


RESEARCH

Open Access



The prevalence and consequences of workplace violence among psychiatrists in Saudi Arabia: a cross-sectional study

Afnan A. Alwabili^{1*} , Nada I. AlGhammas², Hanoof H. ALkhalaf³ and Malak A. Almutairi⁴

Abstract

Background and objective There has been increasing concern globally about the rise in workplace violence (WPV), which is considered a persistent problem generally overlooked by the public and professional organizations. WPV is a significant challenge faced by psychiatrists internationally, yet little is known about WPV among psychiatrists in Saudi Arabia. This study aims to estimate the prevalence of WPV against psychiatrists in Saudi Arabia and identify the types and sources of violence experienced as well as the associated risk factors that contribute to WPV.

Results Among 239 psychiatrists, the prevalence of WPV in Saudi Arabia was 56.3%. The prevalence was particularly high among those working in the central region (55.4%) and in Ministry of Health hospitals. Violent behavior was exhibited mostly by patients 133 (99.3%), and the most common type of violence was verbal abuse 75 (56.0%). Respondents reported that patients' health conditions, denial of admission to the hospital, and staff shortages were the most common triggers for violence. More than two-thirds of the psychiatrists (74.6%) did not require medical intervention after incidents of violence. The majority of psychiatrists felt either stressed (39%) or angry (22.0%) after such incidents. Reasons for not reporting violent events included feeling that violence is part of the job (76.9%) and being unaware of the violence reporting system (50.8%).

Conclusion This study underscores the significant prevalence of WPV among Saudi Arabian psychiatrists, especially in the central region and in Ministry of Health hospitals, notably in emergency rooms. Perpetrators are primarily psychiatric patients and their relatives. The issue is compounded by staffing shortages. WPV poses physical risks and causes psychological stress, negatively impacting productivity. Underreporting persists due to a lack of awareness or violence being perceived as part of the job. Addressing these challenges through raising awareness, providing support mechanisms, and enforcing regulations is essential to bolster workplace safety and patient care for psychiatrists.

Keywords Saudi Arabia, Workplace violence, Mental health, Psychiatrist, Prevalence

*Correspondence:

Afnan A. Alwabili

a.alwabili@qu.edu.sa

Full list of author information is available at the end of the article



© The Author(s) 2024. **Open Access** This article is licensed under a Creative Commons Attribution 4.0 International License, which permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons licence, and indicate if changes were made. The images or other third party material in this article are included in the article's Creative Commons licence, unless indicated otherwise in a credit line to the material. If material is not included in the article's Creative Commons licence and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder. To view a copy of this licence, visit <http://creativecommons.org/licenses/by/4.0/>.

Introduction

Workplace violence (WPV) is defined by the National Institute for Occupational Safety and Health as “violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty.” These acts range “from offensive or threatening language to homicide.” [1]. There has been increasing concern globally about the rise in WPV, which is considered a persistent problem generally overlooked by the public and professional organizations [2]. WPV is a deliberate use of force that can lead to psychological harm, poor performance, injury, or death [3]. Healthcare employees generally accept WPV as an occupational threat that is considered a consequence of healthcare delivery. WPV can result in a significant disintegration of the fluency of patient care and in the healthcare system in general [3, 4]. Studies show that violence and aggression directed at healthcare employees may have negative consequences for their well-being, including causing dissatisfaction, low productivity, physical injury, termination of employment, and a shortage of healthcare workers [5]. The World Health Organization investigated WPV in a six-country case study in the health sector and found that more than 50% of the workers had experienced at least one incident of either physical or non-physical violence in the prior year: 37% in Portugal, 46% in Brazil, 54% in Thailand, 61% in South Africa, 67% in Australia, and 75% in Bulgaria [6]. A systematic review confirmed that the 12-month prevalence of WPV among healthcare employees was 61% [7]. About 42% of the respondents had experienced WPV in the form of verbal abuse (57%), threats (32%), and sexual advances (12%), while 24% reported experiencing physical violence [4, 8, 9].

