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"We are not punching bags": the impact of health-related violence news on nursing students' professional perceptions — a qualitative study

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Abstract

Background Media news of violence in healthcare shape public opinion and exert emotional and professional pressure on healthcare students. For nursing students, such news particularly influences perceptions of the profession during the sensitive pre-graduation stage. This study explores how media-reported violence affects the professional perceptions of senior nursing students.

Methods A phenomenological qualitative design was employed with 28 senior nursing students. Data were collected through semi-structured in-depth interviews and analyzed using content analysis.

Results Four main themes with nine sub-themes emerged: (1) Perceptions and Interpretations of Violence in Healthcare, (2) Individual and Professional Reflections of Violent News, (3) Perceived Causes of Violence in Healthcare, and (4) Suggested Solutions. Students reported emotional reactions such as fear, anxiety, alienation from the profession, reduced motivation, and uncertainty about their future in nursing. At the same time, they displayed solution-oriented thinking and critical awareness of systemic factors.

Conclusions Media exposure to violence-related news generates professional anxiety and secondary traumatic stress in nursing students. It shapes professional identity, weakens commitment, and fosters uncertainty about future roles, while also encouraging reflection on systemic solutions.

Keywords Nursing students, Healthcare violence, Media news, Professional perception

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Introduction

Violence against healthcare professionals is a growing global concern that threatens the integrity of healthcare systems, disrupts service delivery, and diminishes employee motivation and quality of care [1]. According to the World Health Organization, healthcare violence is defined as any incident where healthcare workers are abused, threatened, or assaulted in circumstances related to their work, including physical, verbal, psychological, or any form of harm [2, 3]. Healthcare settings—especially those involving high levels of stress and crisis—are inherently prone to such incidents [4]. Nurses, as the most accessible professionals in the health system with frequent and direct patient interaction, are often the primary targets of this violence [5, 6].

Healthcare sector as the industry most affected by violence globally, underscoring the urgency of the problem [7]. The prevalence of workplace violence varies significantly across studies, depending on the types of violence examined, roles of healthcare providers, employment settings, geographical regions, and definitions and methodologies used. Recent studies stated that healthcare workers are reported to be five times more likely to experience workplace violence than workers in other sectors, and 73% of all non-fatal occupational injuries caused by violence affect healthcare personnel [8]. In Europe, healthcare workers are 16 times more likely to be exposed to violence compared to those in other professions [5]. A systematic review and meta-analysis by Liu et al. (2019), covering data from Asia, Europe, North America, Australia, Africa, and Latin America, found that 61.9% of healthcare workers reported experiencing at least one form of workplace violence—highlighting the global scale of this occupational hazard [9]. The rise in violence in the healthcare sector also poses a critical threat to the sustainability of the global nursing workforce. Research shows that exposure to workplace violence significantly reduces job satisfaction levels among nurses and directly increases turnover intention. Even experiences of psychological and verbal violence alone are strong predictors of turnover intention [10–12]. This creates a cycle where the attrition caused by current violence incidents further exacerbates the already critical global nursing shortage [13]. Therefore, examining the reactions of future workforce members, such as nursing students, to violence news is crucial for developing early intervention strategies to prevent potential staff losses.

In Türkiye, incidents of violence against healthcare professionals have increased not only in frequency but also in severity in recent years. These incidents are no longer confined to high-pressure units such as emergency departments but have spread across various care settings—from outpatient clinics to intensive care units, from family health centers to home care services [14]. Notably, violence in healthcare (VH) has become a recurring topic in the national media. According to a media analysis study, news reports on VH increased by 175% between 2013 and 2018 in print media alone [15]. During this period, violence against healthcare professionals ranked among the most reported issues, alongside public healthcare expenditures, urban hospital crowding, and systemic challenges faced by health personnel.

However, frequent media news of violent incidents can have unintended consequences on both individual and societal levels [16]. A report by the Grand National Assembly of Türkiye warned that extensive media exposure to such content might diminish public respect for healthcare professionals, desensitize audiences to violence, and increase societal tolerance for aggressive behaviors [17]. The report emphasized that media representations of violence could reinforce the perception of violence as a legitimate method of problem-solving and that witnessing violence through the media might have causative effects on aggressive behavior.

Moreover, the pervasive presence of violent healthcare news in both mainstream and social media is likely to impact not only current healthcare professionals but also students who are preparing to enter the field [18]. For nursing students in particular, such reports act as powerful external factors shaping their professional motivation, ideals, and perceptions—especially during the critical pre-graduation phase [19, 20]. However, these indirect effects on students are often overlooked in favor of studying the direct experiences of practicing professionals [5, 6, 21]. Recent studies have shown that workplace violence against healthcare workers remains a widespread and growing global problem. A comprehensive umbrella review highlighted that healthcare workers face high rates of physical, verbal, and psychological violence in different settings and regions, emphasizing that this problem persists worldwide [22]. The authors also note that the COVID-19 pandemic may have exacerbated this phenomenon by increasing social tension and public disappointment with healthcare systems. Supporting this view, a recent meta-analysis reported that both verbal and physical attacks against healthcare workers increased significantly during the pandemic, largely driven by emotional exhaustion, resource scarcity, and increased occupational stress [23]. These findings highlight how the pandemic not only exacerbated structural vulnerabilities in healthcare services but also shaped public perceptions through media narratives that frequently depicted violence in clinical settings. Given that nursing students completed a significant portion of their professional education during or after this crisis, it is likely that their perceptions of the profession were influenced by the proliferation of violence-related news. Thus, it is crucial to raise awareness about how students who have not yet

directly encountered violence might still experience its psychological and professional consequences via media exposure.

