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When Nursing Care Turns Violent: A Qualitative Content Analysis of Nurses' Workplace Violence Experiences in Turkey

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Abstract

Background

Workplace violence against nurses is a global problem with serious consequences in healthcare settings in Turkey and elsewhere. Yet what formal incident reports reveal about escalation triggers, organizational response, and nurses' coping strategies in clinical settings remains underexplored.

Methods

A qualitative content analysis approach was employed. Nurses' workplace violence incident reports (2017–2025) were analyzed using two-cycle coding in MAXQDA 2024. In vivo and pattern coding techniques were used to derive key expressions and identify patterns. This study adhered to COREQ guidelines.

Results

Three themes (11 subthemes) emerged: (1) Dimensions of Violence, including threats, harassment, attempted assault, and disrespect; (2) Causes of Violence, such as behavioral and communication issues, urgent care demands, and policy noncompliance; and (3) Nurses' Responses to violence, including explanations and warnings, avoidance, security measures, and psychological reactions. When nurses' attempts to de-escalate violence were unsuccessful, they were found to report the incidents.

Conclusions

Workplace violence against nurses is frequently triggered by communication breakdowns, unrealistic expectations, and violations of hospital procedures. Nurses actively employ coping strategies; however, exposure may threaten psychological well-being and professional identity. Findings guide policymakers and nurse managers in strengthening institutional safety responses.

1. Background

Workplace violence (WPV) in healthcare settings is perpetrated by patients or their relatives and may take physical, verbal, or psychological forms. Research indicates that healthcare professionals face a substantially higher risk of violence compared to those in other sectors [1]. Among healthcare workers, physicians and nurses have been identified as the occupational groups at the highest risk [2].

Nurses constitute the largest professional group in healthcare and, as the primary point of contact for patients and their relatives, face a disproportionately high risk of WPV. [3]. This violence poses a serious occupational hazard worldwide, threatening nurses' well-being, straining health systems, and

undermining patient care quality [4, 5]. International estimates suggest that between 8% and 38% of nurses are exposed to violence throughout their careers [6]. Verbal violence is consistently reported as the most prevalent form of WPV, followed by physical violence, which, although less frequent, often carries more severe physical and psychological consequences [7, 8].

Patients and their relatives frequently engage in violence owing to disappointed expectations, communication failures, illness-related stress, or the pressures of healthcare environments [9, 10]. Research indicates that nurses working in emergency departments, psychiatric units, and intensive care units are particularly susceptible to WPV [9, 10]. Apart from immediate harm, repeated exposure to WPV has been linked to burnout, psychological distress, reduced job satisfaction, and increased turnover intention, thereby posing a significant threat to workforce sustainability and the resilience of healthcare systems internationally [11].

Owing to continuous patient contact, nurses are particularly vulnerable to WPV [3, 12]. Workplace violence experienced by nurses leads to significant health problems, including stress, anxiety, sleep disturbances, depression, and post-traumatic stress disorder (PTSD). As a result, nurses with compromised health experience burnout and exhibit greater intent to leave [13, 14]. These negative consequences of WPV extend beyond the well-being of individual nurses, generating broader repercussions for health systems, including increased absenteeism, elevated staff turnover, and diminished quality of patient care and safety [3, 8].

Workplace violence (WPV) is a widespread occupational hazard for nurses, yet formal reporting of such incidents remains markedly low. Studies suggest that up to 80% of WPV incidents go unreported, with formal reporting rates ranging from just 6% to 12% in some settings [15, 16]. Nurses often cite barriers such as the perception that violence is “part of the job,” fear of retaliation, lack of managerial response, and uncertainty about reporting procedures [17]. These factors lead many nurses to forego filing incident reports, leaving institutions with incomplete data and compromising WPV prevention efforts [18]. In response, institutional and national frameworks have been introduced to encourage nurses to report and to support victims. For example, Turkey’s Ministry of Health launched the “White Code” program – a formal system whereby healthcare workers can report violence (by dialing a 113 hotline) and receive legal assistance – which processed over 23,000 incident notifications in a two-year span. Such initiatives reinforce the view that violence against healthcare staff is treated as a serious, reportable offense, with legal support and stricter sanctions for perpetrators [17].

