REVIEW

The Journal of Palembang Nursing Studies
https://jpns-journal.com/index.php/jpns
OPEN ACCESS

Workplace violence against nurses and the challenge of underreporting: A literature review

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Volume 4(2), 51-59

http://dx.doi.org/10.55048/jpns162

e-ISSN 2827-8100
p-ISSN 2827-8496

Received : March 4, 2025
Revised : April 8, 2025
Accepted : May 5, 2025
Published : May 15, 2025

ABSTRACT

Background: Workplace violence (WPV) against nurses is a critical global concern that negatively affects nurse well-being, professional performance, and patient safety. Despite its widespread occurrence, WPV is consistently underreported. This persistent gap between high incidence and low reporting limits accurate surveillance, weakens institutional responses, and delays the development of effective prevention strategies.
Objective: To identify the reasons behind the low reporting rate of WPV among health workers, especially nurses
Design: Literature review.
Data Sources: Scopus, Google Scholar, and Taylor & Francis databases were searched using the keywords "Workplace Violence," "Healthcare Workers," and "Nurses."
Review Process: Inclusion criteria comprised articles that discussed WPV prevalence and reporting behaviors and dated from 2020 onward. Screening of titles, abstracts, and full texts was performed, followed by detailed analysis of eligible studies.
Results: Eleven studies from 10 Asian countries were included, with sample sizes ranging from 11 participants in a qualitative study to more than 20,000 registered nurses. Across settings, workplace violence was widespread, with prevalence rates ranging from 13.6% to nearly 90%. Despite this high occurrence, reporting remained limited. Personal barriers to reporting included fear of negative consequences, shame, guilt, and the perception that violence is an unavoidable part of nursing practice. Organizational barriers included unclear or inconvenient reporting procedures, lack of training, absence of system privacy, limited managerial support, and mistrust in reporting mechanisms. Collectively, these factors reinforced underreporting and contributed to unsafe work environments for nurses.
Conclusion: Underreporting of WPV among nurses persists due to both individual and organizational barriers. Addressing this issue requires supportive reporting systems, training on WPV management, and fostering a non-punitive safety culture. Without targeted interventions, unsafe work environments will persist, compromising both nurse well-being and quality of patient care.

Keywords: workplace violence; healthcare; nurses; violence

Serlina, S., Melastuti, E., Wahyuningsih, I. S. (2025). Workplace violence against nurses and the challenge of underreporting: A literature review. *The Journal of Palembang Nursing Studies, 4(2), 51-59*. http://dx.doi.org/10.55048/jpns162

Nursing and Healthcare Practices

- *Many nurses remain silent about WPV due to shame and fear of negative consequences.*
- *Hospital management often provides insufficient attention and support to victimized nurses.*
- *Effective reporting systems and structured training programs are essential to empower nurses in addressing WPV.*

INTRODUCTION

Workplace violence (WPV) against nurses has become a pressing global issue and continues to attract significant research attention. The World Health Organization (2022) defines WPV as the intentional use of power, whether actual or threatened, directed toward an individual or group in work-related circumstances that results in deprivation, maldevelopment, psychological harm, physical injury, or even death. Evidence from numerous studies shows that nurses experience the highest prevalence of WPV among healthcare professionals, primarily due to their close and continuous interactions with patients and their families. Nurses working in emergency departments are particularly vulnerable, with prevalence rates reported as high as 82 percent in some countries (Al-Maskari et al., 2020). The International Council of Nurses has also emphasized that nurses are more frequently exposed to violence compared with other healthcare workers. Although physical WPV has been increasingly recognized and documented, psychological violence, including verbal abuse, intimidation, and emotional harassment, remains relatively overlooked in both research and practice (Hameed et al., 2020).

