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Lived Experience of Nurses in Managing Patients with Violent Behavior

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Abstract
Aim: This phenomenological study explored the lived experiences of nurses in managing patients with violent behavior, focusing on types of violence encountered, precipitating factors, coping strategies, and psychological impact.
Methodology: Ten purposively sampled Filipino registered nurses working in hospitals in the United States participated in semi-structured interviews conducted via Zoom (interview period: January–February 2025). Interviews lasted approximately 30 minutes, were audio–video recorded with consent, and were analyzed using Colaizzi's thematic framework to identify major themes.
Results: Five primary themes emerged: (1) Triggers — predictable escalation patterns, drug-seeking/unmet needs, and substance-related delirium; (2) Emotional and psychological impact — stress, anxiety, trauma, and emotional detachment; (3) Coping mechanisms — communication/de-escalation and self-care; (4) Moving forward — professional growth alongside career doubts; and (5) Institutional response — gaps in policy implementation, training, and post-incident debriefing. Verbal and physical assaults were most common and produced both immediate and persistent psychological effects.
Conclusion: Coordinated institutional interventions are needed. Nursing administration should treat workplace violence as a core safety issue and implement proactive policies, mandatory de-escalation training, reporting systems, and structured post-incident support to protect nurses' well-being and sustain quality care.
Keywords: *Violent Patients, Workplace Violence, Nurses, Qualitative Study, Phenomenology, De-Escalation, Mental Health, Lived Experience*

INTRODUCTION

Researchers and lawmakers worldwide are taking notice of the increasing problem of workplace violence towards nurses. The issue of violence has gained international recognition and grown to be a significant public health concern. Nurses and other healthcare professionals who provide direct patient care, medical facility personnel, and medics are the groups most at risk.

Over the past ten years, there has been a notable rise in violence against nurses, with some studies indicating a 110% increase in violent incidents in the United States of America. Moreover, according to Rahma and Febriyani (2023), half of nurses in the USA (54.8%) reported experiencing violence at work. The violence was carried out by employees in 33.5% of cases and by patients in 57.4% of cases. Another study found that patients (22.6%) and their families (62.3%) were the most common abusers. In this instance, patients and their families are the ones who commit the most violent acts.

For every nurse, workplace violence is recognized as a serious workplace risk. It exists in every nation and in every area of healthcare delivery. Violence towards medical professionals is becoming more common and more severe on a global scale. Sixty-five percent of nurses reported being physically attacked in the previous 12 months (Newman et al., 2023).

There are two types of workplace violence: physical and non-physical. In the past, the most documented and studied type of violence against healthcare professionals has been physical violence (Olasoji et al., 2024). It is

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widely acknowledged that verbal abuse, intimidation, harassment, and threatening behavior may have detrimental effects and that these types of violence also need to be reduced.

Violence is not just an outburst of aggression, but it is an act including verbal, physical, and mental abuse, which places a person at risk of any injury and humiliation. This is also more than physical and verbal assaults, but also a form of intimidation and psychological manipulation.

Nursing staff members' psychological, social, emotional, and physical health may suffer as a result of encountering violent behavior. However, in developing countries, violence toward hospital employees has only lately started to receive widespread attention. Research on aggressive behaviors, such as those that occur in general hospitals, have not been conducted, though. Furthermore, no study examining the experiences of Filipino nurses in USA has been conducted. The purpose of this study's setting is to raise awareness of these experiences (Harliyanti et al., 2022).

Few recent studies have examined the experiences of medical personnel dealing with violent patients in ASEAN nations (Shital & Deepali, 2024; Yulis et al., 2023; Woon, 2023). In the Philippines, it is believed that RNs are "very high risk" of having workplace violence. Nevertheless, there is no information on the prevalence of violence and aggressiveness experienced by registered nurses in hospital environments (Damayanti, 2025).

By using their lived experiences to describe their personal and professional encounters with patient aggression and the ways hostile behavior appears, nurses may also become more knowledgeable in their profession through this research.

The study presents academic significance by addressing the issues encountered by nurses that affect their safety. Investigating the issue contributes to the nursing discipline and the healthcare community, as it could help in developing suggestions for hospital administration to offer support networks to nurses who encounter violent conduct from patients with mental illnesses. Hospital administrators can use the results of this study to develop and put into place suitable support mechanisms for nurses who experience various types of violent patient behavior. Lastly, the results will broaden our understanding of the topic being studied. The study offers a contextual and experiential uniqueness by its focus on a nursing and cultural environment, which offers unique knowledge on practice-based guidelines for a more responsive healthcare system.

Review of Related Literature and Studies

A challenging but essential part of nursing is dealing with patients' violent behavior. Violence in healthcare facilities is a serious problem, as seen by research (Rahma & Febriyani, 2023). Additionally, nurses face aggressive behaviors, including disruptive, verbally abusive, physically unsafe, or physically assaultive behaviors among their patients (Adams et al., 2024; Dunsford, 2021; Pearson, 2022).

In Asean research, it was discovered that nurses were subjected to verbal, emotional, and physical abuse. Being trapped and pursued, being beaten, being punched or grabbed, being kicked, getting spat on, being smothered, and utilizing weapons, like smashing windows, are examples of physical violence. Combinations of these, including being pushed and struck at the same time, occurred in four cases. Numerous occurrences involve verbal violence as well, such as threats, taunts, or demeaning remarks; thus, the experience is not just restricted to physical violence (Adeniyi & Puzi, 2021; Cho et al., 2023; Hou et al., 2023).

In the Philippines, workplace violence has serious negative both emotional and physical impacts on nurses. Physical repercussions can range from small wounds to death or severe disability. The most frequent injuries that healthcare professionals sustain include scratches, stings, bruising, grazes, and cuts to the arms, back, and head. In most cases, serious injuries are uncommon (Ariandi et al., 2023; Damayanti, 2025; Busnello et al., 2022).

The literature presents a gap in the challenging experiences of nurses in managing patients with violent behaviors. Studies state that more research should be conducted on the forms of violence experienced by nurses in the form of verbal, physical, and emotional abuse, which impact their professional as well as personal lives to a great extent. Specifically, no studies were conducted in the USA focusing on the forms of violence experienced by Filipino nurses working there. Moreover, limited studies explore Filipino nurses' lived experiences abroad; few studies focus on phenomenological insight into violence triggers. There is a lack of research on institutional/systemic contributors to violence, and there is a scarcity of research using Colaizzi's phenomenology among foreign Filipino nurses.

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Conceptual Framework

This study aimed to explore the lived experiences of nurses in managing patients with violent behavior. This study, anchored by Lazarus and Folkman's psychological stress and coping theory, was conducted by interviewing selected Filipino nurses.

Furthermore, the study identified five themes: Triggers, Emotional and Psychological Impact, Coping Mechanisms and Support, Moving Forward, and Institutional Response and Support. Each theme includes different sub-themes that elaborate on and explain the study's findings. Finally, practical implications and recommendations were proposed to better support and assist nurses in managing violent patients.

