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KNOWLEDGE AND ATTITUDE TOWARDS WORKPLACE VIOLENCE AMONG NURSES

Original Research

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ABSTRACT

Background: Workplace violence in healthcare is a persistent global concern that severely impacts nurses' well-being, professional integrity, and quality of patient care. Nurses are frequently exposed to verbal, physical, and psychological abuse due to high workloads, patient interactions, and emotionally charged environments. Factors such as understaffing, night shifts, and lack of institutional policies further intensify the risk. Understanding nurses' knowledge and attitudes toward workplace violence is crucial for developing responsive policies and ensuring safer work environments.

Objective: To assess the knowledge and attitudes of nurses regarding workplace violence in a tertiary care hospital in Lahore.

Methods: A descriptive cross-sectional study was conducted over three months among 133 registered nurses in a tertiary hospital in Lahore. Nurses with over two years of clinical experience were included. Data were collected using a structured, modified questionnaire comprising demographic data, knowledge, and attitude components. SPSS version 26 was used for analysis, applying descriptive statistics and chi-square tests to explore associations between demographic variables and workplace violence experiences. Ethical approval was obtained, and informed consent was secured from all participants.

Results: Out of 133 nurses, 93.2% were female and 63.2% were aged between 31–35 years. A total of 61.7% had witnessed workplace violence, and 48.1% had experienced it more than once. Psychological violence was reported by 60.9%, physical by 26.3%, and sexual violence by 12.8%. Verbal abuse was the most common form (46.6%). The main sources were patients' relatives (47.4%) and patients (27.8%). Violence was seen to impact nurse dignity (82.7%), care quality (68.4%), and staff turnover (60.9%).

Conclusion: Workplace violence significantly affects nurses' professional and emotional well-being. Interventions such as policy enforcement, training, and support mechanisms are essential to foster a safer clinical environment.

Keywords: Attitude of Health Personnel, Cross-Sectional Studies, Hospitals, Nurses, Occupational Violence, Patient Care, Workplace Safety.

INTRODUCTION

Workplace violence (WPV) has increasingly become recognized as a major global public health threat, with significant implications for both immediate and long-term health outcomes among workers (1). Among all professions, healthcare workers—particularly nurses—are disproportionately affected. Defined as a multifaceted phenomenon influenced by individual, relational, cultural, and environmental determinants, workplace violence encompasses a wide range of behaviors and actions that diverge from accepted norms and inflict physical or psychological harm (2). Nurses, by virtue of their close and continuous interaction with patients, are among the most frequently exposed professionals. Alarming statistics reveal that nearly 80% of all workplace assaults occur in healthcare settings, with over half of healthcare professionals reporting having experienced some form of violence in the workplace (3). In Egypt, an estimated 92.8% of nurses have been subjected to workplace violence, and notably, 73.8% of them faced such incidents more than ten times during their careers (4). The problem extends beyond a single region. A study conducted in Amman, Jordan, documented that out of 447 nurses surveyed, 18.3% had encountered verbal abuse, while 37.1% had suffered physical assaults—figures that were notably higher among those working in high-stress units such as intensive care, and among less experienced nurses (5). The complexity of WPV is further emphasized by its categorization into vertical and horizontal violence. Vertical violence refers to aggression that occurs between healthcare providers and patients, while horizontal violence is often perpetrated by fellow healthcare personnel or even patients' families (6,7). This violence can manifest as physical aggression or psychological abuse, including but not limited to intimidation, coercion, slander, blackmail, mobbing, and sexual harassment (8).

Multiple systemic and environmental factors contribute to the high prevalence of violence in healthcare settings. Prolonged working hours, understaffing, high-stakes clinical situations, lack of resources, and frequent exposure to death and critical illness exacerbate occupational stress, increasing both the likelihood of violence and its severity (9). Environments such as emergency rooms, psychiatric wards, and geriatric departments are especially vulnerable due to their patient populations and high-pressure nature. Risk factors are further elevated in settings with poor lighting, minimal security presence, or those located in high-crime areas (6). Furthermore, patients and their families may exhibit aggressive behavior due to frustration with long wait times, feelings of powerlessness, or dissatisfaction with care—issues often compounded by a lack of effective communication and weak institutional policies (10). Workplace violence against nurses does not merely harm individual health professionals; it undermines the quality of patient care, threatens job satisfaction, disrupts interprofessional relationships, and hinders women's career progression in a predominantly female workforce (11,12). In the long term, repeated exposure to violence leads to burnout, emotional exhaustion, and increased absenteeism, which in turn aggravates staff shortages and reduces the system's overall efficiency (13). The cumulative impact of violence necessitates robust research aimed at identifying contributory factors, formulating evidence-based prevention policies, and developing effective management strategies. Despite the prevalence of WPV, limited data exist on how nurses perceive and respond to such events. Understanding their level of awareness, preparedness, and attitudes is critical for designing interventions that are not only preventive but also empowering. By examining nurses' knowledge and attitudes regarding workplace violence, this study aims to generate objective insights that can help healthcare institutions recognize existing barriers and implement targeted support mechanisms. Accordingly, the objectives of this study were to assess the knowledge of nurses regarding workplace violence and to evaluate their attitudes toward addressing and managing such violence within their clinical settings.

