

The role of psychosocial safety climate in reducing workplace violence and enhancing coping among healthcare workers: A narrative review

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ARTICLE INFO

Article history:

Received

13 March 2025

Revised in revised form

9 July 2025

Accepted

1 August 2025

Published

1 September 2026

Keywords:

Psychosocial safety climate

Workplace violence

Coping

Healthcare workers

Healthcare

Review

DOI:

10.24191/jchs.v11i2.13398

ABSTRACT

Introduction: Workplace violence (WPV) is a prevalent issue in healthcare, negatively impacting healthcare workers' (HCWs) mental health and quality of patient care. Psychosocial safety climate (PSC) is an organisational construct prioritising psychological well-being and is increasingly recognised for its role in occupational safety and health. However, its influence on WPV and HCWs' coping mechanisms remains underexplored. This review integrates existing literature to examine PSC and its relationships with WPV and HCWs' coping mechanisms. **Methodology:** A narrative review was conducted using PubMed and Scopus to identify primary studies from 2010 to 2024 that examined PSC, WPV, and coping mechanisms among HCWs. Fifteen studies were analysed using relevant work stress models, including the Extended Job Demands-Resources model and the Transactional Model of Stress and Coping. **Results:** Globally, 62% HCWs reported experiencing WPV. While PSC enhances HCWs' well-being through improved support and safety, many healthcare settings report low PSC levels. Emerging evidence suggests that PSC inversely correlates with WPV by fostering better workplace policies and communication. Additionally, PSC appears to moderate workplace deviant behaviours by encouraging adaptive coping, including problem-focused and emotion-focused strategies. However, direct empirical research linking PSC with WPV and HCWs' coping remains limited. **Conclusions:** PSC is a critical yet under-researched factor in WPV prevention. As a modifiable organisational construct, future research should employ longitudinal and mixed-method designs to explore its role in reducing WPV and enhancing coping mechanisms. Findings may inform PSC-driven interventions to promote HCWs' resilience, workplace safety, and WPV prevention.

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1. INTRODUCTION

Workplace violence (WPV), characterised by the World Health Organization as any occurrence in which workers face abuse, threats, or assault while performing work duties or commuting to and from their workplace [1], is a significant global concern. This phenomenon is particularly pervasive in healthcare settings, where healthcare workers (HCWs) working in various units such as emergency rooms, psychiatric wards, and long-term care facilities often encounter physical attacks, verbal harassment, and threats from patients and their family members [2, 3]. The perpetrators of such negative acts can also include HCWs' superiors and colleagues, who may engage in bullying, harassing, or aggressive behaviours at the workplace [4, 5].

Globally, studies estimate that the prevalence of WPV among HCWs is 78.9%, with verbal abuse being the most common form of WPV experienced [1, 6]. These incidents significantly impact HCWs' mental health and well-being, and can result in anxiety, depression, and post-traumatic stress disorder (PTSD) among workers [7, 8]. In addition, WPV can also lead to injuries that can range from minor injuries to serious trauma requiring hospitalization [9]. Workers who experienced WPV often report job dissatisfaction and burnout, and in severe cases, may choose to abandon their careers [10]. The ripple effect of WPV extends to healthcare organisations, due to high turnover rate, suboptimal patient care, and reduced overall healthcare efficiency [7, 8, 11, 12].

Given its significant safety and health concern, various workplace interventions have been proposed to mitigate WPV in healthcare settings. These include education, risk assessment, and training on resilience, de-escalation methods, conflict resolution, personal defence, communication, and coping skills [13]. Coping, i.e., cognitive and behavioural efforts to manage, minimise, or endure the internal and external demands that arise from stressful events [14], has been shown to be an important protective factor that can mitigate the adverse implications of WPV among HCWs [15]. Indeed, previous studies have shown that HCWs' coping mechanism moderated the effect of WPV, and that positive and negative coping mechanism were found to be negatively and positively associated with anxiety among HCWs respectively [16].

In recent years, there has been increasing attention on psychosocial safety climate (PSC) due to its potential to mitigate workplace stress and violence [17]. PSC refers to the shared perceptions within an organisation about its commitment to supporting workers' mental health and creating a psychologically safe work environment [18]. A recent scoping review has demonstrated that high PSC work environments have a negative and significant association with adverse social relations at work, including WPV (1). Though PSC is recognised for its potential to improve the occupational safety and health of workplaces, little is currently known in relation to its influence on WPV, as previous studies were largely focused on its impact on other types of negative workplace interactions such as workplace bullying and harassment [19]. Similarly, there is presently limited understanding on its effect on workers' coping mechanisms as previous studies on the relationship between PSC and coping among workers were mainly concerned with workplace bullying [20].

