result in both physical injury and psychological consequences (e.g., hitting, kicking, pushing, slapping, biting or pinching). Verbal violence, on the other hand, includes insults, threats, profanity or offensive communication (World Health Organization n.d., *Violence and...*). Although the terms “aggression” and “violence” are sometimes used interchangeably, WPV is a specific category of aggression referring to actions intended to cause physical harm (Vincent-Höper et al. 2020). Both physical and verbal violence from patients, their relatives and visitors is a common problem in healthcare settings and represents a major public health challenge (Liu et al. 2018). Nursing is one of the professions particularly exposed to WPV. The highest prevalence is observed among staff working in psychiatric wards, emergency departments and geriatric care facilities (Vincent-Höper et al. 2020). WPV can be classified according to relational structure as vertical or horizontal. Vertical violence refers to interactions between different groups, such as healthcare staff and patients, whereas horizontal violence occurs within a single group – between healthcare workers or between patients themselves (Needham et al. 2012). Physical violence includes various forms of direct bodily harm such as assaults, hitting, kicking, spitting and, in extreme cases, even homicide. Psychological violence, in turn, includes verbal violence, mobbing, sexual harassment, and racial discrimination, and encompasses behaviours such as intimidation, pressure, defamation, slander, blackmail, threats (both verbal and non-verbal), as well as harassment or sexual abuse (Bernardes et al. 2021). It is important to emphasize that risk factors for WPV include direct

contact with individuals with a history of violence or substance abuse (alcohol and drugs), working in poorly lit or unsafe environments, and employment in high-crime areas (Occupational Safety and Health Administration 2016). Cultural violence includes all actions targeting ethnicity, race, language, religion, or place of birth with the aim of violating human dignity. Sexual violence refers to all forms of harassment and assault of a sexual nature that cause feelings of threat, discomfort and humiliation. Due to frequent direct contact with patients and their families, nurses are more exposed to WPV than other hospital staff. Studies indicate that their risk is three times higher. Key factors increasing the likelihood of violence against nurses include young patient age, male gender, difficult socioeconomic conditions, severe mental disorders, refusal of treatment, personality disorders and previous maladaptive behaviours, hospitalizations related to aggressive behaviour, history of domestic violence and possession of weapons (Shohani, Tavan 2024). A review of 18 articles conducted by Pia Contreras Jofre et al. showed that nurses are the most vulnerable group among healthcare professionals. The most frequently reported form of violence was verbal violence, followed by physical violence (Contreras Jofre et al. 2020). In contrast, research by Mohammad M. Alnaeem et al. showed that a large proportion of nurses (81%) experienced verbal violence, while 25.5% reported physical violence. More than half of respondents (44.5%) expressed fear of being attacked at work. The most frequently indicated factors influencing the decision to report incidents were patient condition (23.1%) and severity of the event (19%). Additionally, most nurses (75.9%) reported a lack of preventive programmes in their workplaces (Alnaeem et al. 2025). Cyber forms of WPV, referred to as cyber incivility, involve aggressive behaviours occurring in email communication within the workplace environment. These behaviours may vary in intensity. Cyber incivility is understood as low-intensity deviant behaviours in which the intent to harm the recipient is ambiguous (Spencer et al. 2023). Cyber incivility behaviours may take more severe forms and manifest as rude and disrespectful electronic messages that show a lack of regard for recipients (McCarthy et al. 2019). Cyber aggression, in turn, represents the most severe form of this phenomenon and includes electronic messages intended to deliberately harm an individual or group, which are perceived as offensive, humiliating, harmful or unwanted (Nocera et al. 2022). Cyber violence is a significant and multidimensional problem among nursing staff. It is shaped by organizational culture and power relations and is associated with serious psychological and professional consequences. Its escalation is facilitated by the blurring of boundaries between private and professional life, as well as insufficient corrective measures resulting from fragmented leadership, lack of education and inconsistent institutional responses. Cyber violence and cyber incivility can be considered digital forms of workplace bullying among nurses, negatively affecting their well-being, professional identity, staff retention and

quality of patient care. Effective prevention requires cyber aggression to be recognized as a form of WPV and coordinated organizational actions involving management, education, policy and research to be implemented (Watson et al. 2026). Studies indicate that approximately 36.8% of nurses have experienced cyber violence (Zhang et al. 2025).

