

Violence against psychiatric trainees from Asian countries: A pilot online survey

Arpit Parmar, Sundar Gnanavel¹, Ahmet Gürcan², Yugesh Rai³, Utkarsh Karki⁴, Mariana Pinto da Costa^{5,6}, Anna Szczegielniak⁷, Victor Pereira-Sanchez^{8,9}

Department of Psychiatry, All India Institute of Medical Sciences, Bhubaneswar, Odisha, India, ¹Consultant Psychiatrist, Monkwearmouth Hospital, Sunderland SR51 NB, United Kingdom, ²Department of Psychiatry, Başkent University Faculty of Medicine, Ankara, Turkey, ³Psychiatry Trainee, Essex Partnership University NHS Trust, Essex, United Kingdom, ⁴Child and Adolescent Psychiatry Unit, Kanti Children's Hospital, Nepal, ⁵Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK, ⁶Institute of Biomedical Sciences Abel Salazar, University of Porto, Porto, Portugal, ⁷Department of Psychoprophylaxis, Faculty of Medical Sciences in Zabrze, Medical University of Silesia, Katowice, Poland, ⁸Department of Child and Adolescent Psychiatry, New York University Grossman School of Medicine, New York, NY, USA, ⁹Department of Psychiatry and Clinical Psychology, University of Navarra Clinic, Pamplona, Spain

ABSTRACT

Background: Violence against psychiatry trainees is an important issue to the medical profession. However, this matter has been under researched, especially in Asian countries.

Aim: We aimed to explore the rates and factors associated with violence against psychiatric trainees in Asian countries.

Methods: An online, 15 item cross sectional pilot survey was designed and disseminated among psychiatric trainees in Asia through the World Network of Psychiatric Trainees, national and local networks of trainees, and social media. The questionnaire sought to enquire about the experience of physical, verbal, and sexual assaults and its impact. Data were analyzed using Statistical Package for the Social Sciences (SPSS) V20.0.

Results: A total of 467 responses were obtained from psychiatric trainees in 16 countries in Asia. More than two thirds of participants ($n = 325$, 69.59%) reported a history of assault. Psychiatry inpatient units were the most common setting ($n = 239$, 73.54%). A relatively lower proportion of participants from the East Asian countries reported an assault, compared to other countries ($\chi^2 = 13.41$, $P = 0.001$). Sexual assault was more common among women compared to men ($\chi^2 = 0.94$, $P = 0.002$).

Conclusion: Violence against psychiatric trainees seems common across Asian countries. Our findings call for further systematic investigation of the phenomenon and suggest the need to develop programs to protect psychiatric trainees against the threat of violence and its subsequent psychological complications.

Key words: Assault, psychiatry, trainee, violence

Address for correspondence: Dr. Anna Szczegielniak, Department of Psychoprophylaxis, Medical University of Silesia in Katowice, ul. Pyskowicka 49, 42-612 Tarnowskie Gory, Poland.

E-mail: anna.szczegielniak@sum.edu.pl

Submitted: 10-Apr-2022, **Revised:** 18-Jul-2022, **Accepted:** 13-Oct-2022, **Published:** 03-Mar-2023

Access this article online	
Website: www.indianjpsychiatry.org	Quick Response Code 
DOI: 10.4103/indianjpsychiatry.indianjpsychiatry_256_22	

This is an open access journal, and articles are distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as appropriate credit is given and the new creations are licensed under the identical terms.

For reprints contact: WKHLRPMedknow_reprints@wolterskluwer.com

How to cite this article: Parmar A, Gnanavel S, Gürcan A, Rai Y, Karki U, Pinto da Costa M, *et al.* Violence against psychiatric trainees from Asian countries: A pilot online survey. Indian J Psychiatry 2023;65:373-80.

