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Workplace Violence and Its Association with Job Satisfaction and Psychological Outcomes Among Emergency Department Physicians in Türkiye

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Research Article

Keywords: Workplace violence, Job satisfaction, Minnesota Satisfaction Questionnaire, Physician well-being, Occupational health

Posted Date: March 20th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-8929672/v1

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Additional Declarations: No competing interests reported.

Abstract

Objective

Workplace violence is a common occupational hazard in emergency departments and may negatively affect physicians' professional well-being. This study aimed to determine the prevalence and types of workplace violence among emergency department physicians in Türkiye and to evaluate its association with job satisfaction and psychological outcomes.

Methods

This descriptive, cross-sectional study was conducted between 1 and 15 December 2025 among physicians working in emergency departments across multiple healthcare institutions in Türkiye. Data were collected using a self-administered questionnaire assessing exposure to workplace violence within the past six months and the Minnesota Satisfaction Questionnaire. Group comparisons were performed using non-parametric tests, and multiple linear regression analysis was used to identify factors associated with job satisfaction.

Results

A total of 295 physicians were included, of whom 95.6% reported exposure to at least one type of workplace violence. Verbal violence was the most frequently reported type. Physicians reporting exposure to workplace violence had lower job satisfaction scores, and job satisfaction decreased with increasing number of violence types experienced. Job satisfaction decreased with increasing numbers of violence types experienced. In multivariable analysis, the number of workplace violence types was the only independent predictor of job satisfaction ($\beta = -19.74$, $p < 0.001$). Workplace violence was also significantly associated with burnout and the need for psychological support.

Conclusion

Workplace violence is highly prevalent among emergency department physicians in Türkiye and is strongly associated with reduced job satisfaction and adverse psychological outcomes, particularly with cumulative exposure.

Clinical trial number

Not applicable

INTRODUCTION

Workplace violence (WPV) against healthcare professionals has become a major global public health concern, particularly in high-risk and high-pressure settings such as emergency departments (EDs). The World Health Organization (WHO) estimates that more than 60% of healthcare workers experience some form of violence during their professional careers, ranging from verbal threats to physical assaults and

psychological harassment[1]. Healthcare workers in emergency departments are disproportionately affected by workplace violence due to factors such as patient overcrowding, high emotional tension, unpredictable clinical conditions, and delays in care delivery[2].

In Türkiye, recent data indicate a particularly alarming situation. In a cross-sectional survey of emergency department physicians, a high prevalence of workplace violence—often exceeding 80%—was reported, with verbal and physical violence being the most frequently experienced types[3]. Such high exposure not only poses immediate risks but also threatens physicians' mental well-being and professional performance.

One of the most critical yet relatively underexplored consequences of workplace violence is its impact on job satisfaction. Job satisfaction is a multidimensional construct reflecting an individual's affective response to various aspects of their work, including interpersonal relationships, workload, autonomy, and institutional support. Higher levels of job satisfaction have been associated with increased motivation, reduced turnover intention, and improved quality of care, whereas dissatisfaction has been closely linked to emotional exhaustion and professional burnout[4, 5].

To assess job satisfaction in a structured and validated manner, the Minnesota Satisfaction Questionnaire (MSQ) is widely used in healthcare research. The MSQ evaluates both intrinsic dimensions (such as sense of achievement and responsibility) and extrinsic dimensions (including working conditions and remuneration), thereby providing a comprehensive measure of occupational well-being[6].

Despite growing global attention to workplace violence in healthcare settings, evidence specifically examining its relationship with job satisfaction among emergency physicians in Türkiye remains limited. Therefore, this study aimed to determine the prevalence and types of workplace violence experienced by physicians working in emergency departments and to examine the association between exposure to workplace violence and job satisfaction levels, as measured by the Minnesota Satisfaction Questionnaire.

METHODS

Study Design and Setting

This study was designed as a descriptive, multicenter, cross-sectional survey conducted between 1 and 15 December 2025. The research was carried out among physicians working in emergency departments across multiple healthcare institutions in Türkiye, including university hospitals, training and research hospitals, and state hospitals. The multicenter design was intended to enhance the representativeness and generalizability of the findings across different emergency care settings.

