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Clinical Diagnoses and Their Role in Workplace Violence in  
Healthcare:  
A Review of the Literature

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## Introduction and Overview

If you take time to speak with a healthcare professional, many of them will share their experiences of verbal threats, attacks, and even physical violence. Across the world, and in a variety of healthcare settings, healthcare professionals are experiencing growing incidents of violence, often perpetrated by the patients and family members of the very patients they care for.

Workplace violence (WPV) in healthcare settings is defined by the World Health Organization (WHO) as “incidents where staff are abused, threatened, or assaulted in circumstances related to their work” (International Labour Office, World Health Organization, International Council of Nurses & Public Services International, 2002). These incidents include various forms of aggression, including physical, verbal, psychological (emotional), sexual, and racial violence. Research has shown WPV is a growing global challenge, disproportionately impacting the healthcare sector (Ma et al., 2022; Rawl & Dickson, 2023). Within the United States, the Bureau of Labor Statistics (BLS) reported that in 2022, healthcare workers experienced five to twelve times more violent incidents compared to other industries (Bureau of Labor and Statistics [BLS], 2022). Notably, healthcare workers experience markedly higher rates of violence than other industries: for 2021–2022, the health care/social assistance sector accounted for 41,960 of the 57,610 reported nonfatal WPV cases requiring days off work (BLS.gov, 2022). The American Nurses Association (ANA) National Workplace Violence Study (ANA, 2023) surveyed 7500 nurses and found that 44% of nurses reported they experienced physical violence and 75% reported experiencing verbal abuse while on the job.

The most common form of WPV is classified as Type II violence, where the perpetrator has a legitimate relationship with the business and becomes violent while receiving services. Within healthcare systems, this often means violence is being perpetrated by patients or family members of patients. In the *Crime and Incident Survey* report from the International Healthcare Security and Safety Foundation (2014), Type II violence is reported as alarmingly frequent, making up 75% of aggravated assaults and 93% of all assaults against employees in healthcare.

The impact of WPV is far-reaching. Besides healthcare workers experiencing injury or missed days from work, victims of WPV often experience a range of negative outcomes, including physical injuries, anxiety, depression, stress, burnout, post-traumatic stress disorder (PTSD), and even in extreme cases, the risk of death or suicide (Fricke et al., 2023; Gillespie et al., 2010; Hills & Joyce, 2013; Li et al., 2020; Mento et al., 2020a; Sahebi et al., 2022; Yospe, 2023). In addition to the physical and mental impact on healthcare workers, WPV significantly impacts worker morale and patient care. Research has shown WPV can result in burnout, job dissatisfaction, depression, and anxiety, among many other workplace and personal issues (Eshah et al., 2024; Gerberich et al., 2004; Hills & Joyce, 2013; Pagnucci et al., 2022; Phillips, 2016, 2016). Stevenson et al. (2015) discussed the impact of WPV on patient care, suggesting that levels of care are affected due to nurses having difficulty performing their tasks, interacting less with patients, and showing less empathy towards them. There are clear indications that both workers and patients are negatively impacted by the growing incidents of WPV.

The financial burden of WPV on healthcare is significant. Research has shown WPV results in increases in workers' compensation claims, legal expenses, and staff replacement and recruitment. These costs have been estimated to reach as high as \$4.5 million across the sector (American Hospital Association [AHA], National Institute for Occupational Safety and Health [NIOSH], & The Joint Commission [TJC], 2022). As noted in a meta-analysis of WPV research, the authors note that "the consequences of violence on health organizations are considerable, when considering absence due to work injuries or sick days, absenteeism, burnout, decreased job satisfaction, all factors that strongly affect quality of work, budgets, and costs" (Mento et al., 2020b).

## **Problem Statement**

As seen above, the negative impact of WPV is significant. Increased research and interventions have been introduced to address WPV, primarily in hospital settings. While more institutions are including training and interventions in their ongoing operations, there still exist gaps in the collective understanding of the problem. Common language around incidents, including types of incidents, incident descriptors, and reporting thresholds differ across settings and sub-professions in the healthcare sector. For instance, Safety and Security departments within hospitals are likely to report on certain events, while nursing or other clinical staff may report on a different selection of events. Even within various sectors of healthcare, there are differences in reporting. For instance, some hospitals are staffed with state police and their reporting process and structure is consistent with police practices, while other hospitals hire safety staff trained internally or through private security firms. The reporting for these

hospitals may not include police reports and may have a completely different framework for incident reporting. This lack of consistency in reporting leads to a less accurate picture of the WPV problem.