This review explores WPV and PSC in healthcare settings, HCWs' coping mechanisms against WPV, and the relationships of PSC with WPV and coping mechanism of HCWs, guided by relevant work stress models that include Dollard and Bakker's (2010) Extended Job Demands-Resources model (2) and Lazarus and Folkman's (1984) Transactional Model of Stress and Coping [21]. By synthesising empirical evidence, this review offers insights into how PSC may directly reduce WPV as well as moderate WPV effects by enhancing adaptive coping among HCWs experiencing WPV.

2. METHODOLOGY

2.1 Search strategy and selection of studies

We performed a literature search of publications written in English indexed from 2010 to October 2024 in PubMed and Scopus databases. This period was selected given that PSC was first conceptualised in 2010 [22], thus ensuring that the review captures the most pertinent research on PSC. Combinations of the keywords “psychosocial safety climate”, “workplace violence”, and “coping” were utilised. Any peer-reviewed primary studies examining PSC, WPV, and coping mechanisms among HCWs in diverse healthcare settings were included, including those of quantitative, qualitative, and mixed-method design. For this review, HCWs were broadly defined to include any clinical and non-clinical personnel such as doctors, nurses, paramedics, support staff, public health workers, administrative staff, and hospital management. Non-primary studies including reviews, editorials, commentaries, forewords, opinion pieces, and books, studies that focused only on physical safety climate, and studies not available as full texts were excluded. Searches through the references of articles retrieved were also performed to include relevant studies.

2.2 Data extraction and analysis

We first screened titles and abstracts of the retrieved articles for relevance. Full-text articles were then reviewed in-depth. A narrative synthesis of the selected literature was performed, in which we utilised the Dollard and Bakker’s (2010) Extended Job Demands-Resources model [18] and Lazarus and Folkman’s (1984) Transactional Model of Stress and Coping [21] as our main frameworks for interpretation, as well as relevant literature. The Extended Job Demands-Resources (JD-R) model positions PSC as an antecedent to workplace conditions, and implies that PSC influences both job demands and job resources. Meanwhile, the Transactional Model of Stress and Coping emphasizes the person–environment transaction and suggests that coping mechanisms are influenced by individual appraisal processes, where individuals evaluate the significance of a stressor and their ability to manage it [23]. The data synthesis was performed by identifying key findings related to PSC, WPV, and coping from each study and organising them based on emerging conceptual themes. These themes were then aligned with the theoretical frameworks used. Studies were compared and contrasted to identify patterns, contextual differences, and gaps in the literature, forming the basis for discussion and interpretation.

3. RESULTS AND DISCUSSION

3.1 Prevalence and impact of workplace violence among healthcare workers

HCWs are at high risk of WPV, accounting for 73% of nonfatal injury and illness cases caused by violence in the United States in 2018 alone [24]. This vulnerability mainly arises from their frontline roles and close interactions with patients and their families, often in highly stressful and emotional circumstances [25, 26]. WPV among HCWs is a global issue that has been extensively documented. A meta-analysis of 253 studies involving 331,544 HCWs found that 61.9% reported being exposed to some form of WPV, with 42.5% experiencing verbal abuse and 24.4% encountering physical violence within the past year (3). A recent umbrella review of meta-analysis revealed that the overall prevalence of WPV among HCWs in hospital and pre-hospital settings was 58.7% [27].

In spite of the high figures reported, these numbers are likely to be an underestimation of the true burden of WPV among HCWs, as WPV incidents are often underreported. Research suggests that many HCWs do not report such incidents for various reasons, including fear of retaliation, feelings of

helplessness, or the perception that reporting will not lead to any substantial change [28-30]. Behavioural factors also contribute to underreporting, especially in Southeast Asia, where fear of the negative impacts and feelings of unworthiness are common reasons for not reporting WPV [31].

