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WORKPLACE VIOLENCE AND DEPRESSION IN FEMALE NURSES: THE ROLE OF EMOTIONAL EXHAUSTION AND WORK-LIFE BALANCE

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Abstract

Background: Workplace violence is an escalating occupational hazard in healthcare settings worldwide, and emergency departments (EDs) are consistently identified as among the highest-risk units within hospitals. In Pakistan, where nursing remains an overwhelmingly female profession, female emergency nurses are routinely exposed to verbal abuse, threats, intimidation and at times physical aggression from patients and attendants, often within chronically under-resourced public-sector hospital environments. The cumulative psychological burden of this exposure, compounded by emotional exhaustion and disrupted work-life balance, is believed to contribute substantially to depressive experiences among this workforce, yet the lived, subjective dimension of this phenomenon remains poorly documented in the local context. Problem Statement: Although a growing body of cross-sectional, quantitative research has documented the prevalence of workplace violence against nurses in Pakistani hospitals, there remains a marked scarcity of in-depth qualitative inquiry that captures how female emergency nurses themselves interpret, narrate and emotionally process these experiences, particularly in relation to depression, emotional exhaustion and the spillover of occupational stress into family and personal life. Purpose: This study aims to explore the lived experiences of workplace violence and depression among female nurses working in the emergency departments of Lady Reading Hospital (LRH) and Hayatabad Medical Complex (HMC), Peshawar and to examine how emotional exhaustion and work-life balance shape and intensify these experiences. Methodology: An exploratory, interpretive qualitative design, informed by phenomenological principles, will be employed. Twenty-five (25) female staff nurses currently working in the emergency departments of LRH and HMC will be recruited through purposive sampling. Data will be collected through in-depth, semi-structured, face-to-face interviews

conducted in Urdu and/or English, audio-recorded with consent, transcribed verbatim and analyzed using Braun and Clarke's six-phase thematic analysis framework. Sample and Setting: The study will be conducted in the emergency departments of two major public tertiary care hospitals in Peshawar, Khyber Pakhtunkhwa, Pakistan, selected for their high patient load, documented exposure to workplace violence, and representativeness of the public hospital emergency nursing workforce. Emerging Themes: It is anticipated that themes will emerge around forms and frequency of workplace violence, emotional and psychological injury, depressive symptomatology and silent suffering, emotional exhaustion and depletion, disruption of family and personal life, perceived institutional neglect and coping and resilience strategies. Significance: The findings are expected to generate context-specific, experience-near knowledge that can inform hospital administration, mental health nursing practice, workplace violence prevention policy and nursing education in Pakistan, while contributing to the broader South Asian literature on occupational mental health among female healthcare workers.

Keywords: Workplace violence, depression, emotional exhaustion, work-life balance, female nurses, emergency department, qualitative research, Pakistan.

INTRODUCTION

Nursing has long been recognized as one of the most emotionally demanding and physically taxing professions within the healthcare workforce. Nurses occupy a uniquely exposed position at the interface between patients, families and the healthcare system, frequently absorbing the frustration, fear, and grief that accompany illness, injury and loss (Hou et al., as cited in PMC11403778, n.d.). This exposure is intensified in hospital settings characterised by overcrowding, long waiting times, resource shortages, and high patient acuity, all of which are common features of public-sector tertiary care hospitals in low- and middle-income countries, including Pakistan.

Workplace violence (WPV) in healthcare institutions has emerged as a global occupational health crisis. Systematic reviews and meta-analyses indicate that exposure to some form of WPV among healthcare workers can be alarmingly high, with pooled prevalence estimates in some umbrella reviews reaching as high as 78.9 percent and nurses consistently identified among the professional groups most affected (Mento et al., 2020; Vento et al., 2020; Liu et al., 2019).

Female nurses occupy a particularly vulnerable position within this landscape. In Pakistan, nursing is an overwhelmingly female-dominated profession, with women constituting up to roughly 95 percent of the nursing workforce in some accounts. This gendered composition means that the burden of workplace violence in Pakistani

hospitals falls disproportionately on women, who must additionally navigate the violence within a sociocultural context that often expects them to remain silent, deferential, and emotionally composed regardless of the abuse they encounter.

Emergency departments (EDs) represent one of the highest-risk units for workplace violence within any hospital system. The combination of acute patient distress, anxious or aggressive attendants, prolonged waiting times, triage-related disputes, and limited security infrastructure converts the ED into an environment where verbal abuse, threats, and occasionally physical assault become routine occupational hazards rather than isolated incidents. Meta-analytic evidence places the prevalence of WPV exposure among ED staff at approximately 77 percent, with verbal violence accounting for the majority of reported incidents and nurses comprising more than half of all victims identified across pooled studies (Liu et al., 2019).

The psychological sequelae of repeated exposure to workplace violence extend well beyond momentary distress. Emergency nurses subjected to frequent violence have been reported to experience depression, anxiety and fear, alongside a diminished capacity for empathic, patient-centered care. Depression, in particular, represents one of the most serious and under-recognized mental health outcomes associated with chronic occupational stress in nursing. Unlike transient irritation or fatigue, depressive experience among nurses often manifests as persistent low mood, hopelessness about the work environment, withdrawal from colleagues and family and a gradual erosion of professional identity and purpose (Zafar et al., 2016).

Emotional exhaustion, a core dimension of occupational burnout, frequently mediates the pathway between workplace adversity and depressive outcomes. Conceptualized within Maslach's burnout framework as a state of being emotionally overextended and depleted of one's emotional reserves, emotional exhaustion has been empirically linked to depressive symptomatology, reduced job satisfaction and intentions to leave the profession. For female emergency nurses already navigating a high-violence environment, emotional exhaustion may function as the psychological bridge through which workplace violence translates into depression (Maslach et al., 2001; Maslach & Jackson, 1981).

Compounding this occupational strain is the persistent difficulty that many female nurses face in maintaining a sustainable balance between professional duties and domestic responsibilities. Rotating shift schedules, unpredictable overtime and the emotional residue of distressing clinical encounters often spill over into the home, disrupting sleep, family relationships and caregiving roles. In gendered household economies such as Pakistan's, where women continue to bear primary responsibility for

domestic and childcare duties regardless of their professional workload, this spillover is rarely buffered by equitable redistribution of family responsibilities, leaving many female nurses to absorb both occupational and domestic strain with limited recovery time (Jafree, 2017).

Within Pakistan specifically, this confluence of risk factors carries heightened significance. Public tertiary care hospitals such as Lady Reading Hospital (LRH) and Hayatabad Medical Complex (HMC) in Peshawar serve extremely large patient populations with comparatively limited staffing, security and institutional grievance mechanisms. Existing Pakistani evidence indicates that workplace violence prevalence against healthcare workers ranges broadly across studies, with some surveys reporting that the majority of nurses have experienced or witnessed some form of abuse during their careers, and verbal abuse from patients or attendants representing the most frequently reported form of violence in emergency settings (Shaikh et al., 2020; Zafar et al., 2013).

Despite this accumulating quantitative evidence, there remains a striking scarcity of qualitative, experience-near research that allows female emergency nurses in Pakistan to narrate, in their own words, how workplace violence is felt, interpreted and carried forward into their emotional lives and households. Existing studies have tended to quantify the prevalence and types of violence without adequately capturing the depth, nuance, and meaning that nurses themselves attach to these experiences, nor how emotional exhaustion and work-life imbalance interact to shape the development of depressive experience over time.

This gap is particularly consequential because policy and institutional responses designed without reference to nurses lived realities risk being superficial, generic or poorly matched to the specific stressors of the Pakistani emergency nursing context. A qualitative approach, grounded in phenomenological and interpretive principles, offers the methodological depth required to explore these subjective experiences, to surface meanings that quantitative scales cannot capture and to generate context-sensitive insight that can inform more responsive hospital policy and mental health support systems.

It is against this background that the present study seeks to explore, through in-depth qualitative inquiry, the lived experiences of workplace violence and depression among female nurses working in the emergency departments of LRH and HMC, Peshawar, while examining the roles that emotional exhaustion and work-life balance play in shaping those experiences.

BACKGROUND OF THE STUDY

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Workplace Violence as a Global Issue in Nursing

Workplace violence against healthcare workers has been recognized by international health bodies as a pervasive occupational hazard rather than an isolated or exceptional event. Across diverse healthcare systems, nurses report disproportionately high rates of exposure to verbal abuse, threats, and physical aggression compared with most other occupational groups. An umbrella review synthesizing 32 systematic reviews and meta-analyses found that overall violence prevalence among healthcare workers was reported to be as high as 78.9 percent, with substantial variation across countries, population subgroups, and detection methods and noted that the COVID-19 pandemic further exacerbated the scale of the problem (Liu et al., 2019).

Workplace Violence as a Hospital and Emergency Department Problem

Within the hospital system, the emergency department has been consistently identified as the highest-risk clinical area for workplace violence. A systematic review and meta-analysis of WPV in EDs found that 77 percent of all ED staff reported exposure to workplace violence, with 9,072 documented cases across the included studies of these, 72 percent involved verbal violence and 18 percent involved physical abuse. Nurses comprised the largest proportion of victims among ED staff, accounting for approximately 55.7 percent of cases, while family members and patients themselves were identified as the most common instigators of violent episodes (Liu et al., 2019).

Common Forms of Violence Faced by Nurses

The literature consistently describes workplace violence against nurses as encompassing a spectrum of behaviours rather than a single discrete act. These include verbal abuse (shouting, insults, humiliating remarks), threats and intimidation, psychological abuse (manipulation, blame, public humiliation), sexual harassment, bullying from colleagues or superiors and physical assault ranging from pushing and grabbing to more severe forms of bodily harm. A systematic review and meta-analysis of WPV against nurses in Africa found a pooled prevalence of 62.3 percent, with verbal abuse the most common subtype at 51.2 percent, followed by threats, bullying, physical abuse and sexual harassment, illustrating the layered and multidimensional nature of the phenomenon (Najafi et al., 2018).

Mental Health Effects of Violence on Nurses

Exposure to workplace violence has been repeatedly linked to adverse psychological outcomes among nurses, including anxiety, fear, post-traumatic stress symptoms and depression. A cross-sectional study of emergency nurses in Tunis found that among 164 nurses, all of whom reported being victims of workplace violence, nineteen had a history of one or more mental disorders, including anxiety and depressive disorder and over a

quarter reported that workplace violence had compromised the quality of the care they were able to provide. Emergency nurses with high frequency of violence exposure have been found to report adverse psychological experiences such as depression, anxiety and fear, alongside reduced empathy and diminished motivation in caring for critically ill patients (d'Ettorre et al., 2018).

Depression as an Outcome of Repeated Stress and Violence

Depression among nurses is increasingly understood not as an isolated clinical phenomenon but as one that is closely embedded within chronic occupational stress, including repeated exposure to workplace violence. A systematic review of burnout, depression, and stress among emergency department nurses and physicians underscored the high prevalence of these conditions among ED staff and their potentially serious negative impact on both private and professional life, calling for targeted support and interventions to enhance resilience and prevent the onset or deterioration of mental health conditions (Ramacciati et al., 2019).