INTRODUCTION

Workplace violence (WPV) is defined as any incident in which a person is abused, threatened, or assaulted in circumstances related to their work, including verbal abuse and threats as well as physical or sexual assaults.^[1] WPV has been reported to be common in hospital settings.^[2]

A review of WPV in health-care settings over the last two decades demonstrated that most studies on this topic have focused on the occurrence rate, risk assessment, and management, while fewer studies have focused on assessing the psychological consequences of WPV.^[1] WPV may result in a lack of job satisfaction, issues with recruitment and retention, and lowered health-related quality of life. In particular, trainee doctors in psychiatry feel less safe at work, probably because of less experience, high clinical exposure, out-of-hours service, and difficulties in accessing colleagues to carry out joint assessments.^[3]

Most of the studies on health-care WPV are from North America and Western Europe. Of the studies carried out in Asia, most are from East Asian countries, and the focus has been on the WPV experienced by nurses.^[4] So far, such studies focusing on mental health professionals from Asia have not been carried out.

The objectives of this study were (a) to explore the extent of violence against psychiatric trainees in Asian countries; (b) to identify the common settings in which this violence occurs, its physical and psychological impact, and trainee-reported individual and institutional management of violent episodes; and (c) to explore the potential differences in violence experienced related to victim's characteristics such as gender, psychiatry specialty, and training experience.

MATERIALS AND METHODS

Study design: The study was a part of a larger international online survey entitled "Violence Against Psychiatric Trainees (VAPT) study." The VAPT survey was a cross-national survey designed by trainees of the European Federation of Psychiatric Trainees (EFPT) Research Working Group and distributed across all continents.^[5]

Study instrument: The survey was conducted using a bespoke tool for the purpose of this project [Appendix 1]. The tool consisted of 15 close-ended multiple-choice questions. The questions sought to gather demographic, training-related, and assault-related variables. Based on previous studies, assaults were subclassified into three types: physical, sexual, and verbal (definitions provided in the appendix). The survey tool was not pretested and validated. However, the usability and functionality of the tool were tested before the actual data collection started. In addition to English, this survey was disseminated in Chinese (after a translation-back

translation process) to improve acceptability in mainland China.

Study procedure: Those physicians who were currently in psychiatry training in countries of the United Nations region of Asia were included in the study after an electronic consent was obtained from them. The study followed a convenience snow-ball sampling method. The survey followed an open survey approach. No personal information of the participants was collected or stored. SurveyMonkey platform was used for data collection purposes, except in mainland China, where manual collection through email was used. As per the local needs, we adjusted the data collection method. The survey was disseminated among psychiatric trainees in Asian countries through various online communication channels, including email, Facebook, Twitter, and other messaging apps, harnessing the reach of the World Network of Psychiatric Trainees. Participation in the study was voluntary, and no incentive was provided. The 15 questionnaire items were not randomized and were presented in the same screen. However, to reduce the number/complexity of the questions, adaptive questioning of items and a skip pattern was used. Completeness check was performed before submission. However, respondents were not allowed to review and change their answers. The survey platform would prevent users from re-entering the form using the same navigator and user. Data were collected over 2 years, between June 2018 and August 2020. The results are being reported in accordance with the Checklist for Reporting Results of Internet E-Surveys (CHERRIES) of the Enhancing the Quality and Transparency Of health Research (EQUATOR) network.^[6]

Data analysis: Data were analyzed using Statistical Package for the Social Sciences (SPSS) V20.0. Descriptive analysis was performed using mean, standard deviation, frequency, percentage, median, and interquartile range (IQR), as appropriate. Group comparisons were performed using the Chi-square test, Fisher's exact test, independent sample *t*-test, or Mann-Whitney U (MWU) test, as appropriate. A *P* value of <0.05 was considered significant.

Ethical aspects: The study was reviewed and approved by the Research Ethics Committee of the University of Navarra (Pamplona, Spain; ID 2019.083). Participants' identities were maintained confidential, and no personal identifying details were collected. No one except the investigators had access to the data. The study protocol is registered at the Open Science Framework (osf.io/6z4qy).

RESULTS

Sample characteristics

A total of 467 responses were obtained from psychiatric trainees in 16 countries in Asia (data on view, participation, or completion rates are not available). Around 59.32% of total responses were received from India, Bangladesh, and

the People's Republic of China [Table 1]. The participants' characteristics are summarized in Table 1.

Characteristics of WPV

Characteristics of WPV are summarized in Table 1. A total of 325 (69.59%) participants reported a history of assault. Psychiatry inpatient wards/units were the most common setting where assaults took place ($n = 239$, 73.54%).

