Research Square

Preprints are preliminary reports that have not undergone peer review.
They should not be considered conclusive, used to inform clinical practice,
or referenced by the media as validated information.

# Psychosocial Workplace Violence Is More Broadly Associated with Turnover Intention and Psychological Impact Than Directly Reported Violence Among Nurses: A Cross-Sectional Study in Thailand

**Kriengkrai Prasert**
Nakhon Phanom Hospital
**Rathanith Jaratworapatra**
Kasetsart University Chalermphrakiat Sakon Nakhon Province Campus
**Passakorn Ongarj**
passakorn.on@ku.th

Kasetsart University Chalermphrakiat Sakon Nakhon Province Campus
**Suriya Naosri**
Nakhon Phanom Hospital
**Jiraphut Kittiwatanachod**
Nakhon Phanom Hospital
**Thananpad Jaratworapatra**
Nakhon Phanom Hospital
**Sutthichai Nakphook**
Nakhon Phanom Hospital
**Prabda Praphasiri**
Nakhon Phanom Hospital

**Research Article**

**Keywords:** Workplace violence, Turnover intention, Nurses, Psychosocial factors, Thailand, Cross-sectional study

**Posted Date:** May 21st, 2026

**DOI:** https://doi.org/10.21203/rs.3.rs-9428736/v1

**License:** This work is licensed under a Creative Commons Attribution 4.0 International License.
Read Full License

**Additional Declarations:** No competing interests reported.

## Abstract

# Background

Workplace violence (WPV) is a major occupational health concern among nurses and has been associated with adverse psychological outcomes and increased intention to leave (ITL). However, most studies rely on self-reported WPV, which may underestimate the true burden due to underreporting and sociocultural influences. Psychosocial workplace violence, including experiences of coercion, exclusion, and power imbalance, may better capture latent dimensions that are not reflected in direct reporting.

# Methods

A cross-sectional study was conducted among 593 nurses in Thailand. WPV was assessed using both self-reported exposure and a psychosocial WPV proxy constructed from 13 dichotomized items (score range 0–13; Cronbach's α = 0.88). The proxy was categorized into low, moderate, and high levels. Intention to leave (ITL) was defined as intention to resign or change jobs. Multivariable logistic regression models were used to examine associations between WPV (direct and proxy) and outcomes, adjusting for relevant covariates.

# Results

Overall, 35.9% of nurses reported experiencing WPV in the past 12 months. High intention to change jobs and high intention to resign were reported by 31.5% and 31.0% of nurses, respectively. Psychosocial WPV was significantly associated with intention to leave in a dose–response manner (adjusted odds ratio [AOR] = 2.07 and 3.63 for moderate and high exposure, respectively). Directly reported WPV was also associated with intention to leave (AOR = 2.14) but did not demonstrate a dose–response pattern. Psychosocial WPV was associated with psychological distress, whereas directly reported WPV was not.

# Conclusions

Psychosocial workplace violence showed a dose–response association with both intention to leave and psychological distress that directly reported WPV did not demonstrate. These findings support incorporating psychosocial indicators into workplace violence assessment alongside conventional incident-based measures.

## Introduction

Workplace violence (WPV) against nurses is a major global occupational health concern and has been widely recognized as a threat to both staff well-being and healthcare system sustainability [1]. Nurses are particularly vulnerable due to their continuous and close interactions with patients and their families,

often in high-pressure and resource-constrained environments [2]. Previous studies have reported a high prevalence of WPV, with verbal abuse being the most common form, followed by physical and sexual violence [3, 4]. These experiences not only affect individual nurses but also compromise patient safety, quality of care, and organizational performance.

One of the most critical consequences of WPV is intention to leave (ITL), which has become increasingly important in the context of global nursing shortages. Exposure to workplace violence has been consistently associated with job dissatisfaction, emotional exhaustion, and reduced organizational commitment, all of which contribute to nurses' decisions to leave their jobs [5–7]. However, most existing studies rely on self-reported WPV, which may underestimate the true magnitude of the problem due to underreporting, recall bias, and sociocultural influences, particularly in hierarchical healthcare settings where reporting may be discouraged [8, 9].

Importantly, workplace violence is not limited to overt incidents but also includes more subtle forms of psychosocial violence, such as coercion, exclusion, power imbalance, and communication-related stress. These experiences are often normalized or unrecognized, especially in organizational cultures characterized by strong hierarchical structures and expectations of conformity [10, 11]. As a result, conventional measures of WPV may fail to capture these latent dimensions, leading to potential misclassification and underestimation of their impact.

To address this limitation, the concept of psychosocial workplace violence (WPV proxy) has been proposed to capture underlying experiences that are not reflected in direct reporting. By incorporating indicators related to power dynamics, emotional pressure, and social exclusion, this proxy measure may provide a more sensitive and comprehensive assessment of workplace violence, particularly in contexts where direct reporting is limited [10–12]. However, empirical evidence comparing psychosocial WPV and directly reported WPV in relation to intention to leave remains limited.