WPV against nursing staff is a multifactorial phenomenon resulting from interactions between patient-related, organizational and staff-related factors. The literature emphasizes the need to analyze these determinants in a comprehensive manner, as their co-occurrence significantly increases the risk of violence in the workplace environment (Alnaeem et al. 2025; Feruglio et al. 2025). One of the main sources of patient and visitor violence towards nurses are factors directly related to the patient and their health condition. Research indicates that the patient's clinical status, the severity of disease symptoms and stressful situations are of particular importance (Alnaeem et al. 2025). Hospitalized patients often experience strong emotions such as anxiety, frustration, or a sense of loss of control, which may lead to aggressive behaviours. Additionally, mental disorders, physical pain and discomfort, as well as substance use disorders, play an important role. A systematic review highlighted that aggression often occurs in situations where patients' and their families' expectations are not met and in the context of difficult interpersonal communication. Lack of understanding of the treatment process may lead to increasing tension and, consequently, aggressive behaviours. The involvement of accompanying persons is also important, as they – acting under emotional distress – may exhibit aggression towards healthcare staff (Feruglio et al. 2025). The second key group of factors includes systemic and organizational determinants, which are among the most important predictors of violence in the nursing workplace environment. A study published in "Frontiers in Public Health" showed that as many as 75.9% of respondents indicated a lack of effective WPV prevention programmes (Alnaeem et al. 2025). The absence of procedures and systemic solutions contributes to the perpetuation and normalization of aggression in the professional environment. The most important organizational factors include staffing shortages and workload overload, high-stress working conditions, lack of clear incident reporting procedures and insufficient managerial support (Alnaeem et al. 2025; Cannizzaro et al. 2025). Moreover, ineffective communication between staff and patients may significantly increase the risk of WPV (Alnaeem et al. 2025). Organizational problems such as long waiting times for services or limited resources generate frustration among patients and their families. A scoping review also highlighted the importance of increasing complexity in healthcare systems, higher workload and time pressure, all of which contribute to conflict situations (Cannizzaro et al. 2025). The third group of factors consists of characteristics and resources of nursing staff. Research indicates that individual characteristics of nurses may influence the risk of experiencing aggression (Alnaeem et al. 2025;

Mroczkowska et al. 2025). In particular, professional experience, communication competencies and stress-coping styles are emphasized (Alnaeem et al. 2025). A study conducted in Poland by Renata Mroczkowska et al. showed that younger and less experienced nurses are more frequently exposed to aggression, which may result from limited clinical experience and weaker coping skills in difficult situations. Additionally, high stress levels, lack of team support, and interpersonal difficulties were identified (Mroczkowska et al. 2025). Research on burnout has shown that chronic stress and burnout increase susceptibility to conflicts and reduce the ability to cope with aggression (Vincent-Höper et al. 2020). This may lead to a vicious cycle in which violence increases burnout, and burnout in turn increases the risk of further aggressive incidents. The communication style of healthcare staff is also crucial – insufficient interpersonal skills may lead to escalation of tension (Alnaeem et al. 2025).

Consequences of workplace violence against nursing staff

The consequences of WPV against nurses can be grouped into four main categories: psychological, physical, occupational and organizational/system-level consequences. Although these domains are closely interrelated, such classification facilitates understanding of the multidimensional impact of WPV on healthcare personnel and healthcare systems.