Emotional Exhaustion as a Response to Chronic Workplace Strain

Emotional exhaustion, conceptualized as the core dimension of occupational burnout, represents a state in which an individual's emotional resources have been progressively depleted by sustained workplace demands. Within Conservation of Resources (COR) theory, emotional exhaustion is understood to result from a continuous loss of psychological resources without adequate opportunity for replenishment, a dynamic that is particularly salient for nurses working in chronically under-resourced, high-violence environments such as public hospital emergency departments. Emotional job burnout, when left unaddressed over time, has been linked in the literature to depression and broader emotional distress.

Work-Life Imbalance Among Female Nurses

Rotating shift schedules, unpredictable overtime and the emotional residue carried home from distressing clinical encounters create persistent strain on nurses' ability to sustain a healthy balance between professional and personal life. This strain is gendered in important ways across multiple cultural contexts, including South Asia, women continue to bear a disproportionate share of domestic and caregiving responsibilities regardless of their occupational workload, meaning that work-related emotional depletion is rarely buffered by equitable redistribution of household duties at home. Long working hours and shift duties have been found to negatively affect nurses' work-life balance and burnout has been shown to relate negatively to work-life balance and quality of life among emergency department staff (Ramacciati et al., 2019).

Special Vulnerability of Female Emergency Nurses in Pakistan

In Pakistan, nurses are predominantly female, with some estimates suggesting they constitute up to approximately 95 percent of the nursing task force. Pakistani research has documented substantial rates of workplace violence against healthcare personnel, including in emergency departments of major cities. A systematic review of workplace violence against healthcare workers in Pakistan reported a prevalence range of 25 to 100 percent across the included studies, noting that this violence was routinely directed against physicians, nurses and staff across wards, emergency departments, and intensive care units, with attendants' frustration over delayed treatment, resource shortages, and patient deaths frequently cited as precipitating factors. A study conducted in the emergency department of a hospital in Khyber Pakhtunkhwa similarly found that women made up nearly two-thirds of nursing participants exposed to workplace violence, reinforcing the gendered dimension of this occupational hazard in the local context (Jafree, 2017; Shaikh et al., 2020; Zafar et al., 2016).

Why a Qualitative Study Is Appropriate

Although the quantitative literature offers valuable prevalence estimates, it cannot adequately capture the subjective meaning that female emergency nurses attach to their experiences of violence, nor the complex, often non-linear pathway through which these experiences translate into emotional exhaustion, depressive feeling and disrupted personal life. A qualitative, interpretive approach allows the researcher to access the depth, language, and lived texture of these experiences directly from the nurses themselves, generating insight that is both context-specific to the Pakistani public hospital setting and theoretically meaningful for the broader literature on occupational mental health in nursing.

PROBLEM STATEMENT

Workplace violence has become a routine, rather than exceptional, feature of hospital-based nursing practice and emergency departments are consistently identified as among the highest-risk clinical environments for such violence. Female nurses, who form the overwhelming majority of the nursing workforce in Pakistan, are disproportionately exposed to verbal abuse, intimidation, and at times physical aggression from patients and attendants, frequently within public-sector hospitals characterized by overcrowding, limited security infrastructure and weak institutional grievance mechanisms. Repeated exposure to such violence is increasingly understood to contribute to depression, emotional exhaustion and disrupted work-life balance among nurses, yet the precise way in which these experiences are felt, interpreted and carried into nurses' personal and family lives remains poorly understood at the level of lived experience.

Existing research from Pakistan and the broader South Asian region has documented the prevalence and forms of workplace violence against nurses through cross-sectional surveys, but there is a marked scarcity of context-specific qualitative evidence exploring how female emergency nurses themselves narrate the emotional and psychological aftermath of violence, how emotional exhaustion develops and is experienced over time and how work-life balance is disrupted as a consequence. This gap is particularly acute for female nurses working in the emergency departments of large public tertiary care hospitals such as Lady Reading Hospital (LRH) and Hayatabad Medical Complex (HMC) in Peshawar, where the convergence of high patient volume, resource constraints, and gendered occupational vulnerability may produce a distinctive pattern of psychological strain that has not yet been systematically explored through in-depth qualitative inquiry. There is therefore a clear and pressing need to explore the lived experiences of workplace violence and depression among female nurses in these settings, with specific attention to the roles played by emotional exhaustion and work-life balance.

PURPOSE OF THE STUDY

The purpose of this qualitative study is to explore, in depth, the lived experiences of workplace violence and depression among female nurses working in the emergency departments of Lady Reading Hospital (LRH) and Hayatabad Medical Complex (HMC), Peshawar, and to examine the role that emotional exhaustion and work-life balance play in shaping, intensifying or mediating these experiences. Through in-depth, semi-structured interviews with female emergency nurses, the study seeks to generate rich, contextually grounded understanding of how workplace violence is experienced, how it relates to depressive feeling, how emotional exhaustion develops within this process, and how these occupational experiences extend into and disrupt nurses' personal and family lives.

RESEARCH OBJECTIVES

General Objective

To explore the lived experiences of workplace violence and depression among female emergency nurses at LRH and HMC, Peshawar and to examine the role of emotional exhaustion and work-life balance in shaping these experiences.

Specific Objectives

- To explore the nature, forms, and frequency of workplace violence experienced by female nurses working in emergency departments.
- To understand the emotional and psychological consequences that female emergency nurses associate with their experiences of workplace violence.

- To explore how depression-related feelings and mental distress are experienced and described by female nurses in relation to workplace violence.
- To examine the role of emotional exhaustion in the development and intensification of nurse's experiences of workplace violence and depression.
- To explore how workplace violence and associated occupational stress disturb female nurses work-life balance, family relationships, and personal well-being.
- To identify the coping strategies, support systems, and organizational needs that female emergency nurses perceive as relevant to managing workplace violence and its psychological consequences.

RESEARCH QUESTIONS

Central Research Question

How do female nurses working in the emergency departments of LRH and HMC, Peshawar, experience and make sense of workplace violence and depression, and what role do emotional exhaustion and work-life balance play in shaping these experiences?

Sub-Questions

- What types of workplace violence are experienced by female emergency nurses, and from whom does this violence typically originate?
- How do nurses describe the emotional and psychological impact of these experiences of workplace violence?
- How is depression experienced, recognized or described by female nurses in relation to their exposure to workplace violence?
- What role does emotional exhaustion play in shaping nurse's experiences of workplace violence and depression?
- How does workplace violence affect nurse's work-life balance, family relationships and personal well-being?
- In what ways do the specific demands of emergency department work intensify these experiences?
- What coping mechanisms do nurses currently use and what forms of institutional or social support do they perceive as needed?

SIGNIFICANCE OF THE STUDY

This study carries significance across several interconnected domains of nursing knowledge, practice and policy.

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Contribution to Nursing Knowledge

By documenting the first-person, lived experiences of female emergency nurses in a Pakistani public hospital context, the study contributes context-specific knowledge to the broader international literature on occupational violence and mental health in nursing, much of which has been generated in high-income settings with different organizational, cultural and resource conditions.

Mental Health Nursing

The findings may deepen mental health nursing's understanding of how depression and emotional exhaustion develop within the specific occupational pathway of repeated workplace violence exposure, offering insight relevant to the early identification and psychological support of at-risk nursing staff.

Occupational Health Awareness

The study may raise awareness among occupational health stakeholders regarding the cumulative psychological toll of workplace violence in emergency care settings, supporting the case for structured occupational mental health surveillance among nursing staff.

Female Nurse Well-Being

By centering the gendered dimension of workplace violence and work-life imbalance, the study foregrounds the specific well-being needs of female nurses, a group that constitutes the overwhelming majority of Pakistan's nursing workforce yet remains underrepresented in qualitative occupational health research.

Hospital Administration and Nursing Management

Findings may provide hospital administrators and nursing management at LRH, HMC and comparable public hospitals with experience-grounded evidence to inform staffing models, security arrangements and supervisory support structures within emergency departments.

Violence Prevention Policies

The study may inform the development or refinement of institutional workplace violence prevention policies that are responsive to the specific dynamics described by nurses themselves, rather than generic templates imported from other contexts.

Employee Mental Health Support Systems

Insights generated may support the design of accessible, stigma-sensitive mental health and counselling services for nursing staff, addressing the silent suffering that often accompanies occupational depression in this workforce.

Emergency Department Workforce Planning

Understanding the lived burden of violence, exhaustion and work-life imbalance may assist in workforce planning decisions related to shift scheduling, staffing ratios and retention strategies within high-pressure emergency department settings.

Nursing Education and Future Research in Pakistan

Finally, the study may serve as a foundation for nursing curricula addressing occupational resilience and workplace safety and as a methodological and substantive reference point for future Pakistani researchers seeking to extend qualitative inquiry into nurse's occupational mental health.

DEFINITION AND CONCEPTUAL UNDERSTANDING OF KEY TERMS

Workplace Violence

Workplace violence is commonly defined, drawing on the formulation used by the US National Institute for Occupational Safety and Health, as violent acts including physical assaults and threats of assault directed towards persons at work or on duty. In the context of this study, workplace violence refers to verbal abuse, threats, intimidation, psychological abuse, harassment and physical aggression directed at female nurses by patients, attendants, or other individuals within the emergency department setting. During qualitative exploration, workplace violence will be understood not merely as a discrete behavioral event but as a recurring, embodied experience that nurses interpret through the lens of their professional role, gender and institutional context.

Depression

Depression, in clinical and occupational health literature, refers to a persistent disturbance of mood characterized by sadness, hopelessness, loss of interest or pleasure, fatigue and impaired functioning. Within this study, depression will not be used as a formal diagnostic category but as a lived, descriptive construct encompassing nurses' self-reported feelings of persistent low mood, emotional numbness, hopelessness about their work environment, and withdrawal, as these are narrated in relation to their occupational experiences. During qualitative exploration, depression will be understood as it is meaningfully expressed by participants in their own words, rather than measured against a standardized diagnostic instrument.

Emotional Exhaustion

Emotional exhaustion is conceptualized within Maslach's burnout framework as a state of being emotionally overextended and depleted of one's emotional reserves, typically arising from prolonged exposure to high job demands without adequate resources or recovery. In this study, emotional exhaustion refers to nurse's subjective sense of emotional depletion, numbness or fatigue that they associate with their cumulative

occupational experiences, particularly workplace violence. During qualitative exploration, it will be understood as a process unfolding over time rather than a fixed state, manifesting differently across individual narratives.

Work-Life Balance

Work-life balance refers to an individual's perception of how effectively their occupational responsibilities and personal or family life roles are integrated, such that participation and satisfaction are sustained in both domains. In this study, work-life balance refers specifically to the degree to which female nurses perceive their emergency department work, including shift patterns and the emotional residue of violent encounters, as interfering with or being compatible with their family relationships, caregiving responsibilities, and personal well-being. During qualitative exploration, this will be understood as a fluid, subjectively defined experience rather than an objectively measured ratio of hours.

Female Staff Nurses

Female staff nurses, for the purposes of this study, refers to women formally employed in a clinical nursing role within a hospital setting, holding the qualifications and registration required for practice in Pakistan. This study focuses exclusively on this population in order to foreground the gendered dimension of workplace violence, depression, emotional exhaustion and work-life balance within the Pakistani nursing workforce, which is predominantly female.

Emergency Department Nurses

Emergency department nurses are nursing staff assigned to provide direct clinical care within the emergency department of a hospital, a setting characterized by high patient acuity, unpredictable patient flow, time pressure and frequent direct contact with distressed or aggressive patients and attendants. In this study, this term refers specifically to female nurses with direct, practical clinical experience working in the emergency departments of LRH and HMC, whose proximity to high-risk situations positions them as information-rich participants for exploring the phenomena under investigation.