In addition, the mechanisms linking workplace violence to intention to leave are not fully understood. Psychological distress has been suggested as a potential pathway through which adverse workplace experiences influence turnover intention [6, 13]. Understanding these relationships is essential for developing effective interventions to improve nurse retention and workplace safety.

Therefore, this study aimed to examine the associations of psychosocial workplace violence (WPV proxy) and directly reported WPV with intention to leave and psychological distress among nurses in provincial hospital settings in Thailand.

## Methods

# Study design and setting

This study employed a cross-sectional analytic design to examine associations between workplace violence and intention to leave among nurses. The study was conducted in Nakhon Phanom Province,

Thailand, and included nurses working in 14 hospitals, comprising one provincial hospital and 13 community hospitals. Data were collected between October and December 2025.

## Participants and sampling

The study population consisted of 1,181 registered nurses working across 14 hospitals in Nakhon Phanom Province. Eligible participants were nurses who were actively working in clinical settings during the study period. Nurses on leave, secondment, or in administrative-only roles were excluded. A total of 606 nurses were selected using a proportional stratified random sampling approach. Hospitals were first treated as strata, and the sample size was allocated proportionally according to the number of nurses in each hospital. Within each hospital, participants were further stratified by department, and simple random sampling was applied to select eligible nurses. Of the 606 nurses invited, 593 completed the questionnaire, yielding a response rate of 97.9%.

## Sample size and sampling

The sample size was calculated based on an estimated prevalence of workplace violence of 38.4% among nurses, based on preliminary data collected at Nakhon Phanom Hospital [14], which is consistent with previous studies reporting similar prevalence [15], with a 95% confidence level and a precision of ± 3%, resulting in a minimum required sample of 545 participants. To account for potential non-response, the sample size was increased by 10%, yielding a final target sample of 606 nurses.

## Data collection

Data were collected using a structured, self-administered questionnaire adapted from the International Labor Office/World Health Organization/International Council of Nurses (ILO/WHO/ICN) workplace violence framework and contextualized to the Thai healthcare setting. The questionnaire included sections on demographic characteristics, work-related factors, experiences of workplace violence, psychosocial work environment, and intention to leave. All participants were informed about the study objectives and procedures prior to participation. The full questionnaire is provided in Supplementary File S1.

To minimize social desirability bias, questionnaires were self-administered without supervisor presence. To address potential non-response bias, a 10% sample inflation was applied. Recall bias was minimized by focusing on experiences within the past 12 months.

## Measures

# Workplace violence (WPV)

Directly reported workplace violence (WPV) was measured as a binary variable based on self-reported experience of any form of workplace violence in the past 12 months (yes/no).

## Psychosocial workplace violence (WPV proxy)

Psychosocial workplace violence (WPV proxy) was constructed to capture latent dimensions of workplace violence not reflected in direct reporting. Thirteen items representing experiences of coercion, power imbalance, exclusion, and communication-related pressure were selected based on theoretical relevance. Items reflecting psychological outcomes (e.g., stress) were excluded to avoid overadjustment bias. Each item was dichotomized (1 = yes, 0 = no/uncertain), and a composite score was calculated by summing all items (range: 0–13). The internal consistency of the scale was high (Cronbach's α = 0.88). The score was categorized into three levels: low (0), moderate (1–3), and high (≥ 4).

## Intention to leave (ITL)

Intention to leave (ITL) was defined as a composite outcome indicating intention to resign or change jobs. Participants who reported agreement (score ≥ 4 on a 5-point Likert scale) with either intention to resign or intention to change jobs were classified as having intention to leave. Turnover intention was operationalized using the Turnover Intention Scale (TIS-6) [16].

# Psychological distress

Psychological distress was assessed using a composite measure developed for this study, derived from five items reflecting emotional and work-related impact, including reduced professional pride, decreased job satisfaction, and reduced participation in work activities. The score was dichotomized into high and low levels for analysis.

# Covariates

Covariates were selected based on theoretical relevance and prior literature. These included individual characteristics (sex, education level, and financial status), work-related factors (department, shift work, and years of experience), and institutional characteristics (hospital level). These variables were included to control for potential confounding in the multivariable analyses.

# Statistical analysis

Data were analyzed using Stata version 19 (StataCorp LLC, College Station, TX, USA). Descriptive statistics were used to summarize participant characteristics and the prevalence of workplace violence. Multivariable logistic regression models were used to examine associations between workplace violence (both directly reported WPV and WPV proxy) and outcomes, including intention to leave and psychological distress. Results were presented as adjusted odds ratios (AORs) with 95% confidence intervals (CIs). To assess consistency of findings, associations between workplace violence (both direct

and proxy) and each outcome were examined in separate multivariable models, adjusting for the same set of covariates. Statistical significance was set at $p < 0.05$.