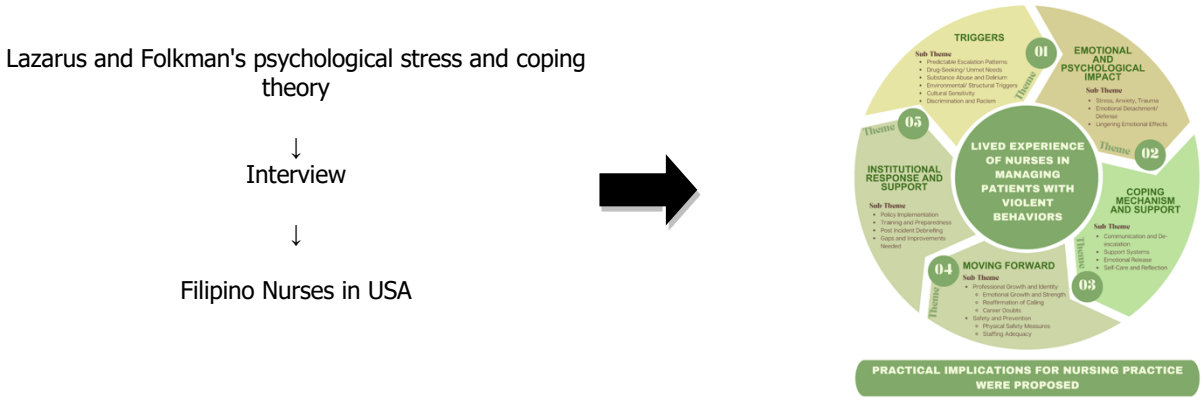

Figure 1. Conceptual Framework of the Study

This study aimed to explore the lived experiences of nurses in managing patients with violent behavior. Furthermore, the study identified five themes: Triggers, Emotional and Psychological Impact, Coping Mechanism and Support, Moving forward, and Institutional Response and Support. Each theme includes different sub-themes that elaborate and explain the findings of the study. Finally, practical implications and recommendations were proposed to better support and assist nurses in handling violent patients.

Under all these issues lie the triggers that cause violent behaviors among the patients. They are drug-seeking behavior, substance abuse, delirium, environmental and structural stressors, discrimination, racism, and predictable escalation patterns. Understanding the triggers allows nurses to have a better understanding of violence as not random acts but brought about by underlying triggers. Understanding triggers is critical in the anticipation and prevention of violent acts.

The model starts by recognizing the' profound psychological and emotional effects of violent conflicts on nurses. All the participants expressed feeling over and over again a sense of trauma, fear, tension, and alienation, and most often with long-term after-effects on their feelings, even after weeks. The theme recognizes nurses' vulnerability and states that violence is not merely an experience with the body but also an individually intimate and intellectual burden.

In dealing with these affective challenges, nurses resort to coping mechanisms. Communication and de-escalation skills, release of emotion, self-care activity, and utilization of support systems were the sub-themes of coping mechanisms that were salient and emerged as important factors. The theme captures how nurses actively seek means of surviving their experience, preventing burnout, and remaining resilient in the face of repeated exposure to aggression.

Besides coping, nurses also explained the impact of such incidents on their professional growth and self-concept. While some of them reported increased emotional strength and reaffirmed their ministry call, others reported career ambiguity and safety issues. Physical safety means and sufficient staffing sub-themes also referred to the existence of systemic protection as ensuring nurses' progress. The theme suggests that violent experience can be transforming and deterrent, depending on how it is facilitated and supported.

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The other significant aspect is the institutions' role in responding to violence at work. Consensus among participants was reached in the enforcement of policy, training, preparedness, post-incident debriefs, and system strengthening. This theme recognizes that although managing on an individual level is crucial, organizational structures and responses are just as critical in ensuring safety and upholding a culture of care.

The core loop of the model is determined by the intersection of all five themes. Taken together, they reflect that violence within healthcare is a mix of individual and organizational problems, being influenced by patient factors, work environment, and personal coping behaviors.

Lastly, the model concludes on practical implications for nursing practice that were derived from the participants' everyday realities. These implications call for improved institutional support systems, tighter policies, improved training, and nurses' welfare. Basically, the conceptual framework can be applied in the current study as it not only summarizes what nurses experience in the midst of violence but also how they respond, survive, and heal.

Theoretical Framework

Lazarus and Folkman's psychological stress and coping theory has tried to explain the origin of psychological stress, which is a complicated phenomenon. These theoretical explanations can be divided into three categories based on how they conceptualize the experience of stress: stress as a stimulant from outside, stress as a reaction, and stress as an individual or environmental transaction. They created the transactional theory of stress and coping in 1984. This psychosocial framework looks at how people view and react to stress in their surroundings. According to this paradigm, stress results from relationships between people and their environment as well as from outside occurrences. The method of assessments, in which people determine if a situation poses a threat or an obstacle based on what they have on hand, is fundamental to the model. Although secondary evaluation evaluates one's capacity to deal with a perceived danger, the initial assessment determines whether an occurrence is detrimental (Biggs, et al., 2017).

The transactional model of stress and coping is a psychological theory that focuses on how individuals decide to cope with stress and how they think about their surroundings. According to the paradigm, stress results from interactions or transactions between individuals and their surroundings rather than from an event.

When human resources are insufficient to meet the pressures they confront, stress arises. To assess if a situation is stressful, individuals employ the method of appraisal, also known as self-evaluation. The term "coping" describes the behavioral and cognitive strategies people use to deal with stress. The investigation of mental processes, or cognitive psychology, benefited greatly from the transactional model of stress and coping. This theory was used in this study to highlight how important assessment is in influencing nurses' experiences, feelings, and their behaviors towards patients with violent behaviors.

Statement of the Problem

Workplace violence against nurses has become a persistent and escalating concern in healthcare settings, leading to serious physical, emotional, and psychological consequences for nursing professionals. Despite existing institutional policies and interventions, many nurses continue to encounter verbal, physical, and emotional aggression from patients and their families. While global studies highlight the prevalence and effects of such violence, limited research has explored the subjective and lived experiences of nurses, particularly Filipino nurses working in hospital settings abroad, who may face additional cultural, emotional, and occupational challenges. Furthermore, existing literature lacks sufficient insight into the triggers of violent patient behavior, its impact on nurses' professional identity and well-being, and the adequacy of institutional support systems. This gap underscores the need for a qualitative investigation that documents the lived experiences of nurses in managing violent patients to inform policy-making better, enhance protective mechanisms, and strengthen psychosocial support in healthcare environments.

Research Objective

To examine the lived experiences of nurses in managing patients with violent behavior.

Specific Objectives

1. To identify the types and triggers of violent behavior encountered by nurses in healthcare settings.
2. To explore the emotional, psychological, and professional impacts of patient violence on nurses.
3. To determine the coping strategies employed by nurses when managing violent patients.
4. To examine the perceived adequacy of institutional policies, training, and support systems addressing workplace violence.

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5. To derive insights and recommendations that may guide the development of improved protection and support mechanisms for nurses.