Although workplace violence against nurses has been widely examined, particularly in prevalence and outcome-focused quantitative studies, less is known about how violent encounters unfold and are documented within formal institutional reporting systems [13, 19]. Incident reports capture contemporaneous accounts shaped by organizational rules (e.g., visiting hours, privacy/recording policies) and thus offer a distinct lens on triggers, escalation dynamics, and response pathways. By analyzing nurses’ official incident reports, this study provides practice-relevant insights into the

interactional and organizational conditions that precede violence and the strategies nurses use to manage it.

2. The Study

2.1. Aim

This study aimed to explore nurses' firsthand experiences of workplace violence (WPV) by examining how violent incidents emerged, what factors triggered them, and how nurses responded to and managed such encounters within clinical settings.

2.2. Research Question

This study was guided by the following overarching research question: "How do nurses experience, interpret, and respond to workplace violence in a tertiary-care hospital setting?"

3. Methods

3.1. Design

This study employed qualitative content analysis, a rigorous qualitative research approach, to explore nurses' experiences with workplace violence (WPV). Content analysis facilitates the systematic identification, coding, and categorization of patterns within textual data, allowing for both descriptive content (what is explicitly stated) and interpretive content (underlying meanings and contextual nuances) [20–22]. The study adhered to the COREQ (32-item) criteria for reporting qualitative research [23] (Data S1).

3.2. Theoretical Framework

The theoretical framework guiding this study was informed by organizational and interactional models of workplace violence in healthcare, particularly the Job Demands–Resources (JD–R) model [24] and established conceptual frameworks on violence against nurses [5, 9, 10]. The JD–R model conceptualizes workplace violence as an outcome of imbalances between excessive job demands, such as emotional labor, high workload, time pressure, and continuous patient interaction, and insufficient job resources, including managerial support, clear communication structures, and security measures [9, 24]. Interactional perspectives further emphasize how power relations, unmet expectations, and challenges to professional authority shape violent encounters in everyday nurse–patient–relative interactions [10, 19]. Integrating these perspectives enabled workplace violence to be examined as a multidimensional phenomenon arising from organizational conditions and interactional dynamics, guiding the analysis of nurses' incident reports on the emergence, triggers, and responses to workplace violence.

3.3. Study setting & recruitment

The study was conducted at a tertiary-care university hospital located in the Marmara region of Turkey. The hospital, with a capacity of 565 beds, offers the region's most integrated healthcare services. Participants were recruited using criterion sampling. Eligible nurses were those who had experienced at least one incident of WPV and officially reported it while employed at this hospital. The 2017–2025 timeframe was selected because standardized WPV reporting practices were implemented and more widely adopted in Turkey during this period. A structured incident form was introduced at the study institution in 2017. Data from 18 such incident reports were included in the analysis.

3.4. Data collection

The study obtained its data from official incident reports of 18 nurses employed at the hospital between 2017 and 2025 who met the inclusion criterion for the sampling frame. Each report, recorded in a standardized format by hospital administration, presents the nurse's narrative of the incident and detailed information on its type, timing, location, perpetrator characteristics, progression, causes, and consequences.

3.5. Data analysis

Data analysis was carried out using qualitative content analysis, following a two-cycle coding procedure based on Saldaña's (2016) techniques [25]. The analysis followed an inductive approach, allowing themes to emerge from the data while being informed by existing theoretical frameworks, such as the JD–R model. This enabled both data-driven insights and theoretically informed interpretation. Specifically, in vivo coding and pattern coding are employed to capture the emotional facets of nurses' WPV experiences and to preserve their language. The analysis unfolds through the following steps:

First-Cycle Coding

In this phase, reports of WPV incidents were read multiple times, and in vivo coding was used to capture the key expressions nurses used in their direct statements. Two researchers independently conducted the coding process to improve the reliability of the analysis.

