ORIGINAL ARTICLE / ÖZGÜN ARAŞTIRMA MAKALESİ

# Face-to-Face with Violence: Experiences of Emergency Nurses: An Interpretative Phenomenological Analysis

## *Şiddetle Yüz Yüze: Acil Hemşirelerinin Deneyimleri: Yorumlayıcı Fenomenolojik Analiz*

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**ABSTRACT**

**Aim:** This study aims to understand how emergency department nurses experience workplace violence, to explore the effects of these experiences on individuals, and to reveal how violence is shaped within their professional lives.

**Material and Methods:** This qualitative study used the interpretative phenomenological analysis design. Data were collected through semi-structured online interviews with 17 nurses working in emergency departments in western Türkiye, between August and December 2024. Audio recordings of the interviews were transcribed verbatim. The study employed criterion sampling, a type of purposive sampling. MAXQDA Analytics Pro 2022 software was used as a supporting tool for data analysis.

**Results:** Analysis of the interview data identified five distinct subthemes: the definition of violence, situational and systemic causes of violence, the multifaceted effects of violence, existing and proposed measures to prevent violence, and coping strategies reported by participants.

**Conclusion:** This study reveals the types of violence emergency nurses experience, their underlying causes, and the multidimensional effects of such violence. Most nurses reported being exposed to verbal or psychological violence at least once during their careers. The effects on nurses were observed in behavioral, physical, psychological, and professional areas. The study also emphasizes the need to strengthen legal regulations and implement deterrent punitive measures to prevent violence. These findings may guide future research and help develop strategies for preventing violence in clinical practice.

**Keywords**: Emergency department, nurse, qualitative research, violence

**ÖZ**

**Amaç:** Bu çalışma, acil servis hemşirelerinin iş ortamında maruz kaldıkları şiddeti nasıl deneyimlediklerini, bu deneyimlerin bireyler üzerindeki etkilerini anlamak ve şiddetin mesleki yaşamlarında nasıl şekillendiğini ortaya koymayı amaçlamaktadır.

**Gereç ve Yöntemler:** Bu çalışma, nitel araştırma yöntemlerinden yorumlayıcı fenomenolojik analiz deseni kullanılarak yürütülmüştür. Veriler, Ağustos ve Aralık 2024 tarihleri arasında Türkiye'nin batısında acil servislerde görev yapan 17 hemşire ile çevrimiçi ortamda gerçekleştirilen yarı yapılandırılmış görüşmeler aracılığıyla toplanmış ve görüşmelerin ses kayıtlarından transkripsiyonlar oluşturulmuştur. Örneklem seçiminde amaçlı örnekleme yöntemlerinden ölçüt örnekleme yöntemi kullanılmıştır. Ayrıca verilerin analizi MAXQDA Analytics Pro. 2022 yazılımı destekleyici araç olarak kullanılmıştır.

**Bulgular:** Görüşmelerden elde edilen veriler, acil servis hemşirelerinin şiddet tanımı, şiddetin görülme nedenleri, şiddetin etkileri, şiddeti önlemeye yönelik önlemler ve şiddetle baş etme yöntemleri olmak üzere 5 alt temada incelenmiştir.

**Sonuç:** Bu araştırma, acil servis hemşirelerinin maruz kaldıkları şiddet türlerini, bu şiddetin nedenlerini ve çok boyutlu etkilerini ortaya koymaktadır. Çalışma bulguları, hemşirelerin büyük çoğunluğunun meslek yaşamları boyunca en az bir kez sözel ve/veya psikolojik şiddete maruz kaldığını göstermektedir. Şiddetin hemşireler üzerindeki etkileri davranışsal, fiziksel, ruhsal ve mesleki boyutlarda ortaya çıkmaktadır. Ayrıca, şiddetin önlenebilmesi için yasal düzenlemelerin güçlendirilmesi ve cezai yaptırımların caydırıcı biçimde uygulanması gerektiği vurgulanmaktadır. Elde edilen sonuçların, gelecekte yapılacak araştırmalara yön vermesi ve klinik uygulamalarda şiddetin önlenmesine yönelik stratejilerin geliştirilmesine katkı sağlaması beklenmektedir.