The majority of participants did not report the assault to any authority ($n = 182$, 56.00%), while 53 (16.31%) participants reported the assault, and measures were taken. Feelings of anxiety, rage, and sadness were the most commonly reported consequences of the assault ($n = 165$, 50.77%). Only a minority of participants reported that training was being provided in their respective hospitals to prevent and manage episodes of aggression, or that there was an established protocol for aggression prevention and management in their hospitals [Table 1].

Variables associated with WPV

Participants with a history of an assault ($n = 325$, 69.59%) were compared with participants with no history of assault ($n = 142$, 30.41%) [Table 2]. Those with a history of assault were more advanced in their psychiatry training (MWU = 18140, $P < 0.001$). However, a relatively lower proportion of study participants from the East Asian countries reported an assault ($\chi^2 = 13.41$, $P = 0.001$) compared to participants from other countries.

Gender differences in assault characteristics

The number of assaults was similar across men (46.77%) and women (53.23) participants ($\chi^2 = 4.83$, $P = 0.09$). Sexual assault history was more commonly reported by the women participants ($\chi^2 = 0.94$, $P = 0.002$). Significantly more women participants reported anxiety, rage, and sadness after an assault ($\chi^2 = 9.93$, $P = 0.002$).

DISCUSSION

This is the first multinational study exploring the phenomenon of violence against psychiatric trainees in Asia. This study was carried out concomitantly in Europe (and globally) by the same research group.^[5] Despite its pilot nature, our results showing that around 70% of psychiatric trainees experienced violent assault, while 62% reported recent violence in the past 12 months warrant both further study and immediate action. As expected, verbal WPV was the most common form experienced, similar to previous studies from Western Europe and North America.^[5,7,8] It is also in line with a recent meta-analysis which reported a 64.9% 12-month prevalence of WPV among (all) health-care workers in Asian countries.^[9]

Almost 48% of the trainees reported a physical assault. This is again in line with previous studies reporting that

25%–56% of trainees experience physical WPV.^[10] The rates were similar across genders, similar to what is reported in the existing literature. However, sexual assault was more commonly reported by female trainees, consistent with a previous study.^[7] Psychiatric inpatient units and emergency units were the most common settings where the assault occurred. This is again in concurrence with previous studies,^[5] and the evidence is similar for WPV experienced by other clinical professionals.^[4,8]

Only one in five trainees reported an established protocol being in place in their respective hospitals for reporting violence. Only around 17% of trainees reported the assault to the authorities. Previous studies have also highlighted the lack of existence/awareness of training and reporting protocols for WPV. This is compounded by the popular misconception that WPV is a “normal” experience in mental health service provision.^[11] Similarly, lack of training for staff and aggression management plans at their institutions or being unaware of their existence was cited as a common theme among mental health trainees in Europe.^[5]

Of interest is the high proportion of psychiatric trainees experiencing WPV in South/South-East Asia. Differences in psychiatric training pathways, service models in mental health, and cultural differences might explain this significant variation.^[12] However, it is possible that the heterogeneity in recruitment and the sampling framework might be the contributing factors.

This study has some inherent limitations in methodology and scope. Our non-probabilistic sampling design based on an online survey may have contributed to selection bias and, therefore, lack of representativeness. The lack of cross-national databases and publicly available figures of psychiatric trainees' workforce in Asia precluded random sampling. The survey tool, which was used in European countries, was not prevalidated in Asia. Also, the distribution of responses across countries in Asia was heterogeneous and lacked statistical power for comparisons. The cross-sectional design is vulnerable to recall bias, and hence, we cannot infer causal associations. We did not explore the characteristics of perpetrators or the variable intensity of abuse episodes. The questionnaire was designed and disseminated only in English and Chinese, which might have limited participation. Within Asia, there are significant regional and national differences in psychiatric training, which have not been considered while interpreting our data. Data about the view rate, completion rate, and participation rates are not available. Notwithstanding these limitations, we were able to obtain one of the largest and widest samples of psychiatric trainees in Asia. Our findings are consistent with previously referenced studies.^[13,14] The low proportion of trainees reporting abuse and the lack of protocols around institutional training for staff are possible areas for improvement.