For the psychological distress outcome, hospital type and debt status were excluded from the adjusted model as preliminary analyses indicated no meaningful association with the outcome and their inclusion did not materially affect the estimates of interest.

As the study used proportional stratified random sampling with allocation proportional to hospital size, no post-stratification survey weights were applied.

# Ethical considerations

This study was conducted in accordance with the Declaration of Helsinki and approved by the Ethics Committee of the Nakhon Phanom Provincial Public Health Office, Thailand (REC 117/68) on 15 October 2025. All participants were informed about the study objectives and procedures prior to participation. Written informed consent was obtained from all participants. Confidentiality and anonymity were strictly maintained, and no personal identifiers were included in the analysis.

## Results

# Participant characteristics

A total of 606 registered nurses were approached, of whom 593 returned completed questionnaires and were included in the analysis (response rate 97.9%). The majority of participants were female (91.2%), with a mean age of 38.6 years (SD = 10.1) and an average work experience of 15.7 years (SD = 10.4).

Overall, 35.9% of nurses reported experiencing workplace violence in the past 12 months (Table 1 and Fig. 1). Among those exposed, verbal violence was the most commonly reported type, with patients and relatives as the most frequent perpetrators (Supplementary Tables S2 and S3). Psychosocial WPV proxy levels were distributed across low, moderate, and high categories (Supplementary Table S5). Regarding intention to leave, 31.5% of nurses reported high intention to change jobs and 31.0% reported high intention to resign (score ≥ 4 on a 5-point Likert scale for each item). Additionally, 29.0% reported high loss of job satisfaction and 27.3% reported diminished professional pride (Supplementary Table S7).

Table 1
Characteristics of study participants by reported workplace violence status

| Characteristic | All<br>N = 593 | No workplace violence<br>N = 380 | Workplace violence<br>N = 213 | p-value |
|---|---|---|---|---|
| **Total participants – n (%)** | 593 (100) | 380 (64.1) | 213 (35.9) | – |
| **Age – years** | | | | |
| Mean ± SD | 38.6 ± 10.1 | 38.6 ± 10.0 | 38.6 ± 10.3 | 0.937 |
| **Sex – n (%)** | | | | |
| Male | 52 (8.8) | 31 (8.2) | 21 (9.9) | 0.482 |
| Female | 541 (91.2) | 349 (91.8) | 192 (90.1) | |
| **Marital status – n (%)** | | | | |
| Single | 255 (43.0) | 157 (41.3) | 98 (46.0) | 0.774 |
| Married | 292 (49.2) | 192 (50.5) | 100 (46.9) | |
| Other | 46 (7.8) | 31 (8.2) | 15 (7.0) | |
| **Education level – n (%)** | | | | |
| Bachelor's degree | 542 (91.4) | 345 (90.8) | 197 (92.5) | 0.479 |
| Higher than bachelor's degree | 51 (8.6) | 35 (9.2) | 16 (7.5) | |
| **Specialized training – n (%)** | | | | |
| No | 396 (66.8) | 253 (66.6) | 143 (67.1) | 0.890 |
| Yes | 197 (33.2) | 127 (33.4) | 70 (32.9) | |
| **Monthly income (THB) – n (%)** | | | | |
| < 15,000 | 11 (1.9) | 9 (2.4) | 2 (0.9) | 0.315 |
| 15,001–20,000 | 54 (9.1) | 37 (9.7) | 17 (8.0) | |
| 20,001–25,000 | 68 (11.5) | 44 (11.6) | 24 (11.3) | |
| 25,001–30,000 | 116 (19.6) | 66 (17.4) | 50 (23.5) | |
| > 30,000 | 344 (58.0) | 224 (58.9) | 120 (56.3) | |
| **Debt burden – n (%)** | | | | |