**Anahtar Kelimeler:** Acil servis, hemşire, nitel araştırma, şiddet

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## Introduction

The World Health Organization (WHO) (1998) defines violence as "a pattern of behavior involving the intentional use of physical force against oneself, another person, or a community that increases the risk of injury, death, psychological harm, impaired development, or deprivation" (1,2). According to the WHO (2021) data, 8% to 38% of healthcare workers are exposed to physical violence, while a much larger proportion are exposed to verbal or psychological violence. One of the units where such incidents occur most frequently is emergency departments (3,4,5). Emergency departments are dynamic environments with a 24-hour "open door" policy, where patients at high risk of death are admitted, time pressure is intense, and communication conflicts are frequent (6).

In the literature, the reasons for violence against healthcare workers include high expectations of patients and their relatives, patients' feelings of pain and discomfort, distrust of triage practices, lack of privacy, communication problems, difficulty controlling anger, and inadequate policies to prevent violence in healthcare settings (6,7). Nurses, in particular, are identified as the healthcare professionals most frequently subjected to attacks by patients and their relatives. Studies show that violence leads to emotional responses such as anger, fear, burnout, and loss of trust in nurses, as well as professional consequences such as low motivation, decreased professional commitment, and job dissatisfaction (3,8,9). In fact, a study conducted by Jiang et al. (2023) with emergency department nurses found that the rate of exposure to violence among nurses in the past year was 70.3%, and it was determined that violence increased their intention to leave their jobs (10). This situation has become a structural problem that affects not only individuals, but also healthcare services as a whole.

Emergency department nurses in Türkiye are the group that interacts most intensively with both patients and their relatives, placing them at high risk for violence. Therefore, understanding how nurses experience this phenomenon and thoroughly examining the causes and consequences of violence are of great importance.

In this context, the research seeks to answer the following questions:

1. How do emergency department nurses define violence?
2. What is the individual, social, and professional causes of violence?
3. What behavioral, physical, psychological, and professional effects does violence have on nurses?
4. How do nurses cope with violence, and what do they suggest to prevent violence in the profession?

The findings from this study are expected to contribute to the development of policies and practices aimed at preventing violence in healthcare settings, ensuring safe working conditions for nurses, and strengthening their coping capacities.

## Material and Methods

### *Research Design*

In this study, the interpretative phenomenological analysis (IPA) design, one of the qualitative research methods, was used to understand the experiences of violence encountered by emergency nurses in their work environment and the effects of these experiences on individuals. Interpretative phenomenology accepts that different individuals perceive the world in very different ways depending on their personalities, previous life experiences, and motivations, and seeks to discover and interpret the subjective meaning of the events, situations, and experiences that individuals have lived through (11,12).

### *Participants*

The research was conducted online between August and December 2024 with nurses working in emergency departments in western Türkiye. The study was conducted with ethical approval obtained from the relevant ethics committee (Decision No. 2024/109, dated 23.07.2024). The study population consisted of nurses working in emergency departments in western Türkiye. The study included nurses who had been working as nurses in the emergency departments of state hospitals in western Türkiye for at least one year and who had experienced violence at least once during their professional practice by a patient, a patient's relative, or a team member. The "criterion sampling" technique, one of the purposive sampling methods, was used in the sample selection (13). Before starting the interviews, all participants were informed about the purpose, process, and confidentiality principles of the research, and their verbal informed consent was obtained. In-depth interviews were conducted with 5 participants at the beginning of the research. When the number of participants reached 17, it was observed that the data obtained began to repeat, and no new information or conceptual insights emerged. At this point, data saturation was considered to have been reached (13,14). The study sample consisted of 17 nurses. Three nurses who agreed to participate in the study were excluded because they discontinued the interview. Additionally, the study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines (15).

### *Data collection process*

The researcher used a semi-structured interview form prepared for the in-depth interviews. The form consisted of six questions about the participant's background (age, education, marital status, years of work in the profession and unit, etc.) and six questions about their experiences of violence in the workplace. The first question, "How do you assess violence? ," is a perceptual question. During the interview, follow-up questions were asked as needed based on these questions.

Interview questions

1. How do you define violence?
2. How often do you encounter violence in the emergency department environment?
3. What are your thoughts on the reasons behind the occurrence of violence?
4. What are the effects of experiences of violence on your personal and professional life?
5. How do you evaluate current practices regarding the prevention and management of violent incidents?
6. What are your methods for dealing with violence?