Research Questions

1. What types of violent behaviors do nurses encounter from patients in healthcare settings?
2. What triggers or conditions contribute to the occurrence of patient aggression toward nurses?
3. How do nurses describe the emotional, psychological, and professional impacts of managing violent patients?
4. What coping mechanisms do nurses employ when dealing with violent behavior in the workplace?
5. How do nurses perceive existing institutional policies, training, and support systems related to workplace violence?
6. What insights and recommendations can be drawn from nurses' lived experiences to strengthen workplace safety and support?

METHODS

Research Design

The study at hand employed the phenomenological research method. Descriptive phenomenology was most suited for this research since it examined nurses' actual experiences dealing with patients who are violent.

In research in social sciences, descriptive phenomenology is frequently employed as a technique to investigate and characterize people's lived experiences. This is a fact-finding analysis that includes a suitable report investigation. It addresses current circumstances, actions, values, ideas, and practices (Shorey & Ng, 2022). Descriptive phenomenology was most suited for this research since it examined nurses' actual experiences dealing with patients who are violent.

Phenomenology is a qualitative research methodology concerned with human lived experiences and endeavors to examine how individuals interpret their own experiences and worlds. Phenomenology is based on philosophy and attempts to reveal the essence or middle meaning of a phenomenon in the same way it is experienced by the direct participants without any preconceptions or assumptions. This is a very fitting methodology for this study, as it enabled the study to explore how nurses think, feel, and emotionally react to instances of patient violence, creating a rich, first-hand account that is impossible through quantitative methods alone. It was also consistent with the constructivist and interpretivist philosophy that underpins this research, which accepts that meaning was constructed and interpreted by people on the basis of their own personal realities.

The descriptive phenomenological approach was used in this study to analyze the responses when examining the study problem in detail. The study of phenomenology looked at how life was experienced by nurses. Descriptive phenomenology used the participants' real-world experiences to explain a particular event or its existence. Personal experiences and a comprehensive knowledge of an event were provided by a detailed account of the incident, thought, awareness, meaning, and emotion. With its breadth and complexity, descriptive phenomenology has produced a useful account of an individual's experience.

Population and Sampling

The data collection process was carried out by the researcher in three hospitals across the United States of America (USA). Particularly, the participants of the study were the selected ten (10) Filipino registered nurses currently employed in the USA; they were selected using purposive sampling. The Filipino nurses working in the USA were selected since they represent the largest migrant nurse group worldwide and are exposed to a high-risk environment where violent patients are present. However, despite this, their voice remains unexplored in qualitative research studying work-based violence. By focusing on these participants, this study fills the contextual gap and could offer insights into developing an inclusive and safe workplace.

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The sample of ten nurses is sufficient for phenomenology research since its main goal is to achieve a detailed description of the lived experiences instead of numerical classifications. This depends on the depth of data, not sample sizes, and thematic saturation when recurring responses already emerged.

For the inclusion criteria, the participants were (1) either male or female, (2) US registered nurses (3) Filipino or Dual citizen, (4) currently employed in the USA for at least 1 year as a nurse in the locale, (5) Working either in emergency departments, psychiatric units, ICU or general wards, and (6) had direct experience with violent patients in clinical settings. Participants were excluded if they were (1) not a USRN, (2) No Filipino citizen, (3) not currently employed in the USA for at least 1 year as a nurse in the locale, (4) Not Working either in emergency departments, psychiatric units, ICU or general wards, and (6) had no direct experience with violent patients in clinical settings.

Instruments

In order to properly gather these questions, the researcher used a semi-structured interview guide to help gather the data that is needed and review the data pertaining to the areas of study under consideration. This was made based on an extensive literature review on workplace violence related to nursing practice and the conceptual framework aligned with the phenomenological approach.

This consists of ten questions, such as "How frequently do you encounter patients exhibiting violent behavior in your workplace?" "What kinds of challenging or harmful behaviors have you experienced from patients in your workplace?"

This instrument was validated using a rubric by nurses with master's degrees in the field. The first validator is a head nurse in the Emergency Department in a tertiary hospital in New Haven, Connecticut, another validator is the director of the nursing department in a hospital located in Miami, Florida, and the last validator is a head nurse in a hospital located in New York.

Data Collection

Before gathering the data, a letter was sent to the hospital administrators to conduct the study, and participants were asked for their consent to participate in this study.

During the gathering of data, data was gathered utilizing a semi-structured questionnaire as part of the interview guide. Before their conversations were recorded remotely using an online conference platform (Zoom). Along with audio and video recordings of the interview, careful note-taking was done during at least a 30-minute session. The interview was conducted from January 2025 to February 2025. Lastly, after completing the transcription, transcripts were returned to the participants for member checking.

Data saturation was utilized to determine the sample size used in this study. Data saturation is achieved when nothing new regarding themes, ideas, or relevant information comes from conducting more interviews. During the collection and analysis of the nurses' experiences, the researcher rigorously recorded the consistency of their patterns and the meanings of their everyday experiences.

By the ninth interview, the researcher had come to the conclusion that the accounts of the respondents continued to reveal similar patterns when it came to their experiences, challenges, coping mechanisms, and emotional effects of dealing with violent patients. There were no significantly new categories or findings coming out, which meant data saturation had been attained, but in order to add to the intensity of the study and to make sure that no outstanding experience was left behind, the researcher conducted an additional tenth interview.

Treatment of Data

Thematic analysis was employed to examine the data collected through open-ended questions, utilizing Colaizzi's framework. Thematic analysis, which involves a thorough review of the collected data to identify and describe recurring patterns, is a suitable and effective technique for understanding a dataset of experiences, ideas, or behaviors.

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The first step was for the researcher to read and re-read each text to gain understanding of the participants' overall statements. In the second step, the interviewer read the first pass aloud, making notes in the transcript during the second reading about the thoughts generated by reading the interview. In the third step, the researcher collected and listed each key phrase on a separate sheet after completing this process.

In the fourth step, connotations from such essential statements were then developed in line with Colaizzi's third stage. The researcher then molded them into concepts and categorized them into groups, and the divisions are further organized into units to form themes or essences.

In phase five, the researcher took the discovered data and incorporated them into an extensive written explanation of the phenomena. After these were completed, the researcher started step six, wherein the detailed descriptions gathered during the interview were simplified into a brief statement representing only the elements considered central to the phenomenon's structure, providing a simple structure in return. In the seventh phase, the researcher took the respondents' statements during the interview to ask if their experience had been recorded.

Lastly, the reporting stage six entailed the researcher selecting rich and evocative quotes to elicit all the themes and using them to build an appropriately written report of participants' everyday lived facts. Through examination, reflexivity was upheld in ensuring that explanations given by the researcher continued to be grounded within the data, along with recognizing the contribution of the researchers towards the examination process. The thematic analysis offered a solid yet adaptable system that supported a detailed, rich, and trustworthy analysis of the rich, individualized accounts provided by nurses in this research.

Ethical Considerations

The study was submitted to concerned university for ethical clearance. The researcher explained to them the procedures for gathering data in the most effective manner possible. Before asking for their consent to participate, participants were informed that participating in this study was voluntary and were given the opportunity to ask questions regarding the topic and receive accurate and appropriate answers. Every participant received a copy of the consent form and the cover letter to protect their privacy, security, and to ensure the confidentiality of information during the interview.