Recruitment and Participants

A total of 412 emergency department physicians were invited to participate through institutional mailing lists, national emergency medicine professional networks, and closed physician messaging groups. Of these, 327 physicians initiated the online survey. Thirty-two responses were excluded due to incomplete questionnaires or missing key variables. The final analytic sample consisted of 295 physicians, corresponding to a response rate of 71.6% and a completion rate of 90.2%.

The study population consisted of physicians actively working in emergency departments, including emergency medicine specialists, resident physicians, and general practitioners.

Inclusion criteria were:

1. Active clinical practice in an emergency department,
2. A minimum of six months of experience in emergency services,
3. Voluntary participation with informed consent.

Physicians on administrative leave during the study period or those submitting incomplete questionnaires were excluded from analysis.

Data Collection Procedure and Data Integrity

Data were collected using an anonymous, self-administered online questionnaire distributed via secure digital platforms. Participation was voluntary, and no personally identifiable information was collected.

To ensure data integrity, the survey platform was configured to allow only one response per device. Mandatory fields were applied to key variables to minimize missing data. IP-based duplicate screening was performed prior to analysis, and no duplicate submissions were identified.

Participants were informed that responses would be analyzed in aggregate form solely for scientific purposes.

Operational Definition and Assessment of Workplace Violence

Workplace violence (WPV) was defined according to the World Health Organization framework as any incident in which staff are abused, threatened, or assaulted in circumstances related to their work.

Participants were provided with standardized definitions and examples of each violence type within the questionnaire to promote consistent interpretation:

- **Verbal violence**: shouting, insults, threats
- **Physical violence**: pushing, hitting, physical assault
- **Psychological violence**: intimidation, humiliation, persistent hostility
- **Sexual harassment**: unwanted sexual comments, gestures, or physical contact

Exposure was recorded if at least one incident occurred within the preceding six months. Participants were allowed to select multiple categories where applicable.

The questionnaire also included items assessing frequency of violence, source of aggression (patient, patient relative, healthcare staff, or administration), reporting behavior, and perceived psychological consequences. The cumulative number of different violence types experienced (range: 0–4) was calculated to reflect overall exposure burden.

Development of the Workplace Violence Questionnaire

The workplace violence questionnaire was specifically developed for the purpose of this study and has not been previously published as a standalone instrument. The item pool was generated following a comprehensive review of existing literature and previously used workplace violence assessment tools in healthcare settings.

Content validity was evaluated by three senior emergency medicine specialists with experience in occupational health research. A pilot test was conducted among 18 emergency physicians to assess clarity, comprehensibility, and contextual appropriateness. Minor wording modifications were made based on pilot feedback.

Assessment of Job Satisfaction

Job satisfaction was assessed using the Minnesota Satisfaction Questionnaire – Short Form (MSQ), a widely used and validated instrument consisting of 20 items rated on a 5-point Likert scale (1 = very dissatisfied; 5 = very satisfied). Total MSQ scores range from 20 to 100, with higher scores indicating greater job satisfaction.

The MSQ evaluates both intrinsic (e.g., achievement, responsibility, autonomy) and extrinsic (e.g., working conditions, institutional policies, remuneration) dimensions of job satisfaction.

Assessment of Psychological Outcomes

Psychological outcomes were assessed using structured single-item questions evaluating self-reported burnout/loss of motivation, sleep disturbance, avoidance of work, and perceived need for psychological support within the past six months. These items were designed to capture perceived psychological impact associated with workplace violence exposure.

Ethical Considerations

The study was conducted in accordance with the Declaration of Helsinki. Ethical approval was obtained from a local non-interventional research ethics committee (Approval No: 25.11.21.09/01; Date: 21

November 2025).

All participants provided digital informed consent prior to participation. Data confidentiality and anonymity were strictly maintained throughout the research process.

Statistical Analysis

Statistical analyses were performed using IBM SPSS Statistics (Version 26.0). Continuous variables were assessed for normality using visual (histograms, Q–Q plots) and analytical methods. As normality assumptions were not met, non-parametric tests were used for group comparisons.

Descriptive statistics were reported as means ± standard deviations, medians with interquartile ranges, and frequencies with percentages, as appropriate.

Group comparisons were conducted using the Mann–Whitney U test for two-group comparisons and the Kruskal–Wallis test for comparisons involving more than two groups. Associations between categorical variables were evaluated using chi-square tests.