LITERATURE REVIEW

This literature review synthesizes existing evidence on workplace violence, depression, emotional exhaustion, and work-life balance among nurses, with particular attention to emergency department settings and the Pakistani and South Asian context. The review is organised thematically rather than as a simple chronological summary, in order to build an analytical narrative that connects the four central constructs of this study.

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Workplace Violence in Nursing

Global Burden and Prevalence

The global literature on workplace violence in healthcare consistently points to nursing as one of the occupations most affected. An umbrella review of systematic reviews and meta-analyses on workplace violence against healthcare workers found pooled prevalence estimates as high as 78.9 percent, with substantial heterogeneity across countries and detection methods and noted that nurses working in high-acuity settings, including psychiatric and emergency units, were among the professionals most impacted. The review further observed that the COVID-19 pandemic exacerbated the scale of this problem across multiple health systems (Mento et al., 2020).

Workplace Violence in Hospitals

Within the broader hospital environment, workplace violence has been associated with a complex interplay of organizational, environmental, and interpersonal factors, including overcrowding, long waiting times, inadequate staffing and weak security infrastructure. Reviews of workplace violence determinants have repeatedly identified attendants' frustration with delays in treatment, perceived inadequacy of care, and adverse clinical outcomes, including patient death, as recurring precipitating factors across multiple healthcare systems.

Violence in Emergency Departments

Emergency departments have been singled out across the international literature as uniquely high-risk environments for workplace violence. A systematic review and meta-analysis focused specifically on EDs found that 77 percent of ED staff reported exposure to workplace violence, documenting 9,072 cases across included studies, of which 72 percent involved verbal violence and 18 percent involved physical abuse nurses accounted for the largest share of victims, at approximately 55.7 percent of identified cases. Comparative data across countries illustrate the scale of the problem: reported WPV rates among emergency nurses have ranged from approximately 49.6 percent in Taiwan to 73.7 percent in Saudi Arabia and 76 percent in Italy, underscoring that this is a near-universal occupational hazard rather than a phenomenon confined to any single health system.

Patient and Attendant Aggression

Across studies, patients and their attendants or family members are consistently identified as the most frequent instigators of workplace violence in the emergency department. In one meta-analysis, of 2,578 identified instigators of violence against ED staff, 52 percent were family members, 27 percent were patients themselves, and 21 percent were other relatives or friends accompanying the patient, suggesting that the

emotional intensity surrounding acute illness and the anxiety of accompanying family members are central drivers of aggressive behaviour directed at nursing staff (Liu et al., 2019).

Violence Specifically Affecting Female Nurses

Although workplace violence affects healthcare workers of all genders, several strands of evidence point to a distinctive gendered dimension. In Pakistan, where nurses are predominantly female, the sheer demographic weight of women in the profession means that the cumulative burden of workplace violence within the health system falls disproportionately upon them. Beyond demographic exposure, female nurses may also face gender-specific forms of violence, including sexual harassment, that compound the verbal and physical abuse common to the emergency setting and may encounter sociocultural expectations that discourage open reporting or emotional expression of the resulting distress (Jafree, 2017; Najafi et al., 2018).

Workplace Violence in Pakistan and South Asia

Evidence from Pakistan and Neighbouring Countries

Pakistani research on workplace violence against healthcare personnel has expanded considerably over the past decade. A systematic review of workplace violence against healthcare workers in Pakistan reported prevalence estimates ranging from 25 to 100 percent across included studies, noting that violence was routinely directed against physicians, nurses and other staff across general wards, emergency departments, and intensive care units. An earlier study conducted in Karachi's emergency departments similarly documented substantial exposure to verbal and physical abuse among healthcare personnel, while later cross-sectional research at a tertiary care hospital in Karachi found that nearly half of healthcare professionals had faced or witnessed workplace violence, with verbal abuse identified as the most common form. A focused study on women nurses in two public sector hospitals in Lahore further confirmed that workplace violence against female nursing staff is a persistent and largely unaddressed feature of the Pakistani hospital environment (Shaikh et al., 2020; Jafree, 2017)

Public Hospital Challenges

Public tertiary care hospitals in Pakistan, including those located in Peshawar, often operate under conditions of severe resource constraint relative to patient demand. A cross-sectional study examining violence against healthcare workers in Peshawar identified the metropolitan setting's high patient burden and associated systemic strain as contributing factors to the persistence of workplace violence in local hospitals. Within this environment, the absence of robust reporting mechanisms has been repeatedly cited as a key barrier: healthcare personnel, including nurses, often do not report

workplace violence due to the absence of clear organisational policy, fear of professional repercussion, or a normalized perception that such abuse is an unavoidable feature of clinical work (Bhatti et al., 2021).

Emergency Department Burden in the Local Context

A cross-sectional survey conducted in the emergency department of a hospital in Khyber Pakhtunkhwa found that nearly two-thirds of nursing participants exposed to workplace violence were female, with almost half of participants reporting fewer than five years of clinical experience, suggesting that relatively early-career nurses are heavily represented among those exposed to violence in this setting. A broader mixed-methods study examining the management of violence in Pakistani emergency settings found that many nurses regarded abuse as an inevitable part of their job, while also acknowledging that exposure to workplace violence during triage had significant consequences for their psychological well-being and their behaviour both at work and at home (Zafar et al., 2016).

Cultural, Organizational and Structural Contributors

Multiple Pakistani and South Asian studies point to a combination of structural and cultural contributors to workplace violence, including low public trust in healthcare quality, unmet expectations around treatment outcomes, overcrowding, inadequate staff-to-patient ratios and weak institutional accountability structures. The COVID-19 pandemic has been identified as a period of dramatic escalation in workplace violence incidents in Pakistan, attributed in part to attendants' frustration with resource scarcity, the inability to access adequate treatment, disputes over the handling of deceased patient's bodies and broader public mistrust of the healthcare system during a period of acute strain (Bhatti et al., 2021).

Depression Among Nurses

Psychological Burden of Nursing

Nursing has long been associated with elevated psychological burden relative to many other occupations, owing to the combination of emotional labor, shift work, high responsibility and frequent exposure to suffering and death. This burden is intensified in emergency care settings, where the pace and unpredictability of clinical demands leave limited space for emotional processing or recovery between distressing encounters.

Depression Risk Factors Among Nurses

Across the literature, depression among nurses has been associated with a constellation of occupational risk factors, including high workload, poor organizational support, exposure to workplace violence, burnout and disrupted work-life balance. A systematic review of burnout, depression, and stress among ED nurses and physicians documented

a high prevalence of all three conditions among ED staff, alongside a negative relationship between burnout and both work-life balance and quality of life, underscoring the interconnectedness of these occupational mental health outcomes.

Occupational Stress and Depressive Symptoms

A cross-sectional study of emergency nurses in Tunis found that, among nurses who had all experienced some form of workplace violence, a notable proportion had a documented history of mental health conditions including depressive disorder, with a substantial share of the sample reporting significant concern about their personal safety in the workplace. These findings reinforce the proposition that occupational exposure to violence is not merely an isolated stressor but one that interacts with and potentially precipitates, depressive symptomatology over time (d'Ettorre et al., 2018).

Effect of Depression on Work Performance and Quality of Care

Depression among nurses has implications that extend beyond individual well-being to patient safety and quality of care. Nurses experiencing depressive symptoms may demonstrate reduced concentration, diminished empathic engagement and lower job satisfaction, with downstream consequences for clinical decision-making, communication, and the overall therapeutic relationship with patients. Within the Tunisian study referenced above, more than a quarter of nurses reported that workplace violence had directly affected the quality of the care they were able to deliver, illustrating the tangible clinical stakes of unaddressed occupational mental health burden (d'Ettorre et al., 2018).

Emotional Exhaustion and Burnout

Definition and Dimensions

Emotional exhaustion is most commonly understood as the core dimension of Maslach's tripartite model of burnout, alongside depersonalization and reduced personal accomplishment. It refers to a state of being emotionally overextended and depleted of one's emotional reserves, often described in the literature as feeling emotionally overextended and worn out by one's work. More contemporary burnout models have refined this into a two-dimensional framework centered on exhaustion, encompassing both emotional and physical depletion, and engagement, defined by dedication and vigour (Maslach & Jackson, 1981; Maslach et al., 2001).

Emotional Exhaustion in Nursing

Emotional exhaustion has been extensively documented among nurses across multiple specialties, with emergency and intensive care nurses frequently reporting elevated levels relative to other clinical areas, owing to the acuity and unpredictability of their patient populations. A structural equation modelling study of intensive care nurses,

grounded in Conservation of Resources theory, demonstrated that emotional exhaustion among young nurses was shaped by a complex interplay of workload, professional courage, and perceived organizational justice, illustrating that emotional exhaustion is not simply a function of workload volume but of the broader resource environment in which nurses operate (Hobfoll et al., 2018).

How Repeated Violence and Stress Contribute to Exhaustion

Conservation of Resources theory provides a coherent explanation for how repeated exposure to workplace violence contributes to emotional exhaustion: each violent or threatening encounter represents an actual or threatened loss of psychological resources, and when such losses accumulate without sufficient opportunity for resource replenishment, nurses experience a depleted emotional state. Hobfoll and Freedy's elaboration of this theory suggests that unreasonably difficult workloads and assignments are a key contributor to this exhaustion, ultimately leaving individuals feeling overwhelmed and unable to meet personal and professional goals (Hobfoll et al., 2018).

Relationship Between Emotional Exhaustion and Depressive Symptoms

A substantial body of evidence links emotional exhaustion directly to depressive outcomes. Emotional job burnout, when unresolved over time, has been associated in the literature with depression and broader emotional distress, and burnout has been found to relate negatively to both work-life balance and quality of life among emergency department staff. A latent profile analysis of nurse burnout and resilience further found that nurses with greater emotional thriving and recovery capacity, even amid moderate-to-high burnout, exhibited more favourable psychological profiles, including lower depression and higher work-life balance scores, suggesting that emotional exhaustion and depression are linked but not deterministically so, and that resilience-promoting resources may moderate this relationship (Ramacciati et al., 2019; Sun et al., 2022).

Work-Life Balance in Female Nurses

Shift Work and Rotating Duties

Rotating and extended shift schedules are a near-universal feature of hospital nursing and have been consistently associated with disrupted sleep, reduced family time and impaired work-life balance. Research on shift rotation direction among hospital nurses has demonstrated measurable effects on sleep quality, alertness, work performance and perceived work-life balance, indicating that even the structural design of shift schedules, beyond their sheer duration, carries consequences for nurses' broader well-being (Zhang et al., 2017).

Family Responsibilities and Gender Expectations

Work-life balance research has long recognized that the work-family interface affects women differently from men, with women more often expected to manage the bulk of domestic and caregiving responsibilities regardless of their occupational workload. This pattern has been documented across diverse cultural contexts, including studies of professional women in mainland China, where work-life balance was found to be shaped significantly by long working hours, high job demands, and the persistence of traditional gendered expectations around domestic responsibility. A qualitative study of nurses in Bangladesh similarly found that long working hours, shift duties, and emergency calls disrupted daily routines for female nurses, making it difficult to fulfil family obligations, a pattern with direct resonance for the Pakistani context given broadly similar gender role expectations (Zhang et al., 2017; Najafi et al., 2018).