To protect the privacy, security, and anonymity of the interviewees, no personal information or personal data was utilized in this study. Moreover, the audio and video files were stored in a password-encrypted computer. Additionally, all interviews and recordings were destroyed 1 month after this study, and the researchers were accessible at any time to address any queries they may have about the study.

RESULTS and DISCUSSION

Themes

Based on the data gathered, five (5) prevailing themes of nurses in managing patients with violent behavior were identified. These include triggers, emotional and psychological impact, coping mechanisms and support, moving forward, and institutional response and support.

Sub-themes	Themes
• Predictable Escalation Patterns • Drug-Seeking / Unmet Needs • Substance Abuse & Delirium • Environmental/Structural Triggers • Cultural Sensitivity • Discrimination and Racism	Triggers
• Stress, Anxiety, Trauma • Emotional Detachment / Defense • Lingering Emotional Effects	Emotional and Psychological Impact

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• Communication and De-escalation • Support Systems • Emotional Release • Self-Care and Reflection	Coping Mechanisms and Support
• Professional Growth and Identity ○ Emotional Growth and Strength ○ Reaffirmation of Calling ○ Career Doubts • Safety and Prevention ○ Physical Safety Measures ○ Staffing Adequacy	Moving Forward
• Policy Implementation • Training and Preparedness • Post-Incident Debriefing • Gaps and Improvements Needed	Institutional Response and Support

Theme 1. Triggers

Based on the data gathered, three (3) prevailing sub-themes on the triggers of violence towards nurses were identified. These include predictable escalation patterns, drug-seeking / unmet needs, substance abuse and delirium.

1.1 Predictable Escalation Patterns

One of the dominant themes to come out of the interviews was the recognition of patterns of habitual escalation that appear to move to violent patient behavior.

Violence towards nurses occasionally erupted at the spur of the moment. Instead, it followed a familiar pattern of emotional and behavioral escalation in patients' pacing, loud voice, agitation, clenched fists, and threatening posturing before finally erupting in verbal aggression, threats, or slapping. This was shared by the participants:

"*They're anxious. Most of the time, they're anxious. Most of these patients, you could, especially if you're specializing in behavioral health you could, you could easily see them, see their signs and symptoms before they become very aggressive. They would they would initially be anxious, like they would be pacing, especially with psych patients. They would talk to self. Sometimes you would see them. Sometimes there are patients being isolated too. Yeah, it usually. Starts with anxiety…*" (P10)

These findings indicate the patterns of where patients' violence starts. These are commonly due to ways in which environmental stressors, intervention delays, or affective disruptions are common. Even minor shifts in tone of voice or tone of expression were previously signs of warning for an impending violent attack. Though attuned to these signs of warning, nurses indicated that they had little control over their ability to respond effectively because they were normally dealing with more than one patient, were short-staffed, or didn't have the powers or the equipment to act.

Nurses indicated that the majority of the patients, especially those in the psychiatric or emergency departments, suffer from acute psychological distress, withdrawal syndrome, or unidentified mental illness. All these conditions in them make the patients highly responsive to mild environmental stimuli. For instance, long waiting times, abandonment or perceived abandonment, or rigidity of hospital routine, such as visiting hours, drug schedules, can be escalated into violent reactions. The nurses' efforts at upholding boundaries, such as declining medication, unwanted visitors, or requests for early discharge, have the consequence of routinely placing them in direct conflict with already contentious patients.

Evidence of patterns of predictable violent behavior escalation towards nurses is clearly upheld by the literature. Weltens et al. (2021) observed that violence in the clinical setting is normally preceded by a series of provable patient behaviors such as pacing, raised voice, and body defensive positioning, which escalate if left unrepaired. Their conclusion highlighted how nurses, as the first professionals to encounter patients, are most often

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the initial responders to see these changes, but with no specific de-escalation training, at risk of becoming violent themselves. Likewise, Olasoji et al. (2024) identified that nurses were able to anticipate escalating violence from cumulative exposure and clinical experience, but institution responses are reactive and not preventive. Their work called for the imposition of more adequate models of communication and intervention policies to prevent the menace of escalation.

This stressful dynamic made nursing emotionally taxing and further complicated nurse–patient relationships. Though they had identified early warning signs of de-escalating behavior, most of the nurses did not feel that they were empowered or well-prepared to deal with such an incident. Most of the participants, who admitted to leaving proper de-escalation interventions out of their training, also expressed regret over their work environments lacking formal policy in dealing with such incidents. Without specific training in therapeutic communication or situational exit, the nurses relied upon personal experience and common sense more than formalized responses.

1.2 Drug-Seeking / Unmet Needs

Another common sub-theme from the participants' accounts was nurses' fears of patients' violence against them due to patients' drug-seeking and unmet patient needs. Substance abusers, chronic pain syndrome patients, or psychiatric patients were instructed by nurses to become habitually violent if their medication needs or perceived entitlements were not met. These hostile reactions are not impulsive but based on frustration, denial, needs, or efforts at manipulation for drug or entry of attention. The nurses documented instances where patients would insist on painkillers, sedatives, or medication drugs rudely and, upon refusal or denial, curse, threaten, hurl objects, or even attack. Other patients would go as far as accusing nurses of abandonment or abuse in an attempt to coerce compliance.

Some of the participants explained how unmet needs were also experienced due to system-related issues like short staffing, excessive patient load, and insufficient time to address patients in a timely manner. If patients perceive themselves as being ignored, neglected, or that their pain or concern is not being addressed, then anger begins. This is particularly true for those with severe discomfort, hunger, or emotional distress. Some nurses described how they felt caught in the middle between opposing pressures, prioritizing by urgency, and therefore creating delays to patients' eyes as negligence.

"*For drug-seeking patients, the violent behavior usually starts if they do not get the medications they want. For Psyched patients, drunks, and high on drugs patients, they are usually violent from the very beginning. If they are not followed, they will speak lies about us nurses or resort to complaints*" (P4)

Thus, violence is the incorrect reaction to institutional constraint, with nurses being the default recipients of patient frustration. Untreated or poorly treated mental illness or disease of drug addiction are more likely to cause emotional dysregulation, paranoia, and manipulativeness. These diseases can lead to irrational thinking or acting on impulse, in which denial or withholding of a felt need is felt as a perceived attack or betrayal. Nurses recalled that patients who were misled, manipulated, or emotionally coerced spoke lies, by exaggerating discrimination or being hurt, to administer drugs prohibited.

1.3 Substance Abuse & Delirium

Among the most significant sub-themes that emerged in the course of the answers given by the participants is the significance of substance abuse and delirium as the dominant precipitants of violence from patients towards nurses. Drug- or alcohol-intoxicated, or acutely delirious due to illness or drug, were universally identified by all the participants as much more likely to physically and verbally attack. Nurses described such events as being highly unpredictable, emotionally demanding, and physically dangerous, particularly since the observed behaviors most often were volatile and at unexpected times.