Table 1: Total responses obtained, sociodemographic variables, and characteristics of violence against participants

Variable	n (%) / mean (SD)
Response rate per country (n=467)	
India	125 (26.77)
Bangladesh	87 (18.63)
People's Republic of China	65 (13.92)
Thailand	34 (7.28)
Nepal	30 (6.42)
Myanmar	25 (5.35)
Indonesia	21 (4.50)
Japan	19 (4.07)
Pakistan	15 (3.21)
Sri Lanka	14 (2.99)
Malaysia	13 (2.79)
Hong Kong Special Administrative Region of the People's Republic of China	7 (1.49)
Philippines	4 (0.86)
Republic of China	4 (0.86)
Singapore	3 (0.64)
Vietnam	1 (0.22)
Socio-demographic variables (n=467)	
Age (in years)	30.15 (4.22)
Gender	
Male	221 (47.32)
Female	246 (52.68)
Training completed	
0-25%	164 (35.12)
26%-50%	99 (21.20)
51%-75%	81 (17.34)
76%-100%	123 (26.34)
Specialty	
General psychiatry	377 (80.73)
Child and adolescent psychiatry	77 (16.49)
Other specialties (such as addiction, neuropsychiatry, and consultation-liaison psychiatry)	13 (02.78)
Characteristics of violence against participants (n=467)	
History of assault (ever)	
Yes	325 (69.59)
No	142 (30.41)
Number of assaults (among those with a history of assault ever) ^a	
Once	83 (25.54)
2-5	185 (56.92)
>5	57 (17.54)
Last assault ^a	
Within last year	202 (62.15)
More than 1 year before	123 (37.85)
Type of assault reported ^{a,b}	
Verbal	269 (82.77)
Sexual	27 (8.31)
Physical	154 (47.38)
Clinical settings where such assault happened ^{a,b}	
Emergency department	122 (37.53)
Psychiatry inpatient unit/ward	239 (73.54)
Outpatient unit	117 (36.00)
Community setting	8 (2.46)
Other places	4 (1.23)
Have you reported any of this/these assault(s) to any authority? ^a	
No, it would be unnecessary (not severe/significant enough)	182 (56.00)
No, it would be useless ("I don't believe that would change anything")	53 (16.31)
Yes, and measures were taken	53 (16.31)
Yes, but measures were not taken	41 (12.62)
Did you call the police or another security officer/guard to help or report the assaults in these cases? ^a	
Yes	113 (34.76)
No	212 (65.24)

Contd...

Table 1: Contd...

Variable	n (%) / mean (SD)
What kind of impact has these assaults have on you? ^{a,b}	
Minor physical injuries	45 (13.85)
Major physical injuries (requiring any medical assistance)	1 (0.31)
Feelings of anxiety and/or rage and/or fear	165 (50.77)
Feelings of sadness and/or guilt and/or other depressive symptoms	48 (14.77)
Feelings of lack of support from your institution	51 (15.69)
Serious ideas about leaving your work in mental health	62 (19.07)
Serious ideas about leaving your work in medicine	15 (4.62)
Other psychological distress	7 (2.15)
No impact	88 (27.08)
Is there any training for the staff in your hospital to prevent and manage the aggressions from patients?	
No	242 (51.83)
Yes	173 (37.04)
I don't know	52 (11.13)
Is there any established plan in your hospital to be followed in case of suffering aggressions from patients?	
Not at all.	106 (22.70)
Some actions are usually taken, such as debriefing and defusing, but there is not an established protocol	207 (44.33)
There is an established protocol to be followed	83 (17.77)
I don't know	70 (14.99)
Other	1 (0.21)

^an=325. ^bMore than one response tolerated

Table 2: Comparison of participants with and without history of assault (n=467)

