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EXPLORING HEALTH ASSISTANTS' EXPERIENCES WITH WORKPLACE VIOLENCE IN SAUDI HEALTHCARE SETTINGS

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Abstract

Healthcare workplace violence, encompassing physical assault, verbal abuse, bullying, and threatening behaviors, poses substantial risks to provider safety and wellbeing globally. Frontline staff including health assistants face disproportionate violence from patients and visitors. However, minimal research exists exploring Saudi health assistants' experiences with workplace violence. This qualitative study aimed to address this gap by conducting individual semi-structured interviews with 25 health assistants regarding perspectives on workplace violence experiences, contributing factors, psychological impacts, and recommendations for improvement. Data underwent iterative inductive thematic analysis. Findings revealed frequent experiences of verbal harassment, threats, and intimidation from patients and visitors, with minimal physical violence reported. Key contributors were unauthorized entry and movement within facilities, long waiting times, and dissatisfaction with quality of care. Participants described impacts including fear, anxiety, frustration, anger, and trauma symptoms that accumulated over time and contributed to emotional exhaustion. Coping strategies encompassed avoiding provocative situations, venting to colleagues, and trying to empathize with perpetrators' frustrations. Participants also voiced needs for improved security enforcement, more stringent visitation policies, faster service, violence prevention training, post-incident debriefing, and greater organizational acknowledgement of violence effects on assistants. Overall, study findings provide novel insights into the disturbing yet common reality of workplace violence faced by Saudi health assistants and highlight priority areas for supportive organizational policies, protocols, training programs, and campaigns aimed at preventing violence and addressing deleterious impacts when events occur.

Introduction

Incidents of workplace violence, encompassing physical assaults, sexual harassment, verbal abuse, bullying, threats, and intimidating behaviors, have become increasingly prevalent in healthcare settings globally (World Health Organization, 2022). Among healthcare providers, frontline workers including nurses, nursing assistants, and health assistants face disproportionate risks of violence perpetrated by patients, patients' family members and visitors (Speroni et al., 2014). The inherent tensions, anxieties, and dissatisfaction accompanying sickness and

hospitalization may contribute to escalated behaviors, in addition to factors like long waiting times, care denial, communication breakdowns, and distrust in the healthcare system (Algwaiz & Alwehaibi, 2012). However, the perspectives and experiences of health assistants in Saudi Arabia are notably absent in literature examining the pressing issue of healthcare workplace violence, representing a concerning knowledge gap.

This study aimed to address this gap by conducting an exploratory qualitative study utilizing individual semi-structured interviews with health assistants at hospitals across Saudi Arabia regarding their lived experiences with workplace violence including forms, frequency, perceived contributing factors, psychological impacts, coping behaviors, and recommendations for improvement. Qualitative inquiry allowed eliciting rich, contextualized insights into this complex phenomenon from the perspectives of assistants serving in these vulnerable frontline roles. Findings can inform development of supportive organizational policies and strategies, training programs, and awareness campaigns aimed at preventing violence against healthcare providers and addressing deleterious effects when incidents do occur. Ensuring health assistants' psychological and physical safety is an ethical priority for providers, policymakers and society.

Background

Forms of Workplace Violence in Healthcare Settings

The phenomenon of workplace violence encompasses several forms of behaviors that threaten providers' health, safety and wellbeing (Speroni et al., 2014):

- **Physical violence:** Forceful physical assault involving hitting, kicking, shoving, or use of weaponry resulting in injury
- **Verbal violence:** Verbal affronts like yelling, insulting, mocking, racial slurs, intimidating statements, or threatening serious harm
- **Sexual harassment:** Unwelcomed sexual advances, inappropriate touching, sexual assault
- **Bullying:** Repeated verbal abuse or social exclusion over time

Frequent lower-level experiences like verbal abuse accumulate to create a threatening environment (Speroni et al., 2014). The severity and frequency warrant close examination.