This study seeks to explore how violent healthcare news affects the professional perceptions (PP) of senior nursing students (SNS) using a phenomenological approach. In doing so, it contributes to a relatively understudied area in the literature and offers insights into the emotional safety and professional engagement of future healthcare professionals. Accordingly, the central research question guiding this study is:*"How do news reports on VH affect the PP of SNS?"*

Table 1 Participant characteristics

P. No	Age	Gender	Exposure to/Witnessing Violence	Violence News Follow-up	Violence News Followed News Source
1	22	Female	Neither	Yes	Social Media- TV- Internet
2	22	Female	Exposed	Yes	Social Media
3	24	Female	Witnessed	Yes	Social Media
4	22	Female	Witnessed	Yes	Social Media
5	23	Male	Neither	Yes	Social Media- Internet
6	22	Male	Neither	Yes	Social Media- TV- Internet
7	23	Male	Neither	Yes	Social Media- Internet
8	23	Female	Witnessed	Yes	Social Media- TV- Internet
9	21	Male	Neither	Yes	Social Media- TV- Internet
10	21	Female	Neither	Yes	Social Media- TV- Internet
11	21	Female	Witnessed	Yes	Social Media- TV- Internet
12	20	Female	Witnessed	Yes	Social Media- TV
13	23	Female	Neither	Yes	Social Media
14	22	Female	Neither	Yes	Social Media
15	22	Female	Witnessed	Yes	Social Media
16	24	Male	Neither	Yes	Social Media- Internet
17	22	Female	Both Happened	Yes	Social Media- TV- Internet
18	21	Female	Exposed	Yes	Social Media- TV- Internet
19	27	Female	Both Happened	Yes	Social Media- TV- Internet
20	24	Male	Neither	Yes	Social Media- TV- Internet
21	21	Female	Neither	Yes	Social Media- TV- Internet
22	25	Female	Neither	Yes	Social Media
23	21	Female	Witnessed	Yes	Social Media- TV- Internet
24	23	Male	Both Happened	Yes	Social Media- TV- Internet
25	21	Female	Witnessed	Yes	Social Media- TV- Internet
26	21	Female	Neither	Yes	Social Media
27	22	Male	Exposed	Yes	Social Media
28	23	Male	Neither	Yes	Social Media- Internet

Method

Research design

This study employed a phenomenological qualitative research design to gain an in-depth understanding of how healthcare violence news impacts the PP of SNS. Phenomenological studies explore individuals' lived experiences and their interpretations of a specific phenomenon [24]. Although a proportion of participants report their understanding of healthcare violence via media rather than personal victimisation, descriptive phenomenology remains an appropriate method for this study because phenomenology examines the lifeworld (the lived, meaning-filled world) of individuals — including meanings generated through mediated experience. Descriptive phenomenology is concerned with how phenomena show themselves to consciousness and how persons experience and make sense of phenomena in their everyday world [25–27]. Media narratives can pervade the lifeworld and shape anticipatory lived experiences; thus, exploring how nursing students experience and interpret media-reported violence is fully consistent with a descriptive phenomenological approach.

Study group

The study group consisted of 28 volunteer SNS enrolled in a university's nursing program in Türkiye between February and April 2025. SNS in this study are defined as students enrolled in the final (fourth) year of a four-year undergraduate nursing programme, who had completed the majority of their clinical rotations and were within one academic term of graduation. These students therefore occupy the transitional phase between student and registered practitioner, making them particularly sensitive to media representations that may shape professional expectations and identity formation. Participants were selected through criterion sampling [28]. Inclusion criteria were: being a SNS, following news related to VH, and voluntarily consenting to participate in the study. Participants were aged between 20 and 27. Among them, 19 were female; 3 reported direct exposure to violence, 9 had witnessed violent incidents, 3 had both witnessed and experienced violence, while 14 had neither witnessed nor experienced such events. All participants reported following healthcare violence news, with social media identified as the most common source (Table 1).

Data collection process

Data were collected through individual semi-structured interviews. The interviews were guided by a semi-structured interview form developed by the researchers based on a review of previous literature on workplace violence and professional identity among nursing students and healthcare workers [5, 18, 21]. The questions were formulated to explore participants' lived experiences and perceptions in line with the phenomenological approach, focusing on their emotional and cognitive responses to news reports about VH. Then validated by three experts with doctoral degrees in psychiatric nursing to ensure content validity. A pilot test was conducted with two students to determine comprehensibility. No negative feedback was recorded. These two students were not included in the study group or analyses. The questions aimed to explore participants' perceptions of healthcare violence news, its impact on their professional attitudes and motivation, emotional reactions, and proposed solutions (Table 2).

Interviews were conducted face-to-face in quiet, distraction-free environments. Each session lasted approximately 40–45 min. All interviews were conducted by the first researcher, who holds a PhD in psychiatric nursing. She working as an academic at the state university where the current study is being conducted. These qualifications facilitated effective guidance and strong communication with participants. On the other hand, the following strategies were implemented to reduce potential power dynamics that could arise from the first researcher's position within the institution: emphasizing that participation was voluntary and that no evaluation would be conducted prior to the interviews; and guaranteeing that the education and training processes would not be affected for any reason, in order to allow students to express themselves more comfortably. The second and third researchers, who hold a PhD in psychiatric nursing and are university academics with clinical experience in psychiatry, assisted by taking notes when necessary. They contributed to the process when additional support was required. All researchers have experience in qualitative interviewing and research design. Their subject-matter expertise and academic qualifications contributed significantly to the reliability of the analysis. With participants' informed consent, all interviews were audio-recorded, and additional field notes were taken as needed. Before ending the sessions, participants were asked if they had anything to add or ask, and interviews were concluded with expressions of appreciation. No repeat interviews were conducted. Data collection proceeded until both code saturation and meaning saturation were achieved. We followed established qualitative guidance: Guest et al. criteria for initial interview sufficiency [29] and Hennink et al. distinction between code- and meaning-saturation [30]. In our dataset, new codes became rare after the 18th interview and no new meaningful thematic categories emerged after the 22nd interview; nonetheless we completed 28 interviews to ensure depth and variation across demographic subgroups. The recordings were later transcribed by the researcher and prepared for analysis. All data were anonymized in accordance with ethical standards, and participants were coded as P1 through P28.

Table 2 Semi-Structured interview form

1. How would you define violence from your own perspective?
2. What does "violence in healthcare" mean to you?
3. What are your thoughts on "news related to violence in healthcare"?
4. In your opinion, what are the causes of violence in healthcare?
5. How do you think violence in healthcare can be addressed?
6. In your view, how can violence in healthcare be prevented?
7. How do news reports about violence in healthcare affect you in general?
8. How do such news reports influence your willingness or motivation to practice the profession?
9. How do these news reports affect your perception of the profession's public reputation or status?

