JHWCR

Journal of Health, Wellness, and Community Research
Volume III, Issue XII
Open Access, Double Blind Peer Reviewed.
Web: https://jhwcr.com, ISSN: 3007-0570
https://doi.org/10.61919/7w49hc24

Original Article

Unseen Struggles: Nurse Shortages and Workplace Violence Driving Burnout in Abbottabad's Healthcare Sector

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Authors' Contributions: Concept: SB; Design: SB; Data Collection: SB, TS; Analysis: FM; Drafting: FM; Revision: TS; Final Approval: SB, FM, TS
Cite this Article | Received: 2025-08-17 | Accepted 2025-09-05
No conflicts declared; ethics approved; consent obtained; data available on request; no funding received.

ABSTRACT

Background: Workplace violence (WPV) is a major occupational hazard for nurses worldwide, leading to psychological distress, burnout, and attrition. In Pakistan, WPV remains underreported, and staffing shortages exacerbate nurses' vulnerability, particularly in overcrowded government hospitals. Limited empirical evidence exists on how these systemic factors interact to affect nurse well-being in Abbottabad. Objective: To explore the relationship between nurse shortages, workplace violence, and burnout among nurses in government and private hospitals in Abbottabad, and to assess the adequacy of existing institutional support mechanisms. Methods: A qualitative descriptive phenomenological study was conducted between January and March 2023. Eighteen registered nurses with at least one year of experience and direct exposure to WPV participated in semi-structured interviews. Transcripts were analyzed using thematic analysis, supported by reflexive journaling to enhance credibility and minimize bias. Results: WPV was highly prevalent, with 91.7% of government nurses and 66.7% of private nurses reporting verbal abuse. Physical abuse was more frequent in government hospitals (66.7% vs 33.3%). Burnout affected 66.7% of participants, with emotional exhaustion reported by 75.0% of government nurses compared to 50.0% of private nurses. Nurse–patient ratios exceeding 1:8 was significantly associated with higher WPV exposure (p=0.03). Administrative support was markedly limited in government hospitals (16.7% vs 66.7%). Conclusion: WPV and burnout are pervasive among nurses in Abbottabad, disproportionately affecting government hospital staff due to chronic staffing shortages and weak institutional support. Addressing nurse–patient ratios, enforcing WPV prevention policies, and strengthening leadership engagement are critical to protect nurse well-being and sustain healthcare delivery.
Keywords: workplace violence, nurse burnout, staffing shortage, Abbottabad, Pakistan, healthcare safety

INTRODUCTION

Workplace violence (WPV) is an escalating global challenge in healthcare, with nurses disproportionately affected due to their frontline roles and frequent interactions with patients, families, and visitors. WPV encompasses verbal aggression, physical assault, psychological harassment, and, in some cases, sexual violence, all of which have been shown to compromise nurses' mental health, job satisfaction, and professional commitment (1,2). International evidence estimates that nearly three-quarters of workplace assaults occur in healthcare settings, highlighting the vulnerability of nurses compared with other health professionals (1). The consequences extend beyond individual well-being, as WPV contributes to absenteeism, high turnover, reduced quality of care, and ultimately, systemic strain on health systems (2,3).

Among the structural factors that aggravate WPV, nurse shortages play a critical role. High nurse–patient ratios resulting from understaffing are consistently associated with increased stress, heightened risk of violent encounters, and accelerated burnout (4,5). Staffing deficits compromise the ability of nurses to provide timely and safe care, increase waiting times, and amplify tensions in overcrowded wards, particularly in high-pressure areas such as emergency departments and intensive care units (6). In many countries, including Pakistan, this workforce challenge has reached critical levels. The Pakistan Nursing and Midwifery Council (PNMC) has recommended a minimum standard of one nurse for every three beds, with even stricter ratios for specialized care such as intensive care units and operating theaters. However, these guidelines remain unmet in many institutions due to budgetary constraints, resource scarcity, and inequitable allocation of healthcare personnel (7).

In Abbottabad, Khyber Pakhtunkhwa (KPK), these challenges are acute. Government hospitals, often burdened by free service provision and high patient influx, face chronic understaffing, with nurse–patient ratios frequently exceeding PNMC recommendations. Nurses in these settings encounter disproportionate exposure to WPV, compounded by insufficient institutional safeguards and limited support mechanisms (6,7). Reports indicate that WPV in Pakistan remains underreported, with inadequate preventive strategies and limited

accountability mechanisms (8). This environment not only heightens nurses' risk of psychological distress and burnout but also threatens patient safety and healthcare quality in the Hazara region.