| Characteristic | All<br>N = 593 | No workplace violence<br>N = 380 | Workplace violence<br>N = 213 | p-value |
|---|---|---|---|---|
| No | 135 (22.8) | 95 (25.0) | 40 (18.8) | 0.083 |
| Yes | 458 (77.2) | 285 (75.0) | 173 (81.2) | |
| **Savings – n (%)** | | | | |
| Yes | 475 (80.1) | 306 (80.5) | 169 (79.3) | 0.729 |
| No | 118 (19.9) | 74 (19.5) | 44 (20.7) | |
| **Department – n (%)** | | | | |
| Inpatient | 160 (27.0) | 108 (28.4) | 52 (24.4) | < 0.001 |
| Outpatient | 97 (16.4) | 65 (17.1) | 32 (15.0) | |
| Emergency department | 82 (13.8) | 35 (9.2) | 47 (22.1) | |
| Surgical | 36 (6.1) | 18 (4.7) | 18 (8.5) | |
| Internal medicine | 12 (2.0) | 9 (2.4) | 3 (1.4) | |
| Pediatric | 18 (3.0) | 14 (3.7) | 4 (1.9) | |
| Operating room / Anesthesia | 34 (5.7) | 26 (6.8) | 8 (3.8) | |
| Intensive care unit | 51 (8.6) | 31 (8.2) | 20 (9.4) | |
| Obstetrics–Gynecology | 48 (8.1) | 29 (7.6) | 19 (8.9) | |
| Primary care | 42 (7.1) | 35 (9.2) | 7 (3.3) | |
| Other departments | 13 (2.2) | 10 (2.6) | 3 (1.4) | |
| **Hospital type – n (%)** | | | | |
| Provincial hospital | 264 (44.5) | 171 (45.0) | 93 (43.7) | 0.779 |
| Community hospital | 329 (55.5) | 209 (55.0) | 120 (56.3) | |
| **Shift pattern – n (%)** | | | | |
| Morning shift only | 254 (42.8) | 173 (45.5) | 81 (38.0) | 0.077 |
| Rotating shift | 339 (57.2) | 207 (54.5) | 132 (62.0) | |
| **Work experience – years** | | | | |
| Mean ± SD | 15.7 ± 10.4 | 15.9 ± 10.3 | 15.4 ± 10.5 | 0.561 |

**Abbreviations:** SD, standard deviation; THB, Thai baht.

**Note:** Values are presented as number (percentage) unless otherwise indicated as mean ± SD. For the Total participants row, percentages in the No workplace violence and Workplace violence columns are calculated from the total sample (N = 593). For all other rows, percentages in the No workplace violence column are based on n = 380 and percentages in the Workplace violence column are based on n = 213. P-values were obtained using chi-square test for categorical variables and independent t-test for continuous variables. Thirty participants who selected 'Other' as hospital type were reclassified as provincial hospital; the provincial hospital total reflects this reclassification (n = 264).

### Association between psychosocial workplace violence and intention to leave

Psychosocial workplace violence (WPV proxy) was significantly associated with intention to leave (defined as intention to resign or change jobs) after adjustment. Compared with nurses reporting low levels of psychosocial violence, those with moderate levels had approximately twofold higher odds of intention to leave (AOR = 2.07, 95% CI: 1.34–3.21), while those with high levels had more than threefold higher odds (AOR = 3.63, 95% CI: 2.22–5.95). A clear dose–response relationship was observed across levels of psychosocial workplace violence (Table 2).

Table 2
Association between psychosocial workplace violence and intention to leave (adjusted model)

| Variable | Adjusted OR | 95% CI | p-value |
|---|---|---|---|
| **Psychosocial workplace violence (WPV proxy)** | | | |
| Low | 1.00 | Reference | – |
| Moderate | 2.07 | 1.34–3.21 | 0.001 |
| High | 3.63 | 2.22–5.95 | < 0.001 |
| **Work environment** | | | |
| Low | 1.00 | Reference | – |
| Moderate | 1.86 | 1.09–3.18 | 0.023 |
| High | 2.06 | 1.12–3.79 | 0.020 |
| **Workload** | | | |
| Low | 1.00 | Reference | – |
| Moderate–High | 1.28 | 0.77–2.14 | 0.344 |
| **Organizational factors** | | | |
| Low | 1.00 | Reference | – |
| Moderate | 1.39 | 0.86–2.26 | 0.177 |
| High | 1.17 | 0.75–1.81 | 0.488 |
| **Other covariates** | | | |
| Gender (female vs male) | 0.90 | 0.47–1.74 | 0.761 |
| Shift (rotating vs morning only) | 1.18 | 0.71–1.97 | 0.517 |
| Hospital type (provincial vs community) | 0.90 | 0.60–1.35 | 0.610 |
| Debt (yes vs no) | 0.88 | 0.58–1.35 | 0.570 |
| Work experience (years) | 0.99 | 0.97–1.01 | 0.170 |

**Abbreviations:** AOR, adjusted odds ratio; CI, confidence interval; OR, odds ratio; WPV, workplace violence.

**Note:** Multivariable logistic regression was used. Results are presented as AORs with 95% CIs. The model was adjusted for work environment, workload, organizational factors, gender, shift work, hospital type, debt status, and years of work experience. The reference category for each variable is indicated. $p < 0.05$ was considered statistically significant.

Association between directly reported workplace violence and intention to leave

Directly reported workplace violence was also significantly associated with intention to leave. Nurses who reported experiencing workplace violence had more than twofold higher odds of intention to leave compared with those who did not report such exposure (AOR = 2.14, 95% CI: 1.46–3.14). However, unlike psychosocial workplace violence, directly reported WPV did not demonstrate a dose–response pattern (Table 3). Nurses working in obstetrics–gynecology had lower odds of intention to leave compared with inpatient ward nurses (AOR = 0.46, 95% CI: 0.21–0.98, p = 0.044) (Supplementary Table S6).