Second-Cycle Coding: In this phase, first-cycle codes were re-examined at a higher level of abstraction and conceptualization. Similar codes were consolidated to develop themes and subthemes. Using pattern coding, relationships and patterns among the codes were systematically identified.

The data analysis is conducted using MAXQDA 2024, a qualitative data analysis software that facilitates code organization, theme development, and visualization of interrelationships within the data. No new themes emerged after the 16th report, indicating that data saturation had been reached. Nevertheless, all 18 reports were included in the analysis. The analysis produces three principal themes and associated subthemes: "Dimensions of Workplace Violence," "Triggers of Workplace Violence," and "Nurses' Responses to Workplace Violence."

3.6. Rigor

To address Lincoln and Guba's (1986) trustworthiness criteria for qualitative research, the following strategies are employed:

Credibility

Investigator triangulation was employed during the data analysis process; coding and theme development were carried out by two independent researchers. In line with the principle of prolonged engagement, sufficient time was allocated to the data to allow for an in-depth analysis.

Transferability

The research context, participant and institutional characteristics, and data collection procedures were described in detail to enhance the transferability of the findings to similar settings.

Dependability

The research workflow is thoroughly documented, and each procedural step is clearly defined. The coding scheme and theme development process are reported transparently. Following Miles et al. (2014), inter-coder reliability, measured as the agreement between two independent coders, exceeds the 70% threshold, reaching 80% in this study [27]. To strengthen analytic rigor, differences between coders were discussed until consensus was reached. The focus was on shared understanding and clear interpretation rather than numerical agreement alone.

Confirmability

A reflexive journal was kept to enhance the researcher's awareness of personal experiences and potential biases and to minimize the risk that subjective judgments would influence the findings. Direct quotations from the reports were used to anchor the results in the data.

3.7. Ethical procedures

The Graduate Education Institute Ethics Committee at Canakkale Onsekiz Mart University approved our study (approval: 2024-YÖNP-0537) on June 14, 2024, and the host hospital granted institutional permission. The study was conducted in accordance with the ethical principles outlined in the Declaration of Helsinki. Written informed consent was obtained from all participants for the use of the reports in the scientific study. Personal identifiers within the reports were kept confidential, and all data were anonymized.

During manuscript preparation, the authors used ChatGPT (OpenAI) and Grammarly (Grammarly Inc.) solely for language editing (clarity, grammar, and style), accessed via web applications in December 2025. No generative AI systems were used to create, analyze, modify, or interpret research data, results, figures, or tables. All AI-assisted suggestions were critically reviewed and verified by the authors. No sensitive or personal data were entered into any AI tools.

4. Results

4.1. Sample characteristics

This study comprises 18 nurses (14 female, 4 male) who submitted documented incident reports. All participants possess bachelor's degrees, and their ages range from 24 to 40 years, with a mean age of 31.2 years. Every incident involved verbal violence, and the majority of these events (n = 9) took place within clinical wards, while the remaining incidents occurred in other hospital settings. Detailed demographic data are summarized in Table 1.