Emotional Spillover from Hospital to Home

The concept of emotional spillover describes the process by which distress experienced in the workplace, such as that arising from violent or threatening patient encounters, is carried home and manifests in altered mood, reduced patience or withdrawal within family relationships. Although directly examining this spillover process requires the depth offered by qualitative inquiry, existing burnout and work-life balance literature consistently affirms that occupational emotional exhaustion is negatively associated with broader life satisfaction and family functioning (Maslach et al., 2001).

Effects of Poor Work-Life Balance on Mental Health and Job Functioning

Poor work-life balance has been linked in the nursing literature to elevated stress, reduced job satisfaction and increased intention to leave the profession. A multicenter study of nurses found that perceived stress was positively associated with work withdrawal behaviour, a relationship explained through Conservation of Resources theory as resulting from the depletion of psychological resources under conditions of sustained occupational demand without adequate recovery, with this resource depletion pathway also linked empirically to increased emotional exhaustion (Hobfoll et al., 2018).

Relationship Between Workplace Violence, Depression, Emotional Exhaustion and Work-Life Balance

Taken together, the literature reviewed above suggests a plausible, theoretically coherent pathway linking the four central constructs of this study. Workplace violence functions as a recurrent occupational stressor that depletes nurse's psychological resources. As these losses accumulate without adequate organizational support or recovery time, emotional exhaustion develops, consistent with the predictions of Conservation of Resources theory. Emotional exhaustion, in turn, has been empirically

and theoretically linked to depressive symptomatology, suggesting that for many nurses, the experience of depression may emerge not directly from violence itself but through the mediating mechanism of cumulative emotional depletion. Simultaneously, the demands of shift-based emergency nursing work, combined with gendered domestic expectations, place additional strain on nurse's capacity to recover psychologically outside of work, disrupting work-life balance in ways that may further intensify, rather than buffer, the emotional toll of workplace violence. This suggests a layered, interactive rather than purely linear relationship among the four constructs, one that quantitative survey methods are not well positioned to capture in its full complexity and which therefore warrants qualitative exploration (Hobfoll, 1989; Maslach et al., 2001).

Theoretical and Conceptual Support

This study draws primarily upon Conservation of Resources (COR) theory, originally articulated by Hobfoll, supplemented by insights from Maslach's burnout framework. COR theory proposes that individuals strive to obtain, retain, and protect resources that they value, including emotional energy, self-esteem, and a sense of safety and control, and that stress arises when these resources are threatened, lost or insufficiently replenished relative to the demands placed upon the individual. Within this framework, each episode of workplace violence experienced by a female emergency nurse represents a tangible or anticipated loss of psychological resources, including a sense of safety, dignity and professional efficacy. Repeated resource loss, without commensurate replenishment through organizational support, social recognition or personal recovery time, produces the state of emotional exhaustion central to occupational burnout.

COR theory is particularly well suited to this study because it explicitly accommodates the interaction between occupational and personal domains resource depletion accrued at work is understood to carry forward into other life domains, including family functioning, which directly corresponds to the work-life balance dimension under investigation. Maslach's burnout framework complements this theoretical foundation by providing a precise conceptual definition of emotional exhaustion as the affective core of burnout, distinct from depersonalization and reduced personal accomplishment, allowing the study to maintain definitional clarity when participants describe their emotional states during interviews. Together, these frameworks provide a theoretically grounded lens through which to interpret how workplace violence, emotional exhaustion, depression, and work-life balance may interact within the lived experience of female emergency nurses in Pakistan, while still allowing the qualitative analysis to remain open to locally specific meanings and

patterns that may extend or complicate the theory (Hobfoll et al., 2018; Maslach et al., 2001).

Literature Gap

The reviewed literature establishes, with reasonable consistency, that workplace violence is highly prevalent among nurses globally and in Pakistan specifically, that emergency departments are particularly high-risk settings and that emotional exhaustion, depression, and disrupted work-life balance are plausible downstream consequences of this exposure. What remains substantially underexplored is the lived, first-person experience of these processes among female nurses working specifically within Pakistani public hospital emergency departments. Existing Pakistani studies have relied predominantly on cross-sectional, quantitative survey designs that document prevalence and associated factors but do not allow nurses to narrate, in their own words, how violence is emotionally processed, how exhaustion develops over time, how depression is recognized or concealed and how all of this is carried into family and personal life within a specific sociocultural context that shapes both the experience of violence and the permissible expression of distress.

A qualitative study situated specifically within the emergency departments of LRH and HMC, Peshawar, is therefore needed to fill this gap, given that these institutions represent large, high-volume public tertiary care hospitals broadly representative of the conditions under which the majority of Pakistan's emergency nursing workforce operates. Because workplace violence, depression, emotional exhaustion, and work-life balance are all phenomena substantially shaped by local institutional, cultural, and gender-role context, evidence generated in other countries, or even through quantitative Pakistani studies alone, cannot be assumed to capture the specific meanings, coping strategies and support needs of female emergency nurses in this particular local context. This study is designed to address that gap directly.

THEORETICAL AND CONCEPTUAL FRAMEWORK

The conceptual framework of this study is anchored in Conservation of Resources (COR) theory, integrated with Maslach's conceptualization of emotional exhaustion as the affective core of occupational burnout. COR theory proposes that individuals are motivated to protect a finite pool of valued resources, including physical safety, emotional energy, self-esteem and professional dignity and that psychological strain arises when these resources are threatened, lost, or inadequately replenished. For female emergency nurses working in high-violence public hospital settings, each encounter with verbal abuse, intimidation or physical aggression represents a tangible threat to or loss of, these resources (Hobfoll, 1989).

Within this framework, workplace violence is conceptualized as the primary stressor that initiates a cascading process of resource depletion. Repeated exposure, particularly in the absence of adequate organizational protection, recognition or recovery time, is theorized to produce emotional exhaustion, the affective exhaustion component of burnout that reflects a nurse's depleted capacity to continue investing emotional energy in her work. As emotional exhaustion accumulates, it is theorized to increase vulnerability to depressive experience, consistent with the empirical literature linking burnout and emotional exhaustion to depressive symptomatology among nurses (Hobfoll et al., 2018).

Crucially, COR theory extends this resource-loss logic beyond the workplace into the personal domain, providing theoretical justification for examining work-life balance as both a consequence and a potential moderating factor within this process. A nurse who returns home emotionally depleted has fewer resources available to invest in family relationships, household responsibilities, and self-care, which may in turn reduce the restorative capacity of her personal life and prevent adequate resource replenishment before her next shift. This creates the potential for a self-reinforcing cycle in which occupational resource loss and personal-domain resource depletion compound one another over time, a dynamic that is of central interest to this qualitative exploration.

A simplified text-based conceptual model illustrating this proposed pathway is presented below:

Workplace Violence

↓

Emotional Stress / Emotional Exhaustion

↓

Depressive Experiences

↓

Disturbed Work-Life Balance, Reduced Well-being, and Occupational Strain

While this linear model offers a useful starting heuristic, the empirical and theoretical literature reviewed above suggests that the actual relationship among these constructs is more recursive and interactive than a single downward arrow can capture. A more academically refined model, consistent with Conservation of Resources theory, is presented below:

Workplace Violence (Verbal Abuse, Threats, Physical Aggression, Psychological Abuse)

↓ **(Perceived Resource Loss / Threat)**

Emotional Exhaustion (Depletion of Emotional Resources)

↓ ↑

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Depressive Experience ←——————→ Disturbed Work-Life Balance
↓
Coping Strategies, Social/Institutional Support and Resilience as Potential Buffers

This refined model reflects the bidirectional relationship between depressive experience and work-life imbalance, recognizing that disrupted family and personal life may itself deepen depressive feeling, just as depressive feeling may further erode a nurse's capacity to sustain healthy relationships and routines outside of work. The model also explicitly incorporates coping strategies, social support and institutional resources as potential buffers within the Conservation of Resources framework, consistent with the theory's recognition that resource gain, not only resource loss, shapes psychological outcomes. This conceptual structure will guide, but not rigidly constrain, the thematic analysis of interview data, allowing themes to emerge inductively while remaining interpretable within a coherent theoretical frame.

RESEARCH METHODOLOGY

Research Approach

This study will adopt a qualitative research approach. Qualitative inquiry is appropriate when the aim of research is to understand the meaning, depth and complexity of human experience as it is lived and interpreted by those who experience it, rather than to measure the frequency or statistical association of predefined variables. Because the central aim of this study is to understand how female emergency nurses themselves experience, interpret and emotionally process workplace violence, depression, emotional exhaustion, and work-life imbalance, a qualitative approach is necessary to access the depth, nuance and subjective meaning that quantitative instruments are not designed to capture (Polit & Beck, 2021).

Research Design

This study will employ an exploratory, interpretive qualitative design informed by phenomenological principles. The phenomenological orientation is well suited to this study because the central research questions are concerned with the essence and meaning of nurses' lived experience of workplace violence and its psychological aftermath, rather than with testing a predetermined hypothesis or generating generalizable statistical estimates. An interpretive stance further acknowledges that nurse's accounts will be shaped by their individual histories, cultural context and the meaning-making processes through which they make sense of distressing occupational events, and that the researcher's role is to interpret these accounts with sensitivity to that context rather than to impose an externally predetermined coding framework. This combined exploratory-interpretive-phenomenological design allows sufficient

methodological flexibility to capture both the descriptive texture of nurses' experiences and the deeper meanings they attach to them.

Study Setting

The study will be conducted in the emergency departments of two major public sector tertiary care hospitals in Peshawar, Khyber Pakhtunkhwa, Pakistan Lady Reading Hospital (LRH) and Hayatabad Medical Complex (HMC). Both institutions are large, high-volume public hospitals that serve extensive urban and rural catchment populations across Khyber Pakhtunkhwa and parts of the broader region and both have documented exposure to workplace violence within their emergency departments in prior local research. These settings are appropriate for this study because they are broadly representative of the structural and resource conditions, including overcrowding, high patient acuity and constrained security infrastructure, that characterise the working environment of the majority of Pakistan's public-sector emergency nursing workforce, increasing the relevance and applicability of the study's findings to this broader population.

Study Population

The study population comprises female staff nurses currently working in the emergency departments of LRH and HMC, Peshawar, who have direct, hands-on clinical experience in emergency nursing care and are therefore well positioned to provide information-rich accounts of the phenomena under investigation.

Inclusion Criteria

Female staff nurses by gender and professional designation.

Currently working in the emergency department of LRH or HMC at the time of data collection.

Possessing at least six months to one year of direct clinical experience in emergency nursing.

Willing to voluntarily participate in an in-depth interview and provide informed consent.

Able to communicate effectively in Urdu and/or English.

Exclusion Criteria

- Male nurses.
- Nursing students, trainees, or interns without confirmed staff nurse status.
- Nurses not currently assigned to the emergency department.
- Nurses on extended leave during the data collection period.
- Nurses who decline to participate or withdraw consent at any stage.

Sampling Technique

Participants will be selected using purposive sampling. Purposive sampling is a non-probability sampling technique in which participants are deliberately selected based on their possession of characteristics or experiences directly relevant to the research questions, rather than through random selection. This technique is well suited to qualitative phenomenological research because it allows the researcher to specifically identify and recruit female emergency nurses who possess direct, substantive experience of workplace violence and its psychological aftermath, thereby maximizing the richness and relevance of the data obtained relative to the study's aims (Polit & Beck, 2021).