To prevent potential bias, interviews were conducted in quiet, appropriate rooms where nurses could respond comfortably and alone. Questions were revised based on

expert opinions to ensure content validity (16). Within the scope of this study, experts in the field of mental health and psychiatric nursing provided detailed feedback on whether the questions were clear and understandable and whether the identified themes were adequately covered, and the interview form was finalized. In addition, a pilot study was conducted by applying the research questions to a nurse who was not included in the study, and the clarity and appropriateness of the prepared questions were evaluated. Based on these evaluations, two questions were restructured: "What do you think are the reasons for experiencing violence?" and "How do you react when you encounter violence? How did you feel?" Two questions, "Types of violence experienced?" and "How did your experience of violence end?", were removed from the form. In addition, explanatory sample items such as "What does this mean to you?", "What do you think are the most important reasons?", and "How did these experiences affect you emotionally?" were added. As a result of these adjustments, the content validity of the interview form was increased, it was made more functional in terms of application, and the final form of the interview form was determined. The interviews, conducted at times convenient for the participants, lasted approximately 40-45 minutes and were conducted in a single session. During the interview, probing questions such as "Could you elaborate on this a little more?" were used to encourage nurses to elaborate on their feelings and experiences. Furthermore, the interviews were conducted with unconditional acceptance, active listening techniques were used to avoid bias, and explanations were provided only when requested by the participant. All interviews were audio recorded, then transcribed verbatim and anonymized using participant codes (#1‑#17) (17). Qualitative data obtained through semi-structured interviews were transcribed and verified by comparing them with the audio recordings. The decoding process was performed independently by the researcher.

***Statistical analysis and interpretive phenomenological analysis***

The analysis of the study data was conducted in accordance with the stages of the Interpretative Phenomenological Analysis (IPA) approach (18). The interview transcripts were read independently and in detail by the researcher to gain familiarity with the content and develop a comprehensive understanding. Significant statements reflecting the nurses' experiences, feelings, and thoughts were identified, and these meaningful sections were reorganized to reveal key themes and patterns. The analysis process involved a careful examination of the contextual nuances present in the data; participant statements were meaningfully grouped to form consistent themes. The themes were then reviewed in detail by the author of the study, and the relationships between themes and sub-themes were analyzed. For the systematic analysis of qualitative data, interview data were coded using MAXQDA 2022 software by a researcher trained in qualitative research and phenomenological analysis, and the coding was then checked and revised (19). After coding was completed, the researcher categorized the data and grouped them into themes and subthemes. These themes were comprehensively evaluated in terms of depth of meaning and richness of content. In addition, the coding and analysis process was independently and thoroughly evaluated by an academic (HS) who is experienced in qualitative research in the field of nursing, has publications in SSCI Q1 indexed journals, and has received training on MAXQDA software. HS independently reanalyzed 30% of the interview data and examined the relationships between codes, themes, and subthemes in depth. This expert has previously conducted qualitative research and is competent in effectively using MAXQDA in the data analysis process. The findings were also presented to nurses to validate the themes and analyses, and their feedback was obtained. This process was carried out as part of the participant validation method used to increase the reliability and validity of the study. In addition, direct quotations from participant statements were included, allowing the reader to evaluate the comments and follow the analysis process. Through these approaches, the researcher aimed to increase the validity and reliability of the study by controlling for possible biases. The analysis results are summarized in tables containing themes, sub-themes, and codes. These tables ensure that the findings are presented in a systematic and transparent manner.

**Results**

The findings regarding the sociodemographic data of emergency nurses are presented in Table 1.

Table 1 contains data on the sociodemographic characteristics of emergency nurses. According to these data, the nurses' ages range from 29 to 49, with a mean age of 41.8 ± 5.3. Most nurses are female, married, and have a bachelor's degree. Nurses' professional experience ranges from 6 to 28 years, while their emergency department experience ranges from 1 to 18 years. In addition, all nurses stated that they had been subjected to violence by patients and/or their relatives.

The themes, subthemes, and codes related to the nurses' experiences of violence in emergency departments are presented in Table 2.

***Theme 1: Definition of violence***

Emergency nurses expressed the theme of violence definition in two sub-themes: definition and the types of violence to which they were most exposed (Table 2).

*Definition*

When asked how they define violence, nurses described it as a misguided way of managing anger, a display of power, and anything that causes harm.