Data analysis

Data were analyzed using content analysis. All analyses were conducted manually by the researchers without the use of any qualitative data analysis software. Coding, categorization, and theme development were carried out using printed transcripts and Microsoft Word tables to allow for a closer, iterative engagement with the data. In this study, data analysis followed an inductive (data-driven) approach within Colaizzi's seven-step phenomenological method [31] (Fig. 1), allowing themes to emerge naturally from participants' lived experiences rather than being predetermined by theory.

1. Reading all participant transcripts multiple times to gain a general sense of the content.
2. Identifying significant statements (meaning units) within the transcripts.
3. Converting these meaning units into codes.
4. Grouping codes into common themes and sub-themes.
5. Interpreting themes in relation to the research question and supporting them with direct quotations.
6. Writing detailed descriptive findings based on the developed thematic structure.
7. Validating the analysis through participant feedback to ensure credibility and meaning accuracy.

Each stage of the analysis was initially conducted independently by all authors. After completing their individual coding and thematic interpretation processes, the researchers met to review, compare, and synthesize their

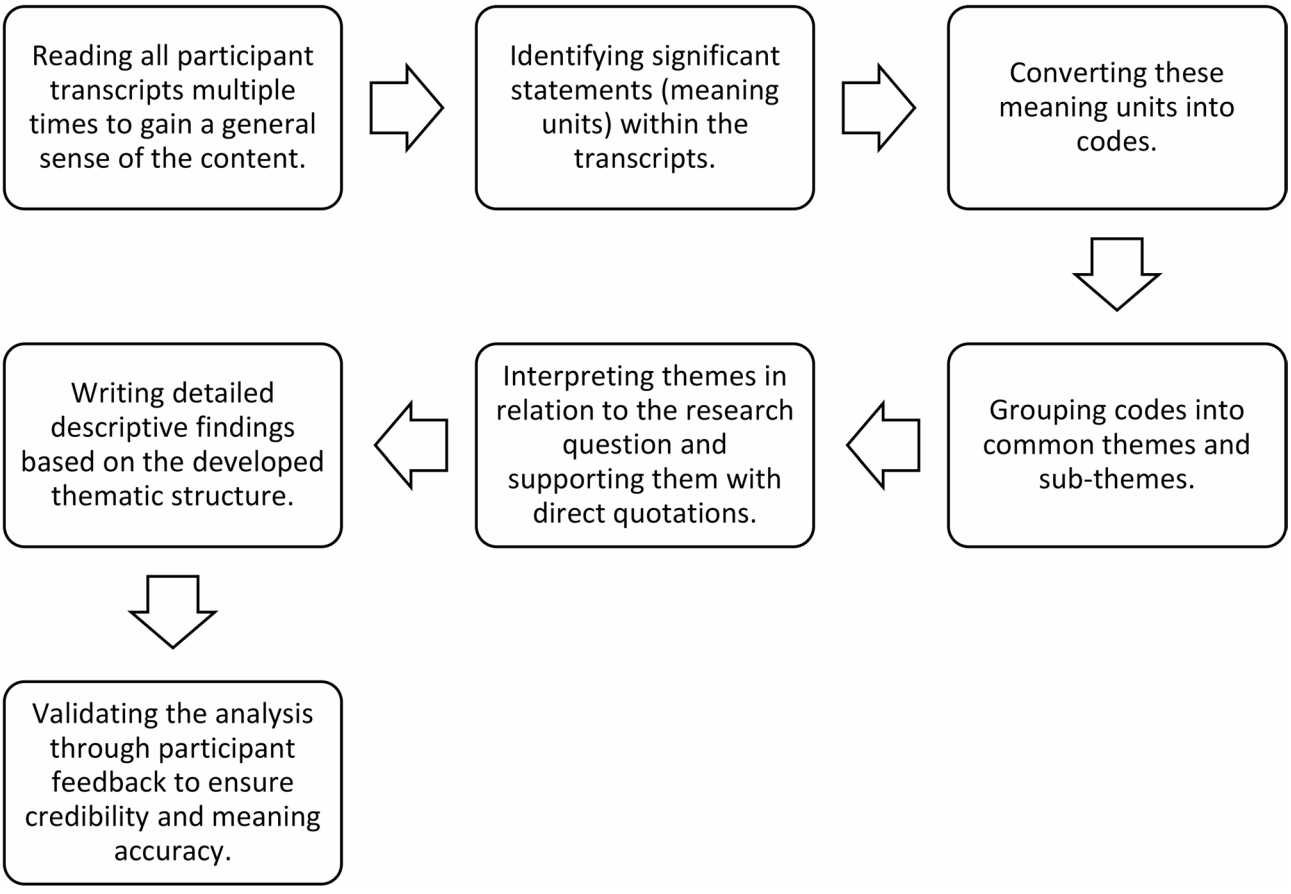


Fig. 1 Seven-steps of Analysis

findings. Through collaborative discussion and consensus-building, the final thematic structure was established, ensuring analytical rigor and interpretive coherence. Throughout the analysis, close attention was paid to content coherence, representational clarity, and semantic depth. A research journal was maintained to document methodological decisions and reflexive insights, while strategies such as bracketing and peer debriefing were employed to minimize bias. The study report was prepared in accordance with the COREQ checklist.

Ethical considerations

Ethical approval for the study was obtained from the Ethics Committee of Health Sciences at Muğla Sıtkı Koçman University (Date: 02.12.2024; Protocol/Decision No: 240154/147), along with institutional permission from the faculty where the students were enrolled. Participants were provided with detailed information about the aim and procedures of the study. Participants were informed in writing that the study was conducted entirely on a voluntary basis, that they could withdraw from the study at any stage at their own request, that they would not receive any financial compensation for their participation in this study, and that this situation would not cause any changes in their educational life. Written informed consent was obtained. All procedures at every stage of the study were conducted in accordance with the current Helsinki Declaration.

Trustworthiness/Rigor

To ensure the trustworthiness of the qualitative research, the four criteria proposed by Lincoln and Guba were applied [32] and the study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist [33]:

- Credibility: Participant statements were analyzed directly and without alteration.
- Transferability: Rich contextual descriptions and participant diversity were provided to facilitate applicability to similar studies.
- Dependability: Coding and theme development were carried out systematically and consistently.
- Confirmability: All analytical decisions and coding patterns were documented to ensure auditability.