Spearman correlation analysis was performed to examine relationships between job satisfaction scores and workplace violence exposure variables.

A multiple linear regression model was constructed to identify independent predictors of total job satisfaction scores. Independent variables included age, gender, professional title, institution type, weekly working hours, and cumulative number of workplace violence types experienced.

Regression assumptions were evaluated prior to model interpretation, including linearity, homoscedasticity, independence of errors, normality of residuals, and multicollinearity. Variance inflation factors (VIFs) were examined to assess multicollinearity.

A two-tailed p-value < 0.05 was considered statistically significant.

RESULTS

A total of 295 physicians working in emergency departments across various institutions participated in the study, including 100 residents, 105 general practitioners, and 90 specialists. Specialists had the highest mean age (35.8 years), followed by general practitioners (29.8 years) and residents (28.3 years). Similarly, specialists reported the longest professional experience (mean: 9.8 years), whereas residents had the shortest duration of experience (mean: 2.1 years).

Weekly working hours were comparable across groups (residents: 54.7 hours, general practitioners: 55.2 hours, specialists: 53.9 hours).Monthly shift numbers were comparable across groups, ranging from 4 to 12 shifts per month.

Job satisfaction scores, as measured by the Minnesota Satisfaction Questionnaire, were highest among general practitioners (mean: 57.7), followed by specialists (mean: 55.2), and lowest among residents (mean: 53.3). Detailed demographic and work-related characteristics of the study population are presented in Table 1.

Table 1
Descriptive Statistics by Title

Title	Mean Age	Mean Experience (years)	Mean Weekly Working (hours)	Mean Monthly Shifts	Mean Minnesota Job Satisfaction Score
Resident	28.3	2.1	54.7	8.1	53.3
General Practitioner	29.8	3.7	55.2	7.6	57.7
Specialist	35.8	9.8	53.9	7.9	55.2

Among the 295 physicians included in the study, 282 (95.6%) reported exposure to at least one form of workplace violence within the past six months. Given the small size of the non-exposed group (n = 13), comparisons between exposed and non-exposed physicians should be interpreted cautiously.Verbal violence was the most frequently reported type across all professional groups. Exposure to verbal violence was reported by 90.5% of general practitioners, 85.0% of residents, and 84.4% of specialists.

Physical violence was reported by 42.9% of general practitioners, 34.0% of residents, and 27.8% of specialists. Psychological violence was reported by 42.9% of general practitioners, 33.0% of residents, and 30.0% of specialists. Although less common, exposure to sexual harassment was also reported, with rates of 8.6% among general practitioners, 6.0% among residents, and 3.3% among specialists. Detailed distributions of workplace violence types according to professional title are presented in Table 2.

Table 2
Violence Exposure by Title

Title	Verbal Violence	Physical Violence	Psychological Violence	Sexual Harassment
Specialist	78 (86.7%)	34 (37.8%)	34 (37.8%)	6 (6.7%)
Resident	91 (91.0%)	36 (36.0%)	38 (38.0%)	7 (7.0%)
General Practitioner	98 (93.3%)	34 (32.4%)	33 (31.4%)	6 (5.7%)

Statistical analysis demonstrated differences in total job satisfaction scores according to exposure to specific types of workplace violence. Physicians reporting exposure to verbal violence had lower mean job satisfaction scores (54.28) compared with those not exposed (66.57), and this difference was statistically significant according to the Mann–Whitney U test ($U = 2835.5$, $p = 0.0355$).

Similarly, exposure to psychological violence was associated with lower job satisfaction scores (mean: 39.66 vs. 64.17), and this difference was statistically significant ($U = 3524.0$, $p < 0.001$). In contrast, no statistically significant differences in job satisfaction scores were observed for exposure to physical violence (mean: 57.39 vs. 54.38, $p = 0.3853$) or sexual harassment (mean: 52.95 vs. 55.62, $p = 0.8827$). The comparison of job satisfaction scores according to specific types of workplace violence is presented in Table 3.