Variable	Participants with history of assault (n=325) Mean (SD)/n (%) / median (IQR)	Participants with no history of assault (n=142) Mean (SD)/n (%) / median (IQR)	t (df) / Chi-square (df) / MWU; P
Age ^a	30.52 (3.92)	29.32 (4.74)	2.85 (464); 0.005**
Psychiatry training completed ^b			
Up to 25%	96 (29.54)	68 (47.89)	16.36 (3); 0.001**
26%-50%	71 (21.85)	28 (19.72)	
51%-75%	60 (18.46)	21 (14.79)	
76%-100%	98 (30.15)	25 (17.60)	
Psychiatry training completed ^c	50.00 (81.50-20.00)	31.00 (68.00-05.00)	18140; <0.001***
Gender ^b			
Male	152 (46.77)	69 (48.59)	0.13 (1); 0.71
Female	173 (53.23)	73 (51.41)	
Specialty ^b			
General psychiatry	263 (80.92)	114 (80.28)	0.49 (2); 0.78
Child and adolescent psychiatry	52 (16.00)	25 (17.61)	
Other specialties	10 (03.08)	3 (02.11)	
Training for aggression prevention and management in the hospital ^b			
Yes	126 (38.77)	47 (33.09)	1.36 (1); 0.24
No/I don't know	199 (61.23)	95 (66.91)	
Established protocol in case of violence present ^b			
Yes	52 (16.00)	31 (21.83)	2.30 (2); 0.31
Some actions are usually taken, but there is not an established protocol	147 (45.23)	60 (42.25)	
No/don't know/other	126 (38.77)	51 (35.92)	
Asian region ^b			
South Asia	195 (60.00)	76 (53.52)	13.41 (2) n; 0.001**
South-East Asia	78 (24.00)	23 (16.20)	
East Asia	52 (16.00)	43 (30.28)	

df=degree of freedom, IQR=interquartile range, MWU=Mann-Whitney U, SD=standard deviation. South Asia: Bangladesh, India, Nepal, Pakistan, Sri Lanka; South-East Asia: Indonesia, Malaysia, Myanmar, Philippines, Singapore, Vietnam, Thailand; East Asia: The Hong Kong Special Administrative Region of the People's Republic of China, Japan, The People's Republic of China, The Republic of China. ^at-Test. ^bChi-square test. ^cMW U-test

Future research should obtain accurate prevalence figures with probabilistic samples and validated instruments.^[15] The consequences of violence among victims, specific individual differences in the impact of violence, and risk/protective factors should be longitudinally studied. To address the

systemic factors perpetuating violence against trainees, national psychiatric associations and the Asian Federation of Psychiatric Associations (AFPA) can take the lead in formulating policies and mandating action at hospitals employing psychiatric trainees, particularly around

reporting and training related to handling workplace-based violence. This includes a need for mandatory processes and protocols in place as relevant to VAPT. An open and dynamic process of reporting and acting on concerns will significantly mitigate the risk of violence against psychiatric trainees.

Acknowledgement

The authors want to manifest their gratitude, first and foremost, to all survey participants, as well as to the colleagues who contributed to survey dissemination and translation, to the colleagues involved in other ramifications of the VAPT Study, to the European Federation of Psychiatric Trainees for hosting the initiative, and to the World Network of Psychiatric Trainees and national trainees' associations and networks involved in data collection.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