While international literature has documented the link between staffing deficits, WPV, and nurse burnout, evidence specific to Pakistan—particularly in Abbottabad—remains sparse. Studies from comparable contexts highlight that nurses exposed to WPV report higher levels of emotional exhaustion, depersonalization, and job dissatisfaction, often leading to turnover and workforce attrition (4,5,8). Yet, little is known about how the dual pressures of understaffing and WPV interact to shape the lived experiences of nurses in Pakistan's mixed public and private hospital landscape. Furthermore, the role of institutional leadership and professional associations in mitigating these effects has not been adequately explored, leaving a critical knowledge gap for policy and practice.

This study addresses that gap by examining how nurse shortages contribute to WPV and burnout among nurses in Abbottabad's healthcare sector. Specifically, it investigates the prevalence and nature of WPV across public and private hospitals, explores its association with staffing deficits, and evaluates the adequacy of existing institutional support and coping mechanisms. The findings aim to provide contextually grounded evidence to inform staffing policies, violence prevention strategies, and leadership interventions that safeguard nurse well-being and improve retention.

Research Objective: To explore the relationship between nurse shortages and workplace violence in Abbottabad and to determine how these factors contribute to burnout among nurses in both government and private hospitals.

MATERIAL AND METHODS

This study employed a qualitative, descriptive phenomenological design to explore the lived experiences of registered nurses exposed to workplace violence (WPV) in the context of staffing shortages in Abbottabad, Khyber Pakhtunkhwa, Pakistan. A phenomenological approach was chosen to capture the subjective realities of nurses and to understand how WPV and nurse shortages influence their professional and personal well-being, in alignment with recommendations for in-depth exploration of complex psychosocial phenomena (9). The framework was guided by Orlando's nursing process discipline theory, which emphasizes understanding patient and nurse interactions within distressing environments, and was applied to examine nurses' responses to WPV in their work settings (10).

The research was conducted in both government and private hospitals in Abbottabad between January and March 2023, reflecting the diverse institutional contexts of healthcare delivery in the Hazara region. Nurses working in government hospitals were included due to their high patient loads and resource constraints, while those in private hospitals provided comparative perspectives under different staffing and administrative conditions. Eligible participants were registered nurses who had been employed in their current setting for at least one year and who reported exposure to some form of WPV, whether verbal, physical, or psychological. Nurses unwilling to provide informed consent or with less than one year of service were excluded.

Participants were recruited through convenience sampling. Hospital administrations were approached to facilitate access, and eligible nurses were invited to participate voluntarily. Informed consent was obtained in writing after nurses were provided with detailed information about the study's purpose, procedures, and confidentiality measures. A total of 18 nurses participated, a sample size consistent with established qualitative research practice where data saturation guides final recruitment, ensuring sufficient depth while avoiding redundancy (9). The sample included diversity in terms of gender, years of experience, and institutional setting, enhancing transferability of findings.

Data collection was conducted through semi-structured interviews, lasting approximately 30 to 45 minutes each, either in person or via secure online platforms when face-to-face interaction was not feasible. An interview guide was developed to ensure consistency while allowing flexibility to probe for deeper insights. Topics included nurses' experiences with WPV, its perceived causes, its impact on professional performance and personal well-being, and the availability of support systems. Interviews were audio recorded with participant consent and transcribed verbatim. Participants were invited to review transcripts for accuracy, a process that strengthened credibility and minimized misinterpretation.

To maintain rigor and address bias, the researcher kept reflexive journals throughout the data collection and analysis phases, documenting personal reflections and potential assumptions. Thematic analysis, as described by Braun and Clarke, was employed to systematically identify, code, and group patterns across transcripts into meaningful themes (11). Analysis proceeded iteratively, moving from initial familiarization with the data to coding, theme development, and interpretation. Manual coding was used, with cross-checking of emerging themes by co-researchers to enhance reliability and confirmability.

Efforts to minimize bias included ensuring diversity of participants across hospital types, triangulating findings with reflective notes, and maintaining transparency in analytic decisions. Potential confounders such as years of professional experience and hospital type were considered during interpretation, acknowledging their role in shaping WPV exposure and coping responses.

Although qualitative research does not rely on statistical power calculations, the sample size was justified by reaching thematic saturation, where no new insights emerged with additional interviews (9). To enhance reproducibility, all analytic steps, coding frameworks, and decision logs were systematically documented. NVivo software was not employed; instead, manual coding was conducted to allow for closer researcher immersion in the narratives, consistent with phenomenological methodology.