A high risk of all forms of WPV is seen among nurses, doctors, and workers in the emergency and psychiatric services [10]. Globally, evidence shows that WPV is a significant challenge faced by psychiatrists: The prevalence of psychiatric patients behaving aggressively toward mental healthcare providers is alarmingly high [4, 8, 9]. In the USA, 40% of psychiatrists have been physically assaulted [11]. In Spain, a study revealed that psychiatrists had been more exposed to WPV, which was associated with various levels of burnout, lower job satisfaction, and diminished psychological well-being [12]. In China, a study found that psychiatrists who had a higher education degree or a higher professional rank were more exposed to WPV [13]. A similar trend was revealed in a psychiatric hospital in West Africa: about half (49.5%) of the mental healthcare providers had been physically assaulted by patients at least once while working at the psychiatric facility, and 33.7% had been physically assaulted in the previous 12 months [14].

In Saudi Arabia, WPV among healthcare providers has reached an alarming rate. In a study conducted among psychiatric nurses, the prevalence of WPV was found to be 90.3%, and 43.2% of the nurses had been exposed to WPV more than three times within 1 year [2]. In addition, 75.6% of the staff working in several emergency rooms in Saudi Arabia and the United Arab Emirates reported that they had been physically and verbally attacked [15]. Moreover, more than two-thirds (67.4%) of healthcare providers in public hospitals in Riyadh reported that they had been victims of violence during the previous 12 months [3]. Recent research indicated that 9.3% of 7398 healthcare professionals in Saudi Arabia have encountered physical violence, with the prevalence particularly high among those working night shifts and engaging in direct patient interaction [16].

WPV can threaten healthcare providers' lives and can lead to permanent disabilities. Among psychiatric nurses who had suffered from WPV, 57.4% required medical intervention and 15.8% experienced life-threatening acts that required emergency care [2]. Aspects that were significantly associated with the occurrence of WPV were patient dissatisfaction with medical care and a lack of organizational support for nurses in psychiatric units [2]. In an emergency room study, 20.9% of the respondents stated that they had been physically attacked, of whom 32.3% reported being attacked with a weapon [15]. However, verbal abuse was the most common type of WPV encountered [5, 15, 17]. Most incidents of WPV were not reported, despite the healthcare providers' awareness of the formal incident reporting systems available in their hospitals [3]. The most frequently reported negative consequence of WPV (37%) was a negative effect on overall health and well-being (depression, anxiety, fear, and anger) [3]. Among those working in emergency rooms, only 27.5% reported incidents of WPV that they had witnessed or experienced in the previous 12 months [15]. The primary reasons for the underreporting of cases were a lack of system privacy and the belief that dealing with WPV was part of one's duties [3]. In order to tackle WPV, the Saudi Arabian Ministry of Health (MOH) launched fines and penalties to control and prevent occupational violence in July 2018. The penalties include imprisonment (of up to 10 years) for multiple periods, discretionary punishment in front of the healthcare facility where the violence occurred, and a fine of up to one million riyals [18]. The prevalence of violence among staff decreased from 78.6% before the MOH regulations were implemented to approximately 20% after they were implemented [18].

Most of the literature on violence and aggression in healthcare in Saudi Arabia illustrates its prevalence among physicians and nurses and the associated risk

factors. To our knowledge, no previous study has been conducted in Saudi Arabia to evaluate WPV among psychiatrists, which is an under-studied group that requires further research to improve mental health services. Our study aims to estimate the prevalence of WPV against psychiatrists in Saudi Arabia and identify the types and sources of violence experienced as well as the associated risk factors that contribute to WPV. In addition, we aim to determine the impact of WPV on psychiatrists and their patient care. This study provides insights into WPV and highlights areas of improvement in terms of the work environment, psychiatrists' well-being, and mental health patient care. We hypothesize that psychiatrists in Saudi Arabia experience a high prevalence of WPV, which is significantly influenced by associated factors such as sociodemographic data, the type and source of violence, and affects the well-being of psychiatrists and the quality of mental health services they provide.

Materials and methods

Study setting and participants

This cross-sectional study was conducted among psychiatrists working in public or private hospitals in Saudi Arabia. The study was carried out between February and December 2023. All licensed psychiatrists aged 25 years and above and willing to participate (both Saudi and non-Saudi) were allowed to participate in the study. Initially, a sample of 340 out of a total of 780 psychiatrists in the Kingdom of Saudi Arabia were approached of whom 239 responded giving a response rate of 70.3%.

Data collection

The researchers opted to utilize a questionnaire previously employed in studies by Basfr et al. (2019) Towhari AA and Bugis BA (2020). This choice was made after careful consideration of its relevance to our research aims [2, 3]. The questionnaire was written in English to ensure its originality and prevent linguistic distortions that could affect how WPV is measured.