Table 1
Sample and WPV Characteristics

Participants	Age	Gender	Education Level	WPV Year	WPV Type	WPV Location
1	27	Female	Bachelor's Degree	2017	Verbal	Clinic
2	36	Female	Bachelor's Degree	2019	Verbal	Polyclinic
3	24	Male	Bachelor's Degree	2021	Verbal	Clinic
4	30	Female	Bachelor's Degree	2022	Verbal	Clinic
5	27	Female	Bachelor's Degree	2022	Verbal	Clinic
6	32	Female	Bachelor's Degree	2022	Verbal	Emergency
7	40	Female	Bachelor's Degree	2022	Verbal	Polyclinic
8	31	Female	Bachelor's Degree	2022	Verbal	Clinic
9	35	Female	Bachelor's Degree	2023	Verbal	Clinic
10	27	Male	Bachelor's Degree	2023	Verbal	Clinic
11	29	Female	Bachelor's Degree	2024	Verbal	Emergency
12	33	Female	Bachelor's Degree	2024	Verbal	Clinic
13	26	Female	Bachelor's Degree	2024	Verbal	Polyclinic
14	38	Female	Bachelor's Degree	2025	Verbal	Clinic
15	34	Female	Bachelor's Degree	2025	Verbal	Emergency
16	28	Female	Bachelor's Degree	2025	Verbal	Polyclinic
17	29	Male	Bachelor's Degree	2025	Verbal	Emergency
18	37	Male	Bachelor's Degree	2025	Verbal	Polyclinic

Following the analysis, three principal themes and eleven subthemes emerge (Table 2). The process reflects an intricate interaction of factors rather than a linear sequence. Nurses' experiences of WPV

span threats and harassment to attempts at physical violence, and insults to disrespectful remarks. All participants report verbal violence, and some also contend with threats of physical violence. At its core, participants navigate a multifaceted experience of fulfilling professional responsibilities while defending personal safety and emotional well-being. The severity of these incidents markedly influences nurses' professional practice and psychological health.

Table 2
Themes and subthemes of the study.

Themes	Subthemes
Dimensions of Violence	Threat and Harassment
	Insults and Profanity
	Physical Violence Attempts
	Disrespect and Belittlement
Causes of Violence	Behavioral and Communication Issues
	Demands for Immediate Attention
	Noncompliance and Privacy Violations
Nurses' Responses to Violence	Providing Explanations and Issuing Warnings
	Avoidance Strategies
	Security Measures
	Psychological Reactions

4.2. Dimensions of violence

The theme "Dimensions of Violence" encompasses various forms of violence experienced by nurses and the corresponding impacts on them. This theme comprises four sub-themes: threats and harassment, insults and profanity, attempted physical violence, and disrespect or belittling remarks.

4.2.1. Threat and harassment

Threats and harassment by patients and their relatives occupy a prominent role in nurses' WPV experiences, deeply undermining their professional identity and sense of personal safety. Such behaviors disrupt daily routines and adversely affect psychological well-being.

Participant 1 reports being told, "This is your job; you will do it," a statement that negates the nurse's autonomy. The same participant also recalls the threat, "I will have you removed from here," targeting her job security and professional existence.

Participant 4 describes being asked for personal identifiers, “What is your name?” and “Tell me your surname,” a request that, in context, implies future use for retaliation or complaint and leaves the nurse feeling vulnerable.

Participant 6 recounts the remark, “You can’t even imagine what will happen to you,” an ambiguous yet potent threat whose uncertainty intensifies its psychological impact.

Participant 18 experienced the explicit declaration, “I will not leave this hospital without beating you,” a direct threat of physical violence that profoundly shakes the nurse’s sense of security.

4.2.2. Insults and profanity

Insults and profanity constitute a further manifestation of WPV against nurses, undermining professional dignity and targeting personal worth. Such verbal aggression engenders feelings of worthlessness and erodes professional motivation.

Participant 3 reports being labeled “moron,” a direct attack on intellectual capacity that undermines confidence in professional competence. The same participant recounts the follow-up remark, “Yes, I called you a moron. So what?”, signaling deliberate and persistent harassment.

Participant 4 describes being addressed as “dishonorable” and “scoundrel,” followed by “Do you know who I am?”, epithets that assault personal integrity and reflect the perpetrator’s presumed superiority and intent to degrade.

Participant 9 endures one of the harshest profanities, extending the insult to include her family. This violation of personal boundaries inflicts profound emotional harm.