Table 3
Association between directly reported workplace violence and intention to leave (adjusted model)

| Variable | Adjusted OR | 95% CI | p-value |
|---|---|---|---|
| **Workplace violence (WPV)** | | | |
| No | 1.00 | Reference | – |
| Yes | 2.14 | 1.46–3.14 | < 0.001 |
| **Work environment** | | | |
| Low | 1.00 | Reference | – |
| Moderate | 2.09 | 1.23–3.53 | 0.006 |
| High | 2.34 | 1.29–4.24 | 0.005 |
| **Workload** | | | |
| Low | 1.00 | Reference | – |
| Moderate–High | 1.30 | 0.78–2.15 | 0.316 |
| **Organizational factors** | | | |
| Low | 1.00 | Reference | – |
| Moderate | 1.30 | 0.81–2.09 | 0.280 |
| High | 1.11 | 0.72–1.72 | 0.630 |
| **Other covariates** | | | |
| Gender (female vs male) | 0.96 | 0.50–1.82 | 0.889 |
| Shift (rotating vs morning only) | 1.05 | 0.63–1.73 | 0.864 |
| Hospital type (provincial vs community) | 0.97 | 0.65–1.44 | 0.867 |
| Debt (yes vs no) | 0.77 | 0.51–1.17 | 0.221 |
| Work experience (years) | 0.99 | 0.97–1.01 | 0.240 |

**Abbreviations:**AOR, adjusted odds ratio; CI, confidence interval; OR, odds ratio; WPV, workplace violence.

**Note:** Multivariable logistic regression was used. Results are presented as AORs with 95% CIs. The model was adjusted for work environment, workload, organizational factors, gender, shift work, hospital type, debt status, and years of work experience. The reference category for each variable is indicated. $p < 0.05$ was considered statistically significant.

**Association between workplace violence and psychological distress**

Psychosocial workplace violence was significantly associated with higher psychological distress. Nurses with moderate and high levels of psychosocial violence had increased odds of distress (AOR = 2.10, 95% CI: 1.14–3.85 for moderate exposure and AOR = 2.31, 95% CI: 1.21–4.42 for high exposure) (Table 4). In contrast, directly reported workplace violence was not significantly associated with psychological distress (AOR = 1.58, 95% CI: 0.94–2.64, p = 0.081) (Supplementary Table S4).

Table 4
Association between psychosocial workplace violence and psychological distress (adjusted model)

| Variable | Adjusted OR | 95% CI | p-value |
|---|---|---|---|
| **Psychosocial workplace violence (WPV proxy)** | | | |
| Low | 1.00 | Reference | – |
| Moderate | 2.10 | 1.14–3.85 | 0.017 |
| High | 2.31 | 1.21–4.42 | 0.011 |
| **Work environment** | | | |
| Low | 1.00 | Reference | – |
| Moderate | 1.12 | 0.53–2.36 | 0.760 |
| High | 1.85 | 0.83–4.13 | 0.135 |
| **Workload** | | | |
| Low | 1.00 | Reference | – |
| Moderate–High | 1.75 | 0.84–3.64 | 0.133 |
| **Organizational factors** | | | |
| Low | 1.00 | Reference | – |
| Moderate | 0.79 | 0.43–1.48 | 0.468 |
| High | 0.69 | 0.39–1.23 | 0.208 |
| **Other covariates** | | | |
| Gender (female vs male) | 1.19 | 0.51–2.76 | 0.691 |
| Shift (rotating vs morning only) | 1.00 | 0.52–1.92 | 0.996 |
| Work experience (years) | 0.99 | 0.96–1.01 | 0.282 |

**Abbreviations:** AOR, adjusted odds ratio; CI, confidence interval; OR, odds ratio; WPV, workplace violence.

**Note:** Psychological distress was the dependent variable. Multivariable logistic regression was used. Results are presented as AORs with 95% CIs. The model was adjusted for work environment, workload, organizational factors, gender, shift work, and years of work experience. Hospital type and debt status were not included as covariates in this model as they were not associated with the outcome in preliminary analyses. The reference category for each variable is indicated. $p < 0.05$ was considered statistically significant.

**Summary of findings**

Overall, both psychosocial and directly reported workplace violence were associated with intention to leave. However, psychosocial workplace violence demonstrated a more consistent dose–response relationship, suggesting that it may better capture the underlying mechanisms linking workplace violence to turnover intention.

## Discussion

This study demonstrates that psychosocial workplace violence (WPV proxy) is more broadly and consistently associated with intention to leave among nurses than directly reported workplace violence, showing a dose–response gradient with both turnover intention and psychological impact that direct WPV reporting did not. This indicates that increasing levels of psychosocial exposure are associated with progressively higher odds of turnover intention, reflecting a cumulative and graded effect.

