

## [Violence Against Social Work Professionals]

### Violence Against Social Work Professionals: A Systematic Review and Meta-Analysis

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## Abstract

**Objective:** Workplace violence (WPV) encompasses threats or acts of physical violence, harassment, or intimidation at work. Social workers are frequently exposed to significant WPV risk due to the nature of their work, so this review examines its prevalence. **Method:** This meta-analysis was reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA Statement) guidelines. A comprehensive search was conducted across six electronic databases. Primary research studies published from 1990 to 2024 that analyzed the prevalence of various forms of WPV against social workers were selected. We assessed study quality using the Joanna Briggs Institute (JBI) tool, and examined between-study heterogeneity using the  $I^2$  statistic. **Results:** We identified 34 independent studies from 14 countries, comprising a total of 44,907 social workers. The random-effects pooled prevalence estimate of non-physical WPV was 56.9% (95% CI [40.0, 73.6];  $I^2 = 98.9\%$ ), while for physical WPV it was 15.3% (95% CI [12.5, 18.1];  $I^2 = 99.9\%$ ). **Conclusion:** Non-physical and physical WPV against social workers is highly prevalent, with significant variation between countries, study location and time period.

**Keywords:** PRISMA, workplace violence, non-physical violence, physical violence, social workers

## **Violence Against Social Work Professionals: A Systematic Review and Meta-Analysis**

WPV refers to acts or threats ranging from harassment and verbal abuse to physical assault, as well as disruptive or intimidating behaviors on work premises, directed either at people at these sites, or elsewhere, but on duty (Centers for Disease Control and Prevention, 2021; Occupational Safety and Health Administration, 2017). The Occupational Safety and Health Administration recognizes four types of WPV: Type One-Criminal Intent; Type Two-Customer/Client/Patients; Type Three-Co-worker; and Type Four-Personal. Specifically, Type Two is aimed at employees by customers, users, patients, inmates, or any other person to whom a service is provided, which will be analyzed in this study.

Regarding the scope of the problem, according to the European Working Conditions Telephone Survey (Eurofund, 2021), approximately 13% of workers in the European Union experienced some type of adverse social behavior at work in 2021 (especially women and frontline workers), which represents an increase of approximately 10% compared to 2015, according to the European Working Conditions Survey (Eurofund, 2016). Although WPV has been documented in various sectors and groups of workers, it is especially common among health care and social services groups. In fact, workers in these sectors are up to *five times more likely* to suffer injuries than other employees (Bureau of Labor Statistics, 2022).

Moreover, the human services industries, such as health, social, and educational care, face a high risk of violence perpetrated by clients due to the nature of the delicate situations they deal with, such as caring for people in vulnerable situations. Social work stands out as a profession exposed to psychosocial risks, as workers are constantly called upon to deal with conflicts and dilemmas and help meet the needs of individuals with various problems (Sá & Azevedo, 2020).

When we talk about WPV, we can usually distinguish two categories: physical violence and non-physical violence (Tian et al., 2022), understanding physical violence as aggressive behavior, such as the use of bodily force, or using an object as a weapon to threaten or cause physical harm (Kagan, 2021). Non-physical violence is associated with the use of language intended to intimidate, instill fear, or undermine another person's self-image, psychological well-being, or professional reputation, either directly, in person, or through technological means, such as by phone or the Internet (Kagan, 2021).

Regarding the effects on the victim, both types might have similar consequences, leading to demoralization, depression, loss of self-esteem, and signs of post-traumatic stress among social workers (Balloch et al., 1998). It also affects work-related stress (Saleh et al., 2020), absenteeism (Shahjalal et al., 2023), and worker turnover (Chen et al., 2022), which can have a financial impact on individuals (De Puy et al., 2015). Other consequences of WPV, similar to those indicated by Lanctôt and Guay (2014) in their review, included physical injuries, pain, sleep disorders, feelings of helplessness, and symptoms like disturbing memories, flashbacks, avoidance, anger, fear, demotivation, and the consumption of alcohol and other drugs.