WPV in healthcare settings typically presents in three primary forms: physical violence, verbal abuse, and psychological violence [32]. Physical violence includes acts such as hitting, kicking, slapping, or other physical aggression. It is often seen in high-risk areas such as emergency rooms, psychiatric wards, and geriatric care units, where patients may be disoriented or aggressive due to medical or mental health conditions [33, 34]. Verbal abuse, the most common form of WPV, includes insults, threats, and demeaning language [35]. This type of violence is pervasive in almost every healthcare setting and often stems from patients' frustration over hospital processes, perceived inadequate care, or dissatisfaction with medical outcomes [36-38]. Several studies highlighted that verbal abuse was the most frequently reported type of WPV, affecting 51.8% to 63.4% of HCWs annually [10, 39]. Finally, psychological violence includes bullying, harassment, and intimidation [33]. This form of violence usually occurs in healthcare settings due to several factors such as inadequate management of WPV, negative workplace culture, lack of trust, and high workloads [40, 41].

The impact of WPV on HCWs is wide-ranging, affecting their physical and mental well-being, as well as their work performance and job satisfaction [7]. Physical violence, in its most immediate form, results in injuries ranging from minor bruises to severe trauma which may require medical attention or extended leave [42, 43]. Psychological impacts of WPV on HCWs are equally, if not more, profound. HCWs exposed to WPV often suffer from chronic stress, anxiety, depression, and, in some cases, PTSD [44, 47]. The cumulative psychological impact of repeated exposure to violence leads to high levels of burnout, characterised by emotional exhaustion, depersonalisation, and reduced personal accomplishment [48].

These psychological effects not only diminish HCWs' quality of life but also directly impact their job performance. HCWs experiencing WPV are more likely to disengage from work, exhibit reduced motivation, and make errors in patient care [49]. Repeated exposure to violence may also lead to HCWs considering to leave their profession entirely, which may exacerbate the existing shortages of qualified healthcare professionals [50].

WPV also has far-reaching consequences for healthcare organisations and undermines the overall functioning of healthcare institutions. Persistent violence leads to low employee morale, increased absenteeism, and high turnover rates, all contributing to operational inefficiency [51]. Recruitment and training costs rise as organisations are forced to replace staff who leave due to violence-related burnout or dissatisfaction. Moreover, the quality of patient care deteriorates as HCWs struggle to maintain focus and perform effectively in hostile work environments [52]. Ultimately, WPV presents a critical challenge to healthcare systems, requiring comprehensive strategies to address its immediate and systemic causes.

3.2 The emergence of psychosocial safety climate and its significance in healthcare settings

PSC, a facet-specific dimension of organisational climate, emerged a decade ago to explain psychosocial risks and psychological health and injuries [22]. PSC refers to the collective perceptions of organisational policies, practices, and procedures that prioritise psychological health and safety [18]. It is rapidly becoming more widely recognised as a crucial workplace aspect in enhancing workers' psychological well-being and safety across industries, as it is able to substantially influence workers' mental health, safety, and performance [22].

Four basic dimensions define PSC [22]. Firstly, management prioritises workers' psychological well-being in situations where organisational productivity and workers' safety have conflicting demands. Secondly, management commits strong emphasis on safeguarding workers' mental health and wellbeing by resolving issues quickly and assertively. Thirdly, effective and efficient communication between the organisation and its workers with respect to psychological well-being and safety is reflected in organisational communication. Lastly, organisational participation is encouraged where every member of the organisation takes part in and contributes towards the protection of psychological health in the organisation.

Under the PSC theory, a high PSC organisation is an organisation where workers are assured to voice their problems and perceive that the organisation will take a supportive course of action when faced with risks [18]. Evidence suggests that PSC is both an antecedent and moderator of the work stress process [22]. As an antecedent of the work stress process, PSC directly influences unfavourable work conditions that lead to psychological health problems among workers [22]. This includes phenomenon such as workplace bullying, harassment, and WPV. Indeed, studies conducted in Australia and Taiwan reported that organisations with low PSC are significantly associated with exposure to WPV [53, 54]. Meanwhile, a study conducted in Pakistan found that safety climate had a significant and negative impact on WPV among HCWs [55].

As a moderator of the work stress process, high PSC acts as a protective buffer against the negative effects of high job demand and high-pressure work environment, including stress and burnout [56]. Indeed, the influence of PSC is shown to be particularly relevant in healthcare, a sector known for its high-stress work environment. Numerous studies have demonstrated how PSC can improve the well-being, safety, and overall performance of HCWs [17, 55, 57-61]. For instance, a study in Australia explored the factors shaping PSC in healthcare and found that organisations with high PSC provide better support systems for their workers, enhancing their perceived safety and psychological health [57]. Meanwhile, HCWs in China was shown to benefit from high PSC in their workplaces as it reduced stress and helped prevent burnout [58]. One study conducted in Italy showed that high PSC negatively impacted emotional exhaustion among HCWs [59], while another demonstrated that high PSC allows the establishment of a working environment perceived as safe by workers, thereby reducing psychological distress from work stressors [60].