WPV against registered nurses is recognized worldwide as a serious threat to public health and the safety of healthcare workers. WPV negatively affects both the quality of care provided and the stability of healthcare systems (ILO/ICN/WHO/PSI 2003; Milczarek 2010). Research indicates that experiencing WPV in healthcare settings leads to numerous physical and psychological consequences among nursing staff. The most common include anxiety disorders, depression, burnout and changes in social functioning (Hilton et al. 2022; Wang et al. 2022). Moreover, exposure to violence may reduce work efficiency, prolong the time needed to perform nursing tasks, and delay the execution of critical responsibilities (Roche et al. 2010). Judith E. Arnetz et al. found that as many as 74% of nurses exposed to WPV reported cognitive problems, particularly in memory and attention, which has significant implications for patient safety and quality of care (Arnetz et al. 2025). Beyond individual effects, it is also important to consider the epidemiological dimension of WPV. The prevalence and frequency of violence directly influence consequences for both staff and entire organizations. A study conducted among nearly 2,000 Italian nurses showed that 32.4% had experienced violence in the past year (Bagnasco et al. 2024). Among triage nurses, violence triggered strong emotional reactions such as anger (25%), irritation (16.7%) and feelings of lack of support (4.2%) (Ferri et al. 2020).

Psychological consequences

The impact of WPV includes both immediate and long-term occupational consequences. Experiences of violence may lead to memory suppression and avoidance behaviours (Alamri et al. 2023), as well as higher staff turnover, burnout and reduced productivity (Oludare, Kotronoulas 2022). Gordon L. Gillespie and Peggy Berry et al. demonstrated that 58.7% of nurses experienced negative psychological reactions after violent episodes, including anxiety, fear, frustration, anger and helplessness. Some participants also reported shame and guilt, often blaming themselves for the incident. Additionally, some nurses expressed concerns about aggression outside the workplace (Gillespie, Berry 2023). Natalia Violim Fabri et al. found that as many as 57.4% of respondents experienced high levels of post-traumatic stress related to physical violence, and 68.3% used psychotropic medications (Fabri et al. 2022). Arnetz et al. highlighted that, in addition to post-traumatic stress, occupational burnout acts as a key mediator between exposure to violence and cognitive deficits such as memory impairment, concentration difficulties and inappropriate reactions (Arnetz et al. 2025). Changmian Ding et al. confirmed the direct impact of WPV on nurses' mental health, including problems with concentration, memory and planning, which poses a serious threat to clinical safety (Ding et al. 2023; Wel-tens et al. 2024). In turn, Li-Chung Pien et al. demonstrated that WPV is associated with poorer sleep quality, manifested by difficulty falling asleep, frequent awakenings and non-restorative sleep (Pien et al. 2024). All these data indicate that the psychological consequences of WPV are extensive and long-lasting, encompassing post-traumatic stress, anxiety, depression and cognitive dysfunction, further reinforced by the high rate of psychotropic medication use. These effects extend beyond the workplace, affecting nurses' sense of safety in their everyday lives. Yudai Kobayashi et al. showed that exposure to WPV is associated with significantly worse mental health outcomes, including lower WHO-5 Well-Being Index scores and higher scores on the K6 (Kessler Psychological Distress Scale) (Kobayashi et al. 2020).

Burnout and occupational consequences

Studies conducted by Sirlene Aparecida Scarpin Tsukamoto et al. demonstrated a significant association between WPV and symptoms of burnout, particularly emotional exhaustion and depersonalization (Tsukamoto et al. 2022). Nurses exposed to physical violence, verbal violence, or fear of violence were more likely to develop emotional exhaustion, which manifests as chronic fatigue and reduced ability to cope with emotional demands. Verbal violence increased the risk of emotional exhaustion more than threefold and depersonalization approximately

2.5-fold, whereas physical violence increased the risk of both dimensions three-fold (Mroczkowska et al. 2025). In the 2025 study by Arnetz et al., both physical and verbal violence were identified as significant predictors of burnout, with psychological violence – including threats and verbal abuse – having a particularly strong impact (Arnetz et al. 2025). Emotional exhaustion emerged as the main predictor of cognitive deficits (memory, attention, and functioning), which has important implications for patient safety and quality of care (Mroczkowska et al. 2025). Similarly, Pien et al., using the Copenhagen Burnout Inventory (a tool for assessing burnout developed by researchers from the National Research Centre for the Working Environment), distinguished between personal burnout and patient-related burnout. In the study group, approximately 43% of nurses reported high levels of personal exhaustion, and more than half experienced patient-related burnout. Verbal violence doubled the risk of both forms of burnout, while the combination of physical and verbal violence further increased the likelihood of negative outcomes (Pien et al. 2024). Several studies consistently indicate that exposure to verbal, physical, and psychological violence is associated with higher levels of emotional exhaustion, depersonalization, secondary traumatic stress, and intention to leave the profession. Verbal violence appears to be a particularly strong predictor of burnout, while repeated exposure contributes to cognitive impairment and reduced work performance (Fabri et al. 2022; Yeh et al. 2020; Kobayashi et al. 2020).