Despite it being suggested that both types of violence can have the same physiological effects, the legislative and social repercussions for the victims (the social workers) have historically been different, depending on whether the violence is physical or non-physical (Boafo et al., 2016). This may be because, for decades, only physical effects of violence were taken into account, overlooking those that were not tangible or physically identifiable, such as the psychological consequences arising from non-physical violence (Boafo et al., 2016).

Additionally, in care professions like Social Work, where verbal violence is the most common type of WPV (Lovašová, 2014), according to Shields and Kiser (2003), there is a

tendency to normalize cases of violence and minimize their consequences, based on the understanding that social workers must endure a certain level of verbal abuse as part of their profession. As Munobwa and colleagues (2023) indicate, when a social worker faces a verbally violent client, the professional finds himself or herself in a situation of dissonance, between protecting their integrity and reporting the client, which may result in the client no longer accessing social services and remaining in a vulnerable situation. This social, institutional, and personal dilemma makes the creation of intervention protocols more complex (Littlechild, 2005).

Thus, it is of great importance to raise awareness of this issue, which is already being reported locally, indicating that the prevalence of WPV among social workers is between 20% (Padyab et al., 2012) and 60% (Padyab et al., 2013). To our knowledge, only two reviews have delved into this aspect in the field of Social Work. Robson et al. (2014), in their review, presented exclusively descriptive results, noting that verbal attacks and threats were common towards social workers assisting children and family members. More recently, in his review, Vidal-Martí (2023) only included research carried out on social workers in Spain, also synthesizing the evidence in a descriptive way, without reporting on the grouped prevalence of WPV.

However, as far as we know, there has been no systematic review with meta-analysis of the prevalence of WPV against Social Work professionals that can provide a global perspective on the state of this issue and help promote common measures to address it. Thus, this review aims to find evidence of the prevalence of WPV among social workers, as well as the prevalence of both physical and non-physical violence, and associated variables at the international level (study location, reflection periods for victims, the country's income level categorization, study period, and quality assessment).

## **Method**

### **Review Design**

This meta-analysis was conducted and reported in accordance with the PRISMA statement (Page et al., 2021).

### **Literature Search and Bibliographical Sources**

The literature search focused on peer-reviewed scientific journal publications presenting estimates of the prevalence of violence directed at Social Work professionals in various areas of professional practice. This search included articles published from January 1990 until January 2024 in the following databases: Web of Science Core Collection (hereinafter referred to as WoS), Scopus, Social Work Abstracts, Social Services Abstracts, APA PsycInfo, and PubMed (MEDLINE). Additional studies were identified by examining other data sources, such as conference abstracts and minutes, expert papers, reference lists of related works previously published in Google Scholar (inserting background titles and using the “cited by” and “related articles” functions) and ResearchGate. Finally, the reference lists of the studies included were also examined for additional literature.

Core controlled vocabulary terms were identified in the Medical Subject Headings (MeSH) and included “social work,” “social worker,” “workplace violence,” and “exposure to violence.” Entry terms (e.g., synonyms) related to each keyword were also used. Finally, other free terms, such as “harassment,” “client violence,” and “occupational risks,” were identified by reviewing keywords from previous studies. All searches followed the PICO framework. For more details on the search process, see supplementary tables S1 and S2.

### **Study Selection Process**

The studies retrieved from each database were imported into the Mendeley Reference Manager (Reiswig, 2010) software in its version for Windows, eliminating duplicate references prior to their evaluation. Two blinded authors (AVA and AML) independently reviewed the titles and abstracts of the records. A study was selected for detailed examination if at least one of the authors deemed it potentially relevant based on its title or abstract. When relevance could not be determined from the title and abstract alone, the full text was reviewed. A third author (FCS), an expert in the field, resolved discrepancies or reasonable doubts about a study's relevance. In cases where the full-text review led to disagreements regarding a study's eligibility, consensus was reached among the authors. These discussions focused on the alignment of the study with the predefined inclusion criteria, as well as the study's rigor and relevance to the research objectives. If disagreement continued, the authors collectively revisited the criteria to ensure that decisions were grounded in the review's aims, facilitating a balanced and transparent consensus.