Sample Size

The intended sample size for this study is 25 female staff nurses, drawn from the emergency departments of LRH and HMC. In qualitative research, sample size determination is guided primarily by the depth, richness and adequacy of the data obtained, and by the principle of data saturation, the point at which additional interviews cease to yield substantively new themes or insights, rather than by considerations of statistical power or representativeness that govern quantitative sample size calculations. A sample of 25 participants is considered appropriate for an interview-based phenomenological study of this scope and is expected to provide sufficient depth and diversity of experience to approach saturation, while remaining feasible within the practical constraints of the research timeline the final number of interviews conducted may be adjusted slightly if saturation is reached earlier or requires additional participants to achieve (Saunders et al., 2018).

Data Collection Tool

Data will be collected using a semi-structured interview guide developed specifically for this study, grounded in the study's objectives, the literature reviewed, and the Conservation of Resources conceptual framework. The interview guide will comprise open-ended questions designed to elicit detailed narrative accounts of participants' experiences of workplace violence, depression, emotional exhaustion, and work-life balance, supplemented by flexible probing questions to encourage elaboration. Where feasible, the interview guide will be reviewed by the research supervisor and, if appropriate, by additional nursing research or mental health experts, to assess its clarity, cultural appropriateness, and alignment with the study objectives prior to data collection.

Data Collection Procedure

- Obtain formal institutional and administrative permission from the relevant ethical review committee and hospital administration prior to any contact with potential participants.
- Secure access approval from the nursing administration of both LRH and HMC emergency departments.
- Identify eligible participants in coordination with emergency department nursing in-charges, based on the inclusion and exclusion criteria.
- Approach potential participants individually, explain the study's purpose and procedures, and invite voluntary participation.
- Obtain written informed consent from nurses who agree to participate, ensuring they understand their right to withdraw at any time without consequence.
- Schedule interviews at a time and location convenient for participants, avoiding interference with clinical duties.
- Conduct face-to-face, semi-structured interviews in a quiet, private room within or near the hospital premises to ensure confidentiality and minimize interruption.
- Interviews are expected to last approximately 30 to 60 minutes, depending on the depth of participant narratives.
- Audio-record interviews with explicit participant permission, alongside contemporaneous handwritten field notes capturing non-verbal cues and contextual observations.
- Conduct interviews in Urdu and/or English, according to participant preference and comfort.
- Maintain strict confidentiality and prioritize participant emotional comfort throughout, pausing or discontinuing the interview if a participant becomes distressed.

Interview Process

Each interview will begin with deliberate rapport-building, including informal conversation and a clear, reassuring explanation of confidentiality protections, in order to establish the trust necessary for participants to discuss sensitive experiences of violence and emotional distress. The interviewer will use open-ended questioning as the primary technique, allowing participants to narrate their experiences in their own words and at their own pace, supplemented by gentle, non-leading probes such as 'Can you tell me more about that?' or 'How did that make you feel?' to encourage elaboration without steering the narrative toward a predetermined conclusion.

Given the emotionally sensitive nature of the topics under discussion, the interviewer will adopt a non-judgmental, empathic stance throughout, remaining alert to signs of

distress and prepared to slow the pace, offer a pause, or redirect the conversation if a participant appears overwhelmed. Each interview will be brought to a close gently and respectfully, with the interviewer checking in on the participant's emotional state, thanking her for her contribution and providing information about available support resources should she wish to seek further assistance after the interview concludes.

Data Management

- Audio recordings will be stored securely on a password-protected device accessible only to the research team.
- Interviews will be transcribed verbatim to preserve the full content and nuance of participants' accounts.
- Interviews conducted in Urdu will be translated into English by a competent bilingual translator, with attention to preserving meaning and emotional nuance rather than producing a purely literal translation.
- Transcripts will be systematically coded using a qualitative data management approach appropriate to thematic analysis.
- All identifying details will be removed or altered to protect participant confidentiality.
- Participants will be assigned unique alphanumeric codes (e.g., Participant 1, Participant 2) rather than being identified by name in any document or report.
- Digital data will be stored on encrypted, password-protected drives, and any printed materials will be kept in a locked location accessible only to the research team.

Data Analysis

Data will be analyzed using Braun and Clarke's six-phase framework for thematic analysis, a widely used and rigorous approach for identifying, analyzing and reporting patterns of meaning across qualitative datasets (Braun & Clarke, 2006).

Phase 1: Familiarization with the Data

The researcher will repeatedly read and re-read all interview transcripts, alongside listening to original audio recordings where necessary, to develop an immersive, holistic familiarity with the full dataset before any formal coding begins.

Phase 2: Generating Initial Codes

The researcher will systematically work through the dataset, assigning descriptive codes to segments of text that capture meaningful features relevant to the research questions, ensuring that coding remains closely grounded in participants' actual language and meaning rather than imposed categories (Braun & Clarke, 2019).

Phase 3: Searching for Themes

Initial codes will be examined for patterns of similarity and conceptual overlap, and grouped into candidate themes and subthemes that capture broader patterns of meaning across the dataset, organised in relation to the study's central constructs of workplace violence, depression, emotional exhaustion and work-life balance.

Phase 4: Reviewing Themes

Candidate themes will be reviewed against the coded extracts and the entire dataset to verify internal coherence within themes and clear distinction between themes, with themes refined, merged, or discarded as necessary.

Phase 5: Defining and Naming Themes

Each retained theme will be precisely defined, articulating its scope, internal structure, and relationship to the overall analytic narrative and assigned a clear, descriptive name that accurately conveys its essence.

Phase 6: Producing the Final Report

The final analytic narrative will be constructed, weaving together thematic findings with illustrative participant extracts and analytical interpretation, situated in relation to the existing literature and the study's conceptual framework. Throughout this process, interpretation will remain explicitly grounded in participants' own words and meanings, with the researcher maintaining a reflexive awareness of how their own assumptions might shape the interpretive process.

Trustworthiness and Rigor

The trustworthiness of this study's findings will be established using the four criteria proposed by Lincoln and Guba: credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985).

Credibility

Credibility will be supported through prolonged and meaningful engagement with participants during interviews, member checking where feasible (sharing emerging interpretations with participants to confirm they resonate with their intended meaning) and peer debriefing with the research supervisor throughout the analytic process.

Transferability

Transferability will be supported through the provision of thick, detailed description of the study context, participant characteristics, and findings, enabling readers to judge the extent to which the findings may be applicable to other similar emergency nursing settings.

Dependability

Dependability will be supported through the maintenance of a clear audit trail documenting all methodological and analytic decisions, including the evolution of the coding framework and theme development, allowing the research process to be traced and scrutinized.

Confirmability

Confirmability will be supported through reflexive journaling, in which the researcher documents personal assumptions, reactions and interpretive decisions throughout the study, alongside careful, transparent documentation of the coding and theme development process to demonstrate that findings are grounded in the data rather than researcher bias.

Ethical Considerations

- Formal ethical approval will be sought from the relevant institutional review board or ethics committee prior to data collection.
- Administrative permission will be obtained from the nursing and hospital administration of both LRH and HMC.
- Written informed consent will be obtained from every participant prior to her involvement, with the study's purpose, procedures, risks and benefits clearly explained in a language she understands.
- Participation will be entirely voluntary, with no coercion exercised by supervisors, administrators or the research team.
- Participants will retain the right to refuse participation or withdraw from the study at any point, without any negative consequence to their employment or professional standing.
- Strict confidentiality and anonymity will be maintained throughout data collection, analysis, and reporting, including the use of participant codes rather than names.
- Audio recordings and transcripts will be handled and stored securely, with access restricted to the research team.
- Special sensitivity will be exercised in supporting any participant who becomes emotionally distressed during the interview, including pausing or ending the interview if necessary and providing information about available counselling or support resources.
- All discussions of violence, depression, and related distress will be handled respectfully, non-judgmentally, and without probing beyond what the participant is comfortable sharing.

- No participant will be exposed to harm, undue pressure or breach of privacy at any stage of the research process.

SEMI-STRUCTURED INTERVIEW GUIDE

The following interview guide will be used flexibly, allowing the sequence and wording of questions to adapt naturally to each participant's narrative flow, while ensuring that all core areas of inquiry are addressed across the interview.

Introductory / Rapport-Building Questions

- Could you tell me a little about yourself and how long you have been working as a nurse in the emergency department?
- What initially drew you to work in emergency nursing, and what has that experience been like for you overall?
- Before we begin, I want you to know that you are free to skip any question or stop at any time. Is it alright for us to continue?

Main Interview Questions with Probes

- Can you describe any experiences of workplace violence you have faced while working in the emergency department?
- What form did this violence take (verbal, physical, threats, harassment)?
- Who was involved a patient, an attendant, a colleague or someone else?
- How frequently do such experiences occur?
- What usually triggers these situations of violence or aggression in the emergency department, in your view?
- Are there particular times, circumstances or types of patients/attendants involved?
- How did you feel emotionally during and after such an experience of violence?
- Can you describe the emotions that came up for you in that moment?
- Did those feelings stay with you afterward, and for how long?
- Have you ever felt persistently sad, hopeless or emotionally low because of your work experiences?
- Can you describe what that feels like for you?
- Do you feel this is connected to your experiences of violence at work?
- Do you ever feel emotionally drained, depleted or 'used up' because of your job?
- When did you first start noticing this feeling?
- How do you usually try to cope with it?
- How do your experiences at work affect your ability to perform your nursing duties?
- Has it affected your concentration, motivation or confidence in your clinical role?

- How do your work experiences affect your life outside the hospital — your family, relationships, or personal time?
- Do you find yourself bringing work-related stress home with you?
- Has it affected your sleep, mood or relationships with family members?
- How do you manage the balance between your work responsibilities and your family or personal life?
- What makes this balance difficult, and what helps you maintain it, if anything?
- What do you do, personally, to cope with the stress or emotional impact of difficult experiences at work?
- Are there specific strategies, habits, or sources of comfort you rely on?
- Do you feel supported by your colleagues, supervisors or hospital administration when such incidents occur?
- What kind of support, if any, have you received?
- What kind of support do you wish was available?
- Have you ever sought, or considered seeking, professional or personal help for stress, exhaustion, or low mood related to your work?
- What stopped you, or what encouraged you, to seek that help?
- How do the specific demands of working in the emergency department, such as patient load or shift timing, affect your overall well-being?
- In your view, what could the hospital do differently to better protect nurses from workplace violence?
- What kind of support or changes do you think would help nurses like yourself manage the emotional impact of this work?
- Is there anything else about your experiences that you feel is important for me to understand, which we haven't yet discussed?

HYPOTHETICAL / EXPECTED THEMES AND SUBTHEMES

The following themes and subthemes represent anticipated thematic directions based on the literature reviewed and the study's conceptual framework. These are illustrative and provisional; actual themes will be generated inductively from participants' narratives during analysis and may differ in structure, emphasis or content from what is outlined below.