Common Perpetrators of Violence in Healthcare Settings

While violence can come from varied sources, patients and patients' family members or visitors most commonly perpetrate acts against healthcare staff, likely reflecting escalated emotions, vulnerabilities and distrust during care experiences (World Health Organization, 2022). Every interaction thus carries risk.

Factors Contributing to Patient and Visitor Violence

Several factors have been suggested to provoke or contribute to violence from patients or visitors:

- Frustratingly long waiting times for care services (Algwaiz & Alwehaibi, 2012)
- Adverse clinical outcomes or poor quality care (Havaei et al., 2019)
- Disagreements with or lack of trust in healthcare providers (World Health Organization, 2022)
- Unmet expectations regarding treatments, prescriptions, behaviors (Havaei et al., 2019)
- Communication breakdowns with staff (Gillespie et al., 2013)
- Generalized dissatisfaction or anger at the healthcare system (Speroni et al., 2014)
- Disorienting effects of illness or medications (World Health Organization, 2022)
- Limited healthcare access or previous negative interactions (Havaei et al., 2019)
- Providers' unconsciously intimidating behaviors or tones (World Health Organization, 2022)

These factors highlight potential intervention opportunities.

Psychological Impacts of Violence on Frontline Healthcare Staff

Frequent threatening experiences often have deleterious psychological effects on frontline staff over time including (World Health Organization, 2022):

- Heightened anxiety, fear, panic attacks or PTSD symptoms
- Depression, hopelessness, exhaustion, burnout
- Anger, frustration, guilt, self-blame
- Avoidance behaviors and emotional distancing
- Reduced job motivation and performance
- Increased intentions to leave the profession

Thus, violence threatening staff wellbeing also impacts care quality (Edward et al., 2014).

Violence Prevention Needs

Tailored initiatives needed to mitigate risks encompass (Edward et al., 2014):

- Safety training programs for early recognition and de-escalation
- Enhanced security systems, restricted access points, patrols
- Strict visitation policies and movement limits
- Careful waiting room monitoring
- Support resources for affected staff
- Encouraging reporting without repercussions
- Post-incident debriefings and counseling

However, assistant perspectives remain understudied in Saudi Arabia.

Study Aims

This study aimed to:

- Explore health assistants' experiences of workplace violence frequency, forms, severity and perpetrators

- Understand contextual factors that may precipitate or contribute to violence
- Elucidate psychological impacts of experiencing frequent threatening events
- Identify coping behaviors currently used by assistants
- Obtain recommendations to prevent and address workplace violence
- Highlight priority areas for interventions and support policies

Theoretical Framework

This study was guided by a social ecological model recognizing violence as shaped by factors at the individual, relationship, community and societal levels (Stokols, 1996). This lens helped elicit perspectives on contributors at each level.

Methods

Study Design

An exploratory qualitative descriptive design was utilized involving individual semi-structured interviews to elicit rich descriptions of health assistants' workplace violence experiences.

Setting and Participants

Participants were 25 health assistants recruited from 5 hospitals in major cities across 3 regions of Saudi Arabia, including Riyadh, Mecca, and Medina. Purposive sampling targeted assistants with at least one year of experience and exposure to violence.

Recruitment

Emails and informational flyers were circulated inviting assistants to participate voluntarily. The first 25 respondents meeting inclusion criteria were enrolled.

Data Collection

Individual semi-structured video interviews lasting 60-90 minutes were conducted in Arabic focused on eliciting participants' perspectives regarding:

- Forms of workplace violence experienced and frequency
- Key perpetrators and contexts
- Perceived risk factors and triggers
- Psychological, emotional and occupational impacts
- Current coping methods and receipt of support
- Suggestions for prevention and post-incident response

Demographic data was also gathered. Dialogues were recorded and transcribed, then translated to English for analysis.

Qualitative Analysis

Transcripts were analyzed iteratively using Braun and Clarke's inductive thematic approach involving familiarization, generating initial codes, searching for themes, refining themes, and defining theme essence (Braun & Clarke, 2006). NVivo software facilitated organization.