Patients exhibiting symptoms of intoxication, withdrawal, or acute confusion from delirium showed diminished orientation, judgment, and self-control. Nurses wrote about episodes in which patients, being in states of altered consciousness, randomly erupted into violence during routine procedures like taking medication, taking vital signs, or helping with cleanliness.

"*For Psyched patients, drunks, and high on drugs patients, they are usually violent from the very beginning*" (P4)

Such reports highlight the extent to which drug-induced and medically induced altered states of mind contribute importantly to violence. Nurses highlighted the fact that such action was not always malevolent or deliberate but mostly the outcome of confusion, hallucination, fear, or panic, yet putting them in jeopardy and distress.

Nurses, especially emergency room nurses, intensive care nurses, and psychiatric nurses, are most likely to receive drug or alcohol-dependent, alcohol-intoxicated, or hospital-induced delirium patients. They are usually

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confused, disoriented, and hallucinating, and have unpredictable behavior and explosive outbursts. Physicians get by occasionally to see their patients quickly, but nurses spend time in close and immediate proximity giving bedside care, taking vital signs, and intervening in emergencies; hence, they are the most exposed and most endangered members of the healthcare team.

Hospital delirium, especially in elderly patients, often goes undetected or is misdiagnosed in the day-to-day clinical practice. As a result, nurses reported that they would at times have to manage confused patients without policy or training. If early signs of restlessness, agitation, or confusion are ignored or left unmanaged, they typically progress to violent behavior.

Based on the literature, drug-seeking and unmet needs are precipitants of violence against nurses. Yulis et al. (2023) conducted a study that determined the recurring pattern among most violent attacks on hospital patients was when nurses withheld patients' medication. Their studies revealed that the substance-dependent patients would become violent if their expectations were not fulfilled.

Their withdrawal from alcohol or drugs agitates them, makes them irritable, hallucinates them, and makes them physiologically restless, all of which predispose them to angry or irrational behavior. Nurses were afraid to be assigned to such patients because their impulsiveness and desperation too commonly expressed themselves in screaming, threats, and even physical assault.

Theme 2. Emotional and Psychological Impact

Upon analysis of the data gathered, three (3) dominant sub-themes regarding the emotional and psychological effects of violent patients on nurses were determined. They are stress, anxiety, trauma, emotional detachment/defense, and residual emotional effects.

2.1 Stress, Anxiety, Trauma

The first sub-theme that emerged during the interviews is trauma, stress, and anxiety experienced by nurses in dealing with violent patients. Nurses repeated and repeated, having to live through chronic stress, anxiety attacks, as well as symptoms of trauma, which built up over time due to ongoing exposure to violence on their job. Verbal, physical, or psychological, the collective effect of violence caused very deep emotional wounds. The implication of these findings is that violence in the health care environment is not only a threat to work, but it is also a very personal experience that would impact the manner in which nurses think, feel, and act on and off the job.

Most of the nurses reported staying awake all the time, waiting for the next attack or shock. They explained that there was a hypervigilant state, particularly during work hours in risky working environments such as the emergency room or psychiatric unit. Transactional tasks such as waking a patient, giving medication, or merely explaining hospital procedures to patients might be the anger that would lead them to become violent. Expectation of violence kept the constant emotional arousal.

Such a response draws attention to the psychological consequences that are left in the wake of violent behaviors. The fear does not end with change; it seeps back home into nurses, leaking into sleep, into loved ones, and into depersonalized work. For others, there is an aftermath in the form of symptoms of post-traumatic stress: flashbacks, avoidance, and numbing.

The psychological and emotional load taken up by nurses for violence can be seen in their responses during the interview, the trauma due to repeated exposure, and the absence of institutional emotional support, all of which go towards weakening mental health in the long run.

"*During the incidents, I am anxious and scared of my arm. Even with training, you will never predict how a patient will react to a certain situation. I honestly got scared during the incident.*" (P7)

While other professionals are faced with one traumatic event, nurses, particularly those working in high-acuity or psychiatric environments, are repeatedly exposed to violent acts. The uncertainty of violence is one of the major contributors to the development of chronic stress and anxiety. The nurse never knows when and where violence will strike, and each shift becomes a minefield. Such pre-attack anxiety, created by fear of returning to violence, has the same psychological effect as the traumatic event itself, creating an endless cycle of emotional distress and trauma.

Nurses reported that they repressed emotional reactions to violent events because job demands required them to immediately resume care of other patients. They did not have time to process the event, think about it, or get debriefed. Gradually, repression resulted in burnout and emotional exhaustion.

The psychological and emotional impact of violence within the workplace on nurses is reported most frequently in the literature. Busnello et al. (2022) explained that nurses who undergo violence, i.e., threats and verbal violence, within their daily practice complained of persistent emotional distress, resulting in anxiety, low

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morale, and not being able to concentrate while on duty. The study highlighted that even though physical harm was not caused in the cases uncovered, the psychological impact of violence in the workplace was irreparable and was deeply ingrained.

This lack of psychological safety and recovery time results in a culture in which emotional trauma is lodged, rather than processed. The psychological and emotional effects of workplace violence on the nurses are deep, intricate, and lasting. The dialectic relationship between recurrent exposure, organisational insensitiveness, inadequate time for affect management, and intrapsychic struggle between survival and care establishes mental health disasters. Fear, tension, and trauma are theoretical concepts to these nurses; these are tangible facts that reform the way in which they work, feel, and exist. These impacts require top priority to mental care support services, debriefing practice, and care culture and genuineness in the health system. The nurses cannot provide empathic care if they are not secured, cared for, and healed themselves.

2.2 Emotional Detachment / Defense

The second prevalent emotional and psychological response among the nurses in this research was emotional detachment and defensive coping as a coping mechanism for dealing with prevalent workplace violence. Most of the participants reported that, with time, the frequent exposure to aggression in the forms of physical, verbal, or emotional, made them emotionally detach from patients. This emotional disconnection was not a shortage in empathy but an adaptive process of disconnecting to prevent further psychological harm. The findings suggest that emotional disconnection is an adaptive response for survival in violent healthcare environments where nurses feel unsafe, unsupported, and emotionally exhausted.

"*I do not take any difficult situation personally; I always see it as a part of my job and move on once it is done. I learned to deal with it as it happens because if you dwell on it even after it is long done, then you can set yourself in a much more difficult situation and can negatively influence your mental health affecting your decision making skills leading to a bad outcome.*" (P3)

These answers show how nurses, repeatedly exposed to violence and trauma, shut down emotionally as a coping mechanism from the psychological effects. Emotional detachment is a response to the reduction of vulnerability and muffles the emotional impact of violent or aggressive interactions. The strategy, though as much a defense as it was, was still relationally and ethically expensive in terms of patient connection lost, job satisfaction lost, and intrapsychic guilt or discomfort.

