

Exploratory Evaluation of a Violence and Harassment Prevention and Response Training Program for Home-Care Professionals

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Abstract

Background: Violence and harassment from service users and their family members are important occupational concerns for home-care professionals. Although practical training may help workers recognize such situations and develop appropriate responses, evidence regarding training programs for multidisciplinary home-care professionals remains limited. This exploratory study evaluated a violence and harassment prevention and response training program.

Methods: A single-group pre-post survey was conducted with participants from two workshops held in Shiga Prefecture, Japan. The training combined lectures, case-based multidisciplinary discussions, and practical exercises addressing physical violence, psychological violence, sexual harassment, and malicious complaints. Forty-eight visiting nurses, home-care workers, care managers, and other professionals completed anonymous questionnaires immediately pre- and post-training. Pre- and post-training data were compared using unpaired analyses because individual responses were not linked. Confidence, reporting behavior, and preventive intentions were compared using Mann-Whitney U tests. Reported experiences during the previous year were compared using chi-square or Fisher's exact tests.

Results: Mean post-training confidence scores were higher than pre-training scores for all violence and harassment categories, although no statistically significant differences were observed. Effect sizes were 0.26 for physical violence and 0.35–0.36 for psychological violence, sexual harassment, and malicious complaints. The mean exploratory composite score representing confidence in responding to non-physical violence/harassment was 2.53 ± 0.83 at pre-training and 2.88 ± 0.89 at post-training; however, the difference was not statistically significant ($p = .062$). No significant differences were observed between pre- and post-training in reporting behavior, preventive intentions, or reported violence/harassment experiences. Participants with a history of malicious complaints had lower mental well-being than those without such experience, although the difference was not significant.

Conclusion: Although no statistically significant differences were observed, multidisciplinary case-based training may provide an opportunity for home-care professionals to reflect on responses to non-physical violence and harassment. These findings should be interpreted as preliminary and hypothesis-generating. Further studies using individually matched data, control groups, and longitudinal follow-up are needed.

Background

Violence and harassment perpetrated by patients, service users, and their family members are important occupational concerns that impact health and social care professionals' safety and mental health. A meta-analysis reported that in addition to physical violence, non-physical forms of violence, including verbal aggression and sexual harassment, are commonly experienced in home-care settings [1]. In Japan, violence perpetrated by service users has also been reported among visiting nurses. However, the implementation rates of individual-level preventive actions (e.g., avoiding visits when there is a risk for violence or withdrawing from a violent situation) and organizational-level measures (e.g., sharing information about service users' violent behavior among staff) were reported to be below 50% [2]. These findings suggest measures to prevent and respond to violence and harassment in home-visit nursing may currently be insufficient at both individual and organizational levels.

Home-care professionals often work alone in service users' private homes when providing services, and immediate support from colleagues or managers may not be readily available if violence or harassment occurs. Previous research identified several potential risk factors for violence against home-care professionals, including service user-related characteristics, working alone, unsafe home

environments, and inadequate training in violence prevention and response [3]. Exposure to violence and harassment in home-care settings has also been associated with stress, burnout, poor mental health, and intentions to leave the profession among home-care staff [4]. Furthermore, violence and harassment are likely to be underreported because home-care professionals may regard such behavior as "part of the job," find it difficult to determine which incidents should be classified and reported as violence or harassment, or encounter unclear reporting procedures and inadequate organizational support [5, 6].

These challenges highlight the need for practical learning opportunities that enable home-care professionals to understand the

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definitions and specific manifestations of violence and harassment, and develop appropriate responses, reporting practices, and managerial support strategies. However, few studies have evaluated the potential educational effects of violence and harassment prevention training that incorporates realistic home-care scenarios and multidisciplinary discussion.

Therefore, this exploratory study aimed to evaluate the potential educational effects of a training program on the prevention of and response to violence and harassment perpetrated by service users and their family members among visiting nurses, home-care workers, care managers, and other related professionals. Specifically, we examined differences between pre- and post-training responses in terms of confidence in responding to violence and harassment, reporting behavior toward supervisors or colleagues, intentions to engage in preventive actions, and recognition of previous experiences of violence and harassment. We conducted a further exploratory analysis to examine associations between home-care professionals' occupational experiences of violence and harassment and baseline mental health status.