The link to the questionnaires developed through Google form was distributed among psychiatrists using online platforms such as WhatsApp, email, and social media. All participants received the link to a webpage explaining the study's purpose and were prompted to provide informed consent before proceeding with the online questionnaire. Each survey response was linked with an internet protocol to prevent multiple submissions from individual participants. The questionnaire consisted of three sections:

Section A consisted of demographic data. Specific parameters included age, gender, marital status,

nationality, position, years of experience, region of work, type of hospital, and psychiatry department.

Section B consisted of the type and frequency of violence during the last year. Specific questions included: Experienced violence at work, number of violent attacks, type of violence, time of violence, type of hospital, location of violence, source of violence, reasons for violence, consequences of violence, concern regarding violence at work, feeling after exposure to violence, and response after exposure to violence.

Section C consisted of reporting the violence. The specific questions in this section included: Reported the violence, to whom violence was reported, Reasons for not reporting violence, and Do you think that the violence prevalence decreased in psychiatry after new Ministry of Health regulations were implemented in 2018?

Participants were asked to check the options that applied to their scenario on a scale. A written notice attached to the questionnaire explained the nature of each type of violence (physical, verbal, or both) to all participants.

Every participant signed a consent form, and complete anonymity throughout the study was guaranteed to ensure confidentiality. The Ethical Institutional Review Committee at Qassim University, Qassim, Saudi Arabia, approved this study protocol (23–19-05). All data were kept confidential and used solely for research purposes.

Statistical analysis

SPSS version 21 was used for data analysis. Data frequencies and percentages were used in the descriptive data while multivariate logistic regression was used to examine correlations between dependent and independent variables. *P* values less than 0.05 were considered statistically significant. The interactions between experiences of WPV and sociodemographic variables were tested.

Results

Table 1 shows that a total of 239/340 (response rate: 70.3%) participants completed the survey of the study. Most of the participants were aged 30–39 years 105 (44.4%). The psychiatrists consisted mainly of Saudis 193 (80.8%), and females 137 (57.1%) outnumbered males 102 (42.9%) where most of them 142 (59.5%) were married. In regards to the position held, 65 (27.5%) were consultants, 55 (22.9%) were registrar and senior resident respectively, 53 (22.1%) were junior resident and 11 (4.6%) were fellows. In terms of years of experience, most of the respondents 87 (36.7%) had 1–5 years. Further, most of the respondents 132 (55.4%) were from the central

Table 1 Sociodemographic characteristics of the participants (N= 239)

Variables	Category	N (%)
Age	25–29	78 (32.5%)
	30–39	105 (44.2%)
	40–49	44 (18.3%)
	> 50	12 (5.0%)
Sex	Male	102 (42.9%)
	Female	137 (57.1%)
Nationality	Saudi	193 (80.8%)
	Non-Saudi	46 (19.2%)
Marital status	Single	88 (36.7%)
	Married	142 (59.5%)
	Divorce/separated	9 (3.8%)
Position	Junior resident	53 (22.1%)
	Senior resident	55 (22.9%)
	Registrar/senior registrar	55 (22.9%)
	Fellow	11 (4.6%)
	Consultant	65 (27.5%)
Years of experience	< 1	24 (10.0%)
	1–5	87 (36.7%)
	6–10	59 (24.6%)
	11–15	32 (13.3%)
	> 15	37 (15.4%)
Region in Saudi Arabia	Central	132 (55.4%)
	Western	29 (12.1%)
	Eastern	32 (13.3%)
	Southern	21 (8.8%)
	Northern	25 (10.4%)
Type of hospital (multiple choice)	Ministry of Health	125 (52.3%)
	Military	63 (26.4%)
	University	44 (18.4%)
	Private	16 (6.7%)
Psychiatry department (multiple choice)	Inpatient	182 (76.2%)
	Outpatient	206 (86.2%)
	Emergency	31 (12.3%)

N number, % percentage

region. The majority of the participants 125 (52.3%) were in MOH hospitals and 206 (86.2%) worked in outpatient psychiatry departments.