Nurses' emotional walls are built of tranches of chronic trauma, disconnection, and emotional need to stay alive in a world where violence becomes the frame and unfinished. Detachment that allows the nurses to stay calm and keep working in the workplace pushes them away from the same values that make their work enhanced in the areas of care, presence, and compassion. This means that the health facilities must acknowledge emotional detachment as an early warning sign and implement trauma-informed care models, daily debriefing, mental health treatments, and cultural change with nurse wellness. It is only here that the nurses are able to initiate the process of healing and form an emotional bond with their patients, and resume practice once again.

2.3 Lingering Emotional Effects

Probably the most important of those sub-themes which nurses' lived experience has brought into existence is the long-standing affective impact of work-related violence and how this affects their behavior, mental health, and general health, many years after the date that the incident occurred. Contrary to fleeting affective responses of fleeting fear or terror, the impact of violence is long-term, cumulative, and frequently implicit, placing invisible psychological burdens on nurses that weaken work performance and personal life. Participants had predicted violent encounters would last months, actually years, and had referred to themselves as nightmares, flashbacks, emotional hyperreactivity, and patient paranoia, even in so-called safe settings.

"*Personally, I almost quit my job because of the trauma that I experienced when I was just starting work here in the US. Until now, I still remember all the violence I encountered when I was just a newbie here in the US…*" (P5)

Yu and Holbeach (2021) established that nurses who underwent trauma through workplace violence had long-term emotional effects like intrusive brooding, flashbacks, and persistent concern. The effects were several years down the line and were exacerbated by institutional apathy. The results indicated in this study for long-term emotional effects of work violence are evidenced both in trauma psychology and in nursing research.

Theme 3. Coping Mechanisms and Support

From the information that was collected, two (2) general sub-themes of coping and nurse support were obtained. These include communication, de-escalation, self-care, and reflection.

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3.1 Communication and De-escalation

Where there is workplace violence, nurses are forced to change so many things as they struggle to defend themselves and minimize the extent of their harm, thus inflicted, most significantly, communication and de-escalation. One could see from the interview answers that nurses also relied upon being in a state to de-escalate peacefully and speak, empathize with affect behavior, send non-combatant body language messages, and deflect hostility as methods of keeping at arm's length threatening hot situations. These are not ritualized contact with patients but survival strategies in life-threatening situations that kill.

Nurses are most frequently the recipients of outbursts from patients initially and the most readily available staff members during emergencies. Nurses do not usually have immediate access to security services, psychiatric services, or team intervention techniques in most centers. Therefore, nurses rely on interpersonal skills to de-escalate threats and ensure safety measures for themselves and their patients.

"*Usually, I always make sure to lessen environmental triggers, talking to the patient in a very calm voice, and always reorienting the patient about the situation. And always anticipant of any possible situation that might happen during sedation management…*" (P7)

Effective communication is not just utilized for patient-centered care but also as self-defense. Defusing a dispute, diffusing hostility, or reconditioning the patient's outlook, de-escalation is attempted by nurses prior to its physical or verbal direction toward violence. For this purpose, emotional intelligence, empathy, and restraint are all derived from the nurse's own internal emotional capital.

Kim et al. (2024) highlighted that nurses utilize verbal strategies to soothe agitated patients when they feel insecure or lack outside support, adding that calm voice, clear boundaries, and active listening are normal skills front-line staff use.

The communication and de-escalation issue is an indication of the high levels of occupational violence response work, the maturity, flexibility, and emotional intelligence of the nurses. Despite the absence or presence of the preventive measures of the institution and environment, the nurses are capable of resolving the issue using communication skills, sympathy, and emotional management. Though such strategies are recognized as effective in the short term, they expose nurses to burnout, emotional exhaustion, and compassion fatigue due to a deficiency in formal education and continuing systemic failure in support. The facts impel health care organizations to initiate highest order formal de-escalation training interventions, infrastructures of emotional support, and worker policies respecting such emotional labor first. Embracing that communication is not only less than a soft skill, but even a survival skill, is nurses' secret to health and patients' purity of care.

3.2 Self-Care and Reflection

Concerning patient violence and aggression as repetitive exposure, nurses protect themselves by defining their own sets of self-reflection and self-care as coping. This is how nurses positively guard their mental, physical, and emotional health following traumatic exposure through conscious processes of self-preservation and meditative practice for the restoration of their sense of self and professional self. Self-care is of all kinds: rest, healthy habits, solitude, prayer, exercise, mindfulness, or a hobby, while reflection is re-thinking their boundaries, values, and emotional state, questioning at times if they are really a caregiver. These are not hedonistic or passive acts; these are acts of active resilience and refusal to be overcome by the emotional depletion of nursing in high-stress, frequently violent environments.

"*I have already mastered some techniques, like some techniques for coping mechanisms to combat burnout, exhaustion, and irritability. and these are number one. gala. number two driving. number three exploring places. In the USA, exploring beautiful places in California. Anything that can contribute to my emotional and mental well being. In short, I prayer I learned to prioritize myself. and that's how I, uh manage optional or difficult situations in my work. I just need some fresh air. It's easy. piece of cake.*" (P9)

For some of these nurses, reflection is a reaffirmation or recommitment of their calling to the nursing profession, perhaps because something has happened that has caused them to question their calling. It is an ethical and emotional dilemma that challenges the nurse to wrestle with slaps of anger, grieving, guilt, and even disillusionment and move toward a place of renewed intention or awareness.

Alzahrani et al. (2023) stated that self-care is an appropriate means of attaining emotional resilience among health care professionals, especially those working in emotionally stressful settings.

Nurses also engage in restorative self-care and intense inner reflection to work through the experiences that otherwise would foster emotional numbness, burnout, and compassion fatigue. These activities enable them to rediscover their purpose, stabilize stress, and maintain their ability to care in the face of adversity.

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Theme 4. Moving Forward

Based on the data gathered, two (2) prevailing sub-themes with different sub-themes on moving forward were identified. These include professional growth and identity and safety and prevention.

Professional Growth and Identity

Based on the data gathered, three (3) prevailing sub-themes on the professional growth and identity of nurses were identified. These include emotional growth and strength, reaffirmation of calling, and career doubts.

4.2 Emotional Growth and Strength

In spite of the affective cost of dealing with patient aggression, a vast majority of the nurses included in the study demonstrated a strong result, such as personal strength and emotional growth. Out of challenging years of exposure to environments of high stress, especially violence, they learned to develop increased resilience, emotional maturity, and coping skills. This development of affect did not come easily; it followed adversity, suffering, and resilience. But for the majority of the nurses, survival of violence was a time of focusing again on their lives. Not only did it affect the manner in which they would handle subsequent instances of the same kind, but also how they perceived themselves, creating a clearer picture of who they are as a person and as a professional.

"*Dahil sa mga ganitong sitwasyon, naging mas malakas akong nars, sa diwa na hindi ko iniisip na alagaan ang mga pasyenteng may mahirap na pag-uugali.*." (P2)

This participant's narrative discloses a transformational learning process in which difficult, and even traumatic, experiences were catalysts to emotional growth. Rather than becoming calloused and estranged, a staggering majority of the nurses indicated moving toward integration of emotional resilience, a blend of empathy, composure, decisiveness, and psychological hardness.