The findings are consistent with previous research showing that workplace violence is an important determinant of nurses' turnover intention [4,17]. However, this study highlights a critical limitation of conventional measures. Directly reported workplace violence captures discrete events but does not reflect the cumulative and continuous nature of exposure. In contrast, psychosocial workplace violence captures ongoing experiences embedded within the work environment, including power imbalance, exclusion, and communication-related pressure. These contextual experiences are more likely to influence long-term behavioral outcomes.

This distinction is particularly relevant in the context of nursing practice. Nursing work is inherently relational and performed under conditions of high workload, emotional demand, and hierarchical organizational structures [14]. Nurses frequently operate at the interface between patients, families, and other healthcare professionals, often with limited autonomy. In such environments, psychosocial stressors tend to accumulate over time, contributing to sustained pressure that may not be captured by incident-based measures.

The absence of a dose–response pattern for directly reported workplace violence further supports this interpretation. Binary measures do not capture the frequency, intensity, or duration of exposure and may be affected by underreporting [8]. In hierarchical and culturally sensitive environments, reporting may be constrained by organizational norms and perceived consequences [9], leading to underestimation of workplace violence.

The findings can be further interpreted within the framework of the Health Belief Model (HBM) [18]. Psychosocial workplace violence reflects not only perceived barriers but also continuous exposure to stressors that influence perceived severity and perceived susceptibility. The observed dose–response relationship suggests that increasing psychosocial burden strengthens these perceptions, thereby increasing the likelihood of intention to leave. In contrast, directly reported workplace violence, measured as isolated events, may not sufficiently capture these ongoing perceptions, limiting its predictive capacity.

The findings of this study are also consistent with evidence from other countries. For example, a cross-sectional study in China reported that 42.8% of nurses had turnover intention and identified workplace violence as a strong predictor [19]. Similarly, higher levels of turnover intention have been reported in Jordan, while lower levels have been observed in countries with stronger organizational support systems, such as Israel and Brazil [20–22]. These variations suggest that turnover intention is influenced not only by individual experiences but also by broader organizational and system-level factors.

The results also provide insight into potential mechanisms linking workplace violence to intention to leave. Psychosocial workplace violence was significantly associated with psychological distress, whereas directly reported workplace violence was not. This suggests that the impact of workplace violence on mental well-being may be driven primarily by continuous psychosocial stressors rather than isolated events. Persistent exposure to such stressors may lead to emotional strain and reduced psychological safety, which are known predictors of turnover intention [23,24].

In addition to workplace violence, work environment factors were also associated with intention to leave. This reinforces the interpretation that workplace violence does not operate in isolation but is closely linked to broader organizational conditions. High workload, limited resources, and organizational constraints may intensify psychosocial stress and amplify the effects of workplace violence. These findings support the view that workplace violence in nursing is a system-level issue rather than an individual-level problem.

From a practical perspective, these findings have important implications for intervention. Current workplace violence prevention strategies often emphasize incident reporting and physical safety measures. However, such approaches may not adequately address the underlying psychosocial conditions identified in this study, including power imbalance, communication barriers, and sustained workload pressure. Effective interventions should therefore focus on improving the overall work environment, strengthening organizational support, promoting fair communication, and addressing hierarchical structures [1].

This study has several limitations. The cross-sectional design limits causal inference, and reverse causation cannot be excluded. Self-reported measures may be subject to reporting bias. Although multiple covariates were included, residual confounding may remain. In addition, measurement of psychosocial workplace violence, although theoretically grounded, may not capture all dimensions of workplace experience. The study was also conducted in a specific provincial context, which may limit generalizability.

Despite these limitations, this study provides important contributions. It introduces a psychosocial measure of workplace violence that captures contextual and cumulative aspects of exposure and demonstrates its stronger association with intention to leave. This finding highlights the importance of measuring workplace violence beyond reported incidents to capture its full impact on workforce outcomes.

In conclusion, psychosocial workplace violence showed stronger and more consistent associations with intention to leave than directly reported workplace violence. Addressing this issue requires a shift from incident-based approaches to a broader focus on the psychosocial work environment and organizational context.

# Declarations


### Acknowledgements

The authors wish to thank the head nurses at all 14 hospitals in Nakhon Phanom Province for facilitating access to participants and supporting data collection. The authors also thank the Vaccine and Influenza Research Center, Nakhon Phanom Hospital, for institutional and logistical support throughout the study.


### Authors' contributions

K.P. and R.J. contributed equally to this work. Conceptualization: K.P., R.J., Sutthichai Nakphook, P.P.; Methodology: K.P., R.J., Sutthichai Nakphook, P.P.; Validation: P.O., Suriya Naosri, J.K., P.P.; Formal analysis: Suriya Naosri, T.J., P.P.; Investigation: K.P., R.J., P.O.; Resources: K.P., R.J., P.O., P.P.; Data curation: Suriya Naosri, T.J.; Writing – original draft: J.K., P.P.; Writing – review and editing: all authors; Visualization: J.K., P.P.; Supervision: P.O., P.P.; Project administration: P.P. All authors read and approved the final manuscript.