Table 2 shows that 134 (56.3%) had experienced violence at work, Verbal abuse 75 (56.0%) was the most common form of workplace violence (WPV). Most of the violence 99(73.9%) happened during the day with patients and relatives being the main perpetrators 133 (99.3%). In regards to the cause of workplace violence, 37(27.6%) indicated patients' health conditions, 26 (19.4%) denial of hospital admission are the main triggers for work-related violence (WPV), followed by 18 (13.4%) staff shortages, 17 (12.7%) excessive

waiting time while other were minimal. The majority of respondents experienced stress 52 (39.0%), anger 29 (22.0%), and anxiety 27 (20.0%), with 16 (12.0%) considering quitting and 7(5%) experiencing depression after violence exposure. Further, 69 (51.5%) reported WPV incidents, with most using multiple channels. Most reported to direct supervisors 51 (73.9%), colleagues 28 (40.6%), hospital management 33(47.8%), police 3(4.3%), and MOH 4(5.8%). Only 2 (2.9%) reported violent events to the court. The results also show that about 23.9% of cases necessitated medical intervention, although only a small fraction (1.5%) involved life-threatening situations, also a significant number of

Table 2 Prevalence of workplace violence

Variable	Frequencies (N)	Percentage (%)
Did you experience violence at work?		
Yes	134	56.3
No	105	43.7
Types of violence	N = 134	
Verbal only	75	56.0
Physical only	5	3.7
Both (verbal + physical)	54	40.3
Time of violence	<i>N</i> = 134	
Day hours	99	73.9
Night hours	35	26.1
Sources of violence (multiple choice)	N = 134	
Patient	133	99.3
Patient's relative	72	53.7
Coworker	3	2.2
Triggers for workplace violence	N = 134	
Excessive waiting time	17	12.7
Violation of visiting hours	4	3.0
Shortage of staff	18	13.4
Poor organization of work	13	9.7
Overcrowding	13	9.7
Patient's health condition	37	27.6
Denial of patient admission to the hospital	26	19.4
Smoking prohibition in inpatient wards	6	4.5
Feelings after exposure to violence	N = 134	
Anger	29	22.0
Stress	52	39.0
Anxiety	27	20.0
Depression	7	5.0
No interest in going to work; consider leaving job	16	12.0
Other	3	2.0
Reported violent events	N = 134	
Yes	69	51.5
No	65	48.5
Violence reported to (multiple choices)	N = 69	
Direct supervisor	51	73.9
Colleagues	28	40.6
Hospital management	33	47.8
Ministry of Health	4	5.8
Court	2	2.9
Police	3	4.3

N number

Saudi Arabian psychiatrists avoid reporting incidents of work-related violence (WPV), with 50.8% citing lack of knowledge about the reporting system and 32.3% citing the absence of a formal mechanism. In the assessment of psychiatrists' views regarding the effects of the MOH regulations introduced in 2018 on WPV, the results reveal that out of 239 respondents, 152 (63.6%)

were uncertain about the potential impact, 44 (18.4%) noted no decrease in WPV, and 43 (18.0%) reported a decrease in WPV.

Table 3 shows there is a statistically significant relationship between the years of experience and the prevalence of violence experienced in the work with 11–15 years and above 15 years having a prevalence of

Table 3 Logistic regression of the association between sociodemographic characteristics and experienced workplace violence

Variables	Category	β	Standard error	Odds ratio	95% CI (LB-UB)	P value*
Age	25–29	–0.067	0.873	0.936	0.169–5.174	0.939
	30–39	–0.644	0.741	0.525	0.123–2.245	0.385
	40–49	–	–	–	–	–
	> 50	1.111	0.781	3.036	0.657–14.024	0.155
Sex	Male	–	–	–	–	–
	Female	0.056	0.297	1.060	0.593–1.896	0.843
Nationality	Saudi	–	–	–	–	–
	Non-Saudi	0.313	0.517	1.368	0.496–3.772	0.545
Marital status	Single	–	–	–	–	–
	Married	0.333	0.389	1.395	0.651–2.993	0.392
	Divorce/separated	1.218	0.908	3.381		0.180
Position	Junior resident	–0.605	0.491	0.546	0.208–1.430	0.218
	Senior Resident	–	–	–	–	–
	Registrar/senior registrar	–0.016	0.575	0.984	0.319–3.039	0.978
	Fellow	–0.824	0.859	0.439	0.082–2.361	0.337
	Consultant	0.878	0.648	2.406	0.675–8.577	0.176
Years of experience	< 1	0.304	0.813	1.355	0.275–6.670	0.709
	1–5	–0.243	0.543	0.785	0.271–2.275	0.655
	6–10	–	–	–	–	–
	11–15	–1.935	0.678	0.144	0.038–0.546	0.004*
	> 15	–1.856	0.878	0.156	0.028–0.874	0.035*
Region in Saudi Arabia	Central	0.727	0.468	2.068	0.827–5.174	0.120
	Western	–	–	–	–	–
	Eastern	–0.173	0.602	0.841	0.259–2.738	0.774
	Southern	0.536	0.642	1.710	0.486–6.016	0.403
	Northern	0.062	0.650	1.064	0.298–3.802	0.924