### ***Eligibility Criteria***

To include a study in this review, it had to meet each of the following Inclusion Criteria (I.C.): I.C.1: Primary research studies published in scientific journals (to ensure the quality, validity and reliability of the evidence used in this review); I.C.2: Studies whose samples were comprised of social workers, or other professionals if they included social workers and presented data disaggregated by professional profile; I.C.3: Studies on the prevalence of various forms of violence committed against social workers in workplaces. The Exclusion Criteria (E.C.) proposed were as follows: E.C.1: Studies that analyzed violence exclusively towards other professionals, or without presenting violence data disaggregated by professional profile; E.C.2: Studies whose analysis did not focus on specifically measuring the prevalence of client violence, or those presenting quantitative data not suitable for meta-analysis; E.C.3: Different studies that

used the same database in multiple publications (in these cases the most recent publication was selected, or that which presented the most complete data); and E.C.4: Validation/analysis studies of the psychometric properties of instruments.

### ***Quality of Studies Included***

The 34 studies eligible for inclusion in this review were assessed for methodological quality using the JBI-Qualitative Critical appraisal tool for prevalence studies (Munn et al., 2014b). This instrument has recently been used to evaluate studies in systematic meta-analysis, exploring workplace violence in different contexts, such as among nurses (Dafny et al., 2023) and physicians (Chakraborty et al., 2022). Two researchers (FCS and AJRC) extracted information independently. In cases of disagreement between two independent reviewers, a discussion between the reviewers occurred, and, in some instances, the Principal Investigator (PI) resolved the conflict. The JBI tool uses nine criteria items, including sample size, sampling, sample description, appropriate statistical analysis and response rates. Each of the nine items receives a quality score of 0 (indicator not present, not met, or unclear) or 1 (indicator applicable and met). The total quality score for each study is the sum of the individual item scores. Consistent with a recent systematic review (Dafny et al., 2023), the total quality scores were classified into three mutually exclusive categories: “low quality” (a score  $\leq 3$ ), “moderate quality” (a score between 4 and 6), and “high quality” (a score  $\geq 7$ ).

### **Data Extraction**

The data was manually extracted to Excel sheets purposely designed for this study. Two reviewers (AVA and AML) independently extracted data from the studies eligible for the following variables: date and country of data collection; non-response rate (proportion of potentially eligible social workers who did not participate or did not complete the surveys);

sample size; gender; mean age; World Bank Group country classifications, by income level; definitions and measurements of WPV; frequency and type of WPV; prevalence rates; and period for measuring WPV. In line with a previous systematic review exploring violence among healthcare workers (Liu et al., 2019), types of WPV were categorized as: 1) physical violence (physical and sexual assaults) and; 2) non-physical violence (verbal abuse, threats and sexual harassment). This data extraction process involved four stages: a systematic comparison of the datasets generated by the authors, discussion of discrepancies, resolution by consensus, and documentation of decisions, minimizing the risk of biases due to errors in data extraction.

### **Data Analysis**

The prevalence rates of WPV against social workers were pooled with a random-effects meta-analysis, assuming heterogeneity between studies, by accounting for both within-study and between-study variance (Card, 2015). This approach improves the generalizability of the findings compared to a fixed-effect approach. The Cochran's Q test (Cochran, 1954) was used, with a significance level of  $p < .10$ , to assess the presence of heterogeneity, as recommended by the Cochrane Handbook (Higgins et al., 2019). Two meta-analyses were computed separately for non-physical victimization (including verbal abuse, threats and sexual harassment) and for physical victimization (threats and sexual harassment). Statistical heterogeneity variance across studies was estimated with the  $I^2$  statistic, with values higher than 75% indicating considerable heterogeneity (Deeks et al., 2023).