Across the various professions found in most large healthcare settings, the language used to categorize incidents is not consistent, nor is the type of data being collected. For instance, physicians, psychologists, nurses, compliance professionals, and safety officers and security staff may all discuss incidents with different terms, contexts, and understandings. Again, this inconsistent language and data collection practice lead to a fragmented picture of WPV in healthcare.

Unique to healthcare is the challenge that the perpetrator of violence is often a person under the care of the target of the violence. In most workplace settings, an employee can protect themselves by walking away, calling the police, or even aggressively defending themselves against a perpetrator. Healthcare workers find themselves in a position where they must continue to care for a patient who may be threatening or attempting to physically assault them. Walking away is not always an option. Existing in this space often leads to the underreporting of incidents, as many in the field see these incidents as common, everyday experiences of being in the profession.

The underreporting of incidents is considered a significant problem when trying to define and understand WPV. Estimates for underreporting range from 29% to 50% (Gerberich et al., 2004). Reasons for underreporting include issues such as a sense that reporting makes no difference, a fear of retaliation from management, a lack of understanding of reporting expectations, processes, and policies, and a lack of time to

complete the reporting process (Judy & Veselik, 2009). Additionally, the culture in many healthcare settings embraces the belief that violence is part of the job. In areas such as Emergency Departments, healthcare professionals prioritize patient care over their own safety, exacerbating feelings of hopelessness and impacting their overall wellbeing (Lyver et al., 2025). For many healthcare professionals, reporting adds to the tasks to be completed in a busy day, and there is little understanding that, from a broader perspective, the data collected can be utilized to improve policies and processes to create a safer work environment.

In addition to inconsistent and mismatched data, there is an overall lack of clinical data regarding the patients involved in WPV incidents. Research suggests that 70 – 80% of incidents occurring in healthcare settings are perpetrated by patients. (AHA, NIOSH & TJC, 2022). While these studies indicate patients are the primary perpetrators of WPV, few research studies capture clinical and diagnostic information about these patients. More data is required to enable informed decision-making on reducing the likelihood and consequences of WPV in medical settings. The purpose of this paper is to review existing research to gain a better understanding of what we know about clinical diagnoses or symptom presentations linked to WPV.

## **Discussion**

As discussed above, most perpetrator-initiated violence in hospitals involves patients. Research has identified some key patient predictors of aggressive behaviors, which include male sex, prior violent behavior, police custody, substance impairment, and underlying psychiatric conditions (Gacki-Smith et al., 2009; Gerberich et al., 2004;

Ma et al., 2022; Pich et al., 2010). While there is certainly speculation that the underlying diagnosis may contribute to the violent behaviors of patients, and perhaps even visitors, little research has been done to confirm this assumption. A growing body of research has identified strong associations between specific clinical diagnoses and the likelihood of patients perpetrating WPV in hospital settings, particularly within emergency departments and psychiatric units. While most patients with psychiatric or medical conditions are not violent, certain diagnoses are disproportionately represented in reported incidents of aggression toward healthcare workers.

### ***Psychiatric Disorders***

**Schizophrenia and Other Psychotic Disorders.** Assumptions are often made that patients diagnosed with Schizophrenia or other psychotic disorders are likely to be more aggressive. This does not play out so clearly in the research. When looking at inpatient psychiatric treatment, higher rates of inpatient violence have been reported with patients with schizophrenia (Iozzino et al., 2015). However, additional research indicates that viewing the diagnosis of schizophrenia or any mental illness alone does not help predict aggression (Elbogen & Johnson, 2009). Mayhew and Chappell (2007) suggest “the majority of violence doesn’t come from people with mental illness.” Risk of aggression increases when patients diagnosed with schizophrenia also have substance use disorders and a history of aggression (Elbogen & Johnson, 2009; Tian et al., 2020). Additionally, those patients diagnosed with schizophrenia who are experiencing acute psychotic episodes or persecutory delusions are among the most frequently associated with physical aggression in hospital settings (Friedman, 2006).