Some participants' statements are as follows:

"Violence is actually a way of mismanaging the anger within people. I think people may resort to violence so as not to appear weak, and people may hide the fact that they have been subjected to violence so as not to appear weak..." (#2)

"All types of violence are very bad. Some people think it is sometimes necessary, but I think it affects productivity in our profession. Violence is actually anything that negatively affects and harms people, both emotionally and physically..." (#9)

| Participant | Sociodemographic characteristics | | | | | |
|---|---|---|---|---|---|---|
| | Gender | Age | Education | Marital status | Years in profession | Years of service in the unit |
| #1 | K | 29 | Bachelor | Single | 6 | 1 |
| #2 | K | 33 | Bachelor | Married | 10 | 8 |
| #3 | K | 39 | Bachelor | Single | 13 | 4 |
| #4 | K | 42 | Associate Degree | Married | 19 | 3 |
| #5 | K | 35 | Bachelor | Married | 14 | 2 |
| #6 | K | 45 | Associate Degree | Single | 16 | 13 |
| #7 | K | 40 | Bachelor | Married | 21 | 18 |
| #8 | K | 41 | Bachelor | Married | 17 | 7 |
| #9 | K | 46 | Bachelor | Married | 23 | 17 |
| #10 | E | 48 | High School | Married | 27 | 14 |
| #11 | E | 44 | Bachelor | Married | 18 | 15 |
| #12 | E | 43 | Bachelor | Married | 20 | 12 |
| #13 | K | 45 | High school | Married | 21 | 5 |
| #14 | K | 41 | Bachelor | Married | 19 | 10 |
| #15 | K | 38 | Bachelor | Married | 14 | 4 |
| #16 | K | 46 | Bachelor | Married | 19 | 10 |
| #17 | K | 49 | High School | Married | 28 | 14 |

**Table 1.** Distribution of nurses' sociodemographic characteristics (n=17)

*Types of violence to which they were exposed*

While most nurses stated that they were exposed to verbal and psychological violence in the emergency department, some participants also mentioned that they were exposed to physical violence.

Some participants' statements are as follows:

"Violence is not only physical; verbal harassment, psychological pressure, and mobbing are also types of violence. We are most exposed to verbal violence in the emergency department..." (#4)

"Violence is a factor that directly affects productivity in our profession. Even patients frequently saying 'you're working for free' is psychological violence in my opinion..." (#7)

"We actually face violence almost every day. Maybe not always physically, but psychologically and verbally almost every day. If we weren't professionals, the situation would turn physical, and it does. And that's very painful..." (#10).

***Theme 2: Causes of violence***

Nurses expressed the theme of reasons for experiencing violence in three sub-themes: individual, social, and professional (Table 2).

*Individual causes of occurrence*

All nurses stated that the individual causes of violence stemmed from personal characteristics (such as lack of self-confidence, dissatisfaction, disrespect), while half stated that it stemmed from the person's desire to release energy and relax, inability to control anger, illness psychology (suffering), and communication problems (inability to express oneself, not listening, etc.). In addition, some participants stated that it stemmed from socioeconomic reasons (lack of education, financial problems), while a few participants stated that individuals were unable to empathize.

*Some participants' statements are as follows:*

"When people come to the emergency department, they are already stressed and impatient. They don't want to wait at all, even if the situation is not urgent. Some see patients whose situation is urgent, but still nothing changes. They are completely incapable of empathy and direct their anger at us. This provides them with a sense of relief." (#3)

"Violence arises directly because people's tolerance level decreases while they wait in the emergency department. It can be verbal or psychological. They also think they can solve everything with violence..." (#9)

"It actually stems from ignorance and economic hardship. People are impatient; they don't want to wait. I try to understand them, but on the other hand, there's the psychology of illness. But they also see the emergency department like a supermarket; they want what they want immediately." (#11)

| Theme | Subtheme | Codes | n* |
|---|---|---|---|
| Definition of violence | Definition | Inappropriate management of anger | 3 |
| | | A display of power | 3 |
| | | Anything harmful | 3 |
| | Types of violence they are exposed to | Verbal violence | 15 |
| | | Psychological violence | 15 |
| | | Physical violence | 6 |
| Reasons for violence | Individual | Personal characteristics | 17 |
| | | Desire to release energy and relax | 8 |
| | | Inability to control anger | 8 |
| | | Illness psychology | 8 |
| | | Communication disorder | 8 |
| | | Socioeconomic reasons | 6 |
| | | Inability to empathize | 3 |
| | Social | Perceived as a right | 6 |
| | | Social media | 4 |
| | | Perception of respect and acceptance | 4 |
| | | Family dynamics | 3 |
| | Professional | Prejudices against healthcare professionals | 15 |
| | | Perception of emergency services | 15 |
| Effects of violence | Behavioral | Intolerance | 8 |
| | | Not wanting to talk | 6 |
| | | Desire to be alone | 6 |
| | | Indifference | 4 |
| | Physical | Fatigue | 12 |
| | | Weariness | 11 |
| | | Being on alert | 8 |
| | | Pain (Head, muscle, etc.) | 7 |
| | | Insomnia | 7 |
| | Mental | Anger | 16 |
| | | Burnout | 9 |
| | | Anxiety | 8 |
| | | Boredom | 6 |
| | | Inadequacy | 5 |
| | | Insecurity | 4 |
| | | Unhappiness | 3 |
| | Professional | Job dissatisfaction | 9 |
| | | Low motivation | 8 |
| | | Decreased compassion | 5 |
| | | Deterioration of professional ethics | 4 |
| Measures to prevent violence | Recommendations | A penal system should be established | 16 |
| | | Their access to healthcare should be restricted | 10 |
| | | Those who commit violence should be required to work at the location where the violence occurred | 3 |
| | | The way children are raised should be changed, starting with families | 3 |
| Methods for dealing with violence | Individual | Smoking | 10 |
| | | Engaging in calming activities | 9 |
| | | Alcohol use | 6 |
| | | Using social media | 5 |
| | Professional | Medication use | 8 |
| | | Seeking professional support | 3 |
| | Social | Spending time with friends | 5 |
| | | Talking with colleagues | 4 |