Physical consequences

The physical consequences of WPV represent an important dimension of its impact on nursing staff. In a study conducted by Gillespie and Berry et al., 16.2% of participants experienced injuries ranging from minor trauma, such as nosebleeds, minor wounds and muscle pain, to more serious injuries (Gillespie, Berry 2023). Exposure to WPV may result in both acute injuries and long-term health problems that negatively affect nurses' ability to perform their professional duties (Gillespie, Berry 2023; Kobayashi et al. 2020). Studies indicate that prolonged exposure to WPV is associated with a range of adverse physical health outcomes, including cardiovascular diseases such as hypertension and angina pectoris, gastrointestinal disorders, chronic pain, sleep disturbances and metabolic conditions, including type 2 diabetes (Kolutek et al. 2024). These health consequences may accumulate over time, contributing to a deterioration in overall health status and quality of life among nursing staff (Kolutek et al. 2024; Kobayashi et al. 2020). Overall, the evidence suggests that WPV may have both immediate and long-term physical consequences, highlighting the importance of effective prevention and early intervention strategies in healthcare settings (Gillespie, Berry 2023; Kolutek et al. 2024). Research indicates that WPV has substantial psychological consequences

for nursing staff, negatively affecting both well-being and professional functioning. Common reactions include anxiety, fear, uncertainty, frustration, anger and feelings of guilt, which may extend into one's private life and manifest as intrusive thoughts (Gillespie, Berry 2023). High levels of post-traumatic stress and persistent anxiety are frequently reported, with nearly 60% of nurses experiencing symptoms such as nightmares and hypervigilance (Fabri et al. 2022; Weltens et al. 2024; Kobayashi et al. 2020). WPV has also been associated with anxiety, depression, reduced psychological resilience, limited social support and lower self-esteem, indicating a considerable cumulative psychological burden (Ding et al. 2023; Chipps et al. 2024; Ceballos et al. 2020). Overall, the reviewed studies consistently indicate that psychological consequences represent one of the most significant outcomes of WPV among nurses. Although the severity of symptoms varies across studies, anxiety, post-traumatic stress, sleep disturbances and cognitive impairment emerge as the most frequently reported effects. These findings suggest that psychological support should be considered a core component of WPV prevention programmes.

Organizational and system consequences

Violence against nursing staff has wide-ranging consequences for professional functioning. It may lead to medical errors, increased absenteeism, staff turnover, burnout, and generate additional costs related to hiring and training new employees. Consequences also include distancing from patients, an increased number of complaints, and cognitive dissonance among staff, which ultimately reduces work productivity and efficiency. The negative atmosphere associated with experiencing violence also affects the quality of nurse–patient interactions. Nurses spend less time with patients and demonstrate reduced sensitivity to their needs, which patients perceive as lower quality of care and reduced satisfaction with healthcare services (Nau et al. 2010; Sohrabzadeh et al. 2015). The consequences of these phenomena are multidimensional: from systemic effects such as increased costs and higher staff turnover, to negative outcomes for personnel, including burnout, reduced productivity and deteriorated therapeutic relationships, resulting in an increased number of complaints (McPhaul et al. 2008; Aivazi, Tavan 2015). At the organizational and system level, WPV contributes to increased staff turnover, absenteeism, recruitment and training costs, and reduced workforce stability. It may also negatively affect patient outcomes through reduced quality of care, impaired nurse–patient relationships and an increased risk of medical errors. Consequently, WPV generates substantial economic and organizational burdens for healthcare systems.