However, the reporting rate of WPV in the health sector remains low (Eshah et al., 2024). Honarvar et al. (2020) found that almost all health workers, particularly nurses, had experienced at least one form of violence in the workplace, and two thirds had suffered from more than one type. Despite the high incidence, the absence of effective reporting mechanisms has led to many cases being left undocumented. Similar findings were reported by Alsaqat et al. (2023) in Saudi Arabia and Lei et al. (2022) in China, where workplace violence, especially verbal abuse, was commonly experienced by healthcare workers. Nevertheless, most victims chose not to report these incidents, reflecting persistent barriers to disclosure and institutional response.

The persistent problem of underreporting workplace violence represents a major challenge in the health sector. When violent incidents are not reported, organizations are unable to obtain accurate data, implement preventive strategies, or establish effective policies to protect healthcare workers. This silence not only perpetuates unsafe working environments but also undermines the well-being and morale of nurses, which in turn may compromise the quality of patient care. Underreporting further weakens institutional accountability, as incidents remain hidden and unresolved, leaving nurses vulnerable to repeated violence. Given the serious implications for both healthcare workers and patient safety, addressing the barriers to reporting is essential for fostering a supportive and safe workplace culture (Hameed et al., 2020). Therefore, the purpose of this study was to analyze the factors contributing to the underreporting of workplace violence in the health sector, with a particular focus on nurses.

METHODS

Design

This study employed a literature review method, which involved systematically collecting, screening, and analyzing published research to obtain a comprehensive understanding of workplace violence underreporting in the health sector. The literature review approach was selected because it allows for the integration of findings from diverse studies, identification of recurring patterns, and critical examination of both personal and organizational factors that contribute to the issue. By synthesizing evidence across multiple sources, this method provides a broader perspective on the barriers nurses face in reporting workplace violence and highlights gaps in existing policies and practices that require further attention.

Search Strategy

The literature search was conducted across three electronic databases: Scopus, Google Scholar, and Taylor & Francis. These databases were

chosen because they are widely recognized for their credibility, comprehensive coverage, and accessibility of peer-reviewed journal articles across health sciences and nursing disciplines. The search strategy was designed to identify relevant studies that examined workplace violence and underreporting among healthcare professionals, with a particular emphasis on nurses. Three core keywords were applied—"Workplace Violence," "Healthcare Workers," and "Nurses." These keywords were selected to capture the broad scope of the topic while ensuring specificity to the nursing profession. Boolean operators (AND, OR) were employed to combine the keywords and refine the search results, thereby reducing the risk of missing relevant studies. The use of multiple databases and a structured set of keywords was intended to minimize bias and ensure that the literature search was comprehensive, objective, and inclusive of diverse study designs and geographical contexts.

Study Selection

The selection of studies was guided by two inclusion criteria. First, eligible articles had to specifically address the high prevalence of workplace violence in the health sector while also discussing the issue of underreporting of such incidents. Second, to capture the most up-to-date evidence, only studies published from 2020 onward were included, thereby reflecting recent trends, current practices, and emerging challenges related to workplace violence reporting in nursing and healthcare settings.

Screening and Eligibility

Screening and eligibility processes were conducted to ensure that the selected articles met the predetermined inclusion criteria. In the initial screening phase, article titles, publication details, and year of publication were reviewed to identify potentially relevant studies. Abstracts and keywords were then examined to confirm that the articles addressed workplace violence in the health sector, with particular attention to issues related to underreporting. To enhance rigor and minimize bias, the screening process was independently performed by two reviewers. Any discrepancies or uncertainties regarding study eligibility were resolved through discussion, and when consensus could not be reached, a third reviewer was consulted to provide input and finalize the decision. This multi-reviewer approach strengthened the reliability and validity of the selection process.

Data Analysis

The articles that successfully passed the screening and eligibility process were then subjected to full-text analysis. Each article was read in detail to extract comprehensive information regarding study objectives, design, population, sample size, key findings, and reported barriers to workplace violence reporting. Particular attention was given to identifying both personal and organizational factors contributing to underreporting, as well as contextual differences across healthcare settings. This in-depth reading and synthesis allowed for a more nuanced understanding of the issue and ensured that the review captured not only the prevalence of workplace violence but also the underlying reasons for the persistent reporting gap.