This was supported by Cho et al. (2023), who also clarified that emotionally challenging experiences are accompanied by the implication of being predictors for individual growth. They went on to state that nurses who were subjected to violence by the patient became resilient at the core, were stricter in more instances, and expanded the role of the healthcare team.

Emotional growth of aggression towards patients is a significant marker of inner strength and adaptability among nurses. Rather than letting violence define them, other nurses opt to give meaning to what occurs so that they may employ it as a stepping-stone for professionals. There are many key reasons why the process works.

4.3 Reaffirmation of Calling

The second result that is seen in the narratives of victimized nurses is that their professional identity as nurses was empowered. They were exposed to physical violence, verbal aggression, emotional injury, and psychological burnout, but most of them felt more powerful about their professional identity as nurses. Far from deterring them, these challenging experiences seemed only to intensify respect for their clinical calling, solidifying dedication to caring for others. First and foremost, those who were ill, confused, or in pain. Exposure to violence, as offensive as it was, was likely to reveal patients' complete vulnerability and not provoke anger, but rather trigger sympathy and a stronger will.

"*It just made my love for my job even stronger, this made me realize that there are a lot of people who needs help in stressful situations, being admitted in the hospital can negatively impact one's mental and physical health, and as a healthcare worker, we are in a unique position to make a positive impact and contribute in provide a positive patient outcome.*" (P3)

This recognition was followed by reflection and emotional resolution, demonstrating that nurses were not immune to the traumatic effects of violence but wished to take meaning and purpose from their experience. They're staying in the profession; it's a constant reassertion of fundamental values underpinned by compassion, mission, and belief in the intrinsic moral value of what they're doing.

The reassertion of calling after trauma appears ironic, but is a well-documented phenomenon in service careers requiring sacrifice, emotional labor, and service. Nurses participating in this study disclosed the fact that violence from patients, instead of deterring them from their career choice, led to them returning and discovering and reasserting their drive for initially desiring to be nurses. The reassertion can be understood by various important observations.

In Hou et al.'s article, the nurses indicated that although their emotional exhaustion due to patient agitation exhausted them, it made them individually committed to practice. Most of the participants perceived such a gathering as "tests", challenging and affirming their care commitment and affective resilience.

Vocation reaffirmation is a reassertion of nurses' rich emotional lives and moral fortitude. In this book, so much is given witness to human suffering, and in this instance, nurses still choose to practice empathy, meaning, and service even in desperation or withdrawal. Their lives attest to the truth that it is not the absence of adversity

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that unites them but learning about meaning. Violence by patients, as hard as it is, is corrective for patients regarding their value, place, and power. To others, a bitter but honest reminder of where they have been and how and why they got there as nurses, and how and why they have survived so long at it. Health systems owe it to themselves to foster and develop such mettle by providing voice, legitimacy, and emotional nutrients for such commitment.

4.4 Career Doubts

While some of the nurses did reaffirm their calling in the wake of patient aggression, other nurses did in fact question their profession, whether they should or could stay as nurses. The emotional toll of chronic aggression, emotional exhaustion, and perceived organizational support lack resulted in some nurses, in fact, questioning if they could stay in the healthcare occupation. These are not passing thoughts but perseverating thoughts post-trauma. Nurses remembered such instances of emotional breaking points when they were humiliated, insecure, or vulnerable, and therefore doubted if it was still worthwhile to hold on to their profession.

"*There was a time when I questioned myself if I was in the right profession …"* (P2)

Nurses illustrated how violent experiences reduce not just a nurse's sense of safety and well-being, but also his or her sense of professional self, career trajectory, and happiness in life. Career insecurity in this case is not a reflection of vulnerability but is a real reaction to constant exposure to violence, abandonment, and emotional exhaustion. This violence and aggression in the workplace are contrary to the very nature of the nursing practice, such as safety, compassion, dignity, and care. If these are constantly being overlooked without managers' perception or influence, nurses have no idea whether their career is still within what they perceive and need as human beings. Career ambiguity arises from a number of inherent issues nurses encounter.

Carver and Beard (2021) discovered that exposure to physical and verbal aggression has serious effects on nurses' mental well-being, which normally results in reduced job satisfaction and intention to resign from practice. Their research identified that the general victimization of violence deters nurses to the extent that midpoints of the majority of them are rethinking long-term occupational allegiance to nursing.

The career uncertainty theme is indicative of the human cost of workplace violence in healthcare. Despite how much nursing has been idealized as a noble and worthwhile profession, its actuality for most nurses is trauma, intimidation, and perpetual lack of backup. If risk can outnumber reward, and safety and legitimacy are not provided by the system, then even the best nurses will start questioning their role in the profession. These are not failures; they are signs of self-awareness, emotional intelligence, and a hunger for meaningful and secure work. To keep their most precious asset, nurses in health systems must confront the source of these uncertainties with trauma-informed leadership, supportive infrastructure, and policy that honors the nurses. It is only then that the profession can properly hold onto the calling that so many nurses previously held with hope and heart.

Theme 5. Institutional Response and Support

Based on the data gathered, four (4) general sub-themes of the institutional response and assistance to the nurses were identified. These are policy implementation, training and readiness, post-incident debriefing, and gaps and areas that should be improved.

5.1 Policy Implementation

One of the sub-themes that rose out of the interviews is the central role of institutional policy enforcement in mapping how nurses feel, react to, and recover from workplace violence. While the majority of the nurses reported having some idea of hospital policies aimed at responding effectively to aggression as well as ensuring workplace safety, their accounts produced a pervasive and unsettling impression that policies may exist on paper but are not implemented in practice. Some of the nurses indicated that while they were physically and verbally assaulted, official guidelines did or did not exist for reporting, documentation, follow-up, or debriefing in their own workplace environments.

"*Our hospitals have a policy regarding the prevention of violence. It includes early identification of aggressive behavior, safety huddles, and protocols about alerting security but is rarely used in real situations. Our hospital also has Zero tolerance for violence against hospital staffs.*" (P7)

Nurses indicated an imbalance between policy-making and policy-implementation. Despite the existence of institutional policies on management of violence, such as incident reporting policy, physical restraint of assaultive patient guideline, and staff support policy, if they are not uniformly implemented and if they are not left open to them, a culture of neglect and exposure is rendered ineffective. The nurses have to protect themselves from violent attacks at the expense of safety and health.

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Several of the nurses complained about not being well-equipped with training regarding their rights or procedures to be followed upon an experience of violence. Inadequate training on violence procedures illustrates organizational failure in providing workers with tools for protection. Without ongoing and organizational communication, policies remain theoretical and inaccessible.

Secondly, there was ineffective leadership. Administrators and managers were described by nurses as doing nothing, ignoring reports, or downplaying incidents. The worth of safety practices is lost if the facility lacks effective leadership that gains and maintains it. Institutional policy is underenforced, underreporting, and normalization of violence are the outcomes of this trivializing or silencing culture.

Not enforcing policies not only risks exposing nurses more to danger, but it also sends the message that their safety and well-being are irrelevant. This sense of abandonment causes emotional exhaustion, fear, resentment, and even withdrawal from consideration of the profession being sought. Nurses believe that violence is just part of the job, when the truth is that the institution should intervene and provide protection.