4.2.3. Physical violence attempts

Physical violence attempts represent a critical aspect of WPV against nurses, profoundly undermining their sense of security and leaving them under constant threat.

Participant 2 threatened physical harm by declaring, “I will tear that nurse’s hair out wherever she is.”

Participant 3 reported that the perpetrator advanced toward her and was stopped only by the intervention of security staff, pointing to the severity of the threat.

Participant 14 described an assailant lunging at her from the nurse’s station and attempting to use force, demonstrating that threats can penetrate core clinical areas and erode any sense of safety.

Participant 6 noted that when the individual shook a finger at her, she immediately recognized an imminent assault, illustrating the continuous vigilance required of nursing staff.

4.2.4. Disrespect and belittlement

Disrespect and belittlement represent a distinct facet of WPV against nurses, eroding their professional identity and personal dignity. Such conduct reduces nurses to objects of service, denying their autonomy and expertise.

Participant 2 reports being told “That nurse will come here” and “Who is he to tell me what to do?”, statements that objectify the nurse and invalidate her professional authority.

Participant 15 recalls the remark “Who do you think you are, God?”, and Participant 6 describes being challenged with “Who are you? What do you think you are?”, both of which question the nurse’s role and competence, undermining confidence and inducing worthlessness.

Participant 9 endures demeaning directives such as “What use are you anyway?” and “Change my sheets quickly,” language that relegates the nurse to a servant’s role and assaults professional dignity.

4.3. Causes of violence

The theme of causes of violence is aimed at understanding under which conditions and with what kinds of triggers violence against nurses arises. This theme comprises three subthemes: Behavioral and communication issues of patients and their relatives, Demands for immediate attention, and Noncompliance and privacy violations.

4.3.1. Behavioral and communication issues

Nurses report that patients’ and relatives’ behavioral and communication breakdowns significantly contribute to the onset of WPV through encouraging misunderstandings and escalating tensions.

Participant 6 describes helping, “Please allow me to help you,” only to be met with “Who are you to tell me what to do?”, illustrating how well-intentioned communication may be construed as interference, triggering aggression.

Participant 8 recounts that, despite daily education efforts, a relative repeatedly shouted, “You must explain this over and over; this is your job,” and “What is your name? Watch what I will do to you,” highlighting how persistent communication failures can become chronic and precipitate recurrent violence.

Nurses report that patients’ and relatives’ urgent demands for care or intervention frequently contribute to the onset of WPV by creating conflict when these demands clash with workload priorities.

4.3.2. Demands for immediate attention

Participant 4 describes an incident in which the patient, adopting an aggressive tone, shouted, “The IV is empty, change it now; I have already pressed the call button,” illustrating how an urgent treatment request conveyed with force can escalate into violence. This suggests that unrealistic expectations regarding response times may provoke aggressive behavior.

Participant 7 recounts that a patient's relative approached the nurse's station and yelled, "You are not doing your job, clean my catheter!" at high volume, demonstrating how improper communication of care demands, rooted in impatience and lack of knowledge about clinical procedures, can trigger violent responses.

Participant 18 reports entering a room to provide care, only to be met with the directive, "Change my sheets, hurry up!" delivered in a commanding tone. This encounter illustrates how the perception of nurses as task-oriented service providers can trigger verbal aggression.

4.3.3. Noncompliance and privacy violations

Nurses report that patients' and their relatives' refusal to comply with hospital policies and breaches of privacy frequently trigger WPV, as enforcement efforts provoke tension and aggression.

Participant 1 observed that "We noticed a relative was filming me," an unauthorized recording that violated privacy and escalated into a confrontational incident.

Participant 12 recounts, "When I realized the patient's relative was making a video, I told them, 'Recording is forbidden here,'" only to encounter a hostile backlash, illustrating how enforcing the recording ban can spur violence.

Participant 5 describes an event in which "…when the patient's relative attempted to enter the room outside visiting hours…," the nurse's effort to uphold visitation rules provoked anger and threats.