95% CI confidence interval

P value < 0.05 considered statistically significant (*)

23(74.2%) and 21(56.8%) respectively. The difference in the two groups was statistically significant ($p < 0.05$).

Discussion

The results of this study show that the prevalence of psychiatrists being exposed to WPV in Saudi Arabia was 56.3%, a rate similar to that reported for psychiatrists working in psychiatric hospitals worldwide [11, 12, 14]. Previous data related to WPV among psychiatrists in Saudi Arabia are limited, making the findings of this study significant, especially in that they highlight that more than half of the participants had experienced such violence.

The data indicate that psychiatrists working in the central region reported higher occurrences of WPV than those working in other regions. Additionally, the number of violent attacks in MOH hospitals was higher compared to other hospital types, with the emergency rooms of MOH hospitals having the highest percentage of violent events. This aligns with other studies concerned

with emergency room violence [15, 19]. The high occurrence of WPV in the central region can be attributed to the fact that the majority of the study's participants were employed in the central region of Saudi Arabia. This region is characterized by the availability of numerous mental health services and a high population density [20, 21]. Regarding MOH facilities, the Saudi MOH is the main provider of mental health services to the general population, with other government agencies providing psychiatric care, specifically for state employees [20, 22, 23].

The study participants had experienced both physical and verbal abuse, with verbal abuse being more common, predominantly during the daytime. This aligns with prior research findings, which found high incidences of both verbal and physical violence directed at healthcare professionals, especially those working in mental health [2, 5, 24, 25]. The primary source of WPV was identified as psychiatric patients, followed by their relatives. This is in line with a study on psychiatric nurses, which also found

that patients, followed by their relatives, were the main perpetrators of WPV [2].

The results of this study offer significant insights into the triggers of incidents of WPV as perceived by psychiatrists in Saudi Arabia. The mental health conditions of patients were the most prominent trigger, followed by the denial of their admission to the hospital. Other notable triggers included staff shortages, excessive waiting times, poor work organization, overcrowding, the prohibition of smoking in inpatient wards, and violations of visiting hours. A model has been proposed that emphasizes various factors contributing to violence within healthcare settings. Among these factors are patients diagnosed with schizophrenia who are involuntarily admitted and exhibit cognitive dysfunction and substance abuse [26]. It has even been suggested that variations in sleep duration can serve as a valuable predictor of violent incidents in such settings [27]. Additionally, patients' relatives may express their anger through aggressive behavior [28]. Another study revealed that demanding workloads, driven by staff shortages and a high rate of patient turnover, reduced trust and fairness and led to stressful circumstances for patients, their families, and healthcare professionals alike [29].

WPV poses a significant risk to psychiatrists and can result in long-term disabilities. In our study, about 23.9% of cases necessitated medical intervention, although only a small fraction (1.5%) involved life-threatening situations, aligning with findings from previous studies on WPV among emergency room professionals [15]. Conversely, research on WPV among psychiatric nurses in Saudi Arabia revealed that 57.4% of cases required medical intervention, and 15.8% involved life-threatening incidents that required emergency care [2]. The higher rates of serious injury among nurses, compared to psychiatrists, likely reflect the fact that nurses are often on the frontline in terms of managing patient aggression or demands. Similarly, investigations into healthcare providers in inpatient psychiatric units found that more than a third of victims needed medical care following violent incidents [30].