Methods

Study design

This study used a single-group pre-post survey design. Participants completed anonymous questionnaires immediately before and after the training program; however, individual pre- and post-training responses could not be linked because no identifiers were collected.

Operational definitions

This study was guided by the comprehensive definition of violence and harassment proposed by the International Labour Organization (ILO). The ILO defines violence and harassment as a range of unacceptable behaviors and practices, or threats thereof, whether occurring once or repeatedly that aim at, result in, or are likely to result in physical, psychological, sexual, or economic harm [7]. Based on this overarching definition, we focused on violence and harassment directed toward home-care professionals by service users or their family members. For the purposes of this study, these experiences were classified into four categories: physical violence, psychological violence, sexual harassment, and malicious complaints.

Participants and Setting

Participants were recruited from two violence and harassment prevention workshops held in Shiga Prefecture, Japan (December 2023 and January 2024). The workshops targeted home-visit nurses, home-care workers, care managers, and related professionals. Approximately 80 participants were expected to attend the two workshops. Participants who provided informed consent and completed both the pre- and post-training questionnaires were included in the analysis.

Training program

The workshop-based training program focused on prevention and response strategies for violence and harassment from service users and family members in home-care settings. The training comprised lectures, case-method group discussions, and practical exercises regarding physical violence, psychological violence, sexual harassment, and malicious complaints.

The program began with a lecture reviewing definitions of violence and harassment, organizational responsibilities, risk assessment, reporting systems, and secondary victimization. Participants then engaged in mixed-profession group discussions and practical exercises using fictional case scenarios developed for home-care settings. One case scenario addressed sexual harassment toward a novice home-care worker by a male service user (i.e., inappropriate touching) in the context of an insufficient organizational response from supervisors. Another scenario focused on psychological violence and malicious complaints from a family caregiver toward home-care staff. Participants discussed contributing factors, appropriate staff responses, managerial responsibilities, and preventive strategies.

The workshop was conducted in mixed-profession groups comprising visiting nurses, home-care workers, care managers, and related professionals. The workshop lasted approximately two hours and consisted of a 15-minute lecture, approximately 70 minutes of group discussions, and group sharing sessions.

Data Collection

Participants completed anonymous questionnaires using Google Forms immediately before and after the training program. To ensure anonymity, no individual identifiers or linking codes were collected. Therefore, although the same participants completed both questionnaires, their pre- and post-training responses could not be linked at the individual level.

The pre-training questionnaire included demographic characteristics, psychological distress assessed using the Japanese version of the Kessler Psychological Distress Scale (K6) [8-10], and mental well-being assessed using the Japanese version of the World Health Organization-Five Well-Being Index (WHO-5) [11, 12]. The K6 and WHO-5 were administered only at pre-training to capture participants' baseline mental health status and explore its associations with their experiences of occupational violence and harassment. The K6 is a widely used 6-item self-report measure assessing psychological distress during the past 30 days. Each item is rated on a 5-point Likert scale from 0 to 4, with total scores from 0 to 24; higher scores indicate greater psychological distress. The WHO-5 is a 5-item self-report measure that assesses subjective well-being during the past 2 weeks. Each item is rated on a 6-point Likert scale from 0 to 5, with total scores from 0 to 25; higher scores indicate better mental well-being. The Japanese versions of both scales have demonstrated acceptable reliability and validity in previous studies [8, 11, 12].

The questionnaire assessed experiences of violence and harassment from service users and family members, including physical violence, psychological violence, sexual harassment, and malicious complaints. Participants' experiences of each type of violence or harassment during their professional careers were assessed in the pre-training questionnaire. Experiences during the past year were assessed both pre- and post-training as an exploratory indicator of whether participation in the training program influenced participants' recognition of previous experiences as being violence or harassment. Confidence in responding to violence and harassment, reporting behavior toward supervisors or colleagues, and intention to engage in violence and harassment prevention activities were assessed both pre- and post-training for each violence and harassment category using 5-point Likert-type scales. Confidence in responding to violence and harassment was rated from 1 ("not confident at all") to

5 (“very confident”). Reporting behavior toward supervisors or colleagues was rated from 1 (“would not report at all”) to 5 (“would always report”). Intention to engage in violence and harassment prevention activities was rated from 1 (“not willing to engage at all”) to 5 (“very willing to engage”). Higher scores for each of the three items indicated greater confidence, a greater likelihood of reporting, and stronger intention to engage in preventive activities, respectively. These exploratory items were developed by the authors based on the operational definitions used in this study, the categories addressed in the workshop, previous literature, and the learning objectives of the training program. Although the items were designed to reflect the content of the training program, they were not derived from a previously validated scale, and no formal content validity testing was conducted.