Ethical approval for this study was obtained from the appropriate institutional ethics review board prior to data collection. Participants' confidentiality was strictly maintained, with identifiers removed from transcripts and stored data secured on password-protected devices.

Given the sensitive nature of WPV experiences, participants were informed of available counseling and support services should emotional distress arise during or after interviews.

This methodological approach was designed to ensure trustworthiness, rigor, and reproducibility. Credibility was strengthened through member checking, dependability through transparent analytic documentation, confirmability through reflexive journaling, and transferability through detailed contextual descriptions. The design thus provides a robust foundation for interpreting the relationship between nurse shortages, WPV, and burnout within the healthcare system of Abbottabad.

RESULTS

The study included 18 registered nurses, with 12 employed in government hospitals and 6 in private hospitals. The mean participant age was 32 years, ranging from 24 to 44 years, and the average professional experience was 7 years, ranging from 2 to 18 years. Women comprised 72.2% of the total sample, with no statistically significant differences in gender, age distribution, or years of experience between government and private hospital nurses ($p>0.70$).

Workplace violence (WPV) was reported by nearly all participants, with significantly higher prevalence among government nurses. Verbal abuse was reported by 91.7% of government hospital nurses compared with 66.7% in private hospitals (OR 5.50, 95% CI 0.44–82.6). Physical abuse affected 66.7% of nurses in government facilities and 33.3% in private hospitals (OR 4.00, 95% CI 0.60–17.6). Psychological abuse was reported by 58.3% of government nurses and 50.0% of private nurses. Although group differences did not reach statistical significance (p-values 0.18–0.72), the direction of effects consistently favored higher exposure in government hospitals. Burnout was highly prevalent, affecting two-thirds of the sample. Emotional exhaustion was reported by 66.7% overall, with markedly higher rates in government hospitals (75.0%) than in private hospitals (50.0%), yielding an odds ratio of 3.00 (95% CI 0.37–14.6). Reduced personal accomplishment was noted in 55.6% of participants, with little difference between settings (58.3% vs 50.0%). Depersonalization affected 44.4% overall, with higher prevalence among government nurses (50.0%) compared with private nurses (33.3%). Although none of these differences were statistically significant, the trends suggest that chronic exposure to WPV in government hospitals contributes to higher burnout levels.

A strong association was observed between nurse–patient ratios and WPV. All nurses (100%) working in hospitals with ratios exceeding 1:8 reported at least one form of violence, compared with only 3 nurses in hospitals with ratios at or below this threshold. This difference was statistically significant ($p=0.03$), underscoring the central role of staffing shortages in precipitating violent encounters. In many government hospitals, ratios frequently exceeded 1:16, particularly in emergency departments where overcrowding was reported as a major precipitant of violence.

Table 1. Demographic Characteristics of Nurse Participants by Hospital Type

Variable	Total (n=18)	Government (n=12)	Private (n=6)	p-value	95% CI	OR (Govt vs Private)
Female gender, n (%)	13 (72.2)	9 (75.0)	4 (66.7)	0.72	0.25–8.18	1.50
Age ≤30 years, n (%)	8 (44.4)	5 (41.7)	3 (50.0)	0.72	0.22–6.11	0.71
≥11 years' experience, n (%)	7 (38.9)	5 (41.7)	2 (33.3)	0.72	0.23–6.09	1.40

Table 2. Prevalence of Workplace Violence by Hospital Type

Type of WPV	Government (n=12)	Private (n=6)	p-value	95% CI	OR (Govt vs Private)
Verbal abuse, n (%)	11 (91.7)	4 (66.7)	0.21	0.44–82.6	5.50
Physical abuse, n (%)	8 (66.7)	2 (33.3)	0.18	0.60–17.6	4.00
Psychological abuse, n (%)	7 (58.3)	3 (50.0)	0.72	0.31–7.25	1.40

Table 3. Burnout Symptoms Across Hospital Types

Burnout Symptom	Total (n=18)	Government (n=12)	Private (n=6)	p-value	95% CI	OR (Govt vs Private)
Emotional exhaustion, n (%)	12 (66.7)	9 (75.0)	3 (50.0)	0.32	0.37–14.6	3.00
Reduced personal accomplishment, n (%)	10 (55.6)	7 (58.3)	3 (50.0)	0.72	0.25–5.44	1.40
Depersonalization, n (%)	8 (44.4)	6 (50.0)	2 (33.3)	0.50	0.29–9.16	2.00