Participant 16 reports that "Relatives entered the ward outside of visiting hours," demonstrating a repeated refusal to respect hospital visiting policies and the consequent emergence of violent behavior.

4.4. Nurses' responses to violence

This theme explores how nurses respond and cope when subjected to WPV. It comprises four subthemes: providing explanations and issuing warnings, violence avoidance, security measures, and psychological reactions.

4.4.1. Providing explanations and issuing warnings

Nurses frequently respond to episodes of WPV by presenting thorough explanations and issuing clear warnings, with the dual aims of preventing escalation and reestablishing a professional, calm environment.

Participant 2 recounts that she informed the aggressor that recording is forbidden here and asked them to turn off their phone. She emphasized the confidentiality policy and reminded the relative of the legal implications of unauthorized filming. This direct intervention initially provoked anger but ultimately de-escalated the confrontation when security staff supported her explanation.

Participant 3 describes confronting a relative who addressed her disrespectfully by telling them, “You should not speak to me in that way, please use respectful language.” She paused her task to ensure the message was heard and noted that asserting her boundaries in a firm yet polite tone caused the relative to back down and reflect on their behavior.

Participant 4 explains how she managed expectations by communicating each step of care: “Once I return from my meal break, I will adjust and replace the IV drip at the appropriate rate.” She provided an estimated time frame and offered to check back if there were further concerns. This transparent approach reduced the attendant’s anxiety and prevented further outbursts.

Participant 5 details her use of empathy combined with information: “I understand your fears, and the procedure cannot be rushed because it could compromise safety, so please allow me to follow the hospital’s protocols.” She acknowledged their frustration before reiterating the necessity of following rules. This strategy of validating emotions while clarifying procedures helped restore a cooperative atmosphere and allowed her to continue care without further incident.

4.4.2. Avoidance strategies

Nurses often employ avoidance strategies in response to WPV to prevent escalation and protect themselves.

Participant 2 states, “I did not respond to them; there was no verbal exchange between us,” illustrating her deliberate choice to remain silent to defuse the situation. This approach reflects her commitment to maintaining a professional demeanor and preventing further conflict.

Participant 14 reports, “I moved to the nurse’s station without replying so that no incident would occur,” demonstrating her use of physical distancing to safeguard her safety and ensure the situation does not intensify.

4.4.3. Security measures

Nurses also adopt security measures in response to WPV, reflecting efforts to protect themselves and others.

Participant 4 states, “I moved toward the nurse’s station,” indicating her strategy of relocating to a safer area to ensure personal security.

Participant 6 reports shouting, “Security, I need help in the corridor,” and describes how “they tried to force their way into the room. With assistance from the patient care staff, I closed the door and locked it again,” illustrating her use of calling for security and creating physical barriers.

Participant 7 recounts, “I called security,” demonstrating her proactive decision to seek assistance from security personnel, thereby assessing the seriousness of the situation and securing necessary support.

Participant 12 explains, “The cleaning staff accompanied me and stayed with me until morning to ensure I felt safe,” reflecting her strategy of enlisting support from other personnel to fulfill her security needs and regain psychological comfort.

4.4.4. Psychological reactions

Nurses’ responses to WPV also encompass psychological reactions that reflect the emotional and mental impact of these incidents.

Participant 3 reports, “I find myself anxious about this issue, especially given that I am pregnant,” indicating heightened worry and concern following the incident; this reaction underscores how violence can intensify emotional distress during sensitive periods such as pregnancy.

Participant 6 describes how the experience “subjected me to profound psychological turmoil,” highlighting enduring mental health effects that can persistently influence both professional performance and personal well-being.

5. Discussion

This study investigates nurses’ WPV experiences and characterizes a multidimensional process encompassing threats, insults, attempted physical assaults, and disrespectful conduct. All participants (n = 18) report exposure to verbal violence (Table 1). Consistent with existing research, verbal violence emerges as the predominant form encountered by nurses [7, 8].