Table 3
Total Job Satisfaction Scores by Type of Workplace Violence Exposure

Violence Type	Mean Score (Exposed)	Mean Score (Not Exposed)	U Statistic	p-value
Verbal	54.28	66.57	2835.5	0.0355
Physical	57.39	54.38	10539.5	0.3853
Psychological	39.66	64.17	3524.0	< 0.001
Sexual	52.95	55.62	2568.5	0.8827

When considering total MSQ scores, physicians exposed to at least one type of workplace violence had lower median scores compared with those without reported exposure ($U = 882.5$, $p = 0.0016$). However, this comparison should be interpreted with caution due to the limited number of physicians reporting no exposure. The distribution of total job satisfaction scores according to violence exposure status is shown in Fig. 1.

The relationship between the number of different types of workplace violence experienced and total job satisfaction scores was examined. Total job satisfaction scores differed across groups defined by the number of workplace violence types experienced. The distribution of total job satisfaction scores according to the cumulative number of violence types is presented in Fig. 1.

A Kruskal–Wallis test revealed a statistically significant difference in total job satisfaction scores among the groups ($H = 39.17$, $p < 0.001$), indicating a progressive decrease in job satisfaction with increasing number of violence types experienced.

Figure 2 presents the results of the multiple linear regression analysis examining factors associated with physicians' total job satisfaction scores. In the regression model, the number of different types of workplace violence experienced within the past six months was the only variable significantly associated with job satisfaction ($\beta = -19.74$, $p < 0.001$).

Other variables included in the model—age, gender, weekly working hours, professional title, and type of institution—were not significantly associated with job satisfaction scores. The model explained 30.8% of the variance in total job satisfaction scores ($R^2 = 0.308$), suggesting that cumulative workplace violence exposure constitutes a major correlate of job satisfaction in this cohort.

Figure 3 shows the distribution of psychological effects reported by physicians according to exposure to workplace violence within the past six months. Burnout/loss of motivation and the need for psychological support were reported more frequently among physicians exposed to workplace violence.

Chi-square analysis demonstrated a statistically significant association between exposure to workplace violence and both burnout/loss of motivation and need for psychological support ($p < 0.05$). No statistically significant associations were observed for sleep disturbance or avoidance of work.

DISCUSSION

This study demonstrates a very high burden of workplace WPV among physicians working in emergency departments in Türkiye within the past six months. Emergency departments are consistently reported as high-risk clinical environments for WPV due to high patient volume, time pressure, heightened emotional distress among patients and relatives, and frequent communication challenges under constrained resources. Recent evidence from Türkiye similarly indicates that WPV is widespread in emergency settings, with verbal aggression often being the predominant form of violence[7]. The exceptionally high six-month prevalence observed in this study may partly reflect the broad operational definition of workplace violence, whereby even a single episode of verbal aggression was sufficient to classify exposure. In addition, the high-risk nature of emergency departments, combined with voluntary participation in an online survey, may have contributed to selection bias, as physicians with prior exposure could have been more motivated to participate. Therefore, the prevalence findings should be interpreted within the contextual and methodological framework of the study.

In our cohort, verbal violence was the most frequently reported type across professional titles, followed by physical and psychological violence, while sexual harassment was less common. This pattern mirrors both Turkish and international literature showing that non-physical forms of violence—such as verbal abuse, intimidation, and psychological aggression—occur frequently and may become normalized as part of emergency care, yet can still generate substantial distress and professional dissatisfaction[8–10]. In addition, studies focusing on emergency department staff highlight that systemic contributors, including crowding, prolonged waiting times, and workflow inefficiencies, are often perceived as triggers for violent incidents, supporting the view that WPV prevention must address both interpersonal and structural determinants[7, 11].

A key finding of this study is the association between workplace violence exposure and overall job satisfaction. Although differences were observed between physicians reporting exposure and those not reporting exposure, the small number of participants in the non-exposed group warrants cautious interpretation of direct group comparisons. Job satisfaction represents an important component of occupational well-being and is closely linked to workforce stability, professional motivation, and quality of care delivery[12]. The observed gap between exposed and non-exposed physicians is consistent with growing evidence indicating that WPV is associated with poorer work-related outcomes, including job dissatisfaction, elevated stress levels, and burnout-related symptoms[5, 13].