**Personality Disorders.** Among psychiatric conditions, personality disorders—especially borderline and antisocial personality disorders—are closely associated with hostile or threatening behavior in clinical settings. These individuals may have impaired impulse control and a heightened sensitivity to perceived slights or authority, contributing to violent outbursts, particularly in high-stress environments like the Emergency Department or inpatient psychiatry (Iozzino et al., 2015). As with schizophrenia and other psychotic disorders, personality disorders are more likely to be problematic when accompanied by a history of aggression and substance use. Stevenson et al. (2025) looked at characteristics and themes of incidents of aggression in Canadian hospitals and identified that nurses were more frustrated and less tolerant of patients with diagnoses of personality disorders and substance use disorders as compared to those patients with other diagnoses. They appeared to see these patients as having more control over their behaviors (Stevenson et al., 2015).

**Bipolar Disorder and Depression.** While mood disorders such as depression and bipolar disorder are not always predictive of violence, the presence of severe manic states or psychotic features such as delusions of persecution can elevate the risk of aggression. Patients in manic episodes may exhibit disinhibited behavior, grandiosity, or irritability, all of which may escalate into violence under stressful conditions or during conflict with staff (Elbogen, E.B., & Johnson, S. C., 2009).

**Substance Use Disorders (SUDs).** Substance use is frequently implicated in WPV incidents (Phillips, 2016; Rawl & Dickson, 2023). Intoxication with alcohol or stimulants such as cocaine and methamphetamine is known to impair judgment and heighten aggression. Iozzino et al. (2015) reviewed and found that inpatient wards with

higher numbers of male patients with alcohol use disorders and patients who were involuntarily hospitalized had higher incidents of aggression.

### ***Medical and Cognitive Disorders***

**Delirium and Dementia.** Patients with altered mental status are identified most commonly with incidents of aggression in healthcare settings (Phillips, 2016). Cognitive impairments such as Alzheimer's disease, dementia, or acute delirium may lead to confusion, fear, or misinterpretation of clinical interactions, ultimately leading to aggressive incidents. Lyketsos et al. (1999) studied 541 patients diagnosed with dementia and found that those patients who had depressive symptoms and impairment of activities of daily living were more likely to be aggressive. In particular, delirium can arise quickly and unexpectedly and lead to aggressive behaviors in patients who may not have been expected to behave this way based on previous history or presenting diagnosis.

**Traumatic Brain Injury (TBI).** TBI patients may exhibit increased aggression due to neurological damage affecting impulse control and emotional regulation. Studies have shown higher rates of agitation and violence in hospital settings among patients with recent or chronic head injuries, particularly if accompanied by substance use or psychiatric illness. (Tateno et al., 2003).

### **Way Forward**

Understanding the nature of WPV is the foundation of creating systems and processes to minimize the impact on our healthcare systems. To effectively address this issue, we must engage in a strategic, multilevel approach that prioritizes both systemic

and frontline preparedness. While much of the work being done to address WPV currently sits at the individual or departmental level, meaningful change will require engaging institutions, national organizations, and the full range of professionals working in healthcare. The following recommendations provide a roadmap towards a more sustainable and comprehensive approach to reducing WPV in healthcare.

### ***Data Infrastructure and Reporting Standards***

A foundational barrier to combating workplace violence is the lack of consistent data collection and reporting. Health systems must invest in standardized reporting systems that allow for easy integration with electronic medical records or existing systems utilized for data collection of WPV. Data collection should include clinical information such as diagnosis, mental status, and intoxication/substance use, along with incident time and location, staffing, escalation triggers, and outcomes. National organizations can create a minimum data set utilized across all settings.

Incident dashboards that offer hospital, departmental, and even unit-level feedback to staff and leadership will assist in creating a culture of transparency, awareness, and continuous improvement. Some regulatory bodies, such as the Joint Commission and state health departments, require some reporting. Creating a standardized approach to this reporting, locally and nationally, will allow for the creation of a robust database and a more holistic view of WPV in our healthcare settings.