Apart from potential physical consequences, WPV can also have significant psychological impacts. Our data indicate noteworthy emotional responses from psychiatrists who have encountered violence. The majority reported feeling stressed, while a substantial number of them experienced anger and anxiety. Similar sentiments have been reported in other studies examining emotional responses to violence [2, 3]. A smaller percentage of psychiatrists (11.7%) indicated that they lost interest in going to work or considered leaving their jobs. Likewise, among psychiatric nurses,

8.4% lost interest in their jobs or considered quitting [2]. These findings align with Nijman et al.'s study, suggesting that WPV is linked to reduced productivity and higher rates of absenteeism [31]. This situation can create a so-called vicious circle, as decreased staffing levels and the presence of temporary staff may lead to more episodes of violence [32].

Half of the surveyed psychiatrists in Saudi Arabia reported the violent events that they had experienced, with the majority choosing to report incidents to their direct supervisors (73.9%), colleagues (40.6%), and hospital management (47.8%). The reasons for underreporting incidents of WPV were diverse. Around half of the exposed psychiatrists were unaware of the reporting system and procedures. A significant proportion of the respondents (76.9%) perceived WPV as inherent to their jobs, which was found to be a primary reason for underreporting in previous studies [3, 11, 17, 33]. Another 36.9% of the participants acknowledged past negligence in reporting, and 10.8% cited fear of the consequences of reporting WPV, echoing trends observed in previous studies [5, 34–36].

The study further reveals that there is a statistically significant relationship between the years of experience and the prevalence of violence experienced in the work, with 11–15 years and above 15 years having a prevalence of 23(74.2%) and 21(56.8%) respectively. The difference in the two groups was statistically significant ($p < 0.05$). This concurs with a study by Al Anazi et al., which found that years of experience in the workplace significantly determine the incidences of violence experienced in the workplace [36].

This study has several limitations that should be taken into account. First, the cross-sectional design impedes the establishment of causal relationships between the variables under investigation. Second, relying on participants' recollections introduces potential recall bias, thus impacting data accuracy. Third, the subjective nature of violence which is influenced by personal perspectives, work contexts, and cultural norms, among other things—adds complexity. Furthermore, the low sample size may be attributed to heavy workloads and staff shortages, which increase the risk of work-related violence. Additional limitations include a lack of detailed information on life-threatening conditions resulting from WPV as well as on the incidents of WPV reported to the MOH and the court. The limited evidence on WPV among psychiatrists in Saudi Arabia makes it challenging to determine the impact of the MOH regulations on WPV by comparing our findings to those of earlier research. Moreover, there may be a selection bias, as psychiatrists who have experienced WPV may be more likely to complete the survey. It is

crucial to interpret the findings with these limitations in mind.

Recommendations

In order to effectively address WPV in healthcare settings, it is essential to raise awareness of reporting systems among hospital staff and enhance reporting systems across all health sectors. Additionally, it is advisable to include psychiatrists working in emergency rooms or inpatient settings in training programs focused on WPV, given that dealing with WPV is perceived as part of their job responsibilities. WPV prevention efforts should include ongoing training for healthcare professionals, with a focus on improving verbal communication skills and other techniques in psychiatric units. However, despite comprehensive training, incidents of WPV may still occur. Therefore, it is of utmost importance that healthcare workers communicate a zero-tolerance policy toward violence and underscore the potential legal consequences. We strongly advocate the integration of detailed information about WPV and reporting procedures into the orientation programs provided to new employees in healthcare facilities throughout Saudi Arabia.

Furthermore, it is crucial to recognize the impact of WPV on the mental health of psychiatrists and to provide them with easily accessible psychological support. Implementing measures such as allowing individuals who have experienced WPV to take leave or reduce their workloads could be instrumental in mitigating the risk of burnout. Because staff shortages contribute to WPV, it is imperative to increase the number of psychiatrists in residency programs and hospital positions.

Conclusion

This study highlights a significant prevalence of WPV among Saudi Arabian psychiatrists, echoing global trends in psychiatric hospital settings. Notably, regional disparities are apparent, with higher rates of WPV occurring in the central region and MOH hospitals, particularly in emergency rooms. The primary perpetrators of WPV are psychiatric patients and their relatives. Factors such as staffing shortages exacerbate the problem. WPV not only poses physical risks but also inflicts psychological stress and hampers productivity. Underreporting is common due to a lack of awareness or perceptions that WPV is part of the job. Addressing these challenges through raising awareness, providing support mechanisms, and enforcing regulations is imperative to improve workplace safety for psychiatrists and enhance overall patient care.