3.3 Level of psychosocial safety climate in healthcare settings

Relative to other theoretical constructs, there are presently limited studies conducted on PSC, which is not unexpected given that it is a relatively new construct that was first introduced in 2010. A recent scoping review revealed that research on PSC were largely conducted in Australia, Malaysia, and Canada, and that more studies from both developed and developing nations are required in the future [17].

Several studies have demonstrated a trend of low PSC scores within healthcare settings across various countries [54, 62]. This suggests that many healthcare organisations may still not prioritise their workers' psychological well-being, potentially exposing them to higher levels of stress, burnout, and WPV. In addition, the present pool of studies on PSC suggests that the level of PSC vary significantly across countries and healthcare systems, and is influenced by organisational, cultural, and systemic factors. For example, comparisons of PSC scores between Taiwanese, Iranian and Australian HCWs revealed that HCWs in Taiwan and Iran perceived significantly lower PSC scores than their Australian counterparts [54, 63]. This disparity highlights the role of cultural and systemic factors in shaping PSC and suggests that interventions to improve PSC need to be tailored to the local context.

3.4 Healthcare workers' coping mechanisms in the face of workplace violence

In the event of WPV, previous studies suggest that HCWs employ various coping mechanisms to cope with their experience of WPV. These mechanisms largely comprised problem-focused coping, emotion-focused coping, and dysfunctional coping [64-66].

Problem-focused coping involves direct actions to solve or mitigate the issue, such as reporting incidents and or attempting to de-escalate the situation. Studies have shown that HCWs, particularly doctors and nurses, favour problem-focused coping as they perceive the stressor to be manageable and believe that direct action can lead to a resolution [67, 68]. This choice is influenced by their interpersonal skills and perceived organisational support [69-71]. Problem-focused coping has been associated with better mental health outcomes among HCWs [71-73].

Emotion-focused coping, on the other hand, involves managing the emotional response to the stressor rather than addressing the root cause of the problem. This may include seeking social support and employing self-calming techniques. According to previous studies, HCWs often adopt this coping

mechanism when they perceive high job demand and negative mood [74]. Interestingly, though this style of coping does not resolve problems, it has been linked to positive mental health outcomes in studies conducted in Japan, Thailand, and Korea, particularly among nurses [75]. This suggests that different cultural contexts may shape the coping mechanism that HCWs find most effective.

Finally, dysfunctional coping involves maladaptive strategies that provide short-term relief but do not help deal with the stressor such as denial and behavioural disengagement [76, 77]. HCWs may adopt this coping mechanism when they perceive an inability to control or change the stressor [78, 79], as it allows them to escape and disengage from stressful situations, particularly in high-stress work environments [80]. Previous studies examining dysfunctional coping mechanisms among HCWs who had experienced WPV have indicated that this form of coping is associated with adverse outcomes, such as PTSD and anxiety [66, 81].

3.5 The role of psychosocial safety climate in reducing workplace violence in healthcare settings

The theory behind PSC is based on Dollard and Bakker's (2010) Extended Job Demands-Resources Model [18]. According to this model, PSC is an upstream organisational resource which precede psychosocial working conditions (both job demands and resources), which in turn predict psychological health and work outcomes via its moderating and mediating effects [18]. Therefore, PSC is seen as directly influential on psychosocial risk factors such as high emotional demands, a resultant condition commonly associated with WPV events [82]. The authors argue that these psychosocial risk factors may prevail at workplaces due to lack of management policies, procedures, and practices aimed at ensuring that job demands are maintained at manageable levels [18].

As illustrated in Figure 1, in the context of WPV, it is hypothesised that a high PSC workplace will demonstrate management priority and commitment to workers' health and safety and put into place WPV policies and procedures such as zero tolerance to WPV policy, psychosocial risk assessments, and investigation and management of WPV incidents. Such policies and procedures will subsequently reduce the prevalence of WPV incidents, reduce the emotional demands of work, and safeguard HCWs' psychological health. Meanwhile, supportive organisational practices that centre on organisational communication and participation such as implementing WPV reporting procedures, training of all levels of staffing on techniques to recognise WPV, and offering debriefing for HCWs who experience WPV is hypothesised to allow HCWs to utilise these organisational resources, leading to maintenance of positive work outcomes.