Results

As a result of the analysis of the interview data, four main themes and their corresponding sub-themes were identified (Table 3; Fig. 2).

Main theme 1: Meaning-Making and perception of VH

This theme reveals how SNS define VH and how they contextualize this phenomenon within their professional framework. Participants perceived VH as a multidimensional issue, emphasizing not only physical but also

Table 3 *Main and Sub-Themes identified in the Analysis, accompanied by illustrative participant quotes*

Participant quote (verbatim)	Initial code	Focused code	Subtheme	Main theme
"Violence is something that can affect a person's entire physical and psychological being, potentially causing trauma—something I would never want to experience." (P8)	Violence affects whole person	Violence as multidimensional (physical & psychological) harm	**Views on the Definition and Types of Violence**	**Main Theme 1: Meaning-Making and Perception of Violence in Healthcare**
"Violence is the choice of those who fail to express themselves and their thoughts in a normal way." (P7)	Violence as communication failure	Violence as expressive act arising from lack of communication		
"To feel anger toward someone who provides care and healing is a sign of weakness. It demotivates me professionally." (P13)	Anger toward caregiver = weakness	Violence perceived as betrayal or ingratitude undermining motivation	**Positioning Violence in the Healthcare Setting**	
"It is very difficult to understand how someone can harm a person who only tries to help." (P6)	Incomprehension of violence in caregiving	Cognitive dissonance regarding violent behavior toward caregivers		
"Every day I hear more of these stories, and I become more afraid—my perspective on the profession is changing." (P4)	Repeated media exposure → increased fear	Anticipatory fear; changing professional outlook	**Fear**, **Anxiety**, **and Alienation from the Profession**	**Main Theme 2: Individual and Professional Reflections of News on Violence**
"It affects me badly—fear, panic… When a healthcare worker is assaulted, it increases others' workload and the risk of further violence." (P2)	Emotional distress; workload concern	Vicarious anxiety and perceived systemic risk		
"It makes me question whether I can do this job. I start interpreting every action as potential violence." (P21)	Self-doubt; hypervigilance	Uncertainty about continuing the profession; sensitivity to neutral acts	**Uncertainty About Continuing the Profession**	
"It makes me lose interest in the profession. Sometimes I don't want to do it at all." (P28)	Professional demotivation	Loss of desire to continue nursing		
"The reputation of our profession is severely damaged by these negative perceptions." (P8)	Damage to reputation	Devaluation of professional identity	**Deterioration in Perceptions of Professional Prestige**	
"The sacredness of nursing is being eroded, and it affects the nurse-patient relationship." (P9)	Erosion of sacredness of nursing	Loss of professional dignity and relational trust		
"We are not punching bags. We are not roly-poly toys you can take your stress out on." (P2)	Resistance to devaluation	Demand for dignity and protection		
"Education is the foundation of everything. We confuse teaching with education. Social education shapes our identity." (P5)	Confusion between education and teaching	Lack of social education as root cause of violence	**Lack of Education and Societal Unawareness**	**Main Theme 3: Opinions on the Causes of Violence in Healthcare**
"We grow up watching violence on TV. This becomes part of our identity." (P16)	Media normalization of violence	Media-induced desensitization and modeling		
"Society doesn't value nurses. We are seen as assistants rather than professionals." (P14)	Lack of societal respect	Perceived undervaluation of nurses		
"Staff shortages, crowded hospitals, and people lacking patience or understanding." (P12)	Staff shortages; crowded hospitals; impatience	Systemic strain and overcrowding as triggers of violence	**Systemic Problems and Security Deficiencies**	
"When the system fails, people become angry and irritable because they can't get appointments." (P25)	Structural inadequacy → displaced aggression	Systemic dysfunction creating aggression toward healthcare staff		
"We don't know how to communicate. We really need to learn this." (P18)	Lack of communication skills	Communication education as preventive strategy	**Education and Awareness**	**Main Theme 4: Suggestions for Combating Violence**
"Things can change if we spread empathy and tolerance through public education." (P16)	Public empathy and tolerance education	Education and awareness as cultural transformation		
"Deterrent penalties should be enforced. Serious sanctions must be imposed on those who commit acts of violence." (P3)	Need for deterrent penalties	Legal and institutional sanctions as deterrents	**Legal and Physical Safety Measures**	
"There should be stronger laws and better security measures to protect us." (P14)	Demand for stronger laws	Legal reforms and institutional protection		