Critical synthesis of the evidence

Although the literature reviewed here consistently demonstrates a strong association between WPV and adverse psychological, physical, and organizational outcomes among nurses, several limitations should be acknowledged. Firstly, the majority of available studies are cross-sectional, which limits the ability to establish causal relationships between exposure to violence and long-term health outcomes. Secondly, substantial heterogeneity exists in the definitions of WPV, measurement tools and reporting systems used across studies, making direct comparisons difficult. Thirdly, the widespread underreporting of violent incidents may result in an underestimation of the true prevalence of WPV and its consequences. Despite these limitations, the overall body of evidence indicates that WPV is a significant occupational and public health problem requiring comprehensive preventive strategies.

Preventive actions and interventions

Research indicates that the causes of underreporting WPV incidents are numerous, including a lack of clearly defined procedures (Hahn et al. 2012), as well as fear of professional consequences and the belief that such incidents are an inherent part of working in healthcare (Hahn et al. 2012; Burak et al. 2021; Frydrysiak et al. 2016). As a result, a vicious cycle emerges: limited reporting leads to a lack of reliable data, which in turn hinders the development and implementation of effective safety policies and appropriate training programmes (Hahn et al. 2012). Actions aimed at reducing violence against healthcare workers (patient-visitor violence) should be multidimensional and include, among others, the development of communication competencies and skills in managing aggression. Although the literature emphasizes the importance of these skills, in practice training in this area is still not widely implemented (Ceballos et al. 2020; Lyver et al. 2025). The consequences of underreporting extend beyond individual incidents and significantly affect the ability of healthcare organizations to accurately assess risks and implement effective prevention strategies. Previous studies indicate that a substantial proportion of violent incidents are never formally documented, largely due to perceptions that reporting is ineffective, fear of negative consequences, normalization of aggression and organizational barriers (Richardson et al. 2018; Christensen, Wilson 2022; Morphet et al. 2018). Consequently, the true prevalence of WPV may be considerably underestimated, limiting opportunities for evidence-based intervention and organizational learning. Organizational commitment appears to play an important role in improving reporting practices, as higher reporting rates

have been observed in institutions actively promoting incident documentation and a culture of safety. The implementation of effective and transparent reporting systems would enable better risk management regardless of the severity of the incident. However, the willingness of healthcare workers to report all forms of WPV remains equally important. Institutional and legal regulations should therefore provide real protection for healthcare workers, support a safe working environment, and promote a culture of safety that ensures respect and protection for both staff and patients (Burak et al. 2025). Evidence suggests that reporting practices remain inconsistent: 43.3% of respondents reported consistently documenting aggressive behaviours, whereas 5.3% never recorded them. Concern for personal safety was the most frequently cited reason for documentation (44.8%), while 40% of those who did not report incidents considered reporting ineffective or pointless (Burak et al. 2021). To reduce the negative consequences of patient-visitor violence it is necessary to implement measures involving both legal system changes and systematic monitoring of such behaviours. An important element of prevention is education of healthcare personnel, particularly through specialized training preparing them to deal with aggression (Lickiewicz et al. 2020). Such programmes are referred to as Aggression Management Programs (AMPs) (Livingston et al. 2010).

To date, no unified methodology for conducting such programmes has been developed; however, a shift in approach is noticeable – from techniques based primarily on physical defence towards preventive strategies. Contemporary approaches emphasize understanding the mechanisms underlying aggressive behaviours. This perspective promotes calm and controlled responses to aggressive patients, which supports both effective management of difficult situations and their prevention. Training allows staff to analyze their own attitudes towards violence and to learn possible responses in hypothetical scenarios (Lickiewicz et al. 2020). It also provides practical guidance on managing aggressive patients, with the primary goal of developing preventive competencies rather than responding only to incidents that have already occurred. Modern training programmes cover a wide range of topics, such as workplace organization, theories and determinants of aggression, risk assessment, principles of communication and conflict de-escalation, physical intervention techniques, ethical and legal issues, and post-incident procedures (ILO/ICN/WHO/PSI 2003). An example of an aggression management program is Therapeutic Aggression Management (TERMA), which has been applied in the training of healthcare students in Poland (Lickiewicz 2017). The programme combines education on the mechanisms and risk factors of aggression, communication and de-escalation strategies, legal and ethical aspects of patient management, teamwork, and selected physical intervention techniques (Lickiewicz 2017). Evidence regarding the effectiveness of aggression management training suggests that programmes