When WPV subtypes were examined, exposure to verbal and psychological violence was associated with lower job satisfaction scores, whereas physical violence and sexual harassment did not reach statistical significance in subgroup comparisons. Several explanations are plausible. First, less frequently reported categories, particularly sexual harassment, may yield lower statistical power and are widely recognized to be underreported because of stigma and fear of adverse consequences. Second, non-physical violence—especially when frequent or recurrent—may exert a sustained “wear-and-tear” effect. Additionally, the present study did not assess frequency, severity, or recency of individual incidents..., which may further explain why certain violence subtypes did not demonstrate statistically significant associations despite their potential clinical impact. First, less frequently reported categories, particularly sexual harassment, may yield lower statistical power and are widely recognized to be underreported because of stigma and fear of adverse consequences[14]. Second, non-physical violence—especially when frequent or recurrent—may exert a sustained “wear-and-tear” effect through anticipatory stress, hypervigilance, and perceived lack of organizational support, ultimately eroding job satisfaction even in the absence of physical harm[13, 15].

Importantly, our findings suggest that the cumulative burden of WPV plays a central role. Rather than a simple exposed-versus-non-exposed distinction, job satisfaction demonstrated a progressive decline with increasing number of violence types experienced, supporting a dose–response pattern. Job satisfaction differed significantly across groups defined by the number of violence types experienced. This pattern is consistent with contemporary models proposing that WPV influences occupational outcomes via cumulative psychosocial stress and deterioration of the work environment. A recent study highlighted mediating roles of perceived stress and work environment in the relationship between WPV and job satisfaction, supporting the plausibility of a dose-related pathway[15].

The multivariable regression model further reinforces the central role of WPV exposure in this cohort. After adjustment for demographic and work-related variables, the number of WPV types experienced within the past six months was the only factor significantly associated with job satisfaction. Although causal inference is not possible in a cross-sectional design, this adjusted finding strengthens the interpretation that WPV exposure is a major correlate of occupational well-being in emergency medicine, beyond differences in age, sex, workload, professional title, or institution type[5, 16]. However, the model explained approximately 30% of the variance in job satisfaction, indicating that additional occupational and organizational factors—such as staffing levels, workload intensity, shift burden, administrative climate, and perceived institutional support—may also contribute to physicians’ job satisfaction and warrant further investigation.

Beyond job satisfaction, WPV in emergency settings is increasingly recognized as a major occupational hazard with important psychological consequences. In our study, burnout or loss of motivation and the need for psychological support were significantly associated with WPV exposure. These findings align with broader literature linking WPV to emotional exhaustion, burnout, and adverse mental health outcomes among healthcare professionals[5, 16].

Practical Implications

Our findings support the need for comprehensive, system-level WPV prevention strategies in emergency departments. International frameworks, including those proposed by the World Health Organization, emphasize multi-component approaches such as clear institutional policies, accessible incident reporting systems, post-incident support, staff training in communication and de-escalation, and organizational accountability[1]. Complementary guidance documents and recent syntheses also stress that effective violence prevention programs typically combine environmental and security measures, staff training, and continuous monitoring[14, 17]. Türkiye-specific evidence likewise points to crowding and workflow pressures as modifiable contributors, suggesting that emergency department process improvements and staffing strategies may be integral to WPV reduction[7].

Limitations

This study has several limitations. First, the cross-sectional design precludes causal inference. Second, WPV exposure was assessed using self-reported data, which may introduce recall bias and social desirability effects; underreporting is a known concern, particularly for sensitive forms of violence such as sexual harassment. Furthermore, the voluntary online survey design may have introduced selection bias, as physicians with prior exposure to workplace violence might have been more likely to participate. Third, the workplace violence questionnaire was newly developed for this study and has not undergone full psychometric validation, which may limit the generalizability and measurement robustness of the findings. Moreover, the absence of detailed assessment of frequency and severity of violence incidents may have limited the precision of exposure characterization. Nevertheless, the multicenter nature of the sample, the consistency of findings across multiple analytical approaches, and their alignment with contemporary literature support the relevance of WPV exposure as a major occupational issue associated with reduced job satisfaction among emergency physicians in Türkiye.

CONCLUSION

This study reveals a very high prevalence of workplace violence among emergency department physicians in Türkiye and demonstrates its significant association with reduced job satisfaction. Exposure to verbal and psychological violence, as well as cumulative exposure to multiple violence types, was linked to lower job satisfaction scores, with the number of violence types emerging as the strongest predictor independent of demographic and institutional factors. In addition, workplace violence was associated with burnout and the need for psychological support. These findings highlight workplace violence as a critical occupational hazard in emergency medicine and underscore the need for comprehensive, system-level prevention and support strategies.