METHODS

This descriptive cross-sectional study was conducted over a period of three months at a tertiary care hospital in Lahore to evaluate the knowledge and attitudes of nurses toward workplace violence. A total of 133 registered nurses participated, selected from an accessible population of 200 nurses working in the hospital. Inclusion criteria comprised registered nurses with a minimum of two years of continuous clinical experience who voluntarily consented to participate in the study. Nursing students and interns were excluded to ensure that participants had sufficient exposure to clinical environments where workplace violence is more likely to occur (3,4). Ethical approval was obtained prior to data collection from the institutional review board (IRB). Informed written consent was obtained from all participants, and confidentiality was ensured throughout the study by anonymizing responses and securely handling the collected data. Participants were assured that their involvement was entirely voluntary and that they could withdraw at any time without any

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repercussions. Data collection was carried out using a pre-tested, modified structured questionnaire developed to gather demographic information and assess nurses' knowledge and attitudes regarding workplace violence.

The questionnaire comprised both closed- and open-ended questions, and its content validity had been previously established in similar research contexts. It included sections addressing socio-demographic characteristics such as age, gender, marital status, education level, and years of clinical experience, followed by items evaluating the participants' understanding of the concept of workplace violence and their perceptions and attitudes toward it. All collected data were coded and entered into IBM SPSS Statistics version 26 for analysis. Descriptive statistics were employed to summarize both qualitative variables (expressed as frequencies and percentages) and quantitative variables (reported as means and standard deviations). The study aimed to maintain methodological rigor and minimize bias by using a standardized data entry protocol and applying consistent interpretation criteria. Ethical principles in line with the Declaration of Helsinki were adhered to throughout the study. These included respecting participants' autonomy, ensuring beneficence and non-maleficence, and preserving justice in recruitment and data handling.

RESULTS

A total of 133 registered nurses participated in the study. The majority, 63.2% (n = 84), were between 31–35 years of age, while 23.3% (n = 31) were aged 25–30 years, and 13.5% (n = 18) were older than 36 years. Female nurses constituted 93.2% (n = 124) of the respondents, with only 6.8% (n = 9) being male. In terms of marital status, 57.9% (n = 77) were single, 39.8% (n = 53) were married, and 2.3% (n = 3) were divorced. Regarding educational qualifications, 39.1% (n = 52) held General Nursing & Midwifery diplomas, followed by 33.1% (n = 44) who had completed Post RN qualifications. BSc Nursing and specialized certifications each accounted for 12.8% (n = 17), while only 2.3% (n = 3) had attained an MSN degree. In terms of professional experience, 55.6% (n = 74) of nurses had 1–5 years of experience, 37.6% (n = 50) had 6–10 years, and 6.8% (n = 9) had more than 10 years of experience. The findings revealed that 61.7% (n = 82) of participants had witnessed workplace violence during duty, while 38.3% (n = 51) had not. More than half (51.9%, n = 69) reported encountering violence once in their career, and 48.1% (n = 64) had experienced it more than once. Key contributing factors included work-related stress (35.3%, n = 47), night shifts (30.8%, n = 41), lack of institutional policies (20.3%, n = 27), and working in critical care areas (13.5%, n = 18). Patient relatives were reported as the most common source of violence (47.4%, n = 63), followed by patients themselves (27.8%, n = 37), co-workers (18.0%, n = 24), and supervisors (6.8%, n = 9).