**Table 2.** Themes, sub-themes, and codes related to nurses' experiences of violence (n=17)
n* has been multiplied.

*Social reasons for occurrence*

Some nurses stated that violence stems from individuals perceiving it as their right. Several participants mentioned that it stems from social media, respect, and the perception of acceptance, and that family dynamics (the environment in which they grew up) are influential.

One participant stated the following:

"Lack of education and low socioeconomic status cause patients to view us as 'servants'. When negative examples on social media are added to this, violence becomes inevitable. They see violence as their right and believe that this is accepted." (#5)

*Professional reasons*

Most nurses stated that the professional reasons for violence stem from prejudices against healthcare

professionals and the perception of the emergency department (as a place where only emergencies should be admitted).

*Some participants' statements are as follows:*

"We already experience psychological and verbal violence at any moment. As if patients' expectations and outbursts of anger weren't enough, statements like 'You're working with my tax money' wear us down. We are constantly at risk of violence. Because they have this absurd, ignorant perception that the emergency department is a place you have to enter urgently, and we can't prevent that..." (#12)

"Patients don't listen, they can't express themselves. They also come to the emergency department with preconceived notions. They think, 'This nurse is going to treat me badly,' so communication breaks down and violence becomes inevitable..." (#17)

***Theme 3: Effects of Violence***

Nurses expressed the theme of the effects of violence in four sub-themes: behavioral, physical, psychological, and professional (Table 2).

*Behavioral Effects*

Some participants stated that the behavioral effects of violence cause intolerance, unwillingness to talk, and a frequent desire to be alone, while a few participants stated that they do not react to any incident/situation.

Some participants' statements are as follows:

"I don't want to communicate with people anymore. I don't have the energy to talk, either at work or in my social life; I constantly want to be alone. Calm, quiet... I constantly feel tired and fed up." (#6)

"If I've experienced serious distress, like being exposed to violence while on duty, it inevitably affects me when I get home. After all, we don't leave our work behind completely when we go home. A person's tolerance level for certain things gradually decreases, and we can become unable to tolerate normal things in our personal lives. My tolerance level is decreasing. For example, after a fight or noise here, when I go home, I don't want anyone to talk." (#14)

*Physical effects*

Most nurses mentioned that the physical effects of violence include fatigue, exhaustion, hypervigilance, pain (head, muscles, etc.), and insomnia.

Some participants' statements are as follows:

"After experiencing violence, I can't sleep when I go home. I feel like I'm being followed, and this makes me extremely anxious." (#1)

"The feeling that we might be subjected to violence at any moment in the emergency department keeps me on high alert. We are constantly on alert, you know. I think we will be exposed to violence at any moment. We are already exposed to more verbal violence from patients and their relatives. For psychological violence, for verbal arguments, for communicative violence. We also have to be on alert for physical violence." (#2)

*Psychological effects*

Participants stated that violence causes them to feel anger, exhaustion, anxiety, weariness, worthlessness, insecurity, and unhappiness psychologically.