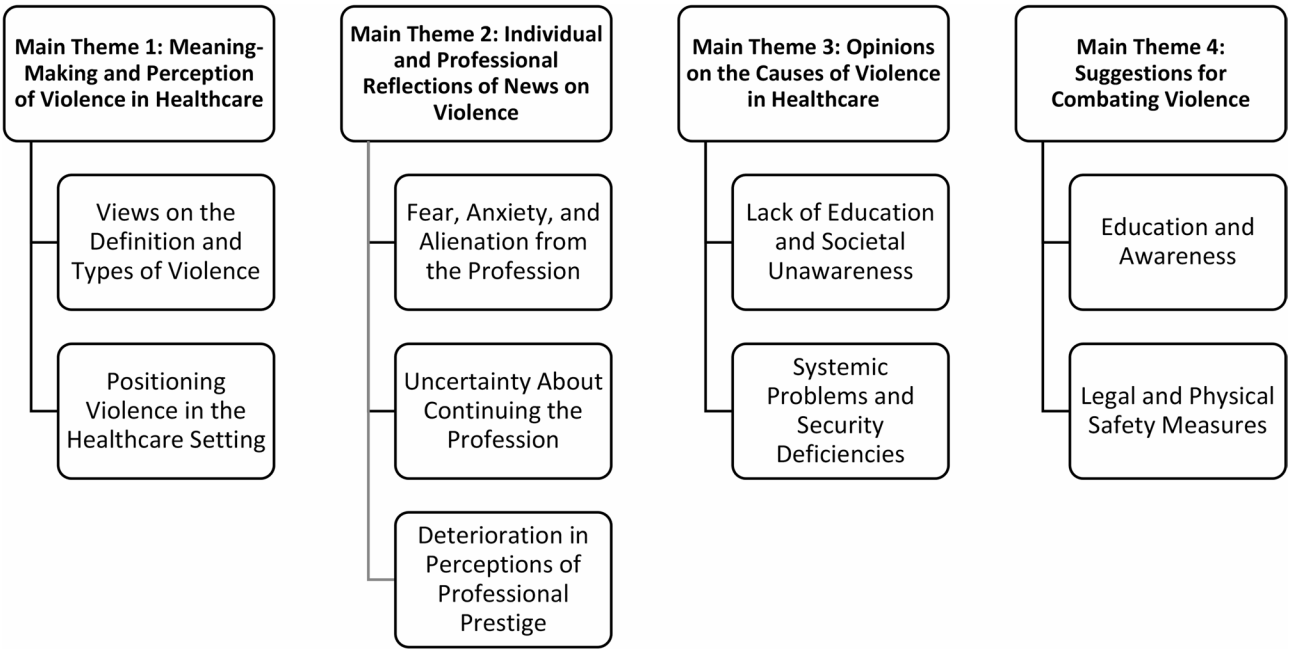


Fig. 2 Main Themes and Sub-Themes

verbal, psychological, and even societal aspects. They distinguished VH from general violence, noting that targeting individuals who provide care makes it more distressing and harder to comprehend. However, what particularly shaped these perceptions was the way media portrayed such incidents. Students frequently referred to news reports that sensationalized violent events in hospitals, describing how these repetitive and emotionally charged stories influenced their understanding of what constitutes violence. Media coverage was seen not only as a reflection of violence but also as a factor that reinforces its visibility and emotional weight within the professional context.

Views on the definition and types of violence

Participants defined violence not only as physical but also verbal, psychological, and economic harm. Some students described violence as a "display of power," "a language for those unable to express themselves," "an uncontrolled outburst of emotion," and "a release of suppressed anger."

> *"Violence is something that can affect a person's entire physical and psychological being, potentially causing trauma—something I would never want to experience." (P8).*
> *"Violence is the choice of those who fail to express themselves and their thoughts in a normal way." (P7).*
> *"It's not only physical—it's also something that can negatively affect an individual psychologically." (P4).*

These views show that students consider violence not just as an individual expression but also as a social, psychological, and systemic consequence.

Positioning violence in the healthcare setting

Most participants perceived VH as distinct from other types of violence, describing it as "experiencing violence in an environment where care and support are provided." This made the incidents of violence they experienced or witnessed feel deeper and more devastating.

> *"To feel anger toward someone who provides care and healing is a sign of weakness. It demotivates me professionally." (P13).*
> *"Violence against healthcare workers shows that their value is not recognized." (P1).*
> *"For me, violence in healthcare is the denial of years of hard work by healthcare professionals." (P8).*

Some participants described such violence as "ingratitude," "disrespect," and "a violation of the sacredness of the profession."

> *"Violence against healthcare workers feels like ingratitude to me." (P11).*
> *"The number of qualified people willing to do this job is decreasing, because violence is becoming normalized." (P7).*

These insights reveal that students perceive violence not just as a professional risk but as a threat to the core values of their future profession.

Main theme 2: individual and professional reflections of news on violence

This theme covers participants' individual and professional reactions to news reports about VH. Students frequently mentioned how these reports impacted them psychologically, affected their attitude toward the profession, and influenced their future plans. Most expressed feelings of fear, anxiety, decreased motivation, and indecisiveness about their professional path. The constant barrage of violence news, therefore, becomes a direct psychological threat that significantly shapes the students' professional identity perception.

Fear, Anxiety, and alienation from the profession

Many participants shared that seeing nurses exposed to violence in the news made them imagine themselves in those situations, causing concern. Even before graduation, these news stories contributed to emotional exhaustion and thoughts of avoidance.

> *"Every day I hear more of these stories, and I become more afraid—my perspective on the profession is changing." (P4).*
> *"It affects me badly—fear, panic… When a healthcare worker is assaulted, it increases others' workload and the risk of further violence." (P2).*
> *"It makes me lose interest in the profession. Sometimes I don't want to do it at all. I ask myself, 'Did I study all these years for nothing?'" (P28).*

Some participants even considered leaving the profession entirely due to the impact of these news reports, indicating that healthcare violence is perceived not as an isolated event but as a crisis shaping future hopes and plans.

Uncertainty about continuing the profession

A significant number of participants reported that VH raised internal conflicts, questioning their ability or desire to pursue the profession—especially for those just beginning their careers.

> *"It makes me question whether I can do this job. I start interpreting every action as potential violence." (P21).*
> *"It's distancing me from the profession." (P15).*
> *"I feel constantly on edge. I love my profession, but maybe I don't want to do it with these people." (P12).*

Although some students remained committed, they still carried the psychological burden of possible future violence.

> *"I feel concerned about my profession, but nothing will stop me. I'll do what I have to, even if it's hard." (P20).*

Deterioration in perceptions of professional prestige

Students frequently noted that news on healthcare violence not only affected them individually but also contributed to the public devaluation of the nursing profession. They expressed concerns that respect for nurses in society had declined and that the profession was being "stripped of its dignity."

> *"The reputation of our profession is severely damaged by these negative perceptions." (P8).*
> *"The sacredness of nursing is being eroded, and it affects the nurse-patient relationship." (P9).*
> *"We are not punching bags. We are not roly-poly toys you can take your stress out on." (P2).*

Many students believed that this loss of prestige harmed society as a whole, not just healthcare workers.

> *"It damages the reputation of the profession and demeans it. Nurses should not be seen as worthless—without them, most things would come to a halt." (P22).*

Overall, this theme reveals that students are deeply affected both personally and professionally. The widespread nature of violence-related news forces them to question their professional identity before they even enter the workforce, threatening their sense of belonging and commitment.

Main theme 3: opinions on the causes of VH

This theme encompasses the explanations offered by SNS regarding the causes of VH. The majority believed that violence stems not from isolated individual behavior but from broader societal, cultural, and systemic roots. These explanations, which often included multiple interwoven factors, demonstrate the students' critical awareness of the issue's complex nature, suggesting that they view the problem as far more structural than single, media-reported events might suggest.

Lack of education and societal unawareness

Many participants cited a lack of public awareness, empathy, and education as underlying causes. These statements reflect both the attackers' and society's general attitudes toward healthcare and its workers.

"I think it's due to uninformed people who can't control their behavior in difficult times." (P20).
"Ignorance, backwardness, lack of conscience, dissatisfaction." (P22).
"Ignorance, impatience, and selfishness." (P19).