The pooled effect size (for non-physical and physical victimization) for each subgroup was calculated, and the effect sizes between subgroups were compared to determine if there were meaningful differences between the subgroup meta-analyses. Specifically, estimate ( $\beta$ ) and their 95% CIs for potential influencing factors were calculated with a random-effects model based on

the number of individuals who were victims of non-physical and physical WPV. Thus, estimate ( $\beta$ ) higher than 1 indicate that WPV violence is more likely to occur. Continuous variables were used for sample size, response rates and average age. The following variables were analyzed as dichotomous: study location (US studies = 0, Europe = 1, Asia = 2, Australia = 3, and South America = 4), period for measuring victimization (entire career = 0, past 24 months = 1, past 12 months = 2, and past 6 months = 3), country-level income category (high = 0, and low = 1), study period (1990 to 2009 = 0, and 2010 to 2023 = 1), and quality assessment (low = 0, moderate = 1, and high = 2). In line with previous studies exploring violence prevalences, sensitivity analysis was performed to explore heterogeneity, reporting effect sizes and 95% CI (Caravaca-Sánchez et al., 2023). We conducted all statistical analyses using the “OpenMeta Analyst” software (version 3.1) for Windows (Borenstein et al., 2014).

## **Results**

### **Results of Literature Search and Study Selection**

Figure 1 shows the PRISMA flowchart (Page et al., 2021), where the process followed for the selection of studies can be seen in a synthetic manner. The bibliographic search reported a total of 484 references ( $n = 476$  from the searches in the databases and  $n = 8$  from the complementary searches). After eliminating duplicate records ( $n = 162$ ), 322 references per title/abstract were examined, and a total of 250 were excluded as not relevant given the object of the review. Subsequently, during the full review of the text, of the remaining 72 studies 38 were eliminated for not meeting the proposed eligibility criteria (see supplementary table S3). Of these, 23 were eliminated because they were studies that assessed only violence towards other professionals (not including social workers or students), or because they did not present data on violence disaggregated by professional profile (E.C.1). Ten others were discarded because they

did not include analyses of the prevalence of client violence in work settings (some of these studies were qualitative investigations that could not be detected during the review of the title and abstract) or because they offered quantitative data not suitable for meta-analysis (E.C.2). Three studies were eliminated because, despite being different publications, they had used the same database in multiple publications (in these cases the most recent publication was selected; E.C.3). Based on E.C.4, two studies were not taken into consideration because they were studies centering on the validation/analysis of the psychometric properties of instruments. Finally, a total of 34 studies met the eligibility criteria and were included in the meta-analysis (see supplementary table S4).

<Insert Figure 1 here>

### **Description of Studies Included**

The main characteristics of the 34 studies included, published between 1993 and 2023, are shown in online supplementary tables S6, S7, S8 and S9. Of these 34 studies, 13 (38.4%) were conducted in North America, 9 (26.5%) in Europe, 7 (20.5%) in Asia, 4 in Australia (11.7%), and 1 (2.9%) in Latin America, including a total of 14 different countries. Regarding country-level income category, only one was conducted in a low-income country (Iran). These publications provided data on a total of 44,907 social workers, with a mean of 1,333 participants (Standard deviation [*SD*] = 407) ranging from 23 to 20,112 participants. Of these, 84.7% were female and 15.3% male. The overall weighted mean age was 38.8 (*SD* = 1.34). Regarding the workplace violence time frame, for 18 (53.0%) of the 34 studies, the reflection period for workplace violence was “entire career.” Defined periods were used in the remaining 16 (47.0%) studies: specifically, in the “past two years” was used in 2 studies (5.9%), “past year” in 12 (35.2%), and “past 6 months” in 2 studies (5.9%; see supplementary table S9). Exploring for

response rate, the overall response rate was 54.7% ( $SD = 19.9$ ). Finally, we included 31 studies that investigated the prevalence of non-physical violence, and 28 studies that assessed physical violence.