Some participants' statements are as follows:

"I often misinterpret even normal situations I experience outside. I can project my inner anger onto an ordinary person outside. This could be someone from my family, or it could be my friends, or even someone I see in traffic." (#8)

"We have experienced violence now, really. Once you experience trauma, everything you go through turns into insomnia and anxiety. I bring that stress home with me. So, for example, when I compare myself now to how I was five years ago, I can say I have a more anxious personality. For example, I get annoyed by everything more easily..." (#13)

"Constant verbal harassment. Being so accessible, so easily spoken to, so easily reached, so easily harassed doesn't make me happy. You come in every day with the worry that something might happen today. People being spoiled. In my opinion, the fact that healthcare is so accessible and that healthcare workers are so disrespected makes it inevitable that we are subjected to violence. I feel worthless and devalued." (#17)

*Professional effects*

Participants stated that violence leads to professional dissatisfaction, low motivation, decreased compassion, and erosion of ethical values.

Some of the participants' statements are as follows:

"Of course, you feel bad. I get angry, I get tachycardia. My work piles up, my morale and motivation disappear. My morale really suffers, I hate my job. Because after the violent patient or relative leaves, I have to continue caring for the patient for another 24 hours. And every time, I think about quitting." (#5)

"I can no longer enjoy my profession. I can no longer approach patients with compassion like I used to. I only come for the money. Before every shift, I worry, 'What will I experience today?'" (#11)

"Experiences of violence diminish my faith in the profession and break my motivation. We work our shifts with grim faces, and it's exhausting because we are exposed to verbal abuse every shift. Our compassion for people is fading, and I just want to do my job and leave." (#15)

***Theme 4: Measures to prevent violence***

Nurses expressed the theme of measures to prevent violence in the form of suggestions in a sub-theme (Table 2).

*Recommendations*

While most participants expressed that a penal system should be implemented to prevent violence and that it should be deterrent, some participants stated that access to healthcare should be restricted. A few participants also stated that perpetrators of violence should be made to work where they committed the violence for a period of time and that the way children are raised should be changed, starting with families.

Some participants' statements are as follows:

"So, they should be a little afraid of violence. Yes, violent incidents occur, and when people don't receive punishment for them, they feel they have the luxury of doing it again. Whereas if they really received punishment, I mean, I think to myself. If someone causes a disturbance in a hospital and wrecks the place, and I end up in court over it, then I think that person should be banned from that hospital, they should be prohibited from ever entering that hospital again, or their access to healthcare should be restricted." (#3)

"There is absolutely no system in place within the current practices to protect healthcare workers from violence. There is absolutely none. There is no security. Even if there were

security, they ultimately don't have much authority or responsibility to protect us. Right now, they're just watching. For example, when a patient's relative attacks me, security says, 'We can't intervene.' So, what am I supposed to do? They're like, 'If it doesn't affect me, let it be.' I think the state should take very serious, decisive measures on this issue. There should be serious sanctions. I think people who use violence should be made to work in the environment they created. For a certain period of time. They should work there, see what happens, witness what goes on. For a certain period of time. Maybe. But the penalties should definitely be more severe. Not just jail time or fines. I think these should be made much harsher, and these penalties should definitely be imposed..." (#14)

***Theme 5: Coping strategies***

Nurses expressed the theme of methods for dealing with violence in three sub-themes: individual, professional, and social (Table 2). While Theme 4 reflects nurses' expectations and assessments regarding external regulations at the institutional, legal, and systemic levels aimed at preventing violence, this theme reveals how nurses subjectively experience the inevitability of violence and the internal and relational adaptation processes they develop to cope with this experience.

*Individual coping methods*

Participants stated that they cope individually with violence by smoking, turning to calming activities (such as reading, watching movies, camping, and sports), drinking alcohol, and using social media.

Some participants' statements are as follows:

"Playing sports, watching movies, and reading books calms me down. If I don't walk for at least half an hour after work, I can't relieve my stress..." (#2)

"... By smoking, of course. I noticed that I increased my smoking frequency. I also drink alcohol occasionally, especially when I can't sleep. It relaxes me." (#6)

"I relax by watching movies and going for walks. Going home and watching something, distracting myself, helps. Otherwise, dealing with the same stress every day is impossible..." (#8)

*Professional coping methods*

Some participants mentioned coping with violence by using medication (such as serotonin reuptake inhibitors, an antidepressant group), while a few participants mentioned coping with violence by seeking professional support.

Some participants' statements are as follows:

"I started taking antidepressants. I couldn't cope any other way. I can't do without the medication now. Otherwise, I was tired of going home crying every day..." (#9)

"I started taking antidepressants. I couldn't take it anymore. Every day, crying spells, insomnia... My doctor said, 'You can't work like this,' and prescribed medication." (#14)

*Social coping methods*

Participants stated that they coped by spending time with friends (going out, chatting) and colleagues.