### Funding

No funding was received for this study.


### Availability of data and materials

The datasets generated and analyzed during the current study are not publicly available due to confidentiality and anonymity commitments made to participants but are available from the corresponding author on reasonable request.

### Ethics approval and consent to participate

This study was conducted in accordance with the Declaration of Helsinki and approved by the Ethics Committee of the Nakhon Phanom Provincial Public Health Office, Thailand (REC 117/68) on 15 October 2025. All participants provided written informed consent prior to participation.

### Consent for publication

Not applicable.

### Competing interests

The authors declare that they have no competing interests.

# References


1. International Labour Office, International Council of Nurses, World Health Organization. Public Services International. Framework guidelines for addressing workplace violence in the health sector. Geneva: ILO; 2002.
2. Hahn S, Müller M, Needham I, Dassen T, Kok G, Halfens RJ. Factors associated with patient and visitor violence experienced by nurses in general hospitals. J Clin Nurs. 2010;19(23–24):3535–46.
3. Liu J, Gan Y, Jiang H, Li L, Dwyer R, Lu K, et al. Prevalence of workplace violence against healthcare workers: a systematic review and meta-analysis. Occup Environ Med. 2019;76(12):927–37.
4. Spector PE, Zhou ZE, Che XX. Nurse exposure to workplace violence, bullying, and sexual harassment: a quantitative review. Int J Nurs Stud. 2014;51(1):72–84.
5. Einarsen SV, Hoel H, Zapf D, Cooper CL, editors. Bullying and harassment in the workplace: Theory, research and practice. 3rd ed. CRC; 2020.
6. Kim Y, Lee H. Workplace violence and nurses' turnover intention: mediating role of burnout. J Nurs Manag. 2016;24(8):E102–10.
7. Laschinger HKS, Grau AL. The influence of personal dispositional factors and organizational resources on workplace violence, burnout, and health outcomes in new graduate nurses. Int J Nurs Stud. 2012;49(3):282–91.
8. Pompeii LA, Dement JM, Schoenfisch AL, Lavery AM, Souder M, Smith CD, et al. Perpetrator, worker and workplace characteristics associated with patient and visitor perpetrated violence. J Saf Res. 2013;44:57–64.
9. Zhang L, Wang A, Xie X, Zhou Y, Li J, Yang L, et al. Workplace violence against nurses: a cross-sectional study. Int J Nurs Stud. 2017;72:8–14.
10. Einarsen S, Hoel H, Zapf D, Cooper CL. Bullying and harassment in the workplace: developments in theory, research, and practice. 2nd ed. Boca Raton: CRC; 2011.
11. Nielsen MB, Einarsen S. Outcomes of exposure to workplace bullying: a meta-analytic review. Work Stress. 2012;26(4):309–32.
12. International Labour Organization. Experiences of violence and harassment at work: A global first survey. Geneva: ILO; 2022.
13. Yildirim D. Bullying among nurses and its effects. Int Nurs Rev. 2009;56(4):504–11.
14. Jaratworapatra R. Workplace violence prevalence among nurses, Nakhon Phanom Hospital. Unpublished data. 2024.
15. Pummala N, Jirapongsuwan A, Siri S, Kalampakorn S. Workplace violence against frontline nurses in a university hospital in Bangkok, Thailand: A cross-sectional study. J Health Res. 2023;37(5):333–40.
16. Bothma CFJ, Roodt G. The validation of the turnover intention scale. SA J Hum Resour Manage. 2013;11(1). https://doi.org/10.4102/sajhrm.v11i1.507. Art. #507.

17. De Simone S, Planta A, Cicotto G. The role of job satisfaction, work engagement, self-efficacy and agentic capacities on nurses' turnover intention and patient satisfaction. Appl Nurs Res. 2018;39:130–40.
18. Rosenstock IM. Why people use health services. Milbank Mem Fund Q. 1966;44(3 Suppl):94–127.
19. Chen M, Xie H, Liao X, Ni J. Workplace violence and turnover intention among Chinese nurses: The mediating role of compassion fatigue and the moderating role of psychological resilience. BMC Public Health. 2024;24(1):2437.
20. Al Momani M. Factors influencing nurses' intention to leave in Jordan. Int J Community Med Public Health. 2017;4(6):1847–53.
21. Dekeyser Ganz F, Toren O. Israeli nurse practice environment characteristics, retention, and intent to leave. Isr J Health Policy Res. 2014;3(1):7.
22. Oliveira EM, Costa LMC, Ramos FRS, Jodas DA, Mendez MJG, León MMP. Burnout syndrome in nursing staff of the Mobile Emergency Care Service. Rev Bras Enferm. 2017;70(1):79–86.
23. Edward KL, Ousey K, Warelow P, Lui S. Nursing and aggression in the workplace: A systematic review. Br J Nurs. 2014;23(12):653–9.
24. Leiter MP, Maslach C. Nurse turnover: The mediating role of burnout. J Nurs Manag. 2009;17(3):331–9. 10.1111/j.1365-2834.2009.01004.x.