Olasoji et al. (2024) also supported these results by determining that multifaceted workplace violence programs, including training, reporting mechanisms, and administrative discipline, drastically reduce violent incidents only when implemented. Policies fail to achieve their purpose without reinforcement and implementation.

The evidence on this topic identifies a disempowering and damaging gap between policy and practice within institutions. Through the failure to maintain their own safety rules, health care organizations put nurses at risk of physical harm and emotional demoralization. Nurses must cope with violent incidents with no clear rules, assistance, or legitimation, resulting in inherent stress, job insecurity, and lost confidence in the system. Institutions need to understand that policy effectiveness is not in paper but in practice. To safeguard their workers, they need to offer direct training, immediate leadership, frequent use, and an atmosphere of accountability and empathy. It is only then that nurses can feel safe, dignified, and empowered to keep carrying out their crucial contributions to the health system.

5.2 Training and Preparedness

The preparedness and training sub-theme arose forcefully from nurses' experience as an essential deficiency in organizational response to patient violence. Several nurses indicated that since they were working within high-risk settings like psychiatric wards, emergency rooms, or geriatric units, they were officially taught how to identify, prevent, or handle violence. A lot of what they did know, they had learned on the job, by peer counseling, self-experimentation, or sheer survival of serial attacks. This active institutional instruction prepared them inadequately and in some cases left them powerless against assaultive patients.

"*Here in the US we are trained for violent behaviors, most of the the hospital provide education to prevent workplace violence such as Avade Training, it helps us to be aware if violent behavior is escalating and how we protect ourselves. First step is know the impending signs of aggressive behavior and how to act on it such as Deescalation techniques, Position yourself that you can escape easily near the exit/door. if the patient keeps on escalating we can call security and call for Code Gray (violent behavior*)…" (P8)

Rahma and Febriyani (2023) noted that nurses who receive training in de-escalation and situational awareness will be more likely to report incidents and respond positively under crisis, which eventually increases their sense of control and safety.

The lack of orientation within institutions and pre-service training leaves nurses in a highly disadvantageous situation as far as managing patient aggression is concerned. Since hospital settings become ever more uncertain and ever more complicated, fewer and fewer nurses are left to cope with unsafe conditions with less than sufficient information and less than sufficient resources. Not only is it potentially harmful to their physical well-being, but it is also diminishing their emotional stability and professional confidence as well. To combat this, health centers need to change from the reactive to the proactive paradigm and fund continuous education, simulation, and crisis intervention training. Providing nurses with the appropriate equipment and information ensures them of their value, removes fear, and enables a culture of safety, empowerment, and professionalism. Nurses are not only safer when they are prepared, but stronger, more confident, and more equipped to care for their patients with dignity.

5.3 Post-Incident Debriefing

The most mentioned and experienced problems that were raised from the interviews may well have been that of the absence of formalized post-incident debriefing following incidents of patient violence. Nurses explained repeatedly that, following victimization by verbal aggression, physical assault, or emotional impacts, they were merely required to go back to work without emotional release, recognition, or institutional support. The failure of a formalized debriefing system left nurses in a state of being deserted, neglected, and at times re-traumatized. This

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failure to maintain after the traumatic event had a tendency to be viewed as an emotional and psychological threat by the very institutions charged with protecting them.

"*Having a debriefing after a violent incident can help with the mental health not just of the nurses but of everyone who witnessed it.*" (P2)

These results indicate that debriefing is not a technical solution, but a psychological imperative. Otherwise, nurses will be left to struggle alone with the overwhelming feelings of fear, anger, guilt, and confusion. It not only impacts their emotional health but also their impression of the culture of care in the workplace.

Nurses' accounts of neglect of post-incident care sit within deeper organizational deficits in trauma-informed care, crisis handling, and organizational compassion. There may be violence protocols for reportage and incident reporting, yet there may be no systematic space for emotional healing, learning, and professional reflection. Various causally connected factors explain why nurses were treated with such disrespect.

Suhanda et al. (2023) supported this by showing that crisis intervention models, such as Critical Incident Stress Debriefing, in their successful implementation, present an immediate reduction in post-traumatic symptoms among healthcare professionals and build a safer and more trusting workplace.

The absence of formal post-incident debriefing revealed gaps in institutional support. Facilities frequently addressed physical injuries but paid limited attention to psychological harm, leaving affected nurses without structured emotional care. Nurses have to battle in vain, their trauma not diagnosed, development stalled, and morale eroded. Towards a normative practice of developing safe and caring communities for organizations, post-incident debriefing should be a daily practice that restores nurse dignity, aids emotional recovery, encourages reflective practice, and educates to resilience. That is when nurses will finally be able to experience their pain being heard, their stories matter, and their safety, emotional and physical is at risk.

Conclusions

Nurses face different forms of violence, primarily verbal and physical assault, common events that threaten nurses' safety but also their psychological integrity. These events are initiated most frequently by thoroughly documented behaviors of provocation, drug-seeking, drug-induced delirium, systems or environmental deficiencies, cultural racism and discrimination, and labeling violence as institutionally constructed and patient-related.

The psychological and emotional effects on the nurses were extreme, whereby all of them went through stress, trauma, emotional numbing, and distress. The nurses, despite these drawbacks, demonstrated high resilience by using many coping strategies, such as de-escalation, emotional release, peer support, and reflective self-care. These responses were, however, self-initiated due to a lack of institutional support.

Recommendations

To address physical and verbal violence issues, medical ward managers could implement a zero-tolerance policy for violence against nurses. This may involve current reporting mechanisms, guard services, and administrative backup for the concerned staff. There could be overt visibility of security on risk wards in order to dissuade violence and take timely action on violent incidents.

Hospital administrators need to enhance early intervention activities by equipping nurses to recognize anticipated behavioral patterns of aggression, especially in patients with addiction, mental illness, or unmet needs. Healthcare facilities need to address environmental cues such as long waiting times, overcrowding, or poor care coordination by enhancing patient flow and giving equal priority to all cases. Improving physical and emotional well-being in healthcare environments can decrease patient aggression and stress. Moreover, healthcare Organizations could reduce nurses' emotional suffering through readily available mental health care in the form of individual counseling services, psychological first aid, and official debriefing after traumatic events. Implementation of peer support groups and safe spaces can also support nurses' trauma and burnout management. Psychological safety at work is essential to ensure nursing staff's mental well-being and physical health.

To ensure physical safety, hospital administrators may invest in safety devices, including alarm systems, safe rooms, and CCTV, and maintain adequate staffing levels, especially in high-risk units. Employment of relief staff or float nurses to support acutely stressed units can enhance staff visibility, patient tracking, and rapid response to behaviors in escalation. Workforce planning will allow the highest priority to be given to nurse safety as a measure of care outcome.

The long-term consequences of repeated exposure to patient aggression on nurses' professional development, family, and well-being may be examined in future studies. Cross-sectional studies across diverse hospital settings can reveal context-dependent issues and inform more targeted interventions.

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