Abbreviations

ED
Emergency Department

MSQ
Minnesota Satisfaction Questionnaire
SPSS
Statistical Package for the Social Sciences
VIF
Variance Inflation Factor
WHO
World Health Organization
WPV
Workplace Violence

Declarations

Ethics approval and consent to participate

The study was approved by the Ethics Committee of the Ufuk University (Approval No: 25.11.21.09/01; Date: 21 November 2025). The work was conducted in accordance with the World Medical Association Declaration of Helsinki. Written informed consent was obtained from all participants involved in the study.

Consent for publication

Not applicable.

Data Availability

All data supporting the findings of this study are available from the authors upon reasonable request.

Competing interests

The authors declare no competing interests.

Funding

Not applicable.

Contributions

This manuscript has a single author.All contributions were made by MÖ

Acknowledgments

Not applicable.

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Figures

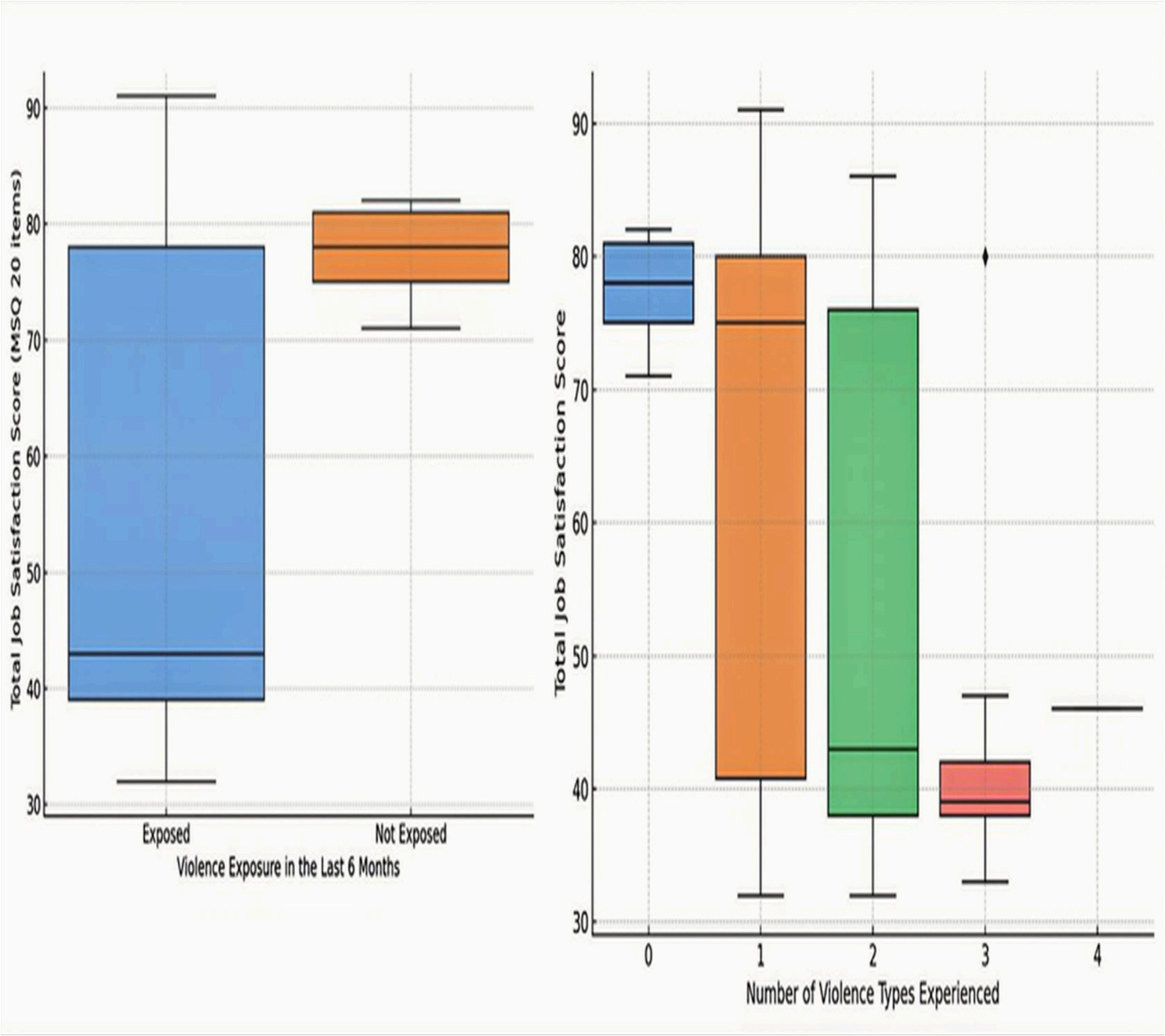


Figure 1

Job satisfaction according to workplace violence exposure and cumulative violence types