### **Results of the Assessment of the Methodological Quality**

The assessment revealed the following quality distribution between the studies: “low quality” ( $n = 5$ ; 14.7%), “moderate quality” ( $n = 15$ ; 44.2%), and “high quality” ( $n = 14$ ; 41.1%). The interrater reliability was 74% (CI: 59–88). Quality scores ranged from 2 (Lovašová, 2018; Puckett & Cleak, 1994) to 9 (Natalier et al., 2020), with a mean score of 5.65 ( $SD = 1.95$ ). Item two (“Were study participants sampled in an appropriate way?”) had the highest mean score of 6.88 ( $SD = 1.76$ ), while item six (“Were valid methods used for the identification of the condition?”) had the lowest mean score of 4.20 ( $SD = 1.40$ ). The quality results are descriptive, and no articles were excluded due to low methodological quality (see supplementary Table S5 and Figure 2).

<Insert Figure 2 here>

### **Prevalence of Non-Physical Violence Against Social Workers**

In total, 31 studies (Table 1) were included in the analysis to estimate the prevalence of non-physical violence, enrolling a total of 43,247 social workers, with a mean age of 38.2 ( $SD = 1.16$ ). The overall pooled prevalence estimate was 56.8% (95% CI [40.0, 73.6]), ranging from 5.9% (95% CI: 5.4, 6.4; Puckett & Cleak, 2021) to 89.5% (95% CI [87.0, 92.0]; Enosh & Tzafrir, 2015). Very high levels of heterogeneity among studies were found ( $I^2 = 99.9\%$ ;  $p < .001$ ; see Figure 3).

<Insert Table 1 here>

<Insert Figure 3 here>

Using subgroup analysis, we investigated possible explanations for between-study variation in non-physical violence prevalences (Table 1). The highest prevalence of non-physical violence was found in studies conducted in Asia (63.1%; 95% CI [47.1, 79.1]), during the past 24 months (74.0%; 95% CI [70.2, 77.8]), high-income category countries (60.3%; 95% CI [50.2, 70.4]), and studies conducted since 2010 to 2023 (63.0%; 95% CI [53.4, 71.5]). In terms of quality assessment, high-quality studies reported the highest prevalence of non-physical violence (58.6%; 95% CI [31.7, 85.6]; all  $p < 0.001$ ).

<Insert Table 2 here>

As reported in Table 3, in European countries the pooled prevalence of non-physical WPV was 73.9% (95% CI [68.7, 79.2]) from 1990 to 2009, and decreased to 62.9% (95% CI [45.5, 80.4%];  $p < 0.001$ ) from 2010 to 2023. By contrast, there was an increasing trend in North America (42.7% [95% CI: 23.3, 62.1] in 1990–2009 vs 64.6% [95% CI: 48.7, 80.6;  $p < 0.001$ ] in 2010–2023) and Asia (33.8% [95% CI: 27.8, 39.7] from 1990 to 2009 vs 68.0% [95% CI: 52.5, 83.4;  $p < 0.001$ ]) in 2010 to 2023.

<Insert Table 3 here>

### **Prevalence of Physical Violence Against Social Workers**

Physical violence was reported in 28 studies, comprising a sample of 41,816 social workers (mean age: 37.9;  $SD = 0.8$  years). The pooled prevalence estimate was 15.3% (95% CI [12.5, 18.1]), ranging from 2.8% (95% CI [1.1, 3.3]; Shier et al., 2016) to 70.5% (95% CI [63.1, 77.8]; Choi & Choi, 2015), with very high heterogeneity ( $I^2 = 98.9\%$ ;  $p < .001$ ; see Figure 4).

<Insert Figure 4 here>

Regarding subgroup analysis for physical violence prevalences (Table 2), prevalences were highest for the following attributes: studies conducted in Asia (21.8%; 95% CI [11.9, 31.7]), during the past 12 months (19.5%; 95% CI [14.8, 24.3]), high income category countries (17.9%; 95% CI [14.4, 21.4]), studies conducted between 1990 and 2009 (21.0%; 95% CI [15.9, 26.3]), and low-quality studies (26.3%; 95% CI [2.5, 50.1]; all  $p < 0.001$ ).