RESULTS

We performed search in three databases namely Scopus, Google Scholar, and Taylor and Francis. After removing duplicates and conducting an initial screening, 1,261 articles were retained for further review. Of these, 1,054 were excluded after title and abstract screening for not meeting the inclusion criteria. The remaining 25 full-text articles were assessed for eligibility, and 14 were excluded because they did not satisfy all inclusion criteria. Ultimately, 11 articles met the eligibility requirements and were included in this literature review (Figure 1).

Table 1 presents 11 studies from different Asian countries that examined workplace violence (WPV) and reasons for underreporting among nurses and healthcare workers. Most of the studies were cross-sectional, with one descriptive study from Iraq and one qualitative study from Malaysia. The number of participants varied widely, from as few as 11 in a qualitative interview study to over 20,000 registered nurses in China. Across the studies, a consistently high prevalence of WPV was reported. In Oman, 87.4% of nurses experienced WPV and often perceived it as unavoidable or part of the job. In Saudi Arabia, nearly half of 7,398 healthcare workers reported verbal abuse but chose not to report it due to fear of negative consequences, lack of clarity about reporting channels, and the perception that reporting was useless. Similar barriers were observed in India, where underreporting was attributed to a lack of awareness about reporting mechanisms.

In Iraq, 78.5% of emergency staff and nurses

Table 1. Incidence of WPV among health workers and reasons for not reporting

Study (year)	Country	Study design	Participants (n)	Reasons
Al-Maskari et al. (2020)	Oman	Cross-sectional study	RN (103), 87.4% had experienced WPV	• Part of the job; • WPV is unavoidable.
Alsaqat et al. (2023)	Saudi Arabia	Cross-sectional study	HW & RN (7,398), 49.1% of them had experienced verbal abuse.	• Reporting is useless; • Afraid of negative consequences; • WPV is not important; Did not know to whom to report the incident.
Garg et al. (2020)	India	Descriptive and cross-sectional study	HW & RN (394), 34.5% had experienced WPV.	• Lack of awareness about the reporting mechanism of workplace violence
Hameed et al. (2020)	Irak	Descriptive study	ED staff & RN (426), 78.5% had experienced emotional violence, 14.3% physical abuse, and 5.2% sexual abuse.	• Pretended nothing happened; • Chose to only inform coworker, family, and friends.
Lei et al. (2022)	China	Cross-sectional study	RN (20,136), 79.39% had exposed to any type of WPV.	• Chose to only inform friends, families, and colleagues.
Honarvar et al. (2020)	Iran	Cross-sectional study	RN (405), 89.6% had experienced one kind of violence and 68.4% suffered from more than one type of violence.	• Nurses were not trained in how to manage violence; • Lack of reporting policy; • Lack of trust in reporting team; • Fear if revenge.

Khan et al. (2021)	Pakistan	Cross-sectional study	HW & RN (842), 51% had experienced and/or witnessed WPV.	• It was not important; • Felt ashamed and guilty; • Reporting was useless; Afraid of negative consequences; Did not know who to report to.
Minhat & Sahiran (2024)	Malaysia	Qualitative study	HW & RN (11), all of them had experienced WPV.	• Perceived norms; • Process barriers; Attitude/beliefs.
Nithimathachoke & Wichiennopparat (2021)	Thailand	Cross-sectional study	ED staff & RN (295), 88.4% had experienced violence.	• Perceived violence as part of their job.
Pidada & Wahab (2024)	Indonesia	Cross-sectional study	HW & RN (482), 13.6% had experienced violence.	• Not important to report such incident; • Subjectivity on the definition of violence; • Unclear reporting procedures; • Lack of management support.
Towhari & Bugis (2020)	Saudi Arabia	Cross-sectional study	HW & RN (210), 78.6% had experienced violence.	• Lack of system privacy; • Perception that the incidents of violence were a part of their daily job; • Did not receive training on reporting system.