focused exclusively on physical self-defence are insufficient and may not adequately prepare healthcare workers for real-life situations. In contrast, broader AMP-based interventions have been associated with improved confidence in managing aggressive patients, enhanced stress-coping abilities, greater job satisfaction, reduced anxiety and better quality of patient care (Lickiewicz et al. 2020; Guay et al. 2016; Lamont, Brunero 2018; Baig et al. 2018). Some studies also report reductions in the frequency of aggressive incidents following implementation of preventive programmes, although the available evidence remains inconsistent and not always statistically significant (Sadatmahaleh et al. 2019).

Based on the literature review by Julia Morphet et al. (2018), effective strategies for preventing WPV can be divided into four key areas:

- **Environmental Risk Management.** This includes organizational and architectural solutions that are often underestimated, despite their significant impact on safety. Ensuring good visibility is crucial; appropriate lighting, glass-enclosed workstations, and the elimination of blind spots increase situational control and the sense of safety. It is also important to restrict access to objects that could be used as weapons, even if they are part of routine equipment. Another essential element is appropriately designed patient examination rooms, equipped with features including two exits, alarm systems and stable, permanently fixed furniture (Morphet et al. 2018).
- **Consumer Risk Assessment.** This strategy focuses on early identification of signals that may indicate an increasing risk of WPV. For this purpose, standardized assessment tools such as the Bröset Violence Checklist are used and may be implemented as early as the patient admission stage. This allows for faster implementation of appropriate preventive measures (Morphet et al. 2018).
- **Staff Education.** Staff training should include not only verbal de-escalation techniques, but also the ability to recognize early signs of agitation or increasing tension in patients. Another important component is basic coping strategies in threatening situations, including self-defence techniques adapted to healthcare settings (Morphet et al. 2018).
- **Management of Violent Incidents.** When preventive measures are insufficient, it is crucial to implement clearly defined response procedures. These include the functioning of intervention teams responsible for rapid staff support (e.g. security or specially trained healthcare personnel). Equally important is the provision of post-incident support, including incident debriefing and psychological assistance for affected staff, which helps reduce the risk of long-term consequences such as post-traumatic stress or burnout (Morphet et al. 2018).

Table 1. Summary of types of workplace violence (WPV), risk factors, consequences, and preventive interventions

Category	Main findings	Examples	Key references
Types of workplace violence	WPV may take physical, verbal, psychological, sexual, and cyber forms	Physical assault, threats, insults, intimidation, sexual harassment, online abuse	ILO/ICN/WHO/PSI 2003; Mroczkowska et al. 2025; Occupational Safety and Health Administration 2016
Patient-related risk factors	Patient characteristics increase the likelihood of violence	Pain, cognitive impairment, dementia, psychiatric disorders, alcohol or drug intoxication	Mroczkowska et al. 2025; Ferri et al. 2020
Organizational risk factors	Work environment contributes to WPV	Staff shortages, excessive workload, overcrowding, long waiting times, inadequate security measures	Ferri et al. 2020; Mroczkowska et al. 2025
Staff-related risk factors	Individual and professional factors may influence exposure	Younger age, limited experience, poor communication skills, fatigue	Mroczkowska et al. 2025; Baig et al. 2018
Psychological consequences	WPV negatively affects mental health	Anxiety, depression, PTSD, sleep disturbances, cognitive impairment	Gillespie, Berry 2023; Fabri et al. 2022; Ding et al. 2023; Kobayashi et al. 2020; Arnetz et al. 2025
Physical consequences	Violence may cause acute and chronic health problems	Injuries, chronic pain, gastrointestinal and cardiovascular disorders	Tsukamoto et al. 2022; Mroczkowska et al. 2025; Guay et al. 2016
Occupational consequences	WPV affects professional functioning	Burnout, absenteeism, reduced productivity, intention to leave the profession	Tsukamoto et al. 2022; Pien et al. 2024; Kobayashi et al. 2020; Arnetz et al. 2025
Organizational and system consequences	WPV impacts healthcare systems and patient care	Medical errors, lower quality of care, increased complaints, staff turnover, economic burden	McPhaul et al. 2008; Aivazi, Tavan 2015; Arnetz et al. 2025
Preventive interventions	Multifaceted interventions are required	Staff training, de-escalation techniques, reporting systems, organizational support, security measures, zero-tolerance policies	Morphet et al. 2018; ILO/ICN/WHO/PSI 2003; Needham et al. 2012; Occupational Safety and Health Administration 2016

Source: own study.