Similar to non-physical WPV (Table 3), the pooled prevalence of physical WPV in European countries was found to be 37.1% (95% CI [1.6, 90.2]) from 1990 to 2009, and decreased to 9.1% (95% CI [2.0, 16.3];  $p < 0.001$ ) from 2010 to 2023, also finding a significant decrease in North America (19.9%; 95% CI [15.3, 24.5]) from 1990 to 2009, decreasing to 4.9% (95% CI [2.6, 7.2];  $p < 0.001$ ). By contrast, there was an increasing trend in Australia (2.4%; 95% CI [0.3, 5.1] from 1990 to 2009 vs 8.8%; 95% CI [5.0, 12.6];  $p < 0.001$ ) from 2010 to 2023).

### **Sensitivity Analysis**

In order to assess the robustness of the meta-analysis and aiming to discern potential sources of variation across studies, we conducted two sensitivity analyses (non-physical and physical violence) by excluding the studies one by one in each step and then generating meta-analysis results based on the remaining studies (see supplementary table S10). The meta-analysis results are consistent for non-physical and physical violence.

### **Meta Regression Analysis**

The results of the meta-regression analysis for non-physical and physical WPV are provided in Table 4. Rates of non-physical WPV were higher when social workers were younger ( $\beta = -0.327$ , 95% CI [-0.401, -0.279],  $SE = 0.325$ ,  $p = .033$ ), among studies conducted in Europe

( $\beta = 0.215$ , 95% CI [-0.651, 0.440],  $SE = 0.222$ ,  $p = .041$ ), and those published from 2010 to 2023 ( $\beta = 0.250$ , 95% CI [-0.110, 0.422],  $SE = 0.076$ ,  $p = .042$ ).

Regarding rates of physical WPV, higher rates were found when studies had smaller sample sizes ( $\beta = -0.004$ , 95% CI [-0.006, -0.002],  $SE = 0.001$ ,  $p = .002$ ). Unlike non-physical WPV, rates for physical WPV were lower in the studies published from 2010 to 2023 ( $\beta = -0.221$ , 95% CI [-0.406, -0.042],  $SE = 0.063$ ,  $p = .039$ ).

<Insert Table 4 here>

## Discussion

### Key Findings

This review analyzed data on the prevalence of non-physical and physical violence perpetrated against Social Work professionals, and certain differences in effect sizes. Data were extracted from 34 studies, conducted in 14 different countries, including a total sample of 44,907 professionals. Based on the literature review carried out for the preparation of this work, the first systematic review and meta-analysis of the prevalence of WPV against social workers at the international level is presented.

Several findings are noteworthy. First, a significant proportion of social workers have suffered non-physical WPV (56.9%) estimated to be higher than physical WPV (15.3%), which is in line with recent reviews of other professional groups (Ramzi et al., 2022). Secondly, the prevalence of WPV varies depending on the geographical area and the period of time analyzed, as in other reviews of health professionals carried out (Liu et al., 2019). Specifically, the prevalence of non-physical and physical WPV was highest in European countries during the period from 1990 to 2009. However, during the period from 2010 to 2023, the highest prevalence of non-physical and physical WPV was in Asian countries. In addition, with respect to the

prevalence of non-physical WPV, it can be observed that it increased in all geographical areas (with the exception of Europe) during the period from 2010 to 2023 (compared to 1990 to 2009). However, the prevalence of physical WPV from 1990 to 2009 (19.9%) was significantly lower in areas like North America compared to 2010 to 2023 (4.9%).