Note: RN = Registered Nurse; HW = Healthcare Worker; ED = Emergency Department; WPV = Workplace Violence

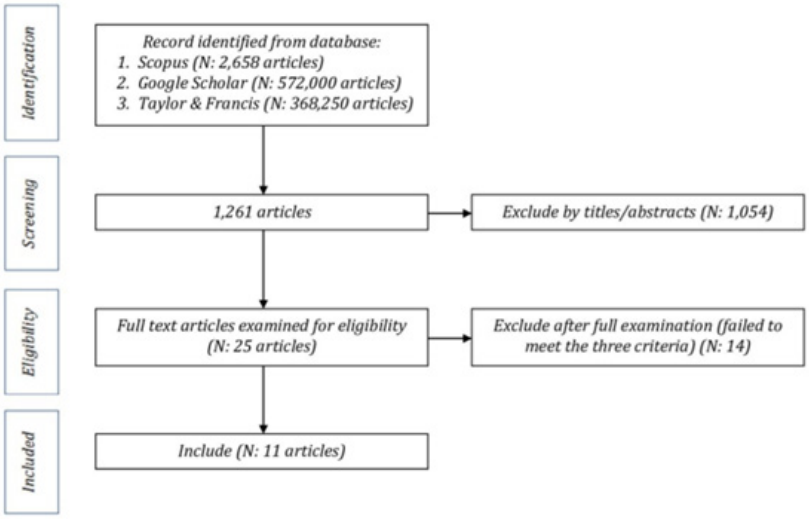

Figure 1. Flowchart of Literature Review Process

experienced emotional violence, while others faced physical and sexual abuse; however, most chose silence, confiding only in family or coworkers. Iranian nurses reported very high rates of exposure, with 68.4% suffering multiple types of violence. They cited lack of training, unclear policies, fear of revenge, and mistrust of reporting teams as barriers. In Pakistan, 51% of participants experienced WPV but refrained from reporting due to shame, guilt, fear of consequences, and uncertainty about reporting channels. Chinese nurses also reported a high prevalence of WPV, with 79.39% exposed, yet most only shared their experiences informally with friends or colleagues rather than using formal systems. In Malaysia, qualitative findings revealed that perceived norms, attitudes, and process barriers discouraged reporting. Thai emergency nurses, of whom 88.4% had experienced WPV, perceived such incidents as simply part of their job. In Indonesia, where 13.6% of healthcare workers reported violence, underreporting was linked to unclear reporting procedures, subjectivity in defining violence, and lack of management support. Finally, in another study from Saudi Arabia, 78.6% experienced WPV, but lack of system privacy, insufficient training, and the perception that violence was part of daily practice were key barriers. Taken together, the studies highlight two major themes: personal barriers such as shame, fear, normalization of violence, and lack of confidence in outcomes; and organizational barriers including unclear procedures, lack of training, limited confidentiality, and inadequate managerial support. These factors collectively reinforce the cycle of underreporting and perpetuate unsafe workplace environments for nurses (Table 1).

DISCUSSION

Personal reasons

Most nurses chose to stay silent and not report violent incidents because of fear of the negative consequences. They fear being stigmatized by their supervisors and co-workers. The feelings of dishonor, shame, and embarrassment were then added to common barriers to reporting. Nurses were also concerned about the reaction from their supervisors who tend to blame and punish the nurses instead of providing support and helping them to reach the root of the problems (Hamed & Konstantinidis, 2022). This led to a lack of motivation and commitment among nurses to actively participate in the incident reporting system.

Nurses were regarded as caring and emphatic, leading to a culture of tolerance of violence, so they often perceive WPV as a part of their job description, developing a sort of normalization of violence in the workplace. They feel reluctant to report the incidents and choose to endure threatening behavior, verbal abuse, or mild physical assault. Nurses with less experience may also regard themselves as less valued, so compared to their leaders, they feel their voice has less importance (Spencer et al., 2023).