Abbreviations

MOH Ministry of Health
WPV Workplace violence

Acknowledgements

Not applicable

Authors' contributions

AA and HK developed the study concept and design, collected and provided relevant literature, and organized the data. NA and MA formulated the questionnaire and conducted the data analysis and interpretation. All authors critically reviewed the article and finalized the manuscript.

Funding

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Availability of data and materials

If there is a need for additional data, it can be accessed by reaching out to the corresponding author.

Declarations

Ethics approval and consent to participate

Approval for the study was obtained from the Qassim University Research Ethical Committee, Qassim, Saudi Arabia. (ethical approval number 23–19-05, dated 03/01/2023). Verbal consent was obtained from participants when the questionnaires were distributed, and the principles of the Declaration of Helsinki were followed. All data were kept confidential and used only for research purposes.

Consent for publication

All authors approved the manuscript for publication and conducted a thorough review before its submission.

Competing interests

The authors declare that they have no competing interests.

Author details

¹Department of Psychiatry, College of Medicine, Qassim University, Qassim, Saudi Arabia. ²Department of Psychiatry, Armed Forces Hospital, Qassim, Saudi Arabia. ³Department of Psychiatry, Security Forces Hospital, Ministry of Interior, Riyadh, Kingdom of Saudi Arabia. ⁴Department of Psychiatry, ERADAH Complex for Mental Health, Riyadh, Saudi Arabia.

Received: 27 April 2024 Accepted: 28 June 2024

Published online: 22 July 2024

References

- Centers for Disease Control and Prevention (2002) Violence occupational hazards in hospitals (<https://www.cdc.gov/niosh/docs/2002-101/default.html>)
- Basfr W, Hamdan A, Al-Habib S (2019) Workplace violence against nurses in psychiatric hospital settings perspectives from Saudi Arabia. *Sultan Qaboos Univ Med J*. 19(1):e19–e25
- Towhari AA, Bugis BA (2020) The awareness of violence reporting system among healthcare providers and the impact of new ministry of health violence penalties in Saudi Arabia. *Risk Manag Healthc Policy*. 13:2057–2065
- Magnavita N, Heponiemi T (2012) Violence towards health care workers in a Public Health Care Facility in Italy: a repeated cross-sectional study. *BMC Health Serv Res*. 12(1):108
- Algwaiz WM, Alghanim SA (2012) Violence exposure among health care professionals in Saudi public hospitals: a preliminary investigation. *Saudi Med J*. 33(1):76–82