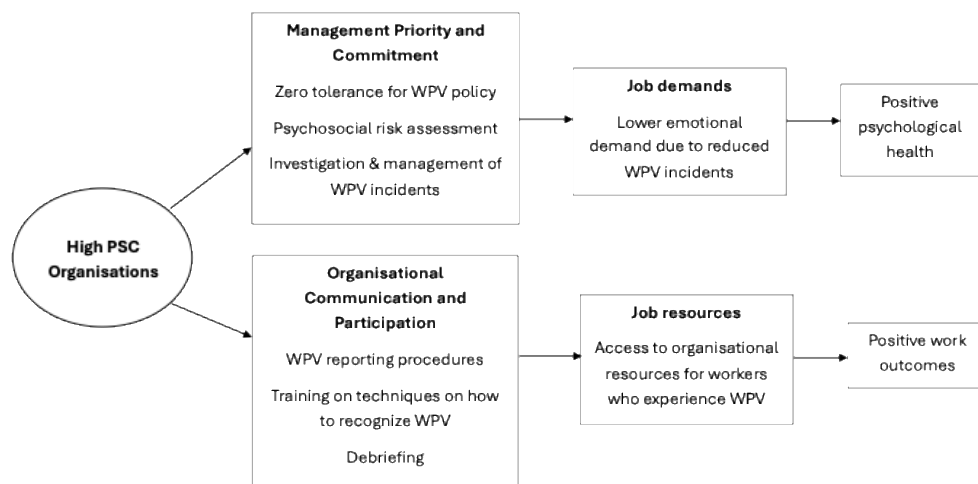


Fig.1 The hypothesised direct influence of psychosocial safety climate (PSC) on workplace violence (WPV) based on Dollard and Bakker (2010) Extended Job Demands-Resources Framework

Indeed, this review identified one study examining the relationship between PSC and WPV, in which the findings demonstrated that high PSC was linked to a lower incidence of WPV among hospital nurses [54]. This was suggested by the authors to be attributed to better workplace policies, practices, and procedures, as well as HCWs being more willing to communicate their concerns and have their concerns being listened to in high PSC healthcare settings.

3.6 The role of psychosocial safety climate in moderating the effect of workplace violence among healthcare workers through coping mechanism

Lazarus and Folkman's (1984) Transactional Model of Stress and Coping conceptualises stress and coping as a process based on changing cognitive appraisals, where stress is a product of primary and secondary appraisals [23]. During primary appraisals, individuals appraise the demands of the stressor, whereas in secondary appraisals, they appraise their own resources for coping with those demands [23]. The individuals then initiate a strategy for coping, which then determines the coping outcomes.

As illustrated in Figure 2, based on the Transactional Model of Stress of Coping [21], it is hypothesised that when HCWs are exposed to stressors such as WPV, they appraise the organisational resources available to them. This includes a high PSC organisation and its associated policies, procedures, and practices to relieve workplace pressures, enhance work input, and reduce psychological harm [18, 83, 84]. When these resources are perceived as sufficient, workers are more likely to feel supported and engage in adaptive coping when exposed to WPV, thus leading to reduced stress and improved psychological and work outcomes. Indeed, problem-focused and emotion-focused coping have been shown to reduce burnout and promote resilience among HCWs during the COVID-19 pandemic [85-87]. In addition, though studies conducted in Egypt and China indicate that HCWs who experienced WPV were more likely to engage in problem-focused coping and report the incident to management if their organisation had a formal system in place for addressing WPV [88-91], the utilisation of these reporting mechanisms by workers depends on the level of PSC in the organisation. As shown by a study in USA, workers in low PSC environments were reported as being less likely to report incidents due to fear of reprisal or inaction from management [92]. Therefore, a perception of high PSC may encourage HCWs to access and utilise existing organisational resources such as WPV reporting procedures established in the workplace, thereby engaging in more adaptive coping mechanism against WPV.