REFERENCES

- d'Ettorre G, Pellicani V. Workplace violence toward mental healthcare workers employed in psychiatric wards. *Saf Health Work* 2017;8:337–42.
- Mento C, Silvestri MC, Bruno A, Muscatello MRA, Cedro C, Pandolfo G, *et al.* Workplace violence against healthcare professionals: A systematic review. *Aggress Violent Behav* 2020;51:101381.
- Dibben C, O'Shea R, Chang R, Woodger J. Safety for psychiatrists – from trainee to consultant. *Psychiatr Bull* 2012;32:85–7.
- Altinbaş K, Altinbaş G, Türkcan A, Oral ET, Walters J. A survey of verbal and physical assaults towards psychiatrists in Turkey. *Int J Soc Psychiatry* 2011;57:631–6.
- Pereira-Sanchez V, Gürkan A, Gnanavel S, Vieira J, Asztalos M, Rai Y, *et al.* Violence against psychiatric trainees: Findings of a European survey. *Acad Psychiatry* 2022;46:233–7.
- Eysenbach G. Improving the quality of Web surveys: The Checklist for Reporting Results of Internet E-Surveys (CHERRIES). *J Med Internet Res* 2004;6:e34.
- Feinstein RE. Violence prevention education program for psychiatric outpatient departments. *Acad Psychiatry* 2014;38:639–46.
- Wu S, Zhu W, Li H, Lin S, Chai W, Wang X. Workplace violence and influencing factors among medical professionals in China. *Am J Ind Med* 2012;55:1000–8.
- Liu J, Zheng J, Liu K, Liu X, Wu Y, Wang J, *et al.* Workplace violence against nurses, job satisfaction, burnout, and patient safety in Chinese hospitals. *Nurs Outlook* 2019;67:558–66.
- Park M, Cho SH, Hong HJ. Prevalence and perpetrators of workplace violence by nursing unit and the relationship between violence and the perceived work environment. *J Nurs Scholarsh* 2015;47:87–95.
- Chen W-C, Hwu H-G, Lin Y-P, Leaoon Guo Y-L, Su T-S, Wang J-D. Workplace violence from psychiatric patients. *J Occup Saf Heal* 2010;18:163–76.
- Varghese A, Joseph J, Vijay VR, Khakha DC, Dhandapani M, Gigini G, *et al.* Prevalence and determinants of workplace violence among nurses in the South-East Asian and Western Pacific Regions: A systematic review and meta-analysis. *J Clin Nurs* 2021;31:798–819.
- Campbell JC, Messing JT, Kub J, Agnew J, Fitzgerald S, Fowler B, *et al.* Workplace violence: Prevalence and risk factors in the safe at work study. *J Occup Environ Med* 2011;53:82–9.
- Hostiuc S, Dermengiu D, Hostiuc M. Violence against physicians in training. A Romanian perspective. *J Forensic Leg Med* 2014;27:55–61.
- Escribano RB, Beneit J, Luis Garcia J. Violence in the workplace: Some critical issues looking at the health sector. *Heliyon* 2019;5:e01283.

APPENDIX 1

1. What is your country?
2. What is your age?
3. What is your gender?
 - a. Male
 - b. Female
 - c. Non-binary
4. Which is your psychiatry specialty of training?
 - a. General (adult) psychiatry
 - b. Child and adolescent psychiatry
 - c. Other official psychiatric specialties (please specify)
5. Which percentage of training have you already completed (i.e., completed years/total years of training; visual scale 0–100%)?
6. Have you ever been (physically, sexually, or verbally) assaulted (see definitions of assaults in the online survey header) by any patient while working as a psychiatric trainee in a mental health setting?
 - a. No (skip to question 14)
 - b. Yes (please continue with the next question)
7. How many times have you been assaulted in any of these ways?
 - a. Once
 - b. 2–5 times
 - c. More than 5 times
8. When did the last(s) assault(s) take place?
 - a. During the last year
 - b. More than a year ago
9. Which type(s) of assault(s) (see definitions) have you suffered? (check what applies)
 - a. Verbal
 - b. Sexual
 - c. Physical
10. In which clinical setting have you suffered this/these assault(s)?
 - a. Emergency department
 - b. Inpatient ward
 - c. Outpatient unit (clinic, hospital department, or other units)
 - d. Community settings (patient's home or other settings)
 - e. Other (please specify)
11. Have you reported any of this/these assault(s) to any authority?
 - a. No, it would be unnecessary (not severe/significant enough)
 - b. No, it would be useless ("I don't believe that would change anything")
 - c. Yes, and measures were taken
 - d. Yes, but measures were not taken
12. Did you call the police or another security officer/guard in these cases to help or report the assaults?
 - a. Yes
 - b. No
13. What kind of impact has these assaults have on you? (check all that apply)
 - a. Minor physical injuries
 - b. Major physical injuries (requiring any medical assistance)
 - c. Feelings of anxiety and/or rage and/or fear
 - d. Feelings of sadness and/or guilt and/or other depressive symptoms
 - e. Feelings of lack of support from your institution
 - f. Serious ideas about leaving your work in mental health
 - g. Serious ideas about leaving your work in medicine
 - h. Other psychological distress (please specify)
 - i. No impact

14. Is there any training for the staff in your hospital to prevent and manage the aggressions from patients?
- No
 - Yes
 - I don't know
15. Is there any established plan in your hospital to be followed in case of suffering aggressions from patients?
- Not at all
 - Some actions are usually taken, such as debriefing and defusing, but there is not an established protocol
 - There is an established protocol to be followed
 - I don't know
 - Other (please specify)