Psychological violence was the most frequently reported type at 60.9% (n = 81), followed by physical violence at 26.3% (n = 35), and sexual violence at 12.8% (n = 17). Psychological aggression predominantly included verbal abuse (46.6%, n = 62), being ignored in the workplace (36.8%, n = 49), and lowered self-esteem (16.5%, n = 22). Among the physical abuse cases, 56.4% (n = 75) involved pushing or sliding, while 43.6% (n = 58) reported the use of instruments. Most respondents (82.7%, n = 110) believed that workplace violence compromises the dignity of nurses. A total of 66.2% (n = 88) considered loud speech and mispronunciation as verbal abuse, while 49.6% (n = 66) identified verbal cues and ignoring behaviors as forms of sexual psychological aggression. In response to physical confrontations, 44.4% (n = 59) acknowledged being pushed or hurled by equipment as violence, whereas 27.1% (n = 36) remained uncertain. Notably, 68.4% (n = 91) of nurses agreed that workplace violence adversely affects nurses' behavior and the quality of patient care, and 60.9% (n = 81) believed it contributes to increased staff turnover. A comparative analysis was conducted to explore potential associations between demographic factors and nurses' awareness or attitudes toward workplace violence. Chi-square testing was applied to determine the significance of relationships between key variables. Findings indicated a variation in workplace violence exposure across age groups. Notably, 100% of nurses aged 25–30 reported having witnessed workplace violence, while only 60.7% of those aged 31–35 and none above 36 years reported the same. This association between age and exposure to workplace violence was found to be statistically significant ($p < 0.05$), suggesting younger nurses may be more frequently exposed or more likely to report such incidents. When comparing professional experience with the belief that violence affects the quality of nursing care, 100% of nurses with 1–5 years of experience agreed that workplace violence impacts care delivery. This was in contrast to more experienced nurses, among whom the proportion of agreement was lower. The association between years of experience and perception of violence's impact on care was also statistically significant ($p < 0.05$), indicating that younger or less experienced nurses may be more sensitive to, or affected by, workplace violence.

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Table 1: Description of Demographical Characteristics

Variables	Number %
Age (Years)	
25-30	31 (23.3%)
31-35	84 (63.2%)
36 >	18 (13.5%)
Gender	
Male	9 (6.8%)
Female	124 (93.2%)
Marital Status	
Single	77 (57.9%)
Married	53 (39.8%)
Divorced	3 (2.3%)

Table 2: Description of Professional Experience(years)

Years of Experience	Frequency (n), Percentage (%)
1-5	74 (55.6%)
6-10	50 (37.6%)
>10	9 (6.8%)

Table 3: Description Regarding Knowledge & Attitude of Study Participants

Variable	Category	n	(%)
Seen any cases of workplace violence on duty	Yes	82	61.7
	No	51	38.3
Encountered workplace violence throughout career	Once	69	51.9
	More than once	64	48.1
Primary causes of violence	Night shift	41	30.8
	Work stress	47	35.3
	Absence of clear policy	27	20.3
	Critical area	18	13.5
Sources of violence	Patients	37	27.8
	Patients' relatives	63	47.4
	Supervisors	9	6.8
	Co-workers	24	18.0
Types of violence	Psychological	81	60.9
	Physical	35	26.3
	Sexual	17	12.8
Categories of psychological violence	Verbal abuse	62	46.6
	Ignorance	49	36.8
	Lowering self-esteem	22	16.5
Kinds of physical violence	By an instrument	58	43.6
	Pushing & sliding	75	56.4
Dignity of nurses threatened by workplace violence	Agreed	110	82.7
	Disagreed	23	17.3
Loud speech & improper pronunciation are forms of verbal abuse	Agreed	88	66.2
	Disagreed	33	24.8
	Not assured	12	9.0

Variable	Category	n	(%)
Sexual abuse involves verbal cues & ignoring is psychological aggression	Agreed	66	49.6
	Disagreed	21	15.8
	Not assured	46	34.6
Being physically pushed or hurled by machinery	Agreed	59	44.4
	Disagreed	38	28.6
	Not assured	36	27.1
Violence impacts nurses' behavior & quality of patient care	Agreed	91	68.4
	Disagreed	29	21.8
	Not assured	13	9.8
Violence raises staff turnover in the nursing profession	Agreed	81	60.9
	Disagreed	45	33.8
	Not assured	7	5.3

Table 4: Cross-tabulated Results of Workplace Violence Analysis

Age vs Seen Workplace Violence (%)	No (%)	Yes (%)
25–30	0.0	100.0
31–35	39.3	60.7
>36	100.0	0.0
All	38.3	61.7

Table 5: Chi-square Test P-values

Comparison	p-value
Age vs Seen Workplace Violence	< 0.05
Experience vs Impact on Care	< 0.05