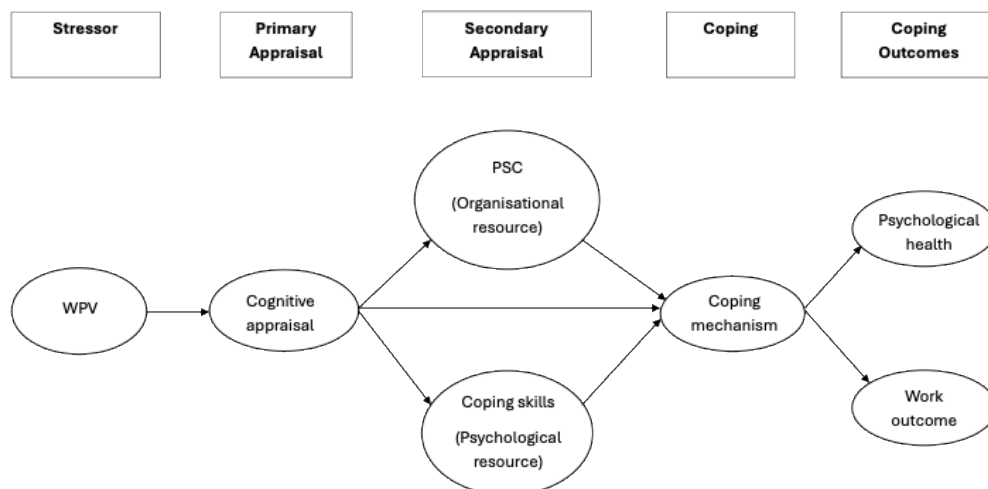


Fig. 2 The hypothesised moderating effect of psychosocial safety climate (PSC) on workplace violence (WPV) through healthcare workers' coping mechanism based on the Transactional Model of Stress and Coping

Concurrently, based on the Transactional Model of Stress of Coping [21], it is hypothesised that when HCWs are exposed to stressors such as WPV, they also appraise their coping skills, which subsequently determine their coping mechanisms. Coping skills, which consist of psychological resources, enhance an individual's ability to choose adaptive coping mechanisms that can improve psychological well-being [93]. Self-efficacy, an important psychological resource, encourages proactive, problem-focused coping such as modifying the stressor or seeking solutions, while resilience supports emotion-focused coping by enabling individuals to adapt to stressors that cannot be changed to maintain emotional stability [94]. Indeed, previous studies have demonstrated that these psychological resources positively influence coping mechanisms, with self-efficacy and resilience reducing the likelihood of maladaptive coping such as avoidance [95, 96].

Though no studies examining the influence of PSC on coping mechanism for WPV were identified in this review, two studies have demonstrated the influence of PSC on coping in the context of workplace bullying, another form of workplace deviant behaviour [97, 98]. These studies suggest that workers in organisations with high PSC are more likely to engage in more adaptive responses to workplace bullying, including reporting incidents, seeking supervisor support, and utilising available mental health resources [97]. In contrast, low PSC environments were reported to foster dysfunctional coping mechanism among workers experiencing workplace bullying, including neglect, avoidance, or withdrawal from the situation, leading to poor psychological health and work outcomes among workers [98]. In addition, though not directly related to PSC, research on HCWs' coping mechanisms in the context of WPV suggests the coping mechanisms used by HCWs in response to WPV are often influenced by the level of organisational support they perceive as well as the coping skills that they have [99, 100]. In this regard, structural and procedural organisational support measures including clear reporting procedures for WPV incidents, prompt managerial response, access to counselling services, and training on conflict de-escalation can assist HCWs in assuming adaptive coping strategies such as problem-focused or emotion-focused coping [101-103].

3.7 Limitations of existing literature

At present, there is a lack of empirical research directly linking PSC with WPV as well as PSC with the coping mechanisms of workers experiencing WPV. In relation to the role of PSC in reducing WPV, the evidence remains scarce, with only a few studies specifically addressing WPV as a distinct outcome [19]. There is also limited data from low- and middle-income countries, further highlighting the need for future studies in diverse geographic contexts. Meanwhile, with regards to the role of PSC in moderating the effect of WPV through workers' coping mechanism, existing studies primarily address the role of PSC in reducing job-related psychosocial risks [17, 19, 104], and does not specifically examine how PSC influence workers' coping mechanisms in response to WPV incidents. This presents a critical knowledge gap and hinders the development of effective WPV interventions that may leverage on workers' coping mechanisms. In addition, many studies rely on cross-sectional designs, which, while helpful in determining associations, are inadequate for establishing causality between the constructs of interest, i.e. PSC, WPV, and coping mechanisms.