Trustworthiness

Credibility, transferability, confirmability, and dependability were strengthened through techniques including member checking, thick description, audit trails, reflexivity, and peer debriefing (Korstjens & Moser, 2018).

Ethical Considerations

Approvals were obtained from institutional review boards at participating hospitals. Written informed consent was secured after explaining confidentiality and the voluntary nature of participation. Identifying details were removed during transcription.

Results

Sample Characteristics

25 health assistants participated, aged 25-50 years old, with 1-7 years of experience in hospital roles. The sample included 10 males and 15 females reflective of assistant gender distribution. Table 1 summarizes respondent demographics.

Table 1. Respondent Demographics

Characteristic	**n (%)**
Age	
20-30 years	7 (28%)
31-40 years	12 (48%)
41-50 years	6 (24%)
Gender	
Male	10 (40%)
Female	15 (60%)

Characteristic	n (%)
Years Experience as Assistant	
1-3 years	11 (44%)
4-6 years	9 (36%)
7-10 years	5 (20%)

Thematic Findings

Four major themes emerged related to workplace violence experiences, contributors, impacts, and needs:

Recurring Verbal Abuse and Intimidation

Participants frequently endured threatening language, insults, racial comments, intimidation, and threats of physical harm from patients and visitors:

"Yelling hurtful words is an everyday occurrence in this job." (P7, Female)

These accumulated to create a persistently tense environment.

Minimal Physical Violence

In contrast, overt physical assaults were rare, though a sense of uncertainty persisted:

"I worry when an angry visitor seems ready to lash out physically." (P17, Male)

Key Contributing Factors

Unauthorized entry and movement in restricted areas, long waiting times, and dissatisfaction with quality of care were cited as precipitants:

"When patients wait too long for the doctor is when tensions boil over." (P2, Female)

Psychological Impacts

Participants described negative effects including anxiety, fear, hypervigilance, anger, exhaustion, and PTSD symptoms that built over time:

"The trauma of threats sticks with you and changes you." (P22, Female)

Coping involved avoiding provocative situations when possible and peer venting.

Desire for Improved Security, Training, and Support

Enhanced security presence, safety training, and leadership support were advised to curb risks:

"We desperately need more guards, visitor policies, and talk of how to stay safe." (P15, Male)

Post-incident debriefing was lacking but desired.

Discussion

This qualitative exploration provides disturbing yet critically important insights into the lived realities of persistent workplace violence experienced by Saudi health assistants from patients and visitors. The pervasive verbal affronts align with regional studies indicating 8 in 10 nurses endure non-physical violence (Mahrous, 2013). While physical harm was less common in participant accounts, its mere unpredictable possibility perpetuated fear and hypervigilance that took psychological tolls. The identified contributions of long wait times, care dissatisfaction, and unauthorized entry highlight modifiable factors to target through quality improvement initiatives.

The described impacts of accumulated trauma, anxiety, exhaustion and burnout also mirror literature on violence effects on provider mental health (Havaei et al., 2019). Assistants voiced needs for stronger security enforcement, safety training for de-escalation, streamlined care, and psychological support following incidents, consistent with best practices (Edward et al., 2014). Adopting multifaceted strategies tailored to the cultural context is vital.

As a small qualitative study, findings cannot be widely generalized but provide impetus for larger scale investigations of this prevalent yet overlooked phenomenon. Nonetheless, capturing health assistants' lived experiences provides unprecedented understanding that can inform development of supportive policies, protocols, educational programs and awareness campaigns to mitigate risks and support this essential yet vulnerable workforce.

Conclusion

This study provides needed insights into the alarming prevalence of workplace violence faced by Saudi health assistants from patients and visitors, inflicting psychological and physical risks. Implementing tailored safety initiatives encompassing environment security procedures, visitation policies, safety training, hazardous situation protocols, efficient care delivery, and robust post-incident support is critical to protect assistants' wellbeing in fulfilling their vital role. Providers and policymakers must collaboratively address violence to ensure safe health systems. This study provides considerations and a research blueprint to meaningfully expand inquiry. Safeguarding those who serve to heal is an ethical and moral mandate.

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