Statistical Analysis

Descriptive statistics were calculated for participant characteristics and pre-training mental health status. Unpaired analyses were used for comparisons of pre- and post-training responses because individual pre-/post-training responses could not be linked. Continuous variables were presented as means ± standard deviations, and categorical variables as frequencies and percentages. Pre-training K6 and WHO-5 scores were summarized descriptively and excluded from the pre-post comparisons. Because confidence in responding to violence and harassment, reporting behavior toward supervisors or colleagues, and intention to engage in violence and harassment prevention activities were assessed using Likert-type ordinal scales, differences between pre- and post-training responses were examined using Mann–Whitney U tests. As an exploratory analysis of changes in participants’ recognition of previous experiences as violence or harassment, differences in the proportions of participants reporting experiences of each type of violence or harassment during the past year before and after the training were examined using chi-square or Fisher’s exact tests, as appropriate. As an exploratory analysis, a composite score representing “confidence in responding to non-physical violence and harassment” was calculated by averaging the three items assessing confidence in responding to psychological violence, sexual harassment, and malicious complaints. This composite score was constructed conceptually and was interpreted as a supplementary exploratory indicator. Pre- and post-training composite scores were compared using the Mann–Whitney U test. Effect sizes for confidence-related outcomes were calculated using Cohen’s d as supplementary standardized mean difference estimates. Furthermore, exploratory analyses were conducted to examine associations between past experiences of violence and harassment and pre-training mental health status (as assessed by the K6 and WHO-5) using Mann–Whitney U tests. All statistical analyses were performed using R version 4.5.1, and statistical significance was set at $p < .05$.

Ethical Considerations

This study was approved by the ethics review committee of Hyogo Medical University (Approval No. 202312-058). Written informed consent was obtained from all participants before participation. Data were collected anonymously and stored securely without information that could identify individual participants.

Results

In total, 48 participants attended the training program and completed both the pre- and post-training questionnaires. Participants

and harassment perpetrated by service users and their family comprised 14 visiting nurses, 18 care managers, 10 home-care workers and six professionals from other occupational groups. Four participants were aged in their 30s, 23 were in their 40s, 15 were in their 50s, and six were in their 60s. The mean length of professional experience was 17.79 ± 8.72 years. The mean K6 and WHO-5 scores at baseline were 3.85 ± 4.04 and 11.73 ± 4.80 , respectively.

The proportions of participants reporting experiences of violence and harassment during the previous year were compared exploratorily between the pre- and post-training responses. Physical violence was reported in 8.3% of pre-training responses and 16.7% of post-training responses; however, the difference was not statistically significant (Table 1). No statistically significant difference was observed in the reported prevalence of psychological violence between the pre- and post-training responses (Table 1).

For all four violence and harassment categories, mean confidence scores were higher in the post-training responses compared with the pre-training responses (Table 2). However, none of these differences were statistically significant. Cohen’s d was 0.26 for confidence in responding to physical violence and 0.35–0.36 for psychological violence, sexual harassment, and malicious complaints. The mean composite score for confidence in responding to non-physical violence and harassment was 2.53 ± 0.83 in the pre-training responses and 2.88 ± 0.89 in the post-training responses; however, this difference was not statistically significant ($p = .062$).

Table 1: Self-reported experiences of violence and harassment during the past year before and after the training program

Type of violence or harassment	Pre-training, n (%)	Post-training, n (%)	p value
Physical violence	4 (8.3)	8 (16.7)	.355
Psychological violence	14 (29.8)	18 (38.3)	.514
Sexual harassment	11 (22.9)	13 (27.1)	.814
Malicious complaints	14 (29.8)	19 (39.6)	.431

Note. The same participants completed the pre- and post-training questionnaires; however, individual responses could not be linked because questionnaires were anonymous. These exploratory comparisons were conducted to examine possible changes in participants’ recognition of their previous experiences as violence/harassment. Percentages were calculated using the number of valid responses for each item. Missing responses were excluded on an analysis-by-analysis basis, and no imputation was performed.