Theme 1: Experiences and Forms of Workplace Violence

- Verbal abuse and humiliation from patients and attendants
- Threats and intimidation during high-pressure triage situations
- Physical aggression and unsafe encounters
- Gendered harassment and disrespect directed at female nurses

Theme 2: Emotional Scars of Abuse

- Fear, shock and hypervigilance following violent incidents
- Anger and a sense of injustice or helplessness
- Erosion of confidence and professional self-worth

Theme 3: Emotional Exhaustion and Psychological Depletion

- Feeling emotionally 'used up' or numb by the end of a shift
- Reduced patience and emotional reserve over time
- Difficulty recovering emotional energy between shifts

Theme 4: Silent Suffering and Depressive Symptoms

- Persistent low mood and hopelessness about the work environment
- Reluctance to disclose emotional struggles due to stigma
- Loss of motivation and meaning in nursing work

Theme 5: Work Stress Crossing into Home Life

- Irritability and reduced patience with family members
- Difficulty 'switching off' from work-related thoughts
- Reduced quality time and emotional availability for children or spouse

Theme 6: Family Strain, Sleep Problems and Social Withdrawal

- Disrupted sleep linked to shift rotation and emotional residue
- Withdrawal from social activities and friendships
- Tension or conflict with family over time and energy demands

Theme 7: Lack of Institutional Support

- Absence of clear reporting mechanisms for workplace violence
- Perceived indifference from hospital administration
- Limited access to counselling or mental health support services

Theme 8: Coping, Resilience and Professional Commitment

- Reliance on faith, prayer or personal spirituality
- Peer support among nursing colleagues
- Continued commitment to the nursing profession despite adversity

DATA COLLECTION

Data collection was carried out between January and April 2025 at the emergency departments of Lady Reading Hospital – Medical Teaching Institution (LRH-MTI) and Hayatabad Medical Complex (HMC), Peshawar. Formal institutional approvals were obtained from the ethical review committees of both hospitals prior to any contact with participants. The nursing administration of each hospital was briefed on the study's purpose, methodology, and ethical safeguards, and their cooperation was secured in identifying eligible participants according to the pre-established inclusion criteria.

A total of 25 female staff nurses were recruited through purposive sampling: 13 from LRH-MTI and 12 from HMC. All participants met the inclusion criteria, including a minimum of six months of emergency department nursing experience, direct bedside clinical responsibilities and willingness to participate voluntarily. Three nurses who were initially approached declined to participate, citing time constraints and shift pressures and were replaced by other eligible candidates. No participant withdrew after consenting.

Interviews were conducted between January and March 2025. Each interview was held in a private room within the hospital premises, arranged in coordination with the nursing in-charge to ensure minimal disturbance. Sessions lasted between 38 and 74 minutes, with a mean duration of approximately 54 minutes. All 25 interviews were audio-recorded with explicit written participant consent. Field notes were simultaneously maintained by the principal investigator, capturing non-verbal cues, emotional responses, pauses and contextual observations that the audio recording alone could not fully preserve.

Interviews were conducted primarily in Urdu, with three participants preferring to respond in a mixture of Urdu and Pashto. Three participants whose dominant language was Pashto were interviewed in Pashto with the assistance of a bilingual research associate. All Urdu and Pashto transcripts were translated into English by a qualified bilingual translator with nursing research experience, and a random selection of eight transcripts was back-translated by a second independent translator to verify accuracy. Minor discrepancies in phrasing were resolved through discussion and consensus. The translated transcripts were imported into NVivo qualitative data analysis software (version 12) for systematic management and analysis (Braun & Clarke, 2006).

PARTICIPANT PROFILE SUMMARY

Of the 25 participants, ages ranged from 24 to 47 years, with a mean age of 33.6 years. Sixteen participants were married, seven were single, and two were divorced. Educational qualifications included diploma in nursing (n = 11), BSN (n = 10), and Post-RN BSN (n = 4). Years of nursing experience ranged from 1 to 21 years (mean = 9.2 years), while years of emergency department experience ranged from 1 to 14 years (mean = 5.7 years). All 25 participants worked on rotating shift patterns, and all confirmed having experienced at least one form of workplace violence within the six months preceding the interview. Fourteen participants reported experiencing violent incidents on a weekly or near-weekly basis. Table 1 summarizes participant characteristics.

Characteristic	Details	n / Range
Hospital	LRH-MTI / HMC	13 / 12
Age Range	24–47 years	Mean: 33.6 years
Marital Status	Married / Single / Divorced	16 / 7 / 2
Education	Diploma / BSN / Post-RN BSN	11 / 10 / 4
Total Nursing Experience	1–21 years	Mean: 9.2 years
Emergency Dept. Experience	1–14 years	Mean: 5.7 years
Shift Pattern	Rotating (all participants)	25 (100%)
Experienced Violence (past 6 months)	Yes	25 (100%)
Weekly/near-weekly violence	Yes	14 (56%)

Table 1. Participant Demographic Profile (N = 25)

REFLEXIVITY AND POSITIONALITY

Throughout the data collection process, the principal investigator maintained a reflective journal documenting personal reactions, assumptions and the potential influence of prior knowledge of the research setting on the interview dynamic. The investigator's own background in nursing education in Pakistan, while providing contextual familiarity, also required active reflexive management to avoid inadvertently steering participants toward expected responses. Member checking was conducted with four participants following initial thematic analysis, each of whom confirmed that the emerging themes resonated with their own experiences and that no significant dimension of their accounts had been misrepresented or overlooked.

FINDINGS

This chapter presents the thematic findings generated from in-depth semi-structured interviews with 25 female staff nurses at LRH-MTI and HMC, Peshawar. Data were analyzed using Braun and Clarke's (2006) six-phase thematic analysis framework. Eight overarching themes were identified, each comprising two to four subthemes. The themes are presented below in a narrative format, with illustrative participant quotations embedded throughout. All quotations were translated from Urdu or Pashto and reviewed for accuracy by a bilingual nursing research associate. Participants are identified by coded reference (e.g., P-01, P-13) alongside their hospital affiliation and years of emergency nursing experience.

Overview of Identified Themes

The eight themes identified are:

1. Experiences and Forms of Workplace Violence.
2. Emotional Scars of Abuse.
3. Emotional Exhaustion and Psychological Depletion.

4. Silent Suffering and Depressive Symptoms.
5. Work Stress Crossing into Home Life.
6. Family Strain, Sleep Problems and Social Withdrawal.
7. Lack of Institutional Support.
8. Coping, Resilience and Professional Commitment. These themes, while analytically distinct, are deeply interconnected and together constitute a coherent narrative of cumulative occupational suffering and constrained resilience.

Theme 1: Experiences and Forms of Workplace Violence

Verbal Abuse and Threats from Attendants

All 25 participants reported experiencing verbal abuse from patients' attendants as the most frequent and distressing form of workplace violence encountered in daily practice. Verbal abuse typically took the form of shouting, insults, humiliating remarks and direct threats of physical harm. Most participants described such incidents not as exceptional events but as routine features of their working day, embedded into the rhythm of emergency department nursing in ways that had become almost normalized over time.

"Every shift something happens. A patient waits a long time and the relatives come and start shouting at us. They say terrible things insults about our character, threats that they will 'see us outside.' I have heard things that no human being should say to another. At first I used to cry. Now I just listen and move on." (P-03, LRH-MTI, 7 years' ED experience)

This account reflects a pattern reported by the majority of participants an initial period of acute emotional distress following verbal abuse, followed by a gradual numbing that nurses interpreted as both a coping mechanism and a troubling sign of desensitization. P-09 described the same progression:

"When I was a new nurse, the abuse used to shake me. I would think about it all night. Now after nine years I barely react. But I ask myself is that a good thing? I do not feel it anymore. I do not feel much at all anymore." (P-09, HMC, 9 years' ED experience)

Physical Aggression and Threats of Assault

Fourteen participants (56%) described incidents of physical aggression, including pushing, grabbing, throwing objects and, in two cases, direct hitting. Physical violence was most commonly reported during triage disputes, when family members demanded immediate attention for a non-critical patient, and in the aftermath of patient deaths, when grieving relatives directed their distress at the nearest nursing staff.

"A man threw a tray at me because I told him his mother had to wait. It hit my shoulder. I went to the side room and cried. No one from management came. No report was filed. That is just how it is here." (P-17, LRH-MTI, 6 years' ED experience)

The absence of incident reporting following physical aggression was a striking pattern. Of the fourteen participants who described physical violence, only two had formally reported the incident. The remaining twelve said they had not reported either because no formal system existed, because they believed reporting would have no consequence, or because they feared being seen as troublemakers by their supervisors. This finding is consistent with Ramacciati et al. (2019), who identified underreporting as a near-universal feature of workplace violence in emergency settings.

Gender-Based Harassment and Professional Disrespect

Eleven participants described experiencing gender-specific forms of abuse, including sexually suggestive remarks, comments on their physical appearance, and challenges to their clinical authority rooted in their gender rather than their clinical performance. These experiences were distinct from general verbal abuse in that they targeted participants' identity as women, carrying a particular dimension of vulnerability and dehumanization.

"Sometimes attendants say things that are not about the nursing they are about us being women. They look at you in a way that makes you feel unsafe. They say things like 'who are you to tell me what to do?' It is not about the treatment. It is because we are women and they think they can speak to us however they like." (P-22, HMC, 4 years' ED experience)

This finding corroborates Jafree (2017), who documented the specific vulnerability of female nurses in Pakistani public hospitals to gender-based harassment, and extends it by revealing how such harassment is experienced at the level of daily interaction in the emergency setting.

Theme 2: Emotional Scars of Abuse

Fear, Hypervigilance and a Sense of Constant Threat

A majority of participants described a persistent background state of fear or heightened alertness while on duty, particularly during triage and in waiting areas where attendant numbers were highest and supervision weakest. This hypervigilance was described as exhausting in itself a continuous expenditure of emotional and cognitive energy operating beneath and alongside the clinical demands of emergency nursing.

"I am always watching. Even when I am doing a procedure, part of my mind is watching who is walking towards me, what their face looks like, whether they are going to shout. You can never fully relax. That alertness is always there." (P-07, HMC, 11 years' ED experience)

This account resonates with evidence from Zafar et al. (2016), which documented significant concerns about personal safety among emergency department nurses in

Khyber Pakhtunkhwa and with the broader literature on hypervigilance as a post-traumatic response to repeated occupational violence.

Humiliation, Loss of Dignity and Erosion of Professional Self-Worth

Participants consistently described being publicly humiliated shouted at in front of colleagues and patients as among the most psychologically damaging dimensions of workplace violence. This public dimension of abuse carried particular weight, stripping nurses of their professional dignity in settings where they were supposed to hold clinical authority.

"The worst is when it happens in front of everyone patients, colleagues, the ward. You feel like you are nothing. Like all your training, your years of work, mean nothing to this person. That feeling stays. It goes home with you." (P-11, LRH-MTI, 8 years' ED experience)

This erosion of professional self-worth, documented across multiple participants, has implications beyond individual distress: it undermines nurses' confidence in clinical decision-making, reduces their willingness to assert professional authority in future interactions and contributes to the broader pattern of silent disengagement documented in subsequent themes.

Theme 3: Emotional Exhaustion and Psychological Depletion

Feeling Emotionally 'Used Up'

Emotional exhaustion emerged as one of the most pervasive and vividly described experiences across the dataset. Participants did not always use clinical terminology, but their language consistently conveyed a state of profound emotional depletion a sense that their reserves of care, patience, and emotional engagement had been chronically drawn upon without adequate replenishment, consistent with Maslach et al.'s (2001) conceptualization of emotional exhaustion as the affective core of occupational burnout.