Discussion

The literature reviewed here consistently indicates that WPV remains a widespread problem affecting nursing staff across diverse healthcare settings. Despite differences in study populations, geographical regions, and methodological approaches, the findings demonstrate a clear association between exposure to

violence and adverse psychological, physical and occupational outcomes. Verbal violence was identified as the most frequently reported form of aggression, although physical, psychological, sexual and cyber violence also contribute substantially to the burden experienced by nurses (Mahmoudi et al. 2026; Burak et al. 2021). The available evidence further suggests that WPV is associated with burnout, anxiety, depression, post-traumatic stress symptoms, reduced job satisfaction and increased intention to leave the profession (Arnetz et al. 2015; Pien et al. 2024).

Several important limitations of the available evidence should be acknowledged. Firstly, most studies included in the literature are cross-sectional, which limits the ability to establish causal relationships between WPV and long-term health outcomes. Secondly, considerable heterogeneity exists in the definitions of WPV, measurement instruments, and reporting procedures used across studies, making direct comparisons difficult. In addition, some variability exists in the reported prevalence of WPV and in the effectiveness of preventive interventions, which may reflect differences in healthcare systems, workplace settings and study methodologies. Third, the widespread underreporting of violent incidents may result in a substantial underestimation of both the prevalence and consequences of WPV (Richardson et al. 2018; Morphet et al. 2018). Future studies should prioritize standardized methodologies, longitudinal designs and rigorous evaluation of preventive interventions to improve the comparability and quality of evidence.

The findings of this review have important implications for healthcare practice and policy. Healthcare organizations should prioritize the implementation of comprehensive violence prevention strategies, including staff education, effective reporting systems, environmental safety measures and access to psychological support following violent incidents (Lickiewicz et al. 2020; Morphet et al. 2018). At the policy level, the development of standardized reporting frameworks and stronger legal protections for healthcare workers may facilitate more accurate monitoring of WPV and support the implementation of evidence-based preventive interventions. Addressing WPV should therefore be regarded not only as an occupational safety priority but also as an essential component of healthcare quality and patient safety.

Conclusions

WPV against nursing staff remains a significant occupational and public health challenge worldwide. The literature reviewed here consistently demonstrates that exposure to violence negatively affects nurses' psychological well-being, physical health, professional functioning and quality of patient care. Verbal violence appears to be the most common form, although physical, psychological, sexual and cyber forms of violence also contribute substantially to the overall

burden. The evidence indicates that WPV is associated with burnout, anxiety, depression, post-traumatic stress symptoms, sleep disturbances, reduced work performance and increased turnover intentions. These consequences affect not only individual nurses but also healthcare organizations through reduced productivity, absenteeism, staff shortages and potential threats to patient safety. Despite growing research interest in this topic, important limitations remain, including underreporting of incidents, lack of standardized reporting systems and methodological heterogeneity across studies. Future research should focus on longitudinal designs, standardized measurement approaches, and evaluation of preventive interventions. Effective prevention requires a comprehensive strategy combining staff education, organizational support, reporting systems, environmental safety measures and policy-level actions aimed at creating safer healthcare workplaces.

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Data Availability Statement

The data analyzed in this narrative review were obtained from publicly available scientific literature. Information regarding the publications included in the review is provided in the reference list.

Declaration of Generative AI Use

Generative artificial intelligence tools were used in the preparation of this manuscript solely for language-related purposes, including language correction and stylistic improvement. The authors take full responsibility for the content of the manuscript, the interpretation of the findings, and the conclusions presented.

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Conflict of Interest Statement

The authors declare no conflict of interest.