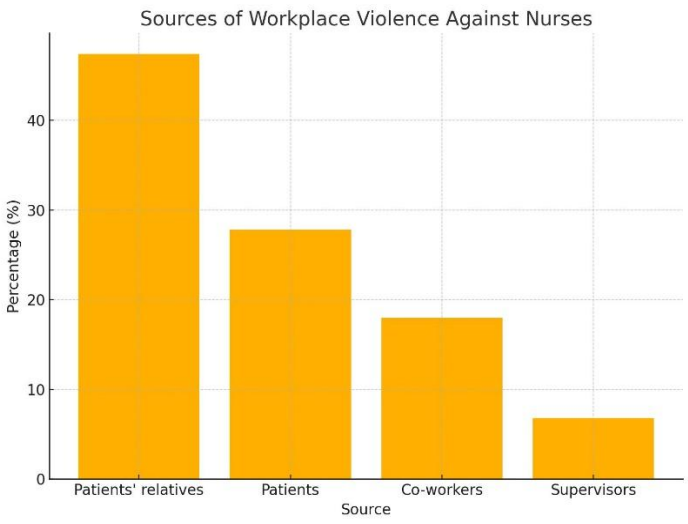

Figure 1 Sources of Workplace Violence Against Nurses

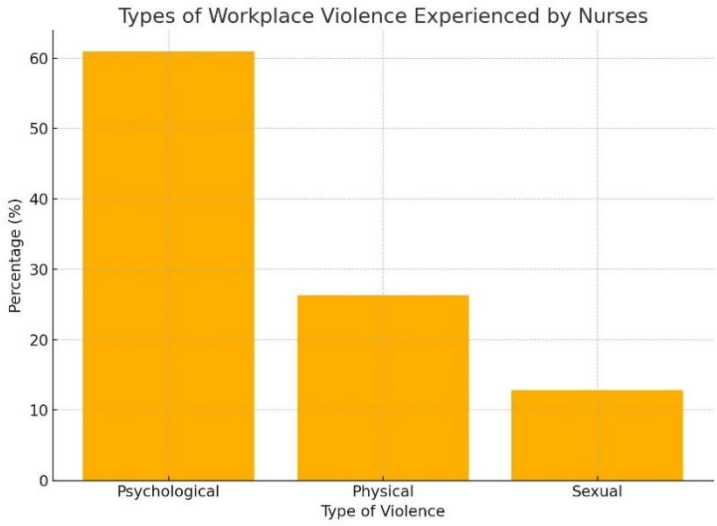

Figure 2 Type of Workplace Violence Experience by Nurses

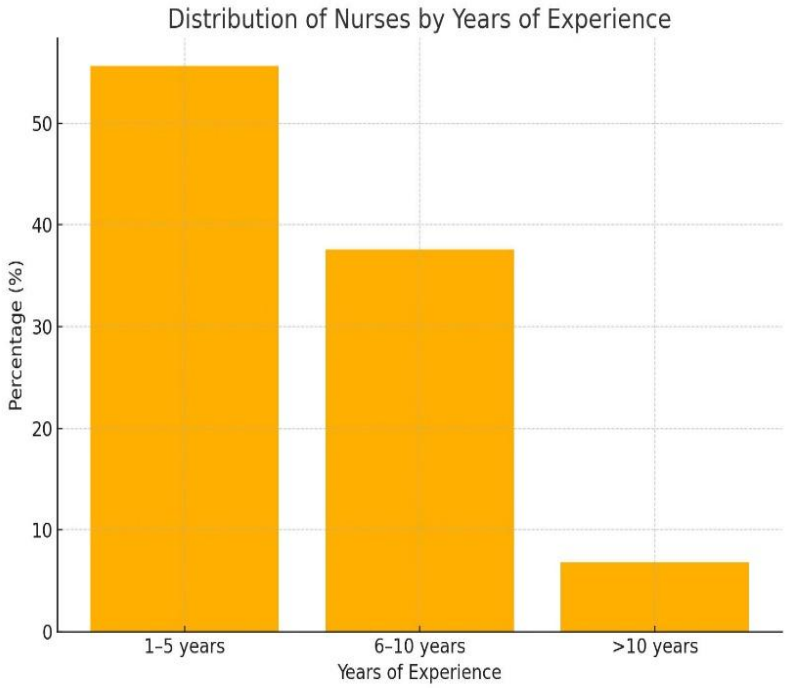

Figure 3 Distribution of Nurses by Yearly of Experience

DISCUSSION

The findings of this study underscore that workplace violence remains a significant occupational hazard among nurses working in tertiary care settings. The overwhelming female predominance among participants reflected the ongoing gendered structure of the nursing profession, historically associated with caregiving roles (14). While the current study did not show major gender-based differences in experiences of violence, literature from northern Portugal indicated that male nurses reported higher rates of psychological violence (15). This inconsistency supports the understanding that workplace violence transcends gender boundaries and affects all nurses regardless of sex, reinforcing the need for inclusive and systemic preventive strategies (16). The high prevalence of psychological violence, especially verbal abuse, aligns with global trends where non-physical aggression has become the dominant form of hostility in healthcare settings (16,17). This form of violence contributes significantly to psychological distress, including burnout and reduced job satisfaction. Nurses reported verbal abuse, workplace ignorance, and lowered self-esteem as the most common indicators of psychological violence. The current findings contrast with research conducted in Saudi Arabia, where long waiting times and miscommunication were identified as key contributors to violence (18). Instead, this study identified primary triggers such as work stress, night duties, critical care postings, and the absence of institutional policies. These context-specific findings suggest that structural and organizational shortcomings play a crucial role in precipitating violent incidents within healthcare institutions.

The study highlighted that patients' families were the most frequent perpetrators of violence, a finding that aligns with previous evidence from Chinese pediatric hospitals, where family members were responsible for the vast majority of incidents (19). The prominence of patient relatives as aggressors' points to potential deficiencies in communication, role clarity, and expectations of care. Psychological violence was the most reported form, corroborating findings from Kuwait and Saudi Arabia, where the lack of guidelines for handling aggression may result in the underreporting of non-physical abuse (20,21). Nurses indicated that psychological violence often preceded physical assault, further suggesting that emotional mistreatment is an escalating precursor to more overt forms of aggression. While the rate of sexual harassment was relatively low at 12.8%, it remains a critical concern. The tendency of such incidents to go unreported due to shame or stigma has been documented in multiple settings, necessitating safe reporting channels and cultural sensitivity training (22). Moreover, although race-based violence was infrequently reported, the underlying phenomenon of invisible racism, as noted in other global studies, cannot be overlooked as a contributor to workplace tension and inequity (15).