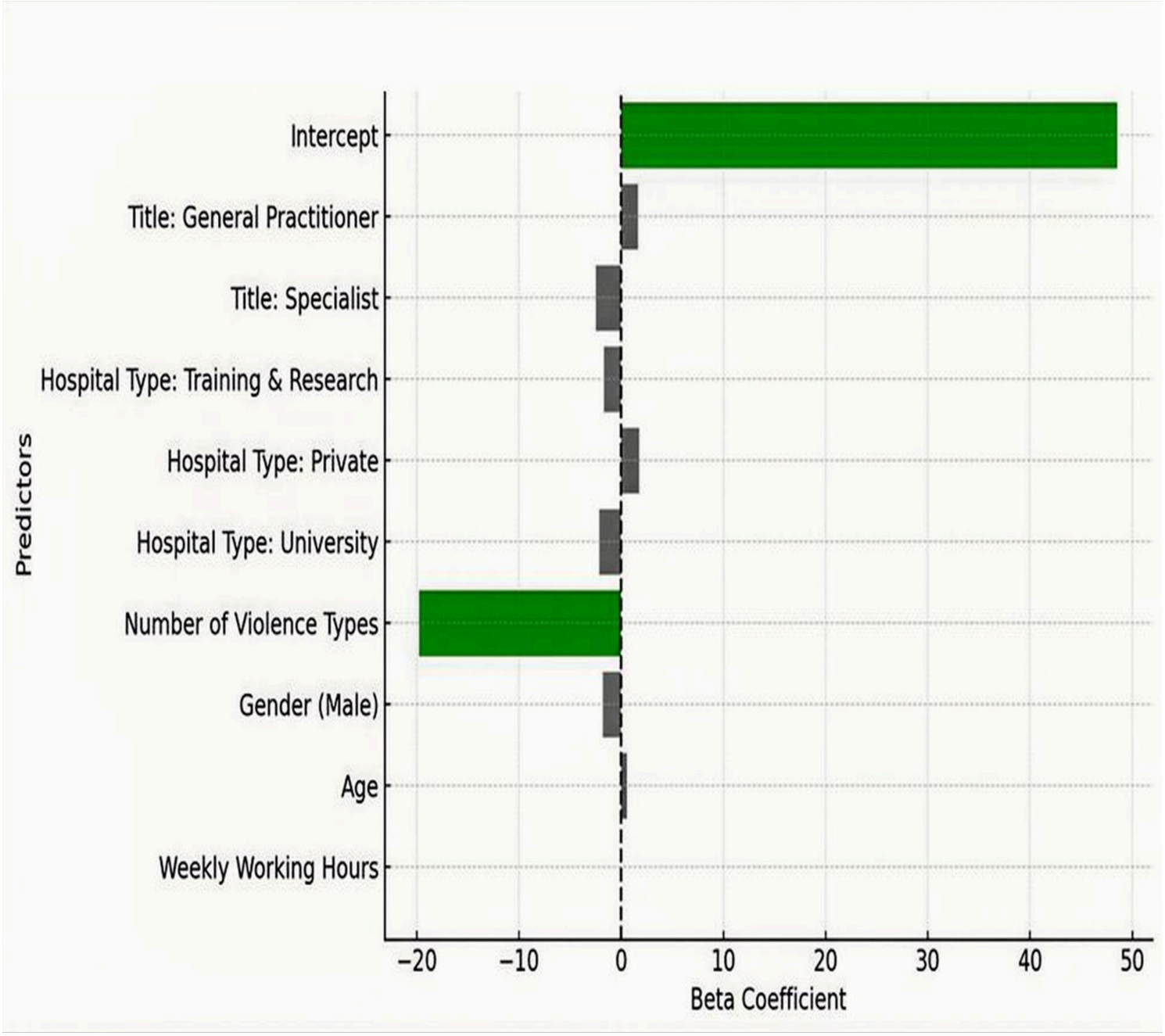


Figure 2

Multiple Linear Regression Analysis of Factors Associated with Total Job Satisfaction Scores