Some participants' statements are as follows:

"...Maybe one coping method could be meeting up with my friends, going out, having fun. Distracting myself feels good..." (#1)

"I try not to talk about the hospital when I meet my friends. But no matter what I do, I go home feeling tense. However, chatting with my friends outside the hospital relaxes me a little..." (#3)

**Discussion**

This study aimed to understand the experiences of violence that emergency nurses encountered by emergency nurses in their work environment and the effects of these experiences on individuals. The findings were evaluated in comparison with the literature, and important conclusions were drawn regarding violence in healthcare.

The findings of this study reveal that emergency nurses have been exposed to violence by patients or their relatives at least once during their professional lives. When approached with the IPA approach, the experience of violence is not only a negative work experience for emergency nurses; it is also understood as an experience that creates a significant break in their professional self-perception and transforms their identity. Nurses defined violence as mismanagement of anger, a display of power, or harmful behavior; they stated that they were most frequently exposed to verbal and psychological violence. The findings show that violence is a widespread problem in emergency departments and are consistent with similar studies in the literature (6,7,20,21,22). Emergency departments are workplaces with a 24-hour "open door" policy where cases requiring urgent intervention and patients at high risk of death are treated, and where both staff and patients and their relatives experience intense stress and tension (6). Research has also indicated that nurses are mostly exposed to verbal violence involving arguments, insults, and threats from patients or their relatives; that violent incidents occur most frequently in emergency departments; and that perpetrators generally go unpunished (6,20,21,22). Along with violence, nurses begin to position themselves not as caring, compassionate, and professional subjects, but as devalued, targeted, and constantly threatened employees. This experience transforms the meaning nurses attach to their profession; nursing ideals (compassion, empathy, helping) are replaced by an emotional withdrawal, distancing, and a self-protective professional stance. In the context of IPA, this situation demonstrates that violence is a threshold experience that erodes nurses' professional identity and leads them to redefine their caregiving role as a duty to be endured rather than a meaningful one. Violence is no longer merely an external threat for nurses; it is an experiential space where hopes, ideals, and a sense of belonging to the profession are eroded. Therefore, due to the inadequacy of criminal sanctions, nurses tend to view violence as part of their profession and often choose not to report the incidents they experience (7,20). However, failure to report such incidents facilitates the recurrence of violence and may increase the risk of incidents resulting in serious injury, permanent damage, and even death. In this context, professional identity ceases to be an idealized identity and is reshaped into an identity centered on survival and psychological protection.

In the study, nurses evaluated the causes of violence at the individual, social, and professional levels. At the individual level, they stated that violence stems from personal characteristics (such as lack of self-confidence, dissatisfaction, disrespect), the desire to release energy and