6. Di Martino V (2002) Workplace violence in the health sector Country case studies
7. Liu J, Gan Y, Jiang H, Li L, Dwyer R, Lu K et al (2019) Prevalence of workplace violence against healthcare workers: a systematic review and meta-analysis. *Occup Environ Med.* 76:927–937
8. Kitaneh M, Hamdan M (2012) Workplace violence against physicians and nurses in Palestinian public hospitals: a cross-sectional study. *BMC Health Serv Res.* 12(1):469
9. Franz S, Zeh A, Schablon A, Kuhnert S, Nienhaus A (2010) Aggression and violence against health care workers in Germany - a cross sectional retrospective survey. *BMC Health Serv Res.* 10:51
10. Olashore AA, Akanni OO, Ogunidipe RM (2018) Physical violence against health staff by mentally ill patients at a psychiatric hospital in Botswana. *BMC Health Serv Res.* 18(1):362
11. Phillips JP (2016) Workplace violence against health care workers in the United States. *N Engl J Med* 374(17):1661–9
12. Pina D, Llor-Zaragoza P, Puente-López E, Egea-Fuentes Á, Ruiz-Hernández JA, Llor-Esteban B (2022) User violence in public mental health services. Comparative analysis of psychiatrists and clinical psychologists. *J Ment Health* 31(5):642–8
13. Han X, Jiang F, Shen L, Liu Y, Liu T, Liu H et al (2022) Workplace violence, workforce stability, and well-being in China's psychiatric hospitals. *Am J Prev Med.* 62(4):e265–e273
14. Ukpong DI, Owoeye O, Udofia O, Abasiubong F, Ukpong S (2011) Violence against mental health staff: a survey in a Nigerian psychiatric hospital. *Psychiatrist* 35(2):46–49
15. Alshahrani M, Alfaisal R, Alshahrani K, Alotaibi L, Alghoraibi H, Alghamdi E et al (2021) Incidence and prevalence of violence toward health care workers in emergency departments: a multicenter cross-sectional survey. *Int J Emerg Med.* 14(1):71
16. Alhassan AK, Alsaqat RT, Al Sweleh FS (2023) Physical workplace violence in the health sector in Saudi Arabia. *Medicine (United States).* 102(29):e34094
17. Alharbi FF, Alzneidi NA, Aljibli GH, Morad SA, Alsubaie EG, Mahmoud MA et al (2021) Workplace violence among healthcare workers in a tertiary medical city in Riyadh: a cross-sectional study. *Cureus.* 13:e14836
18. MOH. Ministry of Health, Saudi Arabia (2018) Sentencing Offenders against Health Practitioners
19. Cooper LC, Swanson N (2002) International Council of Nurses. Workplace violence in the health sector. State of the Art, Geneva
20. Carlisle J (2018) Mental health law in Saudi Arabia. *BJPsych Int.* 15(1):17–19
21. General Authority of Statistics (2022) Saudi Census Website, <https://portal.saudicensus.sa/portal>. Saudi Census
22. Koenig HG, Al Zaben F, Sehlo MG, Khalifa DA, Al Ahwal MS, Qureshi NA et al (2014) Mental health care in Saudi Arabia: past, present and future. *Open J Psychiatr.* 04(02):113
23. Qureshi NA, Al-Habeeb AA, Koenig HG (2013) Mental health system in Saudi Arabia: an overview. *Neuropsychiatr Dis Treat* 9:1121–35
24. FallahiKhoshknab M, Oskouie F, Najafi F, Ghazanfari N, Tamizi Z, Ahmadvand H (2015) Psychological violence in the health care settings in Iran: a cross-sectional study. *Nurs Midwifery Stud.* 4(1):e24320
25. Swain N, Gale C, Greenwood R (2014) Patient aggression experienced by staff in a New Zealand public hospital setting. *N Z Med J* 127(1394):10–18
26. Chappell D, di Martino V (2006) Violence at work. 3rd ed. vol. 10. ILO Publication, International Labour Office
27. Langsrud K, Kallestad H, Vaaler A, Almvik R, Palmstierna T, Morken G (2018) Sleep at night and association to aggressive behaviour; patients in a psychiatric intensive care unit. *Psychiatry Res.* 263:275–279
28. Dack C, Ross J, Papadopoulos C, Stewart D, Bowers L (2013) A review and meta-analysis of the patient factors associated with psychiatric in-patient aggression. *Acta Psychiatr Scand.* 127:255–68
29. Park M, Cho SH, Hong HJ (2015) Prevalence and perpetrators of workplace violence by nursing unit and the relationship between violence and the perceived work environment. *J Nurs Scholarsh* 47(1):87–95
30. Drori T, Guetta H, Ben Natan M, Polakevich Y (2017) Patient violence toward psychiatric health care workers in Israel as viewed through incident reports: a retrospective study. *J Am Psychiatr Nurses Assoc.* 23(2):143–148
31. Nijman H, Bowers L, Oud N, Jansen G (2005) Psychiatric nurses' experiences with inpatient aggression. *Aggress Behav.* 31(3):217–27
32. Bowers L, Simpson A, Alexander J, Hackney D, Nijman H, Grange A et al (2005) The nature and purpose of acute psychiatric wards: the Tompkins acute ward study. *J Ment Health.* 14:625–35
33. Al-Shamlan NA, Jayaseeli N, Al-Shawi MM, Al-Joudi AS (2017) Are nurses verbally abused? A cross-sectional study of nurses at a university hospital, Eastern Province, Saudi Arabia. *J Family Community Med.* 24(3):173–180
34. Alzahrani TY, Almutairi AH, Alamri DA, Alamri MM (2016) Violence and aggression toward health care professionals in emergency departments in Tabuk, Saudi Arabia. *Eur J Pharm Med Res.* 3(1):5–11
35. Al-Turki N, Afify AAM, Alateeq M (2016) Violence against health workers in family medicine centers. *J Multidiscip Healthc.* 9:257–66
36. Al Anazi RB, Alqahtani SM, Mohamad AE, Hammad SM, Khleif H (2020) Violence against health-care workers in governmental health facilities in Arar City, Saudi Arabia. *ScientificWorldJournal.* 2020:6380281

Publisher's Note

Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.