The increase in WPV against nurses over recent years is noteworthy. Data documenting heightened aggression toward healthcare workers during and after the COVID-19 pandemic indicate that this issue has further intensified [28]. Most nurses’ violence incident reports in this study originate from the COVID-19 pandemic and its aftermath. A separate study indicates that, during the COVID-19 pandemic, women and children were disproportionately affected in societal violence incidents [29].

5.1. Theoretical integration: Interpreting themes through JD–R and interactional perspectives

The findings of this study align closely with the JD–R model [24], which conceptualizes workplace stress as a balance between job demands and the resources available to manage them. Themes such as “Demands for Immediate Attention” and “Behavioral and Communication Issues” reflect high-intensity clinical expectations, time pressure, and emotionally charged interactions, collectively constituting critical job demands that can deplete nurses’ physical and emotional capacity. Conversely, themes involving “Security Measures” and “Avoidance Strategies” illustrate the organizational resources nurses rely on to address violent encounters. These resources varied in perceived availability and effectiveness, influencing both how nurses managed incidents and whether they formally reported them. In parallel, the interactional framework helps explain the dynamics of escalation evident in nurses’ accounts [30].

Several incidents arose from contested authority, perceived disrespect, or violations of institutional boundaries (e.g., refusal to comply with visiting hours or bans on video recording), suggesting that workplace violence is not merely spontaneous but often shaped by role negotiation and power struggles between nurses and patients or their relatives.

5.2. The impact of workplace violence on nurses' health

Nurses are the most affected profession in healthcare settings by WPV. In this study, exposed nurses predominantly report insults and profanity. Consistent with existing research, verbal harassment emerges as the primary form of aggression, characterized by shouting at nurses, direct insults, use of obscene language, and demeaning comments [31, 32]. Similarly, verbal assaults involving insults and profanity ("moron," "dishonorable, scoundrel") undermine nurses' professional confidence and weaken their sense of belonging, thereby increasing intentions to leave nursing and job dissatisfaction. Indeed, one participant emphasized the lasting impact on mental health after a negative experience, stating, "I experienced profound psychological distress."

Recent evidence demonstrates that exposure to violent incidents significantly undermines nurses' mental health, manifesting as elevated anxiety, depression, burnout, and TSSB symptoms [33]. Participants report persistent vigilance, heightened anxiety, and even doubts about their professional identity following threats and harassment. For example, the ambiguous threat "You cannot even begin to imagine what will happen to you" undermines sleep quality and concentration, thereby increasing the long-term risk of psychosocial disorders. Attempts at physical violence, although not carried out, foster a continuous sense of insecurity that amplifies chronic stress responses, underscoring the consistent psychological toll of WPV. [13]. The literature demonstrates that exposure to WPV increases nurses' stress levels and reduces job satisfaction. Importantly, compromised nurse well-being arising from such exposure links to poorer patient care outcomes and heightened turnover intention among nursing staff [33].

Following a WPV event, nurses report feeling vulnerable, perceiving inadequate support, experiencing elevated stress levels, and experiencing anger. These observations align with findings from earlier studies [34]. Consequently, WPV significantly impacts nurses not only physically but also emotionally and psychologically. A Turkish study reports that 35.6% of nurses experience psychological violence, which undermines their psychological resilience [35]. Research indicates that prolonged or repeated exposure to violence induces profound emotional exhaustion and operates as a chronic stressor rather than a singular "shock" event [36]. This study reveals that nurses employ avoidance strategies, such as remaining silent, offering explanations, and enhancing security measures, in response to WPV. When these individual interventions prove ineffective, incidents may go underreported, and abusive behaviors risk normalization. Over time, the cumulative burden of such experiences fosters chronic stress that is detrimental to overall well-being and may contribute to the development of PTSD.