relax, difficulty controlling anger, the psychology of illness (suffering), and communication problems (inability to express oneself, not listening). At the societal level, violence is said to be fueled by individuals viewing it as a right, the negative effects of social media, and perceptions of respect and acceptance. At the professional level, prejudices against healthcare workers and the perception of the emergency department as a "place where every patient can be seen immediately" are among the important factors that trigger violence. Similarly, the literature emphasizes that the constant presence of patients and their relatives in emergency departments, where stress levels are high, the impatient and unsympathetic attitudes of patients' relatives, their demands for priority based on the belief that their own patients are more urgent, and the perception that triage is unfair increase violence (3,7,20,22-25). Additionally, low educational level, inadequate information, illness psychology, excessive expectations, communication breakdowns due to anxiety and fear, misuse of emergency departments, the belief that procedures will be performed more quickly, the legitimizing effect of social media on violence, distrust of healthcare workers, and the inadequacy of deterrent penalties are also among the important factors (3,7,20,22-25). In countries with an Eastern culture, such as Turkey, the prolonged presence of patients' relatives in the hospital and their direct involvement in the care process are also considered cultural factors influencing these outcomes.
In the study, nurses stated that violence had multifaceted effects on them at behavioral, physical, psychological, and professional levels. Behaviorally, these included intolerance, avoidance of communication, and a desire to be alone; physically, fatigue, exhaustion, constant alertness, pain (head, muscles, etc.), and insomnia; psychologically, anger, burnout, anxiety, weariness, feelings of worthlessness and insecurity; and professionally, dissatisfaction, low motivation, and decreased compassion were the most frequently mentioned effects. Similarly, the literature indicates that violence causes emotional reactions in nurses such as shock, anger, helplessness, fear, burnout, loss of trust, anxiety, and guilt; behavioral changes such as shouting, speaking loudly, withdrawal, and low self-esteem; and also, low motivation, decreased professional commitment, and decreased work performance, leading to disruption of health services and increased social costs (3,6,7,9,22). It has been reported that nurses exposed to violence are negatively affected physically, mentally, and socially, their work efficiency decreases, and this situation increases their intention to leave their jobs (8). However, although nurses continue to provide care and treatment to their patients with professional ethics and a sense of responsibility, it is thought that the violence they experience negatively affects their job satisfaction and the quality of care.
In the study, nurses stated that they developed various strategies at the individual, professional, and social levels to cope with violence. Individual coping methods included smoking, engaging in calming activities (such as reading books, watching movies, camping, and playing sports), alcohol consumption, and seeking relief through social media. In terms of professional coping methods, some nurses stated that they preferred to use medication, such as serotonin reuptake inhibitors and other antidepressants or seek professional psychological support. Among social coping methods, going out with friends, chatting, and spending time with colleagues stood out. Similarly, a study by Telli and Yilmaz Cayir (2024) reported that nurses experienced verbal or psychological violence during such incidents and later shared these experiences with friends, family members, or colleagues (22). Furthermore, the literature emphasizes that healthcare workers exposed to violence need not only psychological but also spiritual counseling services (26-28).
In the study, nurses emphasized that the current criminal justice system is inadequate for preventing violence and that its deterrent effect needs to be strengthened. Participants suggested that measures such as restricting individuals who commit violence from accessing healthcare services for a certain period and having them work in the same environment to witness the difficulties experienced by healthcare workers could be effective. One of the most effective ways to reduce the risk of violence is to strengthen legal and judicial sanctions. Within the framework of the "Health in All Policies" approach by the World Health Organization (WHO), it is recommended to develop multi-faceted policies and programs at the national and local levels to prevent violence and to increase interdisciplinary collaboration (29,30). In emergency departments, it is important to develop legal regulations, impose deterrent sanctions such as fines or imprisonment on perpetrators of violence, and temporarily restrict their rights to access health services.

***Limitations***

The findings of this study are based on the experiences of a limited number of emergency department nurses, and the generalizability of the results is therefore limited. The fact that the majority of participants were women created an imbalance in gender representation; conducting data collection solely through in-depth interviews partially limited the diversity of experiences. Furthermore, although collecting data through online interviews allowed simultaneous access to nurses working in different hospitals in western Türkiye, some advantages of face-to-face interviews, such as allowing participants to feel more comfortable sharing their experiences in greater depth, may have been lacking. Future studies are recommended to adopt a multicenter design, involving nurses working in different regions. In terms of researcher reflexivity, the first author of this study has clinical experience in nursing and has witnessed violence against healthcare workers professionally. While this facilitated a deeper understanding of the participants' experiences, it also carried the risk of potential bias. Therefore, the researcher kept reflexive notes throughout the data collection and analysis process, constantly questioning her own assumptions, and during the coding phase, she received independent oversight from a second researcher experienced in qualitative research. This method reduced researcher subjectivity and contributed to the self-reflective awareness that forms the basis of the Interpretative Phenomenological Analysis (IPA) approach.

## Conclusion

This study reveals the types of violence to which emergency department nurses are exposed, the causes of this violence, and its multidimensional effects on nurses. The findings show that emergency nurses have been exposed to verbal and/or psychological violence by patients or their relatives at least once during their professional lives. Nurses assessed the causes of violence at the individual, social, and professional levels. The effects of violence on nurses manifested in behavioral terms, such as intolerance, withdrawal, and the desire to be alone; in physical terms, such as fatigue, exhaustion, insomnia, muscle pain and headaches; anger, exhaustion, anxiety, worthlessness, insecurity, and professional dimensions such as loss of motivation, dissatisfaction, and compassion fatigue. Nurses stated that they developed individual, professional, and social strategies to cope with violence. Nurses emphasized that in order to prevent violence, criminal penalties should be increased, the deterrent effect of the current system should be strengthened, and individuals who commit violence should be temporarily restricted from accessing healthcare services and banned from entering healthcare institutions for a certain period of time. It is evident that the phenomenon of violence in emergency departments must be addressed not only in its individual aspects but also in its social and systemic dimensions. Based on the findings of the study, it is recommended to increase awareness campaigns to prevent violence, use posters and billboards with warning messages in hospitals, and strengthen the sense of trust in healthcare workers through social media. Furthermore, increasing the authority and responsibilities of security personnel in healthcare institutions is considered an important step in preventing violent incidents.

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