# Figures

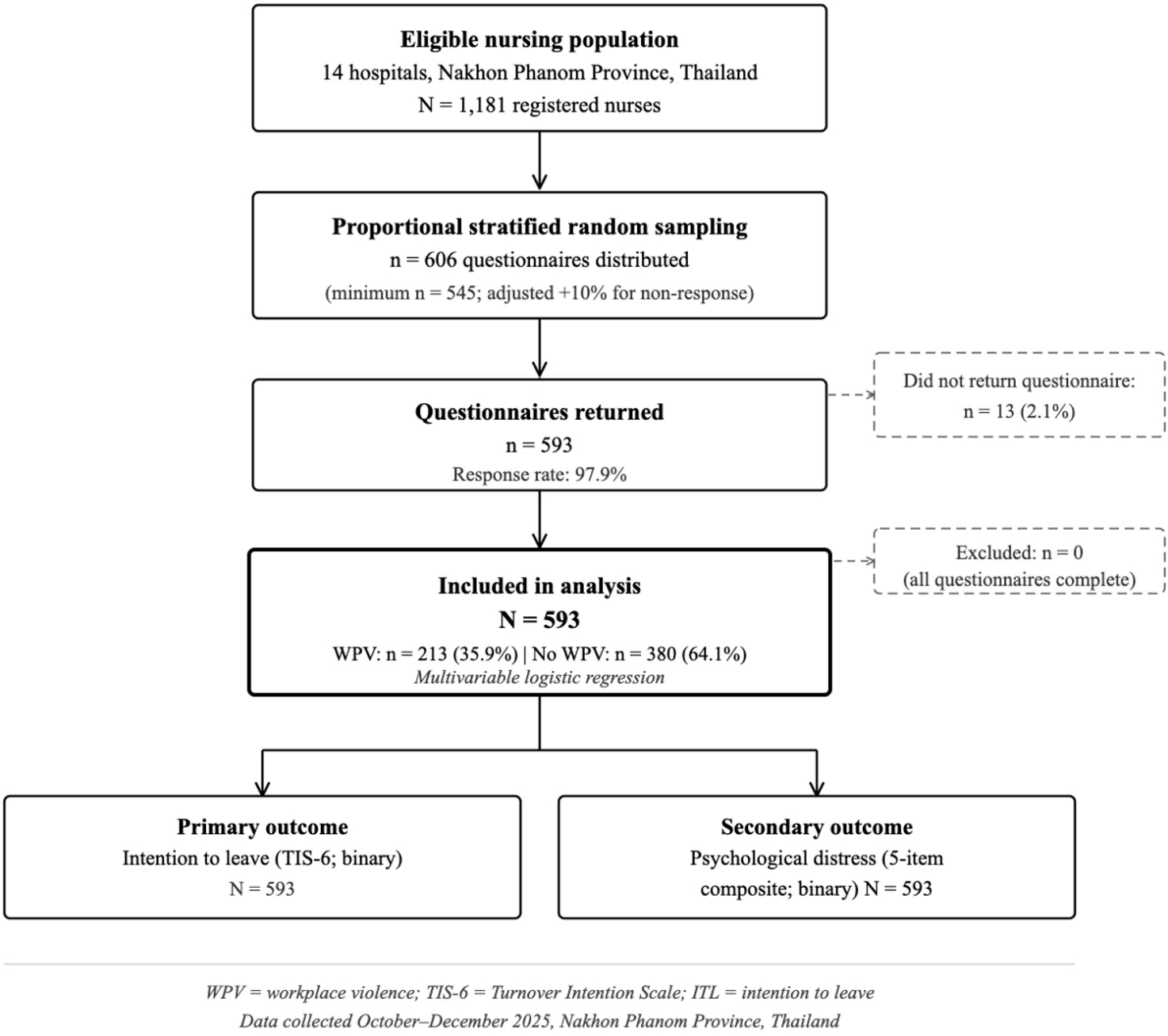



**Figure 1**

Participant flow diagram

**Figure 1.** Participant flow diagram. The total eligible nursing workforce comprised 1,181 registered nurses across 14 hospitals in Nakhon Phanom Province, Thailand. Using proportional stratified random sampling, 606 nurses were selected and approached. Of these, 593 returned completed questionnaires (response rate 97.9%) and all were included in the analysis. Thirteen nurses did not return questionnaires (2.1%).

# Supplementary Files

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

- WPVSupplementaryFileS1questionairEN.docx
- WPVSupplementaryTablesS2S7.docx