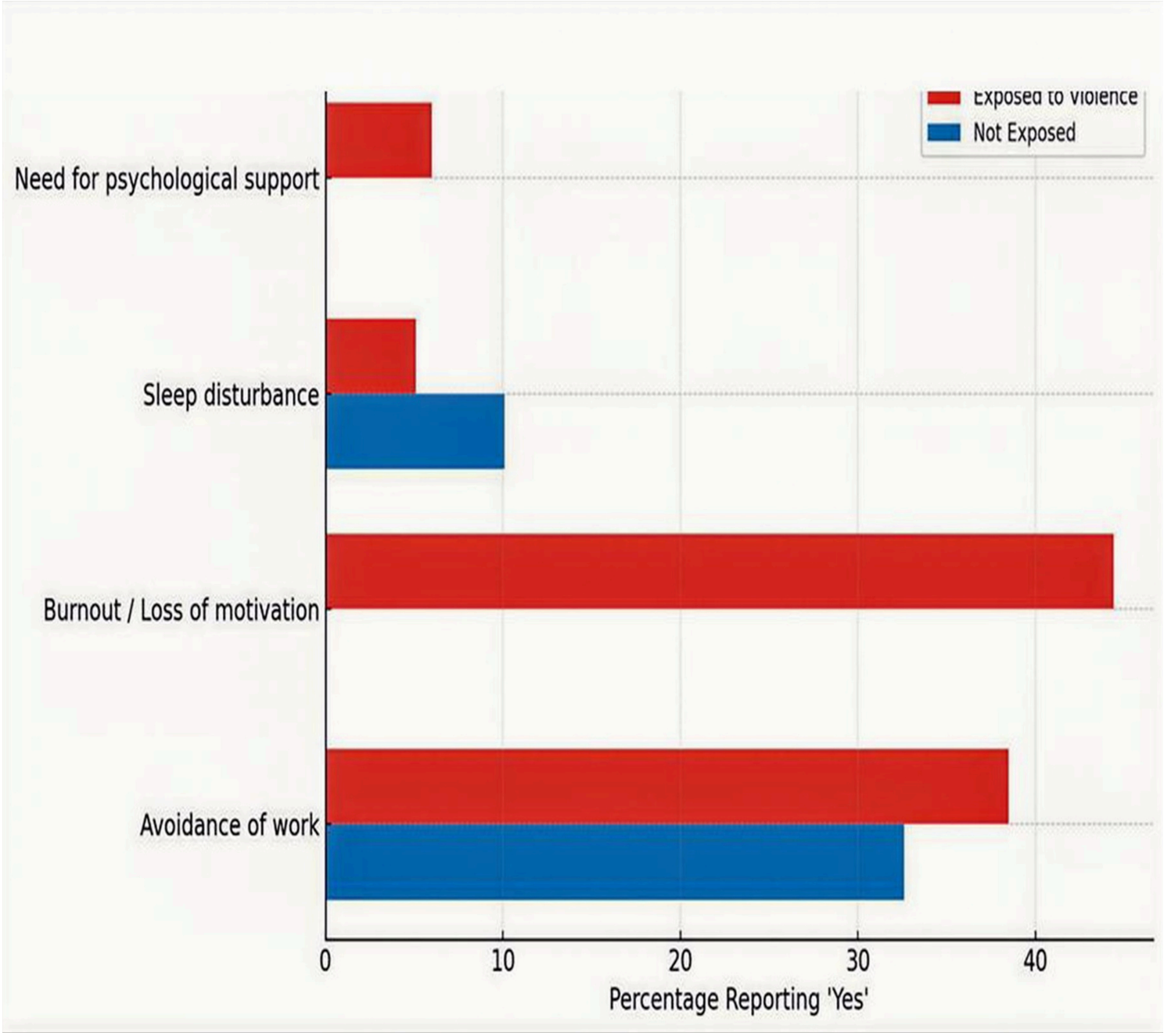


Figure 3

Psychological Impact by Violence Exposure Status

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- Questionnaire.docx