Finally, several sources of heterogeneity between the studies analyzed and their impact on the prevalence of non-physical and physical WPV were identified. Regarding the prevalence of non-physical WPV (56.9%), the systematic review of the associated variables found a statistically significant association between *lower* ages and higher prevalences, contrary to previous reviews among health professionals, which associated *higher* ages with higher prevalences of violence (Liu et al., 2019). In addition, non-physical WPV was also statistically associated with countries in Europe (compared to other geographical areas), unlike previous reviews (Liu et al., 2019) which found the lowest prevalence, precisely, in Europe (31.6%), and the highest in North America (58.7%). Analyzing the prevalence of physical WPV (15.3%) and associated variables, a lower prevalence was associated with a lower number of participants in the study sample, and studies published during the period from 2010 to 2023.

The way victimization was measured also significantly influenced the estimated rate of physical WPV. Unsurprisingly, the shorter the reflection period (e.g., 6 months) for exposure to physical violence, the lower the prevalence of physical violence. For example, physical WPV was estimated at 19.1% over one's entire career (an indefinite reflection period), and decreased significantly, to 3.4%, when measured over the past 6 months. However, this did not happen when exploring the prevalence of non-physical WPV, with no pattern being found. For example, the prevalence of non-physical WPV was higher for “during the last 6 months” (71.8%) than “entire career” (58.6%). This could be due to the number of reports in each category, with a

lower number “during the last 24 months” (1) and during the last 6 months (3) and showing higher prevalence levels than the other categories. However, based on this evidence, in order to reduce recall errors and differential time periods based on working time, future studies exploring WPV rates should define the reflection period, specifying a concrete time period (e.g., 3, 6, 12 months).

### **Comparison with the Literature**

Compared to previous systematic reviews, this meta-analysis has recently added important findings (Robson et al., 2014; Vidal-Martí, 2023) on social workers in several fundamental aspects. The number of original studies included, the perspective of the study, and its scope and depth, were different from those of previous reviews. First, this meta-analysis included 34 independent studies, with a higher number of social workers ( $N = 44,907$ ) and many more events of violence, significantly higher than in the seven studies included in the previous reviews, which ranged from 2,205 (Robson et al., 2014) to 18,873 (Vidal-Martí, 2023) social workers. Second, this study is the first to systematically summarize the evidence on prevalence (using meta-analysis) and the associations addressing WPV and demographic and labor variables against Social Work professionals at the international level. Finally, different risk factors associated with non-physical and physical WPV have been identified against Social Work professionals, with the levels of non-physical violence being higher than those of physical violence in this group, as well as in previous research (Lovašová, 2014).

When comparing our combined estimates based on social workers with these rates based on other professional groups (see supplementary table S11), differences are observed. First, the prevalence of non-physical WPV against social workers is higher than that found in other systematic reviews of health professionals conducted (Liu et al., 2019; Ramzi et al., 2022), and

lower than in that conducted by Aljohani et al. (2021), where approximately three out of four emergency workers had suffered non-physical WPV. Regarding the prevalence of physical WPV, the prevalence found against social workers is in line with studies carried out on health professionals (Aljohani et al., 2021; Lu et al., 2020; Ramzi et al., 2022). However, it is approximately 10 points lower against social workers than the prevalence reported by Liu et al. (2019) for health professionals.

### **Limitations**

Some limitations of this study should be recognized. First, the most important limitation is associated with the high heterogeneity found in our meta-analysis, potentially attributable to variabilities between the studies included, such as wide differences in sample size, with samples ranging from 23 to 20,112 participants; the time window of the WPV in question (ranging from one's entire career to the last 6 months), and the various instruments used in the detection of WPV (in some cases *ad hoc* questionnaires). This methodological diversity could influence the interpretation of the results and their generalization. Second, the quality assessment classified the studies into Low, Moderate and High, according to predefined criteria in the JBI instrument (Munn et al., 2014a). However, this classification could oversimplify the nuanced quality of the individual studies, which may influence the interpretation of meta-analytical results. Third, despite the breadth of search strategies undertaken in six relevant databases (WoS, Scopus, Social Work Abstracts, Social Services Abstracts, APA PsycInfo, and PubMed MEDLINE), the use of terms exclusively in English and limitations regarding the type of documents included (scientific and published articles, exclusively), might have led to the omission of relevant data, potentially limiting the comprehensiveness of the review. Fourth, although this review focused on estimating the prevalence of physical and non-physical violence in the workplace, this generic

grouping limits understanding of the prevalence and nature of the various types of violence, such as verbal abuse, sexual harassment and assault, intimidation, and property damage, among others. This suggests the need for future research allowing for more specific and consistent subgroup meta-analyses, as has been done on other labor groups (Liu et al., 2019), whenever it is possible to obtain this information.