Some emphasized that education extends beyond formal schooling to family and community values:

"Education is the foundation of everything. We confuse teaching with education. Social education shapes our identity." (P5).
"The root cause is lack of education. The public should be educated in groups." (P7).

Systemic problems and security deficiencies

A significant portion of participants highlighted healthcare system failures as violence triggers—especially overcrowded facilities, staff shortages, excessive workloads, and insufficient security.

"Staff shortages, crowded hospitals, and people lacking patience or understanding." (P12).
"The workload is too much. People don't want to wait. That creates tension." (P17).
"Letting people enter hospitals unchecked also increases violence." (P6).

They also noted that patients often directed their dissatisfaction with the system toward individual healthcare workers:

"People come to hospitals exhausted and tense. They blame healthcare workers." (P17).
"When the system fails, people become angry and irritable because they can't get appointments." (P25).

Some pointed out that the lack of information and transparency further fueled aggression:

"Patients are uninformed and impatient, and their lack of trust in the system increases violence." (P18).

Overall, students broadly agreed that VH is more than poor anger management—it's a deep-rooted social and structural issue. The combination of educational gaps, lack of empathy, and inadequate security fosters a climate where violence becomes almost inevitable.

Main theme 4: suggestions for combating violence

This theme presents students' thoughts and suggestions for preventing or reducing VH. The multidimensional and action-oriented responses of the students reflect a fundamental need and belief that combating violence cannot be limited to developing individual communication skills; rather, it requires the simultaneous and determined implementation of institutional mechanisms that demand effective coordination and state policies based on deterrence. These recommendations represent a clear, structural demand for safety and support in direct response to the threat perception amplified by the media's coverage of violence.

Education and awareness

Many participants argued that the foundation of prevention lies in education. They highlighted the need to raise awareness among both the public and healthcare workers in areas such as communication, empathy, anger management, and patient-caregiver interaction.

"We don't know how to communicate. We really need to learn this." (P18).
"Things can change if we spread empathy and tolerance through public education." (P16).
"The public should be educated in groups. Healthcare workers should be friendly and explanatory." (P23).

Some emphasized the use of mass media to support education beyond formal settings:

"Efforts to prevent violence should be more visible on social media—people need to gain awareness." (P26).
"Public campaigns and educational stands should be implemented. Empathy training should be expanded." (P24).

Legal and physical safety measures

Another frequently emphasized area of solution was legal and security measures. Participants felt that current penalties were insufficient to deter violence.

"Deterrent penalties should be enforced. Serious sanctions must be imposed on those who commit acts of violence." (P3).
"Individuals who assault healthcare workers should be restricted from entering hospitals." (P12).
"X-ray machines should be installed at entrances, and people prone to violence should be identified and controlled." (P10).

Some suggested that nurses should be trained or equipped to protect themselves:

"Nurses could be taught self-defense techniques." (P6).

"Pepper spray or stun guns should be provided as defense tools." (P27).
"Emergency alert buttons should be developed for nurses exposed to violence." (P14).

These responses reflect a shared belief that healthcare settings must become safer. They also highlight that combating violence requires more than individual efforts—it demands coordinated state policies and institutional support.

Discussion

This qualitative study was conducted to explore in depth how news reports on VH settings affect the PP of SNS who are on the verge of graduation. Through a phenomenological lens, the findings reveal how SNS experience news about violence against healthcare professionals as part of their lived world rather than as distant information. The emotions of fear, anxiety, and uncertainty expressed by the participants are not isolated reactions but lived meanings that shape their professional consciousness. In this sense, the phenomenon of violence is constituted within their lifeworld, influencing how they imagine and inhabit their future professional roles [25, 26, 34]. The first main theme that emerged from the analysis indicates that SNS define violence not merely as a physical act, but also in its verbal, psychological, and even economic dimensions, demonstrating an advanced awareness of its multidimensional nature. This finding aligns with the World Health Organization's definition of violence, which is not limited to physical harm [2]. Participants' descriptions such as "an uncontrolled outburst of emotions" and "the release of suppressed anger" show that they interpret violence as an expression of inner conflict, a perspective consistent with Galtung's (1990) theory of structural and cultural violence [35]. In this framework, violence is not merely an act but also a manifestation of power imbalances and unexpressed tensions between individuals. Students' descriptions of violence as "a way of expressing oneself when unable to communicate" point to deficiencies in communication skills. Previous studies have similarly emphasized that poor communication in healthcare settings may fuel violent behavior [36, 37]. The fact that participants framed violence on both individual and systemic levels also reflects the development of their professional critical thinking skills.

Students perceived VH environments as a destructive and difficult-to-make-sense-of phenomenon within a system that fundamentally aims to provide help and healing, highlighting the contextual paradox of such incidents. Their characterization of violence with terms reveals that violence is perceived not only as physical aggression but also as a violation of moral and professional values. This moral dimension can be interpreted as part of the existential meaning of nursing identity, where caregiving and compassion are central values. Acts of violence are therefore experienced as violations of the ethical lifeworld that gives nursing its moral grounding [38, 39]. This supports previous findings that suggest the caregiving function of nursing is often misunderstood or undervalued by society [40, 41]. Violence against healthcare workers poses a global threat to both the safety and integrity of health systems, and addressing this issue is vital to protect workers and to restore public trust in the healthcare system [42]. In this context, media representations play a significant role in shaping public perception. Sensationalized or negative news content may undermine trust in healthcare and exacerbate hostile attitudes toward healthcare professionals [43, 44]. Repeated exposure to such media content has been shown to contribute to the normalization of hostile behavior and the creation of a socially toxic climate [18, 45, 46].

Under the second main theme, participants' expressions revealed that VH is not limited to the moment of the act itself; rather, through media dissemination, it gains a broader reach. Students stated that exposure to violent incidents through news stories created a sense of emotional and professional uncertainty and perceived threat—especially as individuals who have not yet fully formed their professional identities. These emotional responses can be understood as anticipatory structures that reflect a lived sense of threat and vulnerability [47]. Students do not only report fear as an emotion; they live it as an existential orientation toward their future. This anticipatory anxiety, shaped by media exposure, transforms abstract fear into a bodily and temporal experience—a fear of what might happen, rather than what has already occurred [48, 49]. These findings resonate with the concept of secondary traumatization [50], which suggests that individuals can experience psychological distress through repeated indirect exposure to traumatic events [51].