3.8 Recommendations and future directions

The PSC of organisations is potentially modifiable and amenable to actions from healthcare policymakers and managers committed to safeguarding the health, safety, and well-being of HCWs. To effectively integrate PSC into healthcare organisations, a multi-faceted approach is essential. This involves implementing a combination of strategies at three levels: the organisational level, the interface between the organisation and workers, and the individual level [105].

At the organisational level, organisational leadership commitment is vital [106]. PSC should be embedded in organisational policies, supported by clear guidelines that address issues such as WPV, stress, and HCWs' safety, health, and well-being. Regular training for healthcare managers and periodic

monitoring of PSC indicators will further strengthen these organisational efforts. These indicators include management's commitment to psychological health, management's priority of psychological health, organisational communication, and organisational participation [107] that can be monitored using surveys such as PSC-12 questionnaire to pinpoint areas needing improvement and enabling proactive interventions before psychosocial risks escalate [82, 108, 109]. In addition, "zero-tolerance" campaigns to promote mutual respect and discourage verbal or physical aggression from patients and their relatives should be implemented [110]. Engaging patients and their family members in violence prevention efforts is crucial, and studies have shown that educating patients and visitors on acceptable behaviours within healthcare settings can reduce incidents of WPV [110, 111]. For instance, patient leaflets and hospital signage on "zero tolerance" policies can help set the public expectations and boundaries [111].

At the organisation-worker interface, fostering effective communication channels and implementing WPV reporting procedures are important [112]. Involving HCWs in decision-making processes and providing accessible conflict-resolution mechanisms can help promote collaboration and trust. Finally, at the individual level, initiatives such as coping skills training, WPV training, debriefings, and access to support programs can empower HCWs and enhance overall employee morale [113].

Future studies may include longitudinal studies that can establish the role of PSC as both an antecedent and buffer for WPV among HCWs, as well as ascertain how PSC influences specific coping mechanisms among HCWs experiencing WPV. In addition, employing a mixed-method approach may be beneficial to explore this relationship by triangulating quantitative data on PSC, WPV, and HCWs' coping mechanisms with qualitative insights into their experiences in healthcare settings characterized by high and low PSC. Understanding these dynamics could help shape future policies and contribute towards the development of targeted, PSC-driven interventions to reduce WPV and promote healthier coping mechanisms among HCWs.

4. CONCLUSION

Existing evidence relating to PSC and its influence in healthcare settings suggest its potential importance in preventing and mitigating WPV. A high PSC has been implied to not only reduce the occurrence of WPV in organisations, but also fosters work environments where HCWs are more likely to adopt adaptive coping mechanisms against WPV. Ultimately, building a strong climate for psychological health and empowering HCWs may be a viable strategy to address WPV in healthcare settings.

5. ACKNOWLEDGEMENTS

The authors would like to acknowledge the support of Universiti Teknologi MARA (UiTM), Cawangan Selangor, Kampus Sungai Buloh and Faculty of Medicine, Universiti Teknologi MARA, Sungai Buloh, Selangor, Malaysia for providing the facilities and support on this research.

6. GENERATIVE A.I DISCLOSURE STATEMENT

During the preparation of this manuscript, the authors used ChatGPT to refine the language and improve the readability of the text. Following the use of this tool, the authors thoroughly reviewed, edited, and verified all content to ensure accuracy. The authors retain full responsibility for the originality, scientific integrity, and final content of the published work.

7. CONFLICT OF INTEREST

The authors agree that this research was conducted in the absence of any self-benefits, commercial or financial conflicts and declare the absence of conflicting interests with the funders.

8. AUTHORS' CONTRIBUTIONS

M.H.A.F: Conceptualisation, methodology, formal analysis, and writing - original draft. E.Z.S: Conceptualisation, methodology, supervision, and writing - review and editing. N.N.A: Supervision, writing - review and editing. A.N.A: Supervision, writing - review and editing.

9. DATA AVAILABILITY

Data sharing is not applicable to this article as no new datasets were generated or analysed during the current study.

10. ETHICS STATEMENT

This study was reviewed and approved by the Medical Research and Ethics Committee (MREC), the Ministry of Health Malaysia [NMRR ID-24-02659-QKF(IIR)] and the UiTM Research Ethics Committee [REC/10/2024 (PG/MR/492)].

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