No statistically significant differences were observed between the pre- and post-training responses for reporting behavior toward supervisors or colleagues in any violence and harassment category (Table 2). Similarly, no statistically significant differences were found in participants’ intentions to engage in preventive actions for any violence and harassment category (Table 2).

Exploratory analyses were also conducted to examine associations between professional-career experiences of violence and harassment and baseline mental health status. No statistically significant associations were observed between any category of professional-career violence and harassment experience and K6 or WHO-5 scores. However, participants with a history of malicious complaints had lower WHO-5 scores than those without such experience, although the difference did not reach statistical significance (11.16 ± 4.99 vs. 12.37 ± 4.83 , $p = .070$).

Discussion

This exploratory study evaluated the potential educational effects of a training program on the prevention of and response to violence

Table 2: Pre–post changes in confidence, reporting behavior, and preventive intentions regarding violence and harassment.

Outcome	Pre mean ± SD	Post mean ± SD	p value	Effect size
Confidence in responding to:				
Physical violence	2.69 ± 0.88	2.94 ± 1.00	.213	0.26
Psychological violence	2.48 ± 0.85	2.81 ± 0.96	.074	0.36
Sexual harassment	2.71 ± 0.92	3.04 ± 0.99	.078	0.35
Malicious complaints	2.42 ± 0.96	2.77 ± 0.99	.078	0.36
Reporting behavior to supervisors or colleagues regarding:				
Physical violence	3.73 ± 0.64	3.75 ± 0.60	.830	—
Psychological violence	3.52 ± 0.74	3.52 ± 0.74	.948	—
Sexual harassment	3.50 ± 0.77	3.56 ± 0.74	.610	—
Malicious complaints	3.79 ± 0.54	3.73 ± 0.57	.567	—
Intention to engage in preventive actions regarding:				
Physical violence	4.40 ± 0.64	4.48 ± 0.62	.521	—
Psychological violence	4.44 ± 0.62	4.48 ± 0.62	.713	—
Sexual harassment	4.44 ± 0.62	4.50 ± 0.62	.579	—
Malicious complaints	4.48 ± 0.62	4.44 ± 0.65	.785	—

* Effect sizes are presented as Cohen's *d*.

and harassment perpetrated by service users and their family members in home-care settings. Participants included visiting nurses, home-care workers, care managers, and other related professionals. Mean confidence scores for responding to physical violence, psychological violence, sexual harassment, and malicious complaints were higher post-training compared with pre-training, although none of these differences reached statistical significance. The effect size was 0.26 for confidence in responding to physical violence, compared with 0.35–0.36 for psychological violence, sexual harassment, and malicious complaints. Similarly, confidence in responding to non-physical violence and harassment (composite score) was higher post-training compared with pre-training, although the difference was not statistically significant. These findings suggested the training program may have provided participants with an opportunity to consider how to respond to violence and harassment, particularly to non-physical forms.

A previous study involving home-care workers reported that computer-based training on workplace violence and harassment prevention improved workers' confidence in preventing and responding to violence and harassment [13]. The present program differed from that intervention as it centered on case-based, multidisciplinary group discussions rather than computer-based training. However, our study showed the mean confidence scores were consistently higher in the post-training responses across all categories of violence and harassment. Although not statistically significant, these findings suggested learning methods that enable participants to articulate appropriate responses to realistic cases and share their perspectives with professionals from other disciplines may help foster confidence in responding to violence and harassment. Few previous studies evaluated training programs addressing violence and harassment in home-care settings and further studies using more rigorous designs, including randomized controlled trials, are warranted.

We observed that the proportions of participants reporting experiences of physical violence, psychological violence, sexual

harassment, and malicious complaints during the previous year were numerically higher in the post-training responses compared with pre-training, although none of these differences were statistically significant. Because the pre- and post-training questionnaires asked about experiences occurring during the same retrospective 12-month period, the higher proportions in the post-training responses cannot be interpreted as indicating an actual increase in the incidence of violence and harassment. Previous research suggests that education and interventions related to workplace violence may increase healthcare workers' awareness and recognition of violent events and the importance of reporting them [14]. Therefore, learning the definitions and covering specific examples of violence and harassment during the training may have prompted some participants to reconsider previous incidents and recognize them as violence or harassment.