Participants reported experiencing anxiety, fear, loss of motivation, and professional burnout due to the repetitive nature of such news news. Particularly striking were statements like "Did I study all these years for nothing?", which reflect how news reports damage students' sense of professional identity and belonging. The literature also indicates that fear of encountering violence correlates with burnout, anxiety, and depression among healthcare professionals, especially nurses [52, 53]. From a phenomenological standpoint, this represents an erosion of vocational meaning—an alienation from the moral and emotional core of caregiving that defines the nursing lifeworld [54]. The fact that students experience such concerns even before entering the profession suggests that VH can have long-term negative consequences for the

future workforce [52, 53, 55]. Bandura's Social Learning Theory (1977) further explains how individuals may learn behaviors not only through direct experience but also by observing others [56]. Thus, by witnessing news reports about violent incidents involving healthcare professionals, students begin to associate these experiences with their own potential future and develop fear.

The expressions of SNS demonstrate that their emotional stability in making career decisions has been shaken. These expressions illustrate how fear and uncertainty are embodied and lived, not only cognitively interpreted. The students' descriptions reveal a disruption in their sense of professional becoming—what phenomenology would describe as an altered relation to one's projected future [57]. This sense of professional uncertainty may hinder the development of a strong professional identity. Johnston et al. (2024) emphasized that witnessing violence can negatively affect students psychologically and potentially lead to reduced job satisfaction and even decisions to leave the nursing profession [58]. Statements like "thinking about quitting" or "tendency to leave" are critical indicators threatening career continuity. Violence, in particular, has been shown to increase negative attitudes toward nursing and jeopardize students' decisions to remain in the field [59]. Kurtgöz and Koç (2025) similarly reported that fear of future violence leads some students to abandon their nursing education or consider pursuing other careers [52]. The psychological burden created by such external threats may result in a decrease in the number of future nurses in the workforce. On the other hand, a few students—despite being exposed to negative situations—expressed strong professional passion and resilience, which may be seen as a beacon of hope for the future of the profession.

Students also emphasized that the destructive effects of violence-related news extend beyond the individual level to the professional image of nursing. This suggests that public perception of the nursing profession is becoming increasingly negative. Metaphors such as "punching bag" and "roly-poly toy" (implying someone who is repeatedly knocked down and forced to get back up) show that students feel devalued and objectified. In this context, the concept of "reputation" is critically important for professional identity formation. The perceived loss of prestige also illustrates how intersubjective meanings shape professional identity. Students' sense of being undervalued or misrepresented reveals how violence is experienced not only as a personal threat but as a collective injury to professional dignity. Such meanings resonate with Galtung's (1969) concept of structural violence, where institutional neglect and social misrecognition become part of one's lived reality [60]. Professional reputation affects not only one's sense of attachment to the profession but also the ethical relationship between the profession and society [61]. Negative media portrayals of nursing complicate students' ability to identify with professional role models and lead to alienation from the profession and a weakened sense of belonging. Moreover, this may undermine the foundation of trust-based communication in nurse-patient relationships, replacing it with distrust, anger, and dominance [14].

The third main theme demonstrates that VH is not merely the result of individual anger management issues or momentary tensions, but is instead rooted in sociocultural and structural factors. When describing violence, participants offered a multilayered analysis that included educational deficiencies, lack of public awareness, systemic problems, and security gaps. By focusing on the contexts and conditions that give rise to violence rather than blaming individuals, participants exhibited a potential for developing social solutions.

Students stressed that the roots of violence lie in a lack of education—not only formal schooling but also deficiencies in family and societal consciousness. Their statements reflect an awareness that the phenomenon of violence is socially learned and maintained within shared meanings of the everyday lifeworld. From a phenomenological–sociological perspective [25, 62], this awareness indicates that students are not merely describing events but are interpreting how social norms and inadequate communication patterns shape lived experience. One participant's statement—"We confuse teaching with educating"—clearly reflects this awareness. Similarly, the literature shows that violence against healthcare workers is most prevalent in environments with low societal empathy, poor health literacy, and weak communication skills [36, 63]. Thus, students' reflections can be seen as an emerging form of critical awareness grounded in lived experience rather than ideological critique—a recognition that violence is not only an individual act but a socially conditioned pattern within the shared lifeworld [64, 65]. The recognition that violence cannot be solely attributed to individual pathology but must be considered within a broader social context indicates that students are developing a socio-cultural perspective [66].

Students also noted that structural deficiencies in the healthcare system significantly contribute to the prevalence of violence. Commonly cited issues include staff shortages, excessive workloads, long waiting times, inadequate hospital infrastructure, and weak security systems. These concerns are echoed in the literature, which points out that inhumane working conditions strain patient-provider relationships and increase the likelihood of conflict [37, 67]. Participants highlighted that failures within the system are often attributed to individual workers, redirecting public anger toward them. This perspective resonates with Galtung's concept of structural violence (1969), which refers to invisible, systemic

inequalities that negatively impact individuals' living conditions [60]. When system-induced failures are perceived as personal shortcomings, latent structural violence manifests in visible aggression. Furthermore, participants' concerns about security lapses—such as uncontrolled entry points and lack of information—underscore institutional negligence and inadequate safety policies [7]. From a phenomenological point of view, these accounts also reveal how structural failures are lived by students as part of their embodied professional reality rather than as abstract policy problems. In this sense, their experiences reflect a situated understanding of violence—where institutional neglect, systemic injustice, and social disregard are perceived not only cognitively but felt emotionally and ethically. This aligns with Merleau-Ponty's (1962) idea that individuals inhabit social structures through their lived bodies and that such structures shape one's sense of agency and vulnerability [64]. The multidimensional and critical analysis developed under this theme reflects a strong understanding among students that violence is not just a product of individual pathology but also a phenomenon intertwined with broader societal and structural dynamics. This awareness strengthens not only their professional identities but also their sense of social responsibility.