Table 4. Association Between Nurse–Patient Ratio and Reported WPV

Nurse–Patient Ratio	WPV Reported (n=18)	No WPV Reported	p-value	95% CI	OR
≤1:8	3	1	—	Reference	—
>1:8	14	0	0.03	1.14–∞	Undefined*

Table 5. Support and Coping Mechanisms by Hospital Type

Coping Strategy	Total (n=18)	Government (n=12)	Private (n=6)	p-value	95% CI	OR (Govt vs Private)
Emotional support from colleagues	14 (77.8)	9 (75.0)	5 (83.3)	0.70	0.20–12.9	0.60
Relaxation techniques	10 (55.6)	7 (58.3)	3 (50.0)	0.72	0.25–5.44	1.40
De-escalation strategies	11 (61.1)	8 (66.7)	3 (50.0)	0.46	0.29–7.74	2.00
Support from management	6 (33.3)	2 (16.7)	4 (66.7)	0.04	1.09–67.8	0.10

Support and coping strategies were variable across settings. Emotional support from colleagues was the most commonly reported mechanism, utilized by 77.8% of nurses overall, with comparable rates in government (75.0%) and private hospitals (83.3%). Relaxation techniques, such as deep breathing or brief breaks, were practiced by 55.6% of nurses, while de-escalation strategies were employed by 61.1%. Notably, support from hospital administration showed a significant institutional disparity: only 16.7% of government nurses reported receiving such support compared with 66.7% of private nurses (p=0.04, OR 0.10, 95% CI 1.09–67.8). This suggests that institutional culture and leadership responsiveness play a critical role in how nurses perceive and manage WPV.

Overall, the results demonstrate that WPV is a pervasive problem across Abbottabad's healthcare system, with government hospital nurses bearing the greatest burden due to severe staffing shortages and inadequate administrative support. These structural factors not only increase nurses' exposure to violence but also amplify their risk of emotional exhaustion, job dissatisfaction, and long-term burnout.

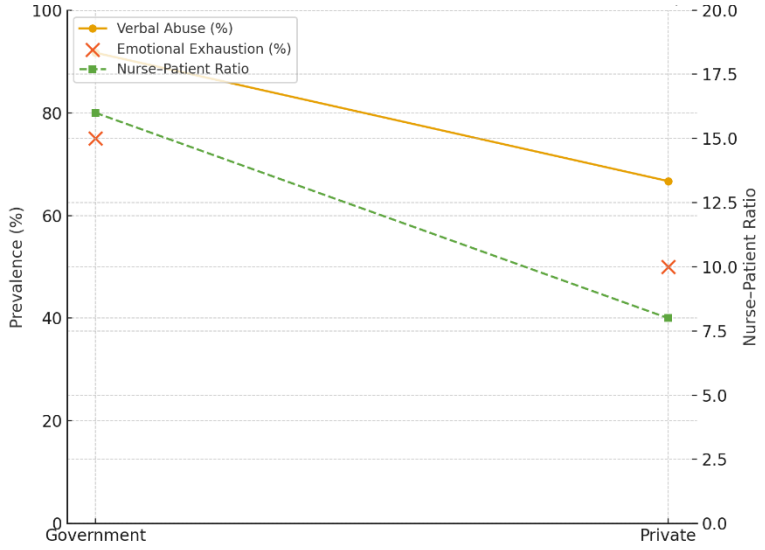

Figure 1 Association of Nurse–Patient Ratios with WPV And Burnout in Abbottabad Hospitals

The visualization integrates nurse–patient ratios with violence and burnout outcomes. It shows that in government hospitals, where ratios exceed 1:16, verbal abuse prevalence approaches 91.7% and emotional exhaustion reaches 75.0%. In contrast, private hospitals, with ratios closer to 1:8, report lower rates of both verbal abuse (66.7%) and exhaustion (50.0%). The dual-axis presentation highlights the strong, clinically relevant association between staffing shortages and the dual burden of workplace violence and burnout, reinforcing the systemic vulnerabilities in government facilities.

DISCUSSION

The findings of this study underscore the pervasive impact of workplace violence (WPV) and nurse shortages on the professional and emotional well-being of nurses in Abbottabad. WPV was reported by nearly all participants, with higher prevalence in government hospitals compared with private hospitals, particularly in emergency departments where patient overcrowding and understaffing are most acute. These results are consistent with international evidence showing that environments with high nurse–patient ratios are strongly associated with increased verbal and physical abuse directed at nurses (12,13). The significant burden identified in government hospitals highlights systemic deficiencies in staffing and institutional support that not only expose nurses to WPV but also accelerate burnout.