Finally, it is critical to recognize the potential cultural bias inherent in the perception and meanings associated with WPV, given that these interpretations may vary between different cultures, which could affect the prevalences reported in the studies included in this review. It is also important to address the difficulty, identified, of establishing an integrative definition of WPV, which has had significant repercussions on research in this field (Waddington et al., 2005). Therefore, it might be wise to initiate a dialogue on a definition of WPV in the specific field of Social Work.

### **Critical Findings and Implications**

This review reveals a number of worrisome trends, a high prevalence of both non-physical and physical violence directed at social workers being of note. In addition, significant disparities in the prevalence of violence between different countries have been identified, as well as the influence of the methodological quality of the studies on the estimates reported. These findings underscore the urgent need for more robust policies, safety measures, and research approaches to effectively address this important public health and occupational safety issue. Table 5 presents, in a concise manner, the main results and their implications for practice, policy and research.

<Insert Table 5 here>

### **Social Work Implications**

While there are several definitions of WPV, with most of them being presented in the articles included in this systematic review (see supplementary table S7), as far as we know there is no specific definition of WPV *against social workers* that addresses the peculiarities of this group. This includes the potential situations that may trigger violence, such as the denial of financial aid; the various settings where such violence may occur, both within and outside of their workplace, particularly during home visits; and a detailed specification of the different forms of both physical and non-physical violence they deal with, which would facilitate recognition of the latter, which, as the results indicate, is the most common type suffered by social workers. For this reason, based on the articles included (see supplementary table S7) and on the definition of WPV in the health sector by Cantera and colleagues (2008), we proposed a specific definition of WPV against social workers.

WPV against social work professionals consists of one or more incidents in the form of hostile conduct towards the social worker by one or more persons served by their service (clients). This hostile behavior generally takes the form of verbal violence (insults, threats, etc.), but can also take the form of emotional or psychological violence, property damage, intimidation, or, in more extreme cases, physical and/or sexual violence. This violence occurs due to circumstances related to the work performed (for example, the denial of financial aid), and endangers the safety of the social work professional, their well-being, or their health (physical, psychological or social). The setting of this violence may include any space (permanent or temporary, as in the case of a home visit) where the social worker carries out their professional tasks, and whatever the service provided to their clients may be (although in the systematic reviews analyzed there is a greater interest in fields like child care and health, in addition to

studies that analyze, in general, the performance of the social worker rendering services that address various problems).

Both the generation of a specific definition of WPV for social work, as well as the visibility of this problem at the global level, could help to dispel false beliefs that downplay or deny the effects that WPV has on social workers, or that erroneously identify WPV towards social workers as being a problem only in some geographical areas. To this end, professional associations could promote joint social policies that protect this group, such as awareness campaigns, supervision sessions, self-help groups for professionals, among others.

### **Conclusions**

Our findings could have important policy implications for the prevention and control of WPV in the social worker community. As noted, WPV against social workers is common around the world. Our systematic review shows high rates of non-physical and physical WPV, as well as significant variation in prevalence rates depending on WPV type, region, and study methodology. Our ability to identify risk factors to facilitate interventions aimed at better protecting social workers during their practice is hampered by a lack of consistent specification in the predictive and methodological models across the studies. Strong evidence will only be available to guide protective interventions when individual studies collect data in ways that increase their accuracy (e.g., a defined reflection period). Meanwhile, the findings in this review suggest that prevention strategies to reduce violence towards social workers in the workplace are urgently needed in order to maintain the social protection system.

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