Staying silent towards violent incidents and being accustomed to violent behavior

will definitely downplay the negative impact of violence on nurses' conditions, including their physical and mental health (Chang et al., 2024). Experiencing violent incidents can lead to low self-esteem, depression, self-blame, mood disorders, anger, anxiety, sleeping problems, chronic headaches, and loss of jobs (Eshah et al., 2024). Thus, WPV is a seriously existing problems which expose nurses to high-risk working conditions. It can trigger an unhealthy environment that affects their performance and reduces their enthusiasm (Abuhasheesh et al., 2024).

Management and organizational reasons

Besides personal sides, management and organizational difficulties also become the reasons for the lack of WPV reporting among nurses. The definition of error was vague and the outcome of an error defined the need for reporting (Hamed & Konstantinidis, 2022). The majority of hospital nurses were also not trained appropriately in how to manage violence in the workplace. Some nurses do not even know how to report the incident, even when there is an existing reporting system in their workplace. They were concerned about the inconvenience of reporting processes and the lack of anonymity and confidentiality in reporting. When violence happens, management personnel often give their attention to patients, not to nurses who become the victims of violence. The hospital immediately tries to reach out and pacify the patient rather than provide support for nurses. This is why most nurses became apathetic and perceived that their reports would not be investigated properly (Song et al., 2021).

Therefore, aggressor prosecution became the least frequent of WPV reactions, while the most common actions are verbal warning and no action. This finding is in line with the statement from Song et al. (2021) that violent incidents were more often reported verbally (74.6%), followed by written form (15.4%) and computer reporting system (10%). Formally documented reporting is usually required to provide accurate data because verbal reporting may not always be available to upper management for policy decisions. The reporting system needs to be simplified, easily analyzed, and non-punitive. The WPVA Perception Scale also needs to be developed to identify which structures and strategies are enablers or barriers to safety culture in the workplace (Tyler, 2023). Nevertheless, formal reporting through writing or electronic reporting system was not effectively implemented. The legal process also took a long time to complete, and most of them did not lead to prosecution and very few resulted in punishment (Sari et al., 2023). Nurses then finally left with the perception that reporting is useless since no positive changes ocurred.

Strengths and Limitations

This review has several strengths. It addresses the underreporting of workplace violence (WPV), a critical but less explored aspect of nursing research, thereby filling an important gap in the literature. By including only studies published from 2020 onward, the review ensures that the findings reflect current challenges and practices. The inclusion of studies from 10 Asian countries provides a broad perspective and allows comparison across diverse healthcare settings. Furthermore, the synthesis captures both personal and organizational barriers, offering a comprehensive understanding of the factors that contribute to underreporting, and identifies consistent themes that are directly relevant for nursing practice and policy development.

Nevertheless, several limitations should be acknowledged. The search was limited to three databases—Scopus, Google Scholar, and Taylor & Francis—which may have excluded relevant studies indexed elsewhere. All included studies originated from Asia, which may limit the generalizability of findings to other regions with different healthcare systems and cultural contexts. In addition, non-English language studies were likely excluded, creating potential language bias. The inclusion of heterogeneous study designs, primarily cross-sectional and self-reported surveys, raises concerns about the consistency and reliability of the evidence. Moreover, no formal quality appraisal of the included studies was conducted, which restricts the ability to assess the strength of the evidence. Finally, the analysis was narrative rather than meta-analytic, limiting the capacity to quantify the associations or determine the magnitude of reporting barriers.

CONCLUSION

Workplace violence in the health sector has emerged as a serious global concern, with nurses experiencing a disproportionately high burden. Despite its prevalence, the reporting

of violent incidents remains consistently low. This underreporting is driven by both personal and organizational factors. On a personal level, nurses often remain silent due to feelings of shame, embarrassment, and fear of negative consequences, as well as the perception that violence is an unavoidable aspect of their professional role. From an organizational perspective, unclear definitions of violence, lack of adequate training in managing WPV, insufficient managerial support, and prolonged or ineffective legal processes further discourage reporting. Addressing these barriers requires the establishment of clear reporting systems, comprehensive training programs, and stronger institutional support to foster a culture of safety and accountability.

Declaration of Interest

The authors declare no conflict of interest.

Acknowledgment

None

Funding

None

Data Availability

None

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