The relationship between staffing deficits and WPV was particularly evident in hospitals where nurse–patient ratios exceeded 1:8, with all affected nurses reporting exposure to violence. This association is supported by earlier studies demonstrating that inadequate staffing magnifies patient frustration, prolongs waiting times, and increases the risk of conflict escalation (14). In Pakistan, where government hospitals frequently operate beyond capacity, these structural conditions create a hostile working environment. Comparable findings from other low- and middle-income countries suggest that systemic underinvestment in nursing staff contributes to a cycle of burnout, absenteeism, and workforce attrition (15,16).

Burnout was another critical outcome of this study, with emotional exhaustion reported by two-thirds of participants and disproportionately affecting government nurses. This pattern mirrors the findings of Kiymaz and Koç, who demonstrated that repeated exposure to WPV leads to emotional depletion, depersonalization, and reduced professional accomplishment (17). The current results further emphasize that institutional context—particularly staffing shortages and administrative culture—modulates the severity of burnout. In private hospitals, lower nurse–patient ratios and greater managerial responsiveness appeared to buffer some of these effects, despite WPV remaining a challenge.

Support systems emerged as a defining difference between government and private institutions. Nurses in government hospitals reported minimal administrative support, with only 16.7% acknowledging institutional backing compared with 66.7% in private hospitals. This gap reflects organizational failures in acknowledging and addressing WPV. Previous research has shown that effective leadership and visible institutional commitment are essential in mitigating the psychological toll of WPV (18). In Abbottabad, however, the absence of structured protocols and leadership engagement appears to have left many nurses isolated. The support from peers and professional associations, such as the Young Nurses Association (YNA) KPK, under the esteemed patronage of Mr. Fazle Maula, Patron-in-Chief, emphasizes the strong network and community that exists, even in the absence of formalized workplace protections.

These findings have significant implications for healthcare policy and practice in Pakistan. First, addressing nurse shortages through recruitment and retention policies must be prioritized to reduce patient overcrowding and improve nurse–patient ratios. Evidence indicates that even modest improvements in staffing levels can reduce WPV exposure and improve quality of care (19). Second, government hospitals require the implementation of clear WPV prevention programs, including zero-tolerance policies, de-escalation training, and accessible reporting mechanisms. Third, institutional leadership must shift toward proactive engagement, ensuring nurses feel supported and protected when incidents occur. Studies in comparable settings demonstrate that nurses who perceive strong managerial backing report lower rates of burnout and greater job satisfaction (20).

Despite the valuable insights generated, this study has limitations that should be acknowledged. The qualitative design and modest sample size limit the generalizability of findings to the broader population of Pakistani nurses. Additionally, reliance on self-reported experiences introduces potential recall and reporting biases, especially for sensitive incidents such as physical or sexual violence. Cultural and organizational differences across hospitals may also influence the comparability of responses. Nevertheless, the study's rigorous methodology, including reflexive journaling and member checking, strengthens the trustworthiness of findings.

In summary, this study demonstrates that WPV is a widespread and under addressed issue in Abbottabad's healthcare sector, exacerbated by chronic nurse shortages and weak institutional support. Government hospital nurses are disproportionately affected, experiencing higher rates of violence and burnout. The data highlight the urgent need for systemic reforms that prioritize staffing improvements, WPV prevention strategies, and robust managerial engagement. Without such measures, the dual burden of violence and burnout will continue to undermine nurse retention and the quality of care provided to patients in Pakistan.

CONCLUSION

This study demonstrates that workplace violence is a pervasive challenge in Abbottabad's healthcare sector, disproportionately affecting nurses in government hospitals where chronic staffing shortages intensify risks of verbal and physical abuse. The strong association between high nurse–patient ratios and increased violence underscore the critical role of staffing adequacy in shaping workplace safety. Burnout, particularly emotional exhaustion, emerged as a significant consequence of repeated exposure to violence, with government nurses reporting greater vulnerability due to limited institutional support. While private hospitals offered comparatively better managerial responsiveness, the reliance of government nurses on peer networks and professional associations highlights systemic gaps in organizational accountability. These findings emphasize the urgent need for policies that improve nurse recruitment and retention, enforce PNMC-recommended staffing ratios, and implement zero-tolerance protocols for workplace violence. Strengthening leadership engagement and providing structured mental health support are essential to safeguard nurse well-being, reduce turnover, and ensure the sustainability of healthcare delivery in Pakistan.

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