The fourth main theme reveals that SNS are not merely identifying the problem of VH but are also positioning themselves as active agents of change who propose solutions and assume social responsibility. Their suggestions fall into two main categories: educational and awareness-raising efforts, and legal and physical safety measures. These two dimensions highlight the need for multifaceted interventions targeting both individual and systemic aspects of violence. Participants' statements reflect a need for preventive interventions against violence. In this context, primary prevention strategies come to the forefront. The literature also supports the effectiveness of public awareness campaigns and media collaborations in reducing VH [7, 14]. Suggestions point to a student profile that is aware of digital tools and seeks to harness mass communication for positive impact. Furthermore, their emphasis on educating both the public and healthcare workers in communication, empathy, and anger management shows that they advocate for a bidirectional awareness process. This approach suggests that combating violence is not limited to external enforcement but also requires internal awareness—a promising strategy. Viewed phenomenologically, this bidirectional emphasis indicates that students perceive violence prevention not only as a behavioral change but as an intersubjective process grounded in empathy and mutual recognition. This aligns with Schütz's (1967) notion of intersubjectivity, emphasizing that professional ethics are co-constructed within shared social meanings rather than imposed externally [62].

Students also emphasized that education alone is insufficient and called for effective and deterrent legal regulations as well as security measures. Concrete suggestions reflect a pragmatic and solution-oriented approach. In a national study, İçbay and Şevik (2024) similarly reported that participants viewed security screening devices as essential in preventing violence [68]. These recommendations show that healthcare professionals are increasingly viewed not only as caregivers but also as individuals in need of protection. The institutional-level expectations expressed by students underscore the need for structural—not just personal—preventive strategies. At the same time, the emergence of defensive strategies can be interpreted through a phenomenological lens as an attempt to reclaim bodily autonomy and safety within a perceived hostile environment. This embodied response illustrates how vulnerability transforms into resilience, a process that redefines professional agency within contexts of risk [64]. And students' suggestions also reveal the emergence of self-protective reflexes in response to the ongoing threat of violence. While these responses show resilience against feelings of helplessness, they also reflect the transformation of healthcare settings into threatening environments that are incompatible with normal service delivery. Such recommendations highlight the weakness of current safety measures and suggest that the system is inadequate in protecting its workforce [69]. Overall, these findings underline the need to view safety not merely as an administrative issue but as an ethical and existential one—where the protection of healthcare workers becomes integral to sustaining the moral integrity of the healthcare system itself.

Limitations

This study has some limitations. Due to the qualitative design the generalizability of the findings is limited. Moreover, this research focused solely on students' perceptions; the views of clinical nurses and nurse educators were not included. Incorporating the perspectives of clinical nurses and educators and comparing these with student views could facilitate a clearer understanding of the profession's development and the dimensions of its societal perception. On the other hand, the present study did not aim to identify the specific perpetrators or the detailed forms of violence reflected in the media. Instead, its primary purpose was to explore how repeated exposure to news about violence against healthcare professionals influences SNS' perceptions, emotions, and professional outlook. Within the phenomenological framework, the focus was placed on participants' meaning-making processes rather than on the factual reconstruction of violent events. Accordingly, the students'

narratives reflected their interpretive and emotional responses to mediated representations of violence rather than firsthand descriptions of incidents. Future research could extend this work by examining how the perceived sources, settings, or actors of violence shape students' professional identity formation and sense of safety within healthcare contexts. Finally, this study is that possible gender-based differences in the perception and meaning of violence were not explored in depth. Although both male and female students participated, the phenomenological analysis did not specifically address potential gendered patterns in interpreting or reacting to violence. Future qualitative research could examine how gender-related socialization and professional identity formation influence nursing students' lived experiences of violence.

Conclusion

The findings of this study indicate that VH is not only a physical threat but is also symbolically reconstructed through media representations, significantly shaping senior SNS' PP. Participants perceive such news not merely as information, but as early warnings about their future in the profession. Media coverage was found to provoke fear, anxiety, and a sense of uncertainty, while also influencing students' perceptions of professional identity, societal respect, and career commitment.

In the first two themes, students appeared to internalize media-exposed violence, which weakened their professional motivation. In the latter themes, they moved beyond passive concern, articulating solutions and recognizing structural flaws—suggesting that media content initiates not only distress but also active professional reflection. However, this process is emotionally taxing and undermines professional self-efficacy, especially for those yet to enter the field.

These results highlight the urgent need for nursing education to go beyond technical instruction and integrate media literacy, emotional resilience, and coping strategies. Moreover, comprehensive individual and systemic measures are essential to prevent healthcare violence and protect the next generation of nurses.

Relevance for clinical practice

This study highlights the profound impact of media reports of VH on SNS' professional identity and career motivation. Recognizing the secondary traumatic stress, fear, and professional insecurity induced by such news is essential for educators, clinical mentors, and policymakers. Integrating structured support systems, reflective discussions, and resilience-building interventions into nursing education can help mitigate negative effects and strengthen professional commitment. Furthermore, raising institutional and societal awareness of the consequences of violence-related media exposure on future healthcare professionals may contribute to safer clinical environments and more sustainable workforce retention.

Abbreviations

PP	Professional perceptions
SNS	Senior nursing students
PhD	Doctor of philosophy
COREQ	Consolidated criteria for reporting qualitative research
VH	Violence in healthcare

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Authors' contributions

STS: Conceptualization, Project administration; STS & SM: Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Resources, Supervision, Validation, Visualization, Writing – original draft, Writing – review and editing. SKÇ: Formal analysis, Funding acquisition, Investigation, Resources, Supervision, Validation, Visualization, Writing – original draft, Writing – review and editing.

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Data availability

Data sets created and/or analyzed during the current study are not publicly available for the aim of protecting informed consent and maintaining confidentiality, but may be obtained from the corresponding author upon reasonable request. All information obtained as a result of the analyses in the study is presented in this paper.

Declarations

Ethics approval and consent to participate

Ethical approval for the study was obtained from the Ethics Committee of Health Sciences at Muğla Sıtkı Koçman University (Date: 02.12.2024; Protocol/Decision No: 240154/147), along with institutional permission from the faculty where the students were enrolled. Participants were provided with detailed information about the aim and procedures of the study. Participants were informed in writing that the study was conducted entirely on a voluntary basis, that they could withdraw from the study at any stage at their own request, that they would not receive any financial compensation for their participation in this study, and that this situation would not cause any changes in their educational life. Written informed consent was obtained. All procedures at every stage of the study were conducted in accordance with the current Helsinki Declaration.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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