Healthcare workers may also regard intimidation or violence from patients or service users as “part of the job,” which may hinder the recognition and reporting of such incidents [15]. In addition, because health and social care professionals are trained to listen to and acknowledge the concerns of service users and their families, they may sometimes interpret psychologically abusive behavior as an expression of distress that should be accepted as part of providing care. Consequently, such experiences may be less readily recognized as victimization. Discussing realistic cases involving psychological violence and malicious complaints may therefore have encouraged participants to reconsider behaviors that they had previously tolerated and identify them as forms of violence or harassment. However, this interpretation remains exploratory because individual pre- and post-training responses could not be matched and this study did not directly assess changes in awareness or sensitivity to violence and harassment.

No statistically significant differences were observed between the pre- and post-training responses in reporting behavior toward supervisors or colleagues or in intentions to engage in preventive actions for any violence and harassment category. Reporting behavior scores were

already relatively high before the training, and preventive intention scores were high across all categories at baseline. These high initial scores may have produced ceiling effects, thereby limiting the ability to detect further changes following the training. Previous studies showed that workplace violence reporting is influenced by individual knowledge and intention as well as organizational factors, including a supportive workplace culture, managerial responses following a report, perceptions that reporting will/will not lead to meaningful change, and the accessibility and clarity of reporting procedures [16, 17]. Educational programs may improve knowledge and confidence in responding to workplace violence; however, training alone may have limited effects on reporting behavior or organizational violence-prevention practices. Multicomponent approaches that incorporate reporting systems, organizational policies, and managerial involvement are therefore recommended [14]. A brief individual-level training program may not be sufficient to produce clear changes in reporting behavior or preventive intentions. Training should therefore be accompanied by organizational measures, including clearly defined consultation and reporting procedures, appropriate post-report support, and education for managers.

In the exploratory analysis of mental health status, participants with a professional history of experiencing malicious complaints had lower WHO-5 scores than those without such experience, although the difference was not statistically significant. K6 scores did not differ significantly by the experience of malicious complaints. Malicious complaints may include verbal and psychological aggression, such as repeated reprimands, excessive or unreasonable demands, and statements that undermine a worker's professional competence [18]. Previous research showed that verbal aggression from patients or customers may be associated with emotional exhaustion, burnout, and psychological distress, even in the absence of physical injury [2, 19]. Therefore, the lower WHO-5 scores observed among participants who had experienced malicious complaints in this study may represent a preliminary indication that exposure to such behavior could adversely affect home-care professionals' well-being. However, given the exploratory nature of this analysis and the limited sample size, this finding requires confirmation in larger studies.

This study had several limitations. First, it used a single-group pre-post design without a control group. In addition, anonymous data collection prevented individual pre- and post-training responses from being matched. Consequently, the observed differences cannot be attributed solely to the training, and the findings should be interpreted as exploratory. Second, the sample was small and comprised participants from workshops conducted in a single region, which limits the generalizability of the findings. Third, the items assessing confidence, reporting behavior, and preventive intentions, as well as the composite score for confidence in responding to non-physical violence and harassment, were used for exploratory purposes; their reliability and validity require further evaluation. Despite these limitations, this study provides preliminary evidence regarding a training program that combined realistic home-care cases with multidisciplinary discussion. In particular, it offers initial insights into confidence in responding to non-physical violence and harassment, which may be difficult to address through didactic education alone. Further research should use longitudinal designs with individually matched responses and include a comparison or control group. Such studies should examine the sustainability of changes in confidence and the effects on actual reporting behavior, organizational safety practices, and the mental health of home-care professionals.

Conclusion

In this exploratory study involving home-care professionals, no statistically significant differences were observed in confidence in responding to violence and harassment between the pre- and post-training responses. However, mean confidence scores were higher after the training for psychological violence, sexual harassment, and malicious complaints, with slightly larger effect sizes than that observed for physical violence. These findings should be interpreted as preliminary and hypothesis-generating. Multidisciplinary training based on realistic home-care scenarios may provide an opportunity for participants to reflect on appropriate responses to non-physical violence and harassment, but the present findings do not establish the effectiveness of the program. Further studies using more rigorous designs are needed to examine the potential educational value, sustainability, and practical effects of this training approach.

Competing Interests

The authors have no competing interests to declare.

Author Contributions

SY designed and conceptualized this study. SY and HF contributed to the acquisition and analysis of data. SY drafted the manuscript with intellectual input and revisions from HF. Both authors were involved in the interpretation of data and critically revised the manuscript for important intellectual content. Both authors approved the final version of the manuscript and agree to be accountable for all aspects of the work.