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One of the strengths of this study lies in its multifactorial approach, capturing various forms and sources of violence and nurses' attitudes toward them. The use of a structured, validated tool helped ensure reliability, while the inclusion of both knowledge and attitude components enhanced the study's depth. Additionally, the statistical association of workplace violence exposure with age and professional experience provided valuable insights into vulnerable subgroups. However, limitations must be acknowledged. The sample size, while adequate for preliminary assessment, restricts generalizability across broader healthcare settings. The study was confined to public sector hospitals, excluding private institutions where workplace dynamics may differ. Furthermore, the absence of inferential analyses on all demographic variables limits the depth of subgroup comparisons. No exploration of coping strategies or post-incident support was included, which could have added another dimension to understanding nurses' experiences and resilience. To strengthen future research, studies should incorporate larger, more diverse samples across both public and private hospitals and include longitudinal designs to assess long-term consequences of repeated violence. Interventional studies evaluating training programs, support systems, and institutional policies are essential to determine what strategies most effectively reduce the incidence and impact of workplace violence. Overall, the study reinforces that violence in healthcare settings, especially psychological violence, is an urgent occupational health concern. Implementation of anti-violence policies, improved organizational communication, regular staff training, and support networks for victims are crucial steps toward creating safer work environments. Integrating periodic workshops and debriefing sessions may further encourage nurses to report incidents without fear and promote a culture of respect, dignity, and accountability.

CONCLUSION

This study concluded that workplace violence remains a critical concern among nurses in tertiary care hospitals, with verbal abuse emerging as the most common form. The findings emphasized that violence often stems from patient relatives, patients themselves, night duty shifts, job-related stress, and the absence of institutional policies. Nurses perceived workplace violence as a direct threat to their professional dignity, the quality of patient care, and staff retention. These insights highlight the urgent need for healthcare institutions to adopt comprehensive anti-violence measures, promote supportive work environments, and provide training on managing violent situations. Encouraging open reporting through regular workshops and counseling can empower nurses to speak up without fear, ensuring their safety and well-being while enhancing the overall quality of care.

AUTHOR CONTRIBUTION

Author	Contribution
Fouzia Noreen Malik*	Substantial Contribution to study design, analysis, acquisition of Data Manuscript Writing Has given Final Approval of the version to be published
Hafiza saima Riaz	Substantial Contribution to study design, acquisition and interpretation of Data Critical Review and Manuscript Writing Has given Final Approval of the version to be published
Ramzana kousar	Substantial Contribution to acquisition and interpretation of Data Has given Final Approval of the version to be published
Ishrat Perveen	Contributed to Data Collection and Analysis Has given Final Approval of the version to be published
Nadia Bibi	Contributed to Data Collection and Analysis Has given Final Approval of the version to be published
Ayesha siddiqa	Substantial Contribution to study design and Data Analysis Has given Final Approval of the version to be published

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