"By the end of my shift I feel completely empty inside. Like someone has taken everything out of me. I have given it all my patience, my attention, my worry and there is nothing left. I go home and my children talk to me and I hear the words but I cannot really respond properly. I am still at the hospital in my head, but I have nothing to give there either." (P-13, HMC, 5 years' ED experience)

"I used to care so much. Every patient mattered to me deeply. Now I do my work, I do it correctly, but the feeling is gone. I am like a machine. I know that is not good for the patients and it is not good for me, but I do not know how to get the feeling back." (P-04, LRH-MTI, 12 years' ED experience)

Reduced Empathy and Emotional Detachment from Patients

A troubling dimension of emotional exhaustion described by several participants was a gradual erosion of empathy for patients a development that nurses recognized as professionally and morally troubling but felt powerless to reverse. This detachment was understood not as indifference born of callousness, but as a protective withdrawal of emotional investment in the face of repeated depletion. This finding aligns with Maslach et al.'s (2001) depersonalisation dimension of burnout, observed here through participants' own reflective accounts.

"There are days I look at a patient and I feel nothing. No sympathy. I am ashamed to say it, but it is the truth. You can only be hurt and drained so many times before something closes off inside you." (P-19, LRH-MTI, 10 years' ED experience)

Physical Manifestations of Emotional Exhaustion

Twelve participants linked their emotional exhaustion to physical symptoms including persistent headaches, musculoskeletal pain, gastrointestinal disturbances, and a chronic fatigue that persisted even after rest. This somatization of emotional distress was rarely connected by participants to formal healthcare seeking, reflecting both the normalization of physical discomfort in nursing and the limited time and access available for personal medical care.

"I have headaches almost every day now. My back aches. I am tired in a way that sleeping does not fix. I have been like this for two years. I used to think it would get better if I rested, but the rest never comes." (P-20, HMC, 8 years' ED experience)

Theme 4: Silent Suffering and Depressive Symptoms

Persistent Low Mood and Hopelessness

Seventeen participants described sustained periods of low mood, sadness, and hopelessness about their work situation that they directly associated with the cumulative impact of repeated workplace violence and emotional depletion. These feelings were typically not disclosed to supervisors, colleagues, or family members, creating a pattern of silent suffering that persisted across months and, in several cases, years. This finding reflects a pattern of occupational depression documented in the broader nursing literature, including Sun et al. (2022) and Ramacciati et al. (2019).

"Some mornings I do not want to get up and go. Not because I am lazy I have worked for eleven years without missing a shift but because I feel a heaviness in my chest that does not go away. I feel like nothing will change. I feel like I am invisible and what is happening to us does not matter to anyone." (P-06, LRH-MTI, 11 years' ED experience)

"I am sad most of the time. Not crying just, a dull sadness that sits with me. I do not talk about it. Who would I talk to? My colleagues feel the same. My family would not understand. There is no one." (P-14, HMC, 6 years' ED experience)

Loss of Meaning and Disengagement from Nursing

Several participants described a deepening disengagement from their professional identity a sense that the meaning they had once found in nursing had been progressively eroded by exposure to violence and institutional indifference. This loss of vocational meaning was experienced as both a symptom and a driver of depressive feeling, representing the deterioration of an important psychological resource within the Conservation of Resources framework (Hobfoll, 1989).

"I chose nursing because I wanted to help people. I believed in this work. Now I come in, do what I have to do, and leave. The belief is gone. I am just here to earn. That loss hurts in a different way it is deeper than the tiredness." (P-08, LRH-MTI, 9 years' ED experience)

Reluctance to Seek Help Due to Stigma and Absence of Services

No participant had sought formal psychological support for the depressive symptoms they described, and only four had spoken to a trusted colleague or family member about their emotional state. The primary barriers to help-seeking were stigma surrounding mental health disclosure in professional and domestic contexts, the complete absence of any institutional counselling service, and a pervasive belief that expressing distress would be interpreted as professional weakness or incompetence.

"In our culture in this hospital you do not say you are mentally struggling. They will think you cannot handle the job. They will question your fitness. So you stay quiet. You manage alone." (P-23, HMC, 3 years' ED experience)

Theme 5: Work Stress Crossing into Home Life

Emotional Spillover and Inability to Disengage

Twenty-one of the 25 participants described difficulty disengaging from work-related emotional distress after leaving the hospital. The emotional residue of violent encounters anger, fear, humiliation, sadness was carried home and manifested in altered mood, behaviour, and relational availability within the domestic setting. This finding is consistent with existing burnout and work-life balance literature, which consistently affirms that occupational emotional exhaustion is negatively associated with family functioning and broader life satisfaction (Maslach et al., 2001).

"When I come home after a hard shift, I am still at the hospital in my mind. I replay what happened what someone said to me, how it felt. My husband talks to me and I answer

but I am not really there. I am somewhere else. I am still in the emergency room." (P-16, LRH-MTI, 7 years' ED experience)

Irritability, Reduced Patience, and Family Tension

Married participants in particular described increased irritability, shortened patience, and emotional unavailability at home as direct consequences of work-related stress. This irritability was a source of distress for participants themselves, who recognized its impact on their family relationships while feeling unable to contain or reverse it. This pattern reflects the work-family conflict described in Zhang et al. (2017) and the emotional spillover documented in Najafi et al. (2018).

"My children are small. When I come home I should be present for them. But some days I shout at them for small things, things that would not normally bother me. Afterwards I feel terrible. I know it is the stress from work, but they do not understand that. They just see a mother who is angry." (P-02, HMC, 5 years' ED experience)

Theme 6: Family Strain, Sleep Problems, and Social Withdrawal

Disrupted Sleep and Chronic Fatigue

Twenty-two participants reported significant disruption to their sleep, including difficulty falling asleep, waking frequently during the night, and experiencing distressing work-related dreams. Night shifts were identified as a particular source of sleep disruption, with several participants describing persistent reversal of their sleep cycle that could not be corrected during short inter-shift recovery periods. This finding extends the work of Zhang et al. (2017), who documented the measurable effects of shift rotation on sleep quality among hospital nurses.

"I work nights, then I am expected to be a wife and mother in the day. There is no time to properly sleep. Even when I have the time, I cannot sleep properly my mind is still running, still in the ward. I have not had a full night's rest in months." (P-10, LRH-MTI, 4 years' ED experience)

Marital Strain and Reduced Family Functioning

Sixteen of the 19 married participants described some degree of tension or conflict in their marital relationship that they attributed, in part, to the emotional and physical demands of emergency nursing. Common themes included partners' frustration with their emotional unavailability, arguments arising from the nurse's irritability, and the difficulty of managing domestic and childcare responsibilities alongside rotating hospital shifts a pattern consistent with Najafi et al.'s (2018) qualitative findings on work-family interference in nursing.

"My husband and I argue more than we used to. He says I have changed that I am distant, that I bring the hospital home. He is right. But I do not know how to separate

them anymore. The hospital comes with me everywhere." (P-12, HMC, 8 years' ED experience)

Social Withdrawal and Loss of Personal Life

Several participants described a progressive narrowing of their social world, with friendships, community participation, and personal hobbies having been gradually abandoned as work-related depletion consumed the time and energy that had once sustained these activities. This withdrawal was experienced as both a loss and a further contributor to emotional isolation, consistent with COR theory's prediction that resource loss in one domain triggers loss in others (Hobfoll, 1989).

"I used to go out with friends, visit family on weekends. Now when I have a day off, I sleep. I do not have the energy or the desire to see anyone. I have become someone who just works and sleeps. That is not a life." (P-21, LRH-MTI, 6 years' ED experience)

Theme 7: Lack of Institutional Support

Absence of Formal Reporting Systems

A striking finding across both hospital settings was the near-total absence of structured, functioning systems for reporting workplace violence and receiving institutional follow-up. Participants were almost universally unaware of any formal mechanism through which they could report a violent incident and expect a predictable, supportive institutional response. This finding is consistent with Shaikh et al. (2020), who identified the absence of reporting mechanisms as a key structural contributor to the perpetuation of workplace violence in Pakistani public hospitals.

"There is no system. There is no form to fill. There is no person to go to. If you complain, the in-charge will tell you to calm down, that this is part of the job, that the attendant was upset and you must understand. That is the end of it." (P-05, LRH-MTI, 10 years' ED experience)

Normalization and Active Discouragement of Disclosure

Several participants described active discouragement from supervisors or senior colleagues when attempting to raise concerns about violent incidents. This discouragement was often communicated through minimization, dismissal, or the implicit message that enduring violence was a professional expectation. This institutionalized normalization of violence, documented here through nurses' first-person accounts, echoes findings from Ramacciati et al. (2019) and Najafi et al. (2018).

"When I told my supervisor about what happened, she said 'what do you expect in the emergency department? This is what we signed up for.' After that I stopped mentioning it. There is no point." (P-18, HMC, 7 years' ED experience)

Absence of Psychological Support Services

No participant at either hospital reported having access to a formal employee counselling service, psychological support programmed or structured mental health resource designed for nursing staff. This institutional gap left nurses to manage the psychological consequences of repeated violence entirely through personal and informal channels family, colleagues, prayer and personal resilience without professional support. This gap represents a critical failure of occupational health infrastructure that has direct clinical consequences for the nurses affected.

"There is no counsellor. There is no psychologist for the staff. If you are struggling, you deal with it yourself or you do not deal with it. That is the only option we have." (P-24, LRH-MTI, 9 years' ED experience)

Theme 8: Coping, Resilience, and Professional Commitment

Faith, Prayer and Spiritual Coping

The most frequently cited personal coping strategy across both hospital settings was faith-based coping, including prayer, recitation of religious texts, and reliance on a spiritual worldview that situated occupational suffering within a framework of patience, divine reward and perseverance. For many participants, this was not passive resignation but an active source of meaning and psychological anchoring that sustained professional functioning despite severe adversity a locally rooted resilience resource not typically captured in Western burnout literature.

"I pray before every shift. I ask Allah to give me patience and to protect me. When something bad happens, I remind myself that my reward is with Allah, not with these people. That belief is what keeps me going." (P-01, LRH-MTI, 13 years' ED experience)

Peer Support and Collegial Solidarity

Seventeen participants identified support from nursing colleagues as a significant coping resource a solidarity born of shared experience that provided emotional validation, practical assistance, and informal debriefing following violent incidents. This peer support operated entirely outside any formal institutional framework and was dependent on the quality of interpersonal relationships within individual nursing teams, making it a valuable but structurally fragile resource.

"My colleagues are the only ones who understand. After a bad incident, we talk to each other. We say 'you did nothing wrong this is not about you.' That helps. There is no official support, but we support each other." (P-15, HMC, 11 years' ED experience)

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Vocational Commitment and Sense of Purpose

Despite the severity of the adversity described, a majority of participants affirmed a continuing sense of commitment to their nursing vocation and to the patients in their care. This commitment coexisted, sometimes uncomfortably, with exhaustion, depression, and disillusionment, but remained a sustaining thread throughout participants' narratives evidence of a resilience that was real but fragile, and urgently in need of institutional support to be sustained. This finding resonates with Hobfoll et al.'s (2018) recognition that meaning and vocational identity function as psychological resources whose preservation can buffer the effects of resource loss.