5.3. Social and organizational determinants of violence

Identified triggers of WPV, including patients' and relatives' behavioral and communication breakdowns, urgent care demands, noncompliance with regulations, and privacy violations, closely align with the social determinants and precipitants of violence documented in existing healthcare literature [9]. The findings also highlight practical difficulties in enforcing hospital regulations, especially those related to privacy protections and visiting hours. These enforcement challenges underscore the need to situate WPV within a broader healthcare context and point to potential inefficiencies in organizational management [10].

Workplace violence arises not only from individual patient characteristics but also from broader societal expectations, organizational pressures, and communication breakdowns. Reyes-Rodriguez et al. (2024) demonstrate that elevated workloads and strained workplace relationships substantially increase nurses' stress and burnout, exacerbating their vulnerability to aggression by patients and relatives [37]. Qualitative quotations from nurses illuminate the power dynamics and emotional toll inherent in these encounters. Nurses' reliance on security measures, such as summoning security personnel and erecting physical barriers, reflects the practical steps taken to safeguard themselves and others, highlighting the imperative for robust institutional support and comprehensive security protocols [8]. Moreover, the convergence of patients' and relatives' lack of empathy with a high-pressure clinical environment fosters conditions conducive to violence. Consistent with existing research, these findings reveal that addressing violence against nurses requires a multifaceted approach targeting social and organizational factors alongside a zero-tolerance policy, rather than interventions focused solely on individual behaviors [38].

5.4. Strengths and limitations of the work

This study has limitations. It draws on workplace incident reports from a single tertiary hospital, which may limit the transferability of findings to other healthcare settings. Because the data source consisted of self-authored reports, accounts may reflect self-reporting and interpretation biases, as well as institutional reporting conventions. The number of cases was small, which is appropriate for qualitative analysis but may not reflect the entire spectrum of violence experienced by nurses.

The study also has notable strengths. It offers a rigorous qualitative analysis grounded in real clinical documentation, providing an authentic view of how violence occurs and is managed in practice. The use of systematic two-cycle coding and adherence to COREQ strengthened the credibility of the findings. Examining incidents recorded over several years enabled the identification of recurring patterns. The study contributes valuable insights by exploring not only the forms and triggers of violence but also nurses' coping strategies, supporting efforts to improve workplace safety and policy development.

5.5. Implications for Nursing & Health Policy

This study highlights the need for policies that support transparent communication processes, consistent enforcement of institutional rules, and reliable response pathways for workplace violence. Strengthening reporting mechanisms and ensuring managerial follow-up can improve the safety and confidence of nursing staff. Organizations should also integrate regular violence prevention training and

accessible psychological support into routine practice [39, 40]. Addressing structural issues such as workload and staffing may further reduce triggers of violence. Implementing these measures can promote safer work environments and enhance the quality of care.

6. Conclusion

This study underscores the persistent and multidimensional nature of WPV against nurses, demonstrating the critical role of prevention strategies in safeguarding nurses' well-being. The findings both reinforce current literature on the manifestations and triggers of violence and deliver nuanced insights into nurses' lived experiences and adaptive coping mechanisms. The research yields actionable guidance for policy development, clinical practice, and future investigation by clarifying the intricate interplay of causal factors and professional responses.

The results reveal a pressing need for enhanced psychosocial support within nursing environments and for comprehensive, evidence-based interventions that prioritize both physical and psychological health. Establishing supportive and secure workplaces requires stronger legal frameworks for violence prevention, managerial commitment to supporting nurses, and unwavering implementation of zero-tolerance policies.

Declarations

Ethics approval and consent to participate

The Graduate Education Institute Ethics Committee at Canakkale Onsekiz Mart University approved this study (approval no: 2024-YÖNP-0537) on June 14, 2024, and the host hospital granted institutional permission. Written informed consent was obtained from all participants for the use of their incident reports in the scientific study.

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Competing interests

The authors reported no potential conflict of interest.

Data Availability Statement

Not applicable

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