### ***Integrated Risk Assessment Models***

Embedding risk screening tools within the admission process can help identify individuals with elevated risk for aggression. This is integrated in some settings, such as psychiatric intake systems, but is not, at this time, in use across all healthcare systems.

Assessments can include information such as previous history of aggression, diagnoses of dementia or psychosis, active substance abuse, or any observed behavioral cues such as agitation or verbal threats.

Daily or shift-based safety meetings can be utilized to update staff on new or escalating threats and discuss de-escalation plans tailored to meet the needs of the current staffing and the patient being addressed. The inclusion of unit, department, or hospital-wide leadership in these meetings allows for not only localized adjustments to be made for patient care, but for system or policy issues to be addressed in real time.

### ***Workforce Training and Education***

Though many institutions mandate some form of violence prevention training, the effectiveness of generic or one-time modules may not meet the needs of all institutions. Newer technologies and learning approaches offer opportunities to offer dynamic training models that include case-based simulation training for specific scenarios staff may encounter in their setting. For instance, training could include modules on de-escalation techniques for psychiatric symptoms, role-play exercises involving aggressive visitors or family members, and legal and ethical guidance on restraint, seclusion, and duty to warn.

To help create a more universal understanding of WPV in the workplace, it is important that training is interdisciplinary and includes all members of the team. By including all members of staff in a hospital or other setting, a common language regarding WPV can be created, along with a team approach to addressing WPV.

### ***Environmental and Structural Redesign***

Healthcare spaces are often created with the needs of traditional healthcare in mind. Addressing WPV is not always front of mind when designing spaces, and therefore, spaces may not have good visibility or lighting and may create unsafe areas for staff. Environmental risk assessments should be conducted routinely across all departments. Environmental interventions might include the installation of secure rooms with unobstructed exits for staff. Panic buttons, surveillance cameras, and alarm systems could assist in maintaining a safe work environment. Ensuring nurse stations are situated in spaces allowing for clear visibility and adequate barrier protection could also assist in reducing risk. These efforts may not only reduce WPV but also demonstrate that the institution prioritizes safety.

### ***Policy Recommendations and System-Level Mandates***

National leadership is needed to create a consistent policy landscape. California has taken steps to create a comprehensive database that could be used as a springboard to begin a national effort to collect data on WPV. OSHA has voluntary guidelines for WPV reduction, and there have been talks about adopting mandatory reporting. Such a mandate may assist in pushing efforts to standardize data collection forward and at the local level, putting robust WPV reduction programs in place to include post-incident debriefing and medical and psychological support for affected employees to ensure no staff member feels abandoned after reporting violence.

WPV in healthcare settings is a complex and growing crisis that demands urgent and coordinated action. From inconsistent reporting practices to underappreciated links between patient diagnoses and aggression, the current system lacks the clarity and structure needed to effectively address this threat. WPV harms not only the physical

and mental health of healthcare workers but also undermines patient care, institutional morale, and financial stability. While individual departments and various hospitals and systems have made strides to address these issues, systemic change is needed to implement standardized data collection, risk assessment processes, staff training, environmental design, and national policy mandates. By building a unified, evidence-based framework, healthcare institutions can begin to reduce WPV, safeguard the well-being of their workforce, and improve the health outcomes for the patients they serve.

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## Author Biography

**Karen Nelson, Ph.D.** is a licensed psychologist and Assistant Professor of Clinical Psychology at the Sam Houston State University College of Osteopathic Medicine. Over the course of her career, she has worked with diverse populations, including college students, adolescents, families, and individuals within forensic settings. Prior to joining SHSU-COM in 2023, Dr. Nelson served as Director of Psychology and Forensic Services at a hospital treating patients court-ordered for psychiatric care, where she led initiatives focused on workplace violence prevention, patient safety, and de-escalation strategies.

She has consulted with multiple forensic and mental health hospitals to improve patient care practices, particularly around seclusion, restraint, and staff safety. Her clinical and administrative expertise informs her ongoing commitment to advancing trauma-informed care and fostering safer therapeutic environments in high-risk settings.



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