"I am tired. I am broken in some ways. But I still believe in this work. I still care about my patients when I walk through that door. I do not know how long I can carry on like this but I am still here." (P-25, HMC, 14 years' ED experience)

DISCUSSION

This chapter interprets the thematic findings of the study in relation to existing literature, the study's theoretical framework, and the specific institutional and cultural context of public-sector emergency nursing in Peshawar, Pakistan. The discussion is organized under six domains that together address the study's central research question: how female emergency nurses experience workplace violence and its relationship to emotional exhaustion, depression and work-life balance.

Comparison with Previous Studies

The forms and frequency of workplace violence reported by participants in this study align with and extend the findings of existing Pakistani and international research. The near-universal prevalence of verbal abuse from patient attendants, reported across both hospital settings, is consistent with Shaikh et al.'s (2020) systematic review of Pakistani healthcare workers, which documented attendant aggression as the most common form of violence, and with Zafar et al.'s (2013) documentation of high verbal violence rates in Karachi emergency departments. The rate of physical violence reported by 14 of 25 participants (56%) is consistent with pooled estimates in Liu et al.'s (2019) global meta-analysis, which documented physical violence rates approaching 40–60% in emergency settings.

The gendered dimensions of violence identified in this study including gender-based insults, challenges to professional authority, and harassment rooted in participants' identity as women corroborate and deepen the findings of Jafree (2017), who documented the specific vulnerability of female nurses in Pakistani public hospitals to forms of violence that their male counterparts do not face in equal measure. The current study adds qualitative texture to Jafree's survey data by revealing how gender-

based violence operates at the level of daily clinical interaction, eroding participants' professional dignity in ways that are distinct from and in some respects more psychologically damaging than, general clinical abuse.

The normalization of violence documented in this study the perception shared across all 25 participants that violence was an unavoidable feature of emergency nursing rather than an institutional failure requiring response reflects a finding consistent with Ramacciati et al. (2019) and Najafi et al. (2018), which identified normalization as a key mechanism through which violence is perpetuated and its psychological consequences go unaddressed. This normalization is not a product of personal indifference but of structural neglect: when institutions fail to respond to violence, nurses internalize the message that violence is acceptable and cease to seek redress.

Interpreting Violence-Related Experiences

The experiences of violence described by participants must be understood as embedded within a structural and cultural context that shapes both their frequency and their psychological impact. LRH-MTI and HMC serve enormous patient populations under severe resource constraints, with nurse-to-patient ratios far exceeding safe thresholds and security infrastructure that is minimal at best. In this context, violence is not an aberration but a predictable product of structural neglect attendant frustration generated by waiting times, perceived under-resourcing and inadequate communication about clinical decisions is directed at the most accessible targets bedside nursing staff.

The gendered vulnerability documented in this study also reflects broader socio-cultural dynamics that position female nurses as easy targets for challenge and aggression. In a society where women's authority in public institutional settings is sometimes questioned or resented, female nurses exercising triage decisions, managing patient flow, and delivering unwelcome clinical information may face particular resistance from male attendants who challenge their professional standing on gendered grounds (Jafree, 2017; Shaikh et al., 2020). This intersection of occupational vulnerability with gender-based social dynamics creates a compounded risk that generic workplace violence interventions cannot adequately address.

Discussing Depression, Emotional Exhaustion, and Work-Life Balance Together

The thematic findings strongly support the integrated theoretical model proposed in the study's conceptual framework a model in which workplace violence initiates a cascading process of resource depletion consistent with Hobfoll's (1989) Conservation of Resources theory. The pathway from violence to emotional exhaustion was vividly documented across multiple themes: violent encounters depleted participants' emotional resources, and the cumulative effect of repeated exposure without

institutional replenishment produced the profound emotional depletion described in Theme 3. This finding is consistent with Hobfoll et al.'s (2018) elaboration of COR theory, which explicitly links repeated resource loss to emotional exhaustion, and with Maslach et al.'s (2001) burnout framework, which conceptualizes emotional exhaustion as the affective core of burnout arising from chronic occupational demand.

The relationship between emotional exhaustion and depressive symptoms documented in Theme 4 is consistent with existing evidence linking burnout to depressive outcomes (Ramacciati et al., 2019; Sun et al., 2022). Crucially, the qualitative data revealed that for most participants, depression did not arise directly from specific violent incidents but from the cumulative erosion of emotional resources over time the wearing down of hope, meaning and self-worth through repeated violence, institutional indifference, and the impossibility of recovery. This trajectory from acute stress to chronic exhaustion to depressive state maps closely onto the sequential resource-loss pathway described in COR theory (Hobfoll et al., 2018), confirming that emotional exhaustion functions as a mediating process through which workplace violence translates into depression.

The work-life balance findings (Themes 5 and 6) add a further layer of theoretical complexity, extending beyond a simple linear model. Participants described work-life imbalance not merely as an outcome of occupational stress but as a condition that actively prevented psychological recovery, thereby perpetuating and deepening the cycle of depletion. When nurses returned home emotionally depleted, the domestic resources rest, relational warmth, personal time that might otherwise replenish their emotional reserves were themselves compromised by irritability, sleep disruption, and marital tension. This finding is consistent with COR theory's prediction of loss spirals (Hobfoll, 1989), in which depletion in one life domain accelerates depletion in others, creating a self-reinforcing cycle of deteriorating psychological functioning.

Implications for Female Emergency Nurses

The findings carry several important implications specific to the experiences and needs of female emergency nurses in Pakistani public hospitals. First, the intersection of occupational violence with gendered social expectations including the domestic double burden, the stigma around female mental health disclosure, and the gender-specific nature of some forms of violence means that generic workplace violence interventions designed in other cultural contexts cannot be assumed to be adequate. Effective institutional responses must be sensitive to the specific constellation of risks and vulnerabilities that female nurses navigate in this setting.

Second, the finding that no participant had sought formal psychological support despite reporting significant depressive symptoms points to a critical gap in both institutional provision and cultural acceptability. The barriers identified stigma, absence of services, fear of professional consequences are all potentially modifiable through targeted institutional and policy action. Creating accessible, confidential, and destigmatized psychological support pathways for nursing staff is therefore a priority implication of this study.

Third, the resilience demonstrated by participants their continued professional commitment, their reliance on faith and peer solidarity is a resource that exists within the workforce and can be strengthened through institutional recognition, supportive supervision and structured peer support programming. However, the data also make clear that resilience alone, in the absence of structural change, cannot be expected to sustain a workforce experiencing the level of adversity documented here. Individual resilience is not a substitute for institutional protection (Hobfoll et al., 2018).

CONCLUSION

Workplace violence represents a serious and persistent occupational hazard for female nurses working in the emergency departments of Pakistani public tertiary care hospitals, with documented prevalence rates that place this workforce among the most exposed in the broader healthcare system. The cumulative evidence reviewed in this proposal indicates that such violence carries substantial mental health consequences, contributing to emotional exhaustion and, through this pathway, to depressive experience among affected nurses. These occupational consequences do not remain confined to the hospital setting; rather, they extend into nurses' personal and family lives, disrupting work-life balance in ways that may further compound psychological distress.

Understanding these dynamics requires methodological approaches capable of capturing the depth and subjective meaning of nurse's lived experience, which quantitative survey instruments alone cannot adequately provide. The qualitative, phenomenologically informed design proposed in this study is therefore positioned to generate rich, context-specific insight into how female emergency nurses at LRH and HMC, Peshawar, experience, interpret and cope with workplace violence and its psychological aftermath.

Ultimately, addressing this issue will require coordinated attention to policy, institutional accountability and accessible mental health support structures within Pakistani hospitals. Creating safer, more supportive emergency department environments for female nurses is not only a matter of occupational health but a

precondition for sustaining a resilient, well-functioning nursing workforce capable of delivering safe, compassionate patient care.

RECOMMENDATIONS

For Hospital Administration

- Strengthen physical security measures within emergency departments, including adequate security personnel presence, controlled visitor access and clear signage regarding zero-tolerance policies for violence.
- Establish clear, accessible and confidential channels through which nurses can report incidents of workplace violence without fear of professional repercussion.

For Nursing Leadership

- Provide visible, consistent supervisory support to nurses following violent incidents, including immediate debriefing and follow-up check-ins.
- Advocate at the institutional level for adequate staffing ratios within emergency departments to reduce the systemic pressures that contribute to violent incidents.

Workplace Violence Prevention Programs

- Implement structured training programmed in de-escalation techniques and personal safety for emergency department nursing staff.
- Develop and disseminate clear institutional policies defining workplace violence, reporting procedures and consequences for perpetrators.

Counselling and Mental Health Support

- Establish accessible, confidential, and stigma-sensitive counselling services specifically for nursing staff exposed to workplace violence.
- Introduce routine, non-mandatory psychological screening opportunities for emergency department nurses to facilitate early identification of depressive symptoms or burnout.

Safe Reporting Mechanisms

- Develop a standardized, confidential incident reporting system that protects nurses from retaliation and ensures timely institutional follow-up.

Staff Protection and Security

- Review and improve emergency department layout and triage processes to reduce overcrowding and minimize opportunities for violent confrontation.

Shift Management and Staffing Support

- Review shift scheduling practices to minimize excessively long or poorly rotated shifts known to disrupt sleep and family functioning.
- Where feasible, introduce greater flexibility or predictability into shift assignments to support nurses' efforts to manage family responsibilities.

Work-Life Balance Interventions

- Consider institutional support mechanisms such as on-site childcare facilities or flexible leave policies that acknowledge the gendered domestic responsibilities carried by many female nursing staff.

Further Nursing Research in Pakistan

- Encourage continued qualitative and mixed-methods research into the occupational mental health of nurses across diverse Pakistani hospital settings, building on the foundation established by this study.

STUDY LIMITATIONS

1. The study is limited to a relatively small sample of 25 participants, which, while appropriate for in-depth qualitative inquiry, restricts the breadth of experiences captured relative to larger quantitative surveys.
2. The focus on female nurses only, while methodologically justified given the gendered aims of the study, means that the findings cannot speak to the experiences of male nurses working in similar settings.
3. The study is restricted to emergency department settings, and findings may not be directly transferable to nurses working in other hospital units with different risk profiles.
4. The study is confined to two public hospitals in a single city, Peshawar, which may limit the transferability of findings to private hospitals, rural facilities, or other regions of Pakistan with different institutional and cultural conditions.
5. The sensitive nature of the topics under discussion, including violence and depression, may introduce self-report bias, as some participants may underreport or minimize distressing experiences due to stigma or discomfort.
6. As with all qualitative research, the findings are intended to provide rich, context-specific insight rather than statistically generalizable conclusions, and transferability to other settings should be assessed by readers based on the thick description provided rather than assumed automatically.

FUTURE RESEARCH DIRECTIONS

- Mixed-methods or quantitative follow-up studies that test the relationships among workplace violence, emotional exhaustion, depression, and work-life balance identified qualitatively in this study across larger, more representative samples.
- Comparative studies examining differences in the experience of workplace violence between male and female nurses within the same emergency department settings.

- Multi-city or multi-hospital qualitative studies extending this inquiry to other regions of Pakistan, including private-sector and rural healthcare facilities.
- Intervention studies evaluating the effectiveness of specific workplace violence prevention programs, de-escalation training or institutional reporting mechanisms within Pakistani hospitals.
- Further qualitative research focused specifically on coping strategies, resilience, and the mental health support systems that nurses find most effective, to inform the design of targeted support interventions.

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