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References

1. Byon HD, Lee M, Choi M, Sagherian K, Crandall M, et al. (2020) Prevalence of type II workplace violence among home healthcare workers: A meta-analysis. *Am J Ind Med* 63: 442-455.
2. Fujimoto H, Greiner C, Hirota M, Yamaguchi Y, Ryuno H, et al. (2019) Experiences of Violence and Preventive Measures Among Nurses in Psychiatric and Non-Psychiatric Home Visit Nursing Services in Japan. *J Psychosoc Nurs Ment Health Serv* 57: 40-48.
3. Phoo NNN, Reid A (2022) Determinants of violence towards care workers working in the home setting: A systematic review. *Am J Ind Med* 65: 447-467.

4. Hanson GC, Perrin NA, Moss H, Laharnar N, Glass N (2015) Workplace violence against homecare workers and its relationship with workers health outcomes: a cross-sectional study. *BMC Public Health* 15:11.
5. Byon HD, Liu X, Crandall M, Lipscomb J (2020) Understanding Reporting of Type II Workplace Violence Among Home Health Care Nurses. *Workplace Health Saf* 68: 415-421.
6. Spencer C, Sitarz J, Fouse J, DeSanto K (2023) Nurses' rationale for underreporting of patient and visitor perpetrated workplace violence: a systematic review. *BMC Nurs* 22: 134.
7. International Labour Organization (2019) Violence and Harassment Convention, 2019 (No. 190).
8. Furukawa TA, Kawakami N, Saitoh M, Ono Y, Nakane Y, et al. (2008) The performance of the Japanese version of the K6 and K10 in the World Mental Health Survey Japan. *Int J Methods Psychiatr Res* 17:152-8.
9. Kessler RC, Andrews G, Colpe LJ, Hiripi E, Mroczek DK, et al. (2002) Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychol Med* 32: 959-976.
10. Sakurai K, Nishi A, Kondo K, Yanagida K, Kawakami N (2011) Screening performance of K6/K10 and other screening instruments for mood and anxiety disorders in Japan. *Psychiatry Clin Neurosci* 65:434-41.
11. Awata S, Bech P, Koizumi Y, Seki T, Kuriyama S, et al. (2007) Validity and utility of the Japanese version of the WHO-Five Well-Being Index in the context of detecting suicidal ideation in elderly community residents. *Int Psychogeriatr* 19:77-88.
12. Awata S, Bech P, Yoshida S, Hirai M, Suzuki S, et al. (2007) Reliability and validity of the Japanese version of the World Health Organization-Five Well-Being Index in the context of detecting depression in diabetic patients. *Psychiatry Clin Neurosci* 61:112-119.
13. Glass N, Hanson GC, Anger WK, Laharnar N, Campbell JC, et al. (2017) Computer-based training (CBT) intervention reduces workplace violence and harassment for homecare workers. *Am J Ind Med* 60: 635-643.
14. Somani R, Muntaner C, Hillan E, Velonis AJ, Smith P. (2021) A Systematic Review: Effectiveness of Interventions to De-escalate Workplace Violence against Nurses in Healthcare Settings. *Saf Health Work* 12: 289-295.
15. Cooper CL, Swanson N (2002) Workplace violence in the health sector: State of the art. Geneva: International Labour Office, International Council of Nurses, World Health Organization, and Public Services International.
16. Xu D, Zhou J, Yang M, Yang L, Li Q, et al. (2025) Barriers and facilitators to reporting workplace violence among healthcare workers: A mixed-methods systematic review. *Nurs Outlook* 73: 102443.
17. Lee J, Havaei F, Hirani S, Adhami N (2025) Nurses' Workplace Violence Reporting Behaviours and Reasons for Not Formally Reporting: A Cross-Sectional Secondary Analysis. *J Clin Nurs* 34: 4235-4245.
18. Grandey AA, Kern JH, Frone MR (2007) Verbal abuse from outsiders versus insiders: comparing frequency, impact on emotional exhaustion, and the role of emotional labor. *J Occup Health Psychol* 12: 63-79.
19. Vincent-Höper S, Stein M, Nienhaus A, Schablon A. (2020) Workplace Aggression and Burnout in Nursing-The Moderating Role of Follow-Up Counseling. *Int J